Moral Distress: A Catalyst in Building Moral Resilience

Helping nurses move from victimization to empowerment.

ABSTRACT
Moral distress is a pervasive problem in the nursing profession. An inability to act in alignment with one's moral values is detrimental not only to the nurse's well-being but also to patient care and clinical practice as a whole. Moral distress has typically been seen as characterized by powerlessness and victimization; we offer an alternate view. Ethically complex situations and experiences of moral distress can become opportunities for growth, empowerment, and increased moral resilience. This article outlines the concept and prevalence of moral distress, describes its impact and precipitating factors, and discusses promising practices and interventions.

Keywords: ethics, moral agency, moral distress, moral resilience, nurse empowerment

Fifty-five-year-old Roberta Dawkins was rushed to the ED with stomach pains and was quickly diagnosed with a peptic ulcer. (This case is a composite based on our experience.) She was admitted for monitoring to a 35-bed medical–surgical nursing unit, which currently held 33 patients and was staffed with four RNs, one nursing assistant, and a unit clerk. Martha Keller, a nurse with three years of medical–surgical experience, was assigned to care for Ms. Dawkins along with seven other patients: three were at postoperative day 1 status, three had complex medical problems, and one was awaiting discharge. During Ms. Keller's shift, Ms. Dawkins pressed her call button frequently, stating she was in pain and asking, "What's wrong with me? I've never felt like this before." The nurse could see that her patient was afraid and that her pain wasn't being relieved with the medications ordered by the admitting physician. Ms. Dawkins was becoming diaphoretic, her blood pressure was rising, and her oxygen saturation level was dropping. Ms. Keller's intuition told her something was wrong, but she couldn't ascertain the source of the problem. She made several calls to the admitting physician but was unable to convince him that Ms. Dawkins needed further evaluation. She informed the charge nurse and the nursing supervisor of the situation and documented her assessment in the patient's electronic medical record.

With so many patients to attend to, Ms. Keller was torn as to how to fulfill her professional responsibilities to each of them. She felt that she was "spread so thin" that she couldn't provide safe, high-quality care to any of her patients, and she also felt that she was failing as Ms. Dawkins's patient advocate. This situation was common in her hospital; many of her colleagues were exhausted and considering leaving either their current jobs or the profession. The hospital's employee engagement scores were at an all-time low, after consistently trending downward for the last

three years. At the end of her shift, Ms. Keller told another nurse, "How can I see myself as a 'good nurse' under these circumstances? I'm supposed to help my patients, not hurt them!"

Every day, under a wide variety of circumstances, nurses in all roles and specialties are confronted with complex ethical questions that challenge their integrity. They struggle to balance competing obligations to their patients and families, their colleagues on the health care team, the organization where they practice, the surrounding community, society—and themselves. Often working within health care systems that are driven by cost concerns, external metrics, and organizational expectations that undermine person-centered care, many nurses despair at their inability to maintain their personal and professional integrity. When they're unable to translate their moral beliefs into ethically grounded actions, moral distress ensues.

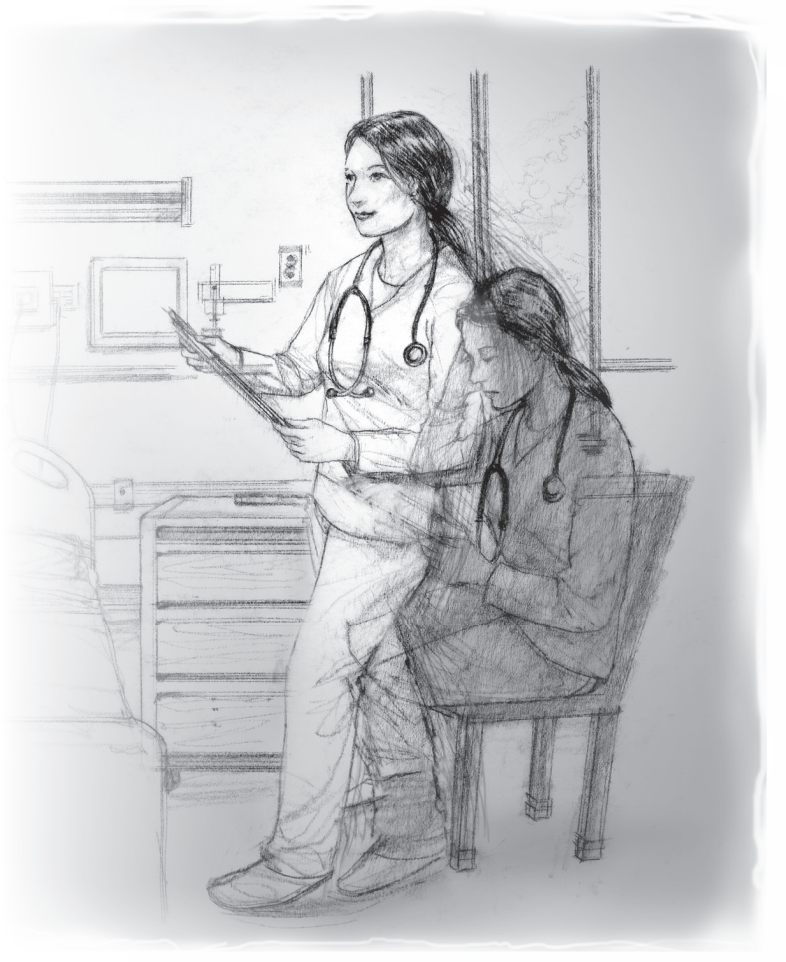


Illustration by Janet Hamlin.

WHAT IS MORAL DISTRESS?

The term *moral distress* was coined by ethicist Andrew Jameton to describe the negative feelings that arise when one decides on a morally correct action in a given situation, but is constrained from taking that action.[1] Jameton identified two distinct components of moral distress: *initial distress*, experienced in real time as the situation unfolds; and *reactive distress*, which arises after the situation has passed and involves lingering feelings about one's failure to act on the initial distress. This reactive distress, also known as *moral residue*, has been associated with a loss of personal moral identity and with long-term adverse consequences.[2]

Moral distress differs from other types of stress and from related phenomena such as burnout, compassion fatigue, and psychological distress.[3] Specifically, moral distress occurs when one recognizes one's moral responsibility in a situation; evaluates the various courses of action; and identifies, in accordance with one's beliefs, the morally correct decision—but is then prevented from following through.[4] Moral distress is distinct in that it involves the violation of one's core moral values, has the capacity to erode personal integrity, and may undermine moral identity.[3] At its heart, moral distress is a type of suffering that arises in response to "challenges to, threats to, or violations of professional and individual integrity."[5]

Prevalence. There is abundant research indicating that moral distress is a widespread problem in health care, occurring not only among nurses but also among physicians, pharmacists, therapists, social workers, and others.[6-8] And while the reported intensity of such distress varies, at least one study has found that nurses and other providers experience moderate-to-high levels of moral distress on a regular basis.[9]

In critical care settings, moral distress may stem from decisions regarding life-sustaining treatments,[10] often when the use of advanced technologies and overly aggressive care are perceived to be medically "futile."[11-13] In pediatric and neonatal intensive care, moral distress arises when there are questions as to whether the treatments being provided serve the best interests of the child.[14] In oncology settings, nurses grapple with ethical questions regarding informed consent, truth telling, and the patient's overall quality of life.[15] Similarly, nurses providing end-of-life care can experience moral distress when trying to access resources to relieve suffering; when providing aggressive care that has no apparent benefit; and when family members or other surrogate decision makers, whose understanding and values may differ from those of the patient and the health care team, are involved.[11, 16, 17] And in psychiatric settings, moral distress can stem from actions that restrict patients'

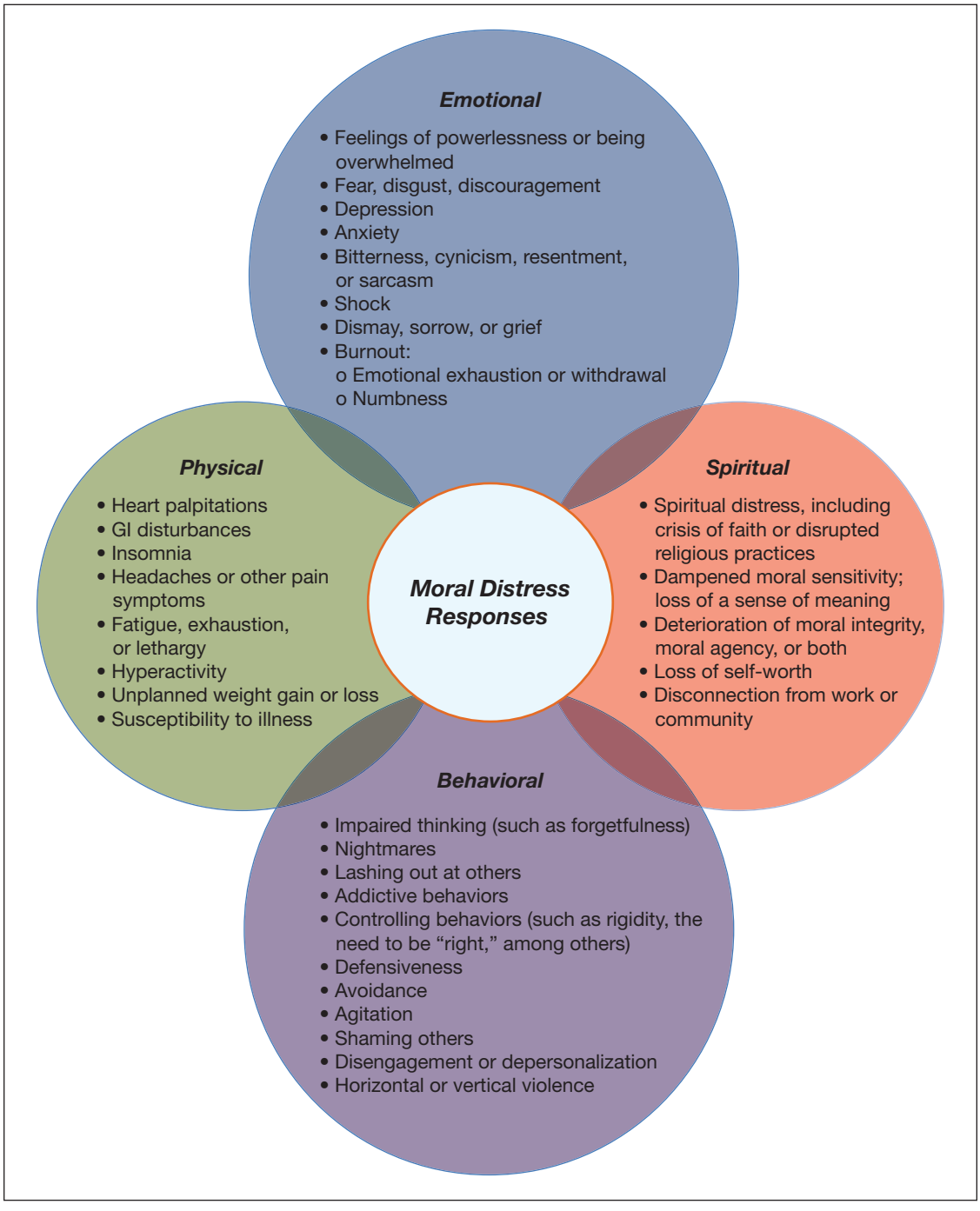
freedom, such as involuntary hospitalization or forced medication administration.[18]

In each of these settings, then, nurses face situations that threaten their core values and integrity and put them at risk for not adhering to the American Nurses Association (ANA) *Code of Ethics for Nurses with Interpretive Statements*.[19]

THE IMPACT OF MORAL DISTRESS

For the individual, moral distress can result in debilitating frustration, anger, and guilt.[6, 20] Unacknowledged or unjustifiable moral compromises can lead to the deterioration of one's moral integrity and possibly of one's *moral agency*, which has been defined as "having the capacity to make moral judgments and to

Figure 1. Selected Individual-Level Responses to Moral Distress[6, 9, 12, 20-24]



act upon them" despite personal or institutional constraints.[21] Long-term psychological consequences can include withdrawal, emotional exhaustion, depersonalization toward patients, and burnout.[6, 9] Repeated or prolonged experiences of moral distress and moral residue can interact, resulting in what Epstein and Hamric call the *crescendo effect*, in which "new situations evoke stronger reactions as a clinician is reminded of earlier distressing situations."[2] See Figure 1[6, 9, 12, 20-24] for a depiction of the wide range of responses to moral distress.

Because moral distress affects such a wide range of health care professionals, it stands to reason that it may be a factor in teamwork erosion, decreased quality of patient care, and poor patient outcomes. Consider this example: a patient is no longer responding to aggressive treatment, the attending physician refuses to offer the patient the option to stop such treatment, and the nurse believes the team has a moral responsibility to offer the patient that option. If the nurse feels unable to act on her or his moral values, moral distress will ensue. Moreover, the nurse may begin to doubt the physician's decisions, and the physician may start to question the nurse's competence. Team cohesion and communication erode. If the patient and her or his family members sense such dissension, they may question the physician's decisions or the nurse's credibility, or engage in "splitting" behaviors that pit some clinicians against others.

In such cases, for nurses, moral distress can lead to avoidance behaviors such as decreased interactions with patients and families, less personalized care, and emotional withdrawal from patients.[12] Moral distress has been associated with perceived failure to meet patients' and families' needs[25] and perceived decreases in the quality of patient care.[12, 26, 27] It also increases nurses' risk of burnout, decreased job satisfaction, and even departure from the nursing profession.[7, 28]

PRECIPITATING FACTORS

Individual factors. At the individual level, moral distress may be triggered by decreased self-confidence or increased fear,[21, 29] a diminished sense of moral agency,[4, 21] an inability to modulate one's responses to suffering,[30] diminished moral sensitivity,[30, 31] and conflicts with one's religious or spiritual beliefs.[32]

A lack of self-confidence may cause nurses to hesitate in voicing their concerns or to withdraw from conversations altogether.[21] In some settings, nurses may fear retaliation, such as job termination, if they make their moral stance known.[29] The sense of being "voiceless" during morally complex conversations can lead to feelings of powerlessness and can hamper the ability to bring one's perspective to the discussion.[4] These precipitating factors can erode moral agency, which requires self-awareness, the ability to apply critical thinking in ambiguous or uncertain situations, and the ability to act with moral integrity despite resistance, power differentials, or fear. A diminished sense of moral agency can result in moral distress.[4, 21]

Clinicians who aren't able to maintain mental and emotional stability in the face of suffering are also at risk for moral distress. The inability to regulate one's nervous system in such situations activates the stress response commonly known as "fight, flight, or freeze."[30] In such cases, the clinician's response may shift (often unconsciously) toward relieving her or his own distress rather than serving the patient's needs. Feelings of helplessness may override the connection to the patient.[33] The clinician's subsequent behavior may worsen the underlying ethical conflict, further impede communication and collaboration, and intensify oppositional stances in a given situation.[34]

Moral distress is also associated with *moral sensitivity*, which has been described as an awareness of both a patient's vulnerability and the moral implications of making a decision on her or his behalf.[31] Being morally sensitive requires exercising empathy and being able to understand the perspective of others, as well as upholding the nurse's professional obligation to maintain patient integrity. It also involves attunement to the ethical context of clinical care; to competing obligations to patients, colleagues, and self; and to one's duty to preserve one's own integrity.[35]

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The relationship between moral sensitivity and moral distress is unclear. It's possible that clinicians with diminished moral sensitivity experience higher levels of moral distress,[36] either because they fail to recognize and explore the ethical aspects of a case, or because they retreat to self-defensive actions and a "cover your tracks" mindset.[31] It's also possible that having heightened moral sensitivity could lead to higher levels of moral distress, such as when a clinician is aware of the moral implications of patient care decisions but finds they aren't being addressed. Either way, cultivating moral sensitivity should contribute to a greater awareness of the ethical dimensions of troubling cases. And when team members are able to share their feelings with colleagues, this helps to create a work environment that's more likely to support moral agency.[31]

Team, environmental, and systems-based factors. One common team factor that can trigger moral distress is intrateam conflict.[25] Such conflict can be attributed to various causes, including differences in world

views and role perceptions,[23] personal moral codes,[32] levels of power and authority,[4] and skills in communication and collaboration.[15] For nurses, conflict may arise in relation to the provision of poor quality or "futile" care, unsuccessful patient advocacy, and unrealistic hope to patients and their families.[27]

In workplace environments that don't support the integrity of team members, a "blame" atmosphere may prevail in response to human errors; levels of team and individual work engagement are reduced, and the advancement of safety is impaired.[37,38] When levels of moral distress are high, work engagement is often low.[37] This has far-reaching implications, as organizations with engaged staff have been found to "deliver better patient experience, fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation, and less absenteeism and stress."[38]

Although nurses' primary obligation is to their patients, they also have an obligation to address their own suffering.

An institution's overarching moral climate—the organizational and sociopolitical context of the practice environment—also affects individual perceptions of moral agency. A culture characterized by intrateam conflict, excessive workloads, and contentious power dynamics can prevent individuals from acting as moral agents.[4,39] It's worth noting that such factors make it harder for nurses to adhere to Provision 6 of the ANA's *Code of Ethics*, which states that "the nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care."[19]

Other system-based sources of moral distress include restrictive institutional policies, power structures, and regulatory practices, as well as limited human and material resources.[40] Although sociopolitical factors, such as discriminatory practices and social and health inequities, and institutional policies and politics haven't been well studied with regard to moral distress, there is some evidence that these factors also precipitate feelings of helplessness and impede moral agency.[7]

AN ALTERNATIVE VIEW

Despite its many negative effects, moral distress can precipitate positive, growth-producing experiences. Establishing an alternative "story" about a morally distressing situation can help clinicians to shift their perspective from that of a victim to one of empowered agency.[41] For example, in recently published narratives, Pniewski[42] and Hallett[43] described experiences characterized by high moral stakes and challenges. Pniewski, a hospice nurse, was a caregiver for a dying patient whose views were racist and misogynist; Hallett, a psychologist, found herself involved in a death row case. Though each struggled with complex ethical issues, each retained her sense of integrity and exercised effective moral agency. This outcome stands in stark contrast to the usual depiction of moral distress as inherently negative and disempowering. For Pniewski and Hallett, moral distress served as a positive catalyst for growth. Their experiences suggest that a way forward in addressing moral distress involves developing a more robust understanding of how we can transform such distress into *moral resilience*.

Moral resilience has been defined as "the capacity of an individual to sustain or restore [her or his] integrity in response to moral complexity, confusion, distress, or setbacks."[44] As one of us (CHR) has proposed elsewhere, moral resilience encompasses several dimensions, including the following (which are direct quotes)[44]:

- knowing who you are and what you stand for in life
- a commitment to ongoing exploration, refinement, or in some cases revision of one's values, ideals, and point of view (moral conscientiousness)
- cultivating self-regulatory capacities
- being responsive and flexible in complex ethical situations
- [the] capability to discern the boundaries of integrity including the exercise of conscientious objections
- the ability to be resolute and courageous in one's moral action despite resistance or obstacles
- being able to discern when one has exerted sufficient effort to fulfill one's ethical obligations and to be realistic about one's limitations and the constraints and pressures of the situation
- seeking meaning in the midst of situations that threaten integrity or cause dissonance with one's moral sensitivity and reasoning

The concept of moral resilience continues to evolve; more investigation is needed to further understanding of its contours and impact.

PROMISING PRACTICES AND INTERVENTIONS

Various strategies can offer starting points for those seeking to transform their moral distress into moral agency and resilience.

Individual approaches. As noted above, effectively addressing moral distress requires moving

from victimhood toward a more empowered stance, one that understands moral distress to be an indicator of moral conscientiousness rather than of moral failure. Cognitive, emotional, and behavioral strategies can all be useful in helping a clinician to make this transformation.

Ethics education is a vital component in building an individual's coping capacities[23] and decreasing the intensity and frequency of moral distress.[45] There is evidence that nurses who have had ethics education feel more confident in their ability to recognize and address morally distressing situations, and are more likely to access ethics resources (such as institutional ethics committees or consultation services) for support when making ethically difficult decisions.[46] See *Selected Evidence-Based Moral Distress Interventions*[22, 47-51] for a list of interventions aimed at implementing ethics education into clinicians' training. Some of these focus specifically on moral distress, while others seek to address one or more of its root causes or precipitating factors.

One study among South Korean nursing students found that there was a correlation between the amount of time devoted to ethics content in the curricula and the level of moral reasoning that students attained.[52] The findings suggested that "principled thinking" could be enhanced by cultivating both moral sensitivity and moral reasoning. Other researchers have found the standard educational approach to be limited; they suggest a more robust form of ethics learning. For example, noting that narratives offer "a way of raising questions and searching for answers," Austin and colleagues have proposed that clinicians share their stories of morally distressing cases in order to reveal the ethical complexities of patient care decisions.[53] And two programs for practicing nurses have incorporated elements such as personal and unit action plans, simulation learning, peer support, and case analyses.[47, 50]

Arguably the most successful approaches to alleviating moral distress have focused on the subjective aspects of decision making, engaging rather than discounting the emotions involved.[48, 50, 54, 55] Such approaches encourage the exploration of the "microethical" aspects of clinical work—the "view from the inside," which is unique to a given situation and point in time and is "created in the relational space between the participants."[56] Creating morally habitable work environments means encouraging nurses (and other clinicians) to voice their emotional concerns,[54] and this is essential to the provision of nursing care that more closely meets the core values of the profession. New educational interventions should strive to create such environments, using a robust variety of approaches. Effective educational models such as the Clinical Ethics Residency for Nurses (CERN) may also be brought to bear.[50] CERN programs are based on the premises that nursing education should aim to improve the quality of care for both patients and families; that conflicting values and opinions can result in ethical problems; and that, if unresolved, these problems can result in a reduced quality of care, moral distress, and decreased nurse retention.[50]

Other interventions that may ease or diminish the detrimental effects of moral distress include practices that increase mindfulness and self-reflection and tactics that foster resiliency and overall well-being.[34] The literature of neuroscience and social psychology has described how having a more positive, empathic mindset can facilitate engagement, problem solving, and creative thinking[30]; and it's been posited that applying this knowledge to clinical ethics may lead to greater self-awareness, better attunement to patient and family concerns, and stronger communication and teamwork.[34] Means for developing a more positive affect include self-reflective writing[57, 58] and using narrative methods to "rehabilitate" stories associated with moral distress.[41]

Selected Evidence-Based Moral Distress Interventions

Individual Level

The 4A's to Rise Above Moral Distress[22]
An interactive question-and-answer framework, developed by the American Association of Critical-Care Nurses, that can guide nurses in recognizing and addressing moral distress.

Clinical Ethics Residency for Nurses[50]
A 10-month, 96-hour program aimed at decreasing nurses' moral distress and increasing their ethical competency, moral agency, and confidence in ethical decision making.

Moral distress workshop[47]
A 4-week workshop aimed at helping ICU nurses identify moral distress responses and various coping mechanisms.

The Moral Distress Education Project
www.cecentral.com/node/1106
A free, two-hour self-guided program created to help nurses understand the causes of moral distress and how it can be addressed.

Moral distress intervention[49]
A one-day, didactic and interactive workshop developed to help respiratory therapists better address ethical and end-of-life issues.

Team Level

Facilitated Ethics Conversations[51]
A unit-based program designed to help bedside nurses and other providers develop greater confidence and improve skills in dealing with complex ethical situations.

Pediatric Quality of Life Program[48]
A program providing didactic learning and expert consultations to pediatric health care teams in order to help members identify and cope with complex ethical situations involving children.

Collective, interdisciplinary approaches. Prevalent moral distress in combination with a lack of intrateam communication can lead to diminished quality of care, reduced job satisfaction, and poor patient outcomes.[8] Experts have recommended interventions such as ethics rounds, discussion groups, and debriefing that could improve interdisciplinary communication.[59] Such interventions might help team members to develop more collaborative approaches to recurring moral quandaries and to consider all represented viewpoints when making decisions. Better interdisciplinary communication may help nurses to feel that their opinions matter, and thus more empowered; and a sense of empowerment in turn can lead to decreased levels of moral distress and higher quality patient care.[60] And in morally distressing situations, nurses often turn to colleagues who understood the challenges they faced, underscoring the vital role of supportive peer communication.[18]

Interventions that incorporate role-play or simulation learning might also help to dissolve tension and expand interdisciplinary understanding.

Institutional measures. Direct attempts to improve an institution's overall moral climate include implementing ethics committees, ethics rounds, and ethics-based forums,[20, 23, 59] as well as strategies to improve the transparency of communication between administrators and practitioners.[39] Although the Joint Commission now mandates institutional ethics committees for hospital accreditation,[63] nursing presence on these committees varies from institution to institution. Bedside nurses, advanced practice nurses, nurse managers, and directors of nursing all have unique perspectives, and are needed on ethics committees to advocate policy development or reform aimed at addressing moral distress. Nurses can play a central role in improving access to ethics consultation services, the development of end-of-life policies and practices, and the generation of institutional mechanisms for facilitating "conscientious objections."[64]

Various strategies can offer starting points for those seeking to transform their moral distress into moral agency and resilience.

Specific recommendations for collaborative or team-based interventions largely come from studies using participatory research or survey methods. In one survey, nurses reported feeling frustrated by differing ethical perspectives that were held by nurses and physicians.[61] The researchers recommended improving nurse–physician communication through discussions that explore their differing perspectives and role expectations. Similarly, findings from a qualitative study revealed that, although critical care nurses and physicians shared a commitment to relieve patients' suffering, their differing perspectives about care arose largely from their different roles: the physicians bore the burden of "having to make" treatment decisions, while the nurses bore the burden of "living with" and carrying out those decisions.[62] The researchers stated that poor communication was a clear cause of moral distress, and recommended interdisciplinary discussion to help each group better understand the other's burden.

Suggested interventions for teams include structured interdisciplinary debriefing sessions, interdisciplinary discussions to facilitate explicit discourse about morally distressing cases, and colleague-to-colleague dialogues to foster mutual understanding.[14, 45, 48, 59, 61] Beginning in 2007, one large health care system implemented a unit-based Facilitated Ethics Conversations program, which has provided evidence of the effectiveness of such interventions.[51]

Some organizations have created separate nursing ethics committees to help support nurses in ethically complex situations and promote their engagement in interdisciplinary and organizational dialogue. Such committees play a role in implementing interventions and institutional changes, and can provide nurses with a sense of empowerment and agency. In the future, nurse-led quality improvement projects might also design processes that routinely assess for cases likely to cause moral distress, identify contributing factors, and develop targeted interventions.

Several factors make practice environments increasingly likely to engender moral distress; these include nurse staffing shortages, increased patient acuity, lack of intra- and interdisciplinary collaboration, and an unsafe or inadequate moral climate.[37, 61, 65] Mitigating these environmental factors will require significant political as well as organizational change.

In short, providing supportive networks, fostering workplace climates based on trust and openness, and removing barriers to interdisciplinary communication are crucial steps in empowering nurses to handle moral distress with resilience. Many experts have emphasized the importance of addressing institutional power dynamics to empower clinicians as moral agents.[39, 54, 66] Efforts to reduce moral distress might be best served by developing systems that address all

What Nurses Can Do to Address Moral Distress

- **Recognize the symptoms of moral distress.** Practice awareness of your somatic, emotional, and cognitive responses to ethically complex situations. Notice any patterns that precipitate your symptoms. When symptoms arise, pause and ask yourself about their meaning.
- **Reflect on and be curious about the ethical aspects of clinical situations.** Clarify and name the ethical dilemma. Explore your assumptions, biases, and the influence of past experiences. Identify the source of your distress, learn about contributing factors, and be open to new viewpoints and solutions. Use team meetings and patient care conferences as opportunities for interdisciplinary discussion.
- **Reconnect to your original purpose and intention for being a nurse.** Notice when feelings of hopelessness, despair, or apathy arise. Staying connected to your purpose will help motivate principled actions. Discover ways to help yourself remember your intentions as a nurse; create rituals as reminders.
- **Commit to your personal well-being.** When you're depleted and exhausted, your capacities for responding (rather than reacting) to moral distress are diminished. Commit daily to support your own well-being as described in Provision 5 of the American Nurses Association (ANA) *Code of Ethics for Nurses with Interpretive Statements*.[19]
- **Support and restore your moral integrity.** Become familiar with the experiences of acting either in accordance with or counter to your core values. When your moral integrity is threatened, engage those core values and your moral courage to protect what you stand for personally and professionally.
- **Learn to listen to your intuition and somatic responses,** which can offer valuable guidance. As with other sources of information, check their validity by asking: "What might these signals mean in this situation?" "How might they inform my actions?" "Who do I want to be in this moment?"
- **Develop ethical competence.** Cultivate your moral sensitivity and moral reasoning skills, and practice refining your conscience. Apply tools for ethical discernment and analysis to cases that arise in everyday practice. Create regular forums (such as ethics rounds) with skilled facilitators to foster discussion of challenging cases.
- **Speak up about your ethical concerns** in a proactive, productive way. Expand your repertoire of inquiry and communication skills. Learn how to convey your concerns such that they can be heard and understood. Apply methods such as the Situation, Background, Assessment, Recommendation Toolkit (www.ihi.org/resources/pages/tools/sbartoolkit.aspx) to difficult situations.
- **Take principled actions.** These cover a wide range, and might include committing to a personal resilience plan, engaging in programs to improve the skills needed to cope with ethically complex situations, creating new methods for recognizing and addressing the precipitating factors of moral distress, and developing organizational policies and practices that support moral agency.
- **Contribute to a culture of ethical practice.** Become an agent in creating a workplace environment that minimizes moral distress. In keeping with Provision 6 of the ANA's *Code of Ethics*,[19] recognize and honor your responsibility to work collectively toward a culture in which ethical practice is expected, valued, and supported.

levels (individual, unit or team, and organizational) of the practice environment, and involving all stakeholders in establishing or changing the ethical rules by which institutional decisions are made.[65]

WHAT CAN NURSES DO?

As the opening case study illustrates, many nurses aren't sufficiently able to recognize, navigate, and take principled action in morally distressing situations. Nurses in all roles and specialties must have the necessary knowledge, skills, and abilities to do so. Ms. Keller felt the effects of moral distress as she tried to manage her heavy patient load; but she was unable to identify the ethical issues and felt ill-equipped to navigate the ethical quandaries of the situation. But moral dilemmas and conflicts are an inevitable part of nursing practice; it's unrealistic to believe they can be avoided. Indeed, morally distressing situations offer opportunities for nurses to learn and to maintain or restore their integrity and well-being.

Let's imagine how the opening case might have unfolded differently. When Ms. Keller becomes aware of her moral distress, her next steps are to consider and appreciate the precipitating factors, name the ethical conflict, and examine why addressing it matters to her. She reconnects with her core values and intentions as a nurse, which serve to ground her in determining what the situation calls for and provide motivation for taking action. Throughout this process, Ms. Keller also takes steps to restore or renew her own well-being and, if necessary, her moral integrity. Although nurses' primary obligation is to their

patients, they also have an obligation to address their own suffering. As the ANA's *Code of Ethics* states, "The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness and integrity, maintain competence, and continue personal and professional growth."[19] Ultimately, Ms. Keller determines which actions are best aligned with the profession's values, as delineated in the ANA's *Code of Ethics*, and takes those actions. This requires steadfast effort, courage, and ethical competence. Ms. Keller further recognizes that she has an obligation to foster a culture of ethical practice in her workplace. Besides acting as a patient advocate for Ms. Dawkins, she bring her concerns about the case to the nursing leadership and contributes to team efforts to address the root causes of her moral distress.

It's essential that nurses stop seeing themselves as powerless victims of moral distress. Instead, nurses can acknowledge that their moral distress arises from having a strong moral compass—their deeply held values and the commitment to relieve the suffering and promote the well-being of their patients. Nurses can step forward in a new way—one that reflects their moral agency and courage. See *What Nurses Can Do to Address Moral Distress*[19] for some simple ways to begin to shift one's relationship to moral distress and build moral resilience. The American Association of Critical-Care Nurses' 2006 public policy statement on moral distress (www.aacn.org/wd/practice/docs/moral_distress.pdf) further includes suggestions for how to engage one's institution and its leaders in assessing and improving the handling of morally distressing situations. Together, we can develop more robust notions of moral distress and devise strategies that allow us to meet morally distressing situations more effectively for all concerned. ▼

For 29 additional continuing nursing education activities related to ethical issues, go to www.nursingcenter.com/ce.

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REFERENCES

1. Jameton A. *Nursing practice, the ethical issues*. Englewood Cliffs, NJ: Prentice-Hall; 1984. Prentice-Hall series in the philosophy of medicine.
2. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. *J Clin Ethics* 2009;20(4):330-42.
3. Weinzimmer S, et al. Critical care nurses' moral distress in end-of-life decision making. *J Nurs Educ Pract* 2014; 4(6):6-12.
4. Epstein EG, Delgado S. Understanding and addressing moral distress. *Online J Issues Nurs* 2010;15(3).
5. Thomas TA, McCullough LB. A philosophical taxonomy of ethically significant moral distress. *J Med Philos* 2015;40(1): 102-20.
6. Oh Y, Gastmans C. Moral distress experienced by nurses: a quantitative literature review. *Nurs Ethics* 2015;22(1):15-31.
7. Pauly BM, et al. Framing the issues: moral distress in health care. *HEC Forum* 2012;24(1):1-11.
8. Whitehead PB, et al. Moral distress among healthcare professionals: report of an institution-wide survey. *J Nurs Scholarsh* 2015;47(2):117-25.
9. Allen R, et al. Moral distress among healthcare professionals at a health system. *JONAS Healthc Law Ethics Regul* 2013; 15(3):111-8.
10. St Ledger U, et al. Moral distress in end-of-life care in the intensive care unit. *J Adv Nurs* 2013;69(8):1869-80.
11. Cavinder C. The relationship between providing neonatal palliative care and nurses' moral distress: an integrative review. *Adv Neonatal Care* 2014;14(5):322-8.
12. Gutierrez KM. Critical care nurses' perceptions of and responses to moral distress. *Dimens Crit Care Nurs* 2005;24(5): 229-41.
13. Özden D, et al. Intensive care nurses' perception of futility: job satisfaction and burnout dimensions. *Nurs Ethics* 2013; 20(4):436-47.
14. Sauerland J, et al. Assessing and addressing moral distress and ethical climate. Part II: neonatal and pediatric perspectives. *Dimens Crit Care Nurs* 2015;34(1):33-46.
15. Pavlish C, et al. The nature of ethical conflicts and the meaning of moral community in oncology practice. *Oncol Nurs Forum* 2014;41(2):130-40.
16. Klein SM. Moral distress in pediatric palliative care: a case study. *J Pain Symptom Manage* 2009;38(1):157-60.
17. Piers RD, et al. End-of-life care of the geriatric patient and nurses' moral distress. *J Am Med Dir Assoc* 2012;13(1):80. e7-80.e13.
18. Deady R, McCarthy J. A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspect Psychiatr Care* 2010;46(3): 209-20.
19. American Nurses Association. *Code of ethics for nurses with interpretive statements*. Silver Spring, MD; 2015. http://www.nursingworld.org/codeofethics.
20. Musto LC, et al. Toward interventions to address moral distress: navigating structure and agency. *Nurs Ethics* 2015; 22(1):91-102.
21. McCarthy J, Gastmans C. Moral distress: a review of the argument-based nursing ethics literature. *Nurs Ethics* 2015; 22(1):131-52.
22. American Association of Critical-Care Nurses, Ethics Work Group. *The 4A's to rise above moral distress*. Aliso Viejo, CA; 2004. http://www.aacn.org/WD/Practice/Docs/4As_to_Rise_Above_Moral_Distress.pdf.
23. Burston AS, Tuckett AG. Moral distress in nursing: contributing factors, outcomes and interventions. *Nurs Ethics* 2013; 20(3):312-24.

24. Rushton CH, et al. Burnout and resilience among nurses practicing in high-intensity settings. *Am J Crit Care* 2015; 24(5):412-20.
25. Bruce CR, et al. A qualitative study exploring moral distress in the ICU team: the importance of unit functionality and intrateam dynamics. *Crit Care Med* 2015;43(4):823-31.
26. DeKeyser Ganz F, Berkovitz K. Surgical nurses' perceptions of ethical dilemmas, moral distress and quality of care. *J Adv Nurs* 2012;68(7):1516-25.
27. Schluter J, et al. Nurses' moral sensitivity and hospital ethical climate: a literature review. *Nurs Ethics* 2008;15(3):304-21.
28. de Veer AJ, et al. Determinants of moral distress in daily nursing practice: a cross sectional correlational questionnaire survey. *Int J Nurs Stud* 2013;50(1):100-8.
29. LaSala C, Bjarnason D. Creating workplace environments that support moral courage. *Online J Issues Nurs* 2010;15(3).
30. Rushton CH, et al. A framework for understanding moral distress among palliative care clinicians. *J Palliat Med* 2013; 16(9):1074-9.
31. Lützén K, Ewalds-Kvist B. Moral distress and its interconnection with moral sensitivity and moral resilience: viewed from the philosophy of Viktor E. Frankl. *J Bioeth Inq* 2013; 10(3):317-24.
32. Davis S, et al. Influencers of ethical beliefs and the impact on moral distress and conscientious objection. *Nurs Ethics* 2012;19(6):738-49.
33. Back AL, et al. "Why are we doing this?": clinician helplessness in the face of suffering. *J Palliat Med* 2015;18(1):26-30.
34. Rushton CH, et al. Addressing moral distress: application of a framework to palliative care practice. *J Palliat Med* 2013; 16(9):1080-8.
35. Lützén K, et al. Moral stress, moral climate and moral sensitivity among psychiatric professionals. *Nurs Ethics* 2010; 17(2):213-24.
36. Nejadsarvari N, et al. Relationship of moral sensitivity and distress among physicians. *Trauma Mon* 2015;20(2):e26075.
37. Lawrence LA. Work engagement, moral distress, education level, and critical reflective practice in intensive care nurses. *Nurs Forum* 2011;46(4):256-68.
38. The King's Fund. *Leadership and engagement for improvement in the NHS: together we can. Report from the King's Fund leadership review 2012*. London: National Health Service; 2012. Leadership review; http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf.
39. Rodney PA. Seeing ourselves as moral agents in relation to our organizational and sociopolitical contexts : commentary on "a reflection on moral distress in nursing together with a current application of the concept" by Andrew Jameton. *J Bioeth Inq* 2013;10(3):313-5.
40. Hamric AB. Moral distress in everyday ethics. *Nurs Outlook* 2000;48(5):199-201.
41. Nelson HL. *Damaged identities, narrative repair*. Ithaca, NY: Cornell University Press; 2001.
42. Pniewski J. Black horseman lane: a reflection. *Narrat Inq Bioeth* 2013;3(2):117-20.
43. Hallett K. The sanctity of life—the sanctity of choice. *Narrat Inq Bioeth* 2013;3(2):95-8.
44. Rushton CH. Moral resilience: a capacity for navigating moral distress in critical care. *AACN Adv Crit Care* 2016; 27(1):111-9.
45. Sauerland J, et al. Assessing and addressing moral distress and ethical climate, part 1. *Dimens Crit Care Nurs* 2014; 33(4):234-45.
46. Grady C, et al. Does ethics education influence the moral action of practicing nurses and social workers? *Am J Bioeth* 2008;8(4):4-11.
47. Beumer CM. Innovative solutions: the effect of a workshop on reducing the experience of moral distress in an intensive care unit setting. *Dimens Crit Care Nurs* 2008;27(6):263-7.
48. Brandon D, et al. Impact of a pediatric quality of life program on providers' moral distress. *MCN Am J Matern Child Nurs* 2014;39(3):189-97.
49. Brown-Saltzman K, et al. An intervention to improve respiratory therapists' comfort with end-of-life care. *Respir Care* 2010;55(7):858-65.
50. Grace PJ, et al. Clinical ethics residency for nurses: an education model to decrease moral distress and strengthen nurse retention in acute care. *J Nurs Adm* 2014;44(12):640-6.
51. Helft PR, et al. Facilitated ethics conversations: a novel program for managing moral distress in bedside nursing staff. *JONAS Healthc Law Ethics Regul* 2009;11(1):27-33.
52. Park M, et al. The relationship of ethics education to moral sensitivity and moral reasoning skills of nursing students. *Nurs Ethics* 2012;19(4):568-80.
53. Austin W, et al. An overview of moral distress and the paediatric intensive care team. *Nurs Ethics* 2009;16(1):57-68.
54. Austin W. Moral distress and the contemporary plight of health professionals. *HEC Forum* 2012;24(1):27-38.
55. Robinson EM, et al. Enhancing moral agency: clinical ethics residency for nurses. *Hastings Cent Rep* 2014;44(5):12-20.
56. Truog RD, et al. Microethics: the ethics of everyday clinical practice. *Hastings Cent Rep* 2015;45(1):11-7.
57. Pennebaker JW. Why write about trauma or emotional upheaval? In: *Writing to heal: a guided journal for recovering from trauma and emotional upheaval*. Oakland, CA: New Harbinger Publications; 2004. p. 3-16.
58. Sexton JD, Pennebaker JW. The healing powers of expressive writing. In: Kaufman SB, Kaufman JC, eds. *The psychology of creative writing*. New York: Cambridge University Press; 2009. p. 264-73.
59. Wilson MA, et al. Moral distress: levels, coping and preferred interventions in critical care and transitional care nurses. *J Clin Nurs* 2013;22(9-10):1455-66.
60. Browning AM. CNE article: moral distress and psychological empowerment in critical care nurses caring for adults at end of life. *Am J Crit Care* 2013;22(2):143-51.
61. Hamric AB, Blackhall LJ. Nurse-physician perspectives on the care of dying patients in intensive care units: collaboration, moral distress, and ethical climate. *Crit Care Med* 2007; 35(2):422-9.
62. Oberle K, Hughes D. Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *J Adv Nurs* 2001; l33(6):707-15.
63. Joint Commission. *Comprehensive accreditation manual for hospitals*. Oakbrook Terrace, IL; 2015.
64. Lewis-Newby M, et al. An official American Thoracic Society policy statement: managing conscientious objections in intensive care medicine. *Am J Respir Crit Care Med* 2015; 191(2):219-27.
65. Atabay G, et al. Impact of ethical climate on moral distress revisited: multidimensional view. *Nurs Ethics* 2015;22(1): 103-16.
66. Varcoe C, et al. Moral distress: tensions as springboards for action. *HEC Forum* 2012;24(1):51-62.