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Moral Distress: a Study of Personal and Organizational Factors

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MORAL DISTRESS: A STUDY OF PERSONAL AND ORGANIZATIONAL FACTORS

(Thesis format: Integrated Article)

by

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Graduate Program in School of Nursing

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ABSTRACT

Nursing is a practice grounded in ethics. Every nursing act is measured against requisite moral standards to do no harm, to promote justice, to be accountable, and to provide safe and competent care. However, as nurses attempt to act, there may be obstacles to pursuing the course of care as agreed to with the patient: inadequate staffing, cost-containment strategies, and policy constraints. In attempting to reconcile ideals of practice with what may be an opposing reality, nurses may experience moral distress. The purpose of this study was to examine how structural empowerment, psychological empowerment, interprofessional collaboration, compassion, and the perception of the quality of care affect nurses' perceptions of moral distress and the relationship between moral distress and intention to leave. It is organized in an integrated article format comprised of 4 papers. The first paper traces how the concept of nurse moral obligation arises and the possible sources of nurse moral distress. The second paper is a scoping review of the variables that have been correlated with moral distress. The literature suggests the constructs structural and psychological empowerment, interprofessional collaboration, quality of care, and intention to leave are associated with it. Compassion is also considered as it is a core nursing attribute. The third paper concerns itself with understanding compassion fatigue and compassion in a nursing context. The fourth article reports the findings of a study conducted to exam the relationships of the variables structural and psychological empowerment, interprofessional collaboration, compassion, quality of care, and intent to leave with the variable moral distress. The study confirmed the hypothesized relationships between structural empowerment, psychological empowerment, quality of care, and moral distress but not between moral distress and

intent to leave. One mediating but no moderating relationships were found. The findings of these papers demonstrate that moral distress continues to be an important issue in nursing. With these findings and with those from other studies there is an opportunity to begin the work on studies to evaluate strategies to mitigate moral distress as it relates to the nurse-patient therapeutic relationship.

Keywords: moral distress, structural empowerment, psychological empowerment, quality of care, interprofessional collaboration, compassion, intent to leave, therapeutic relationship

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To my friends your support, belief in me, and wonderful sense of humour has made this a much easier journey. I am blessed to have friends such as you in my life. Thank you.

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CHAPTER 1

INTRODUCTION

This chapter provides the background to and outline of this study on moral distress. First, the background and reasons for this study are presented. Next, the proposed model and significance are introduced. Finally, an overview of the following chapters will be provided.

Background

In order to understand the genesis of moral distress one must first understand the place of moral behavior in nursing. Not only is a moral perspective expected of and assumed by nurses, nurses willingly accept this perspective as essential to their role. The moral component of nursing arises from the "primary principle of obligation" (Carper, 1978, p. 20). Much has been written about the requirement for moral knowing and moral comportment in nursing (Carper, 1978; Chinn & Kramer, 2011; Corley, 2002; White, 1995). At its very foundation, nursing is a moral practice (Nortvedt,1998). Nurses are educated into an understanding of their specific moral responsibility.

Moral Distress

Moral distress is defined, for nursing, as a form of psychological distress. Moral distress was first noted by Jameton in the nursing literature in 1984. It is a phenomenon that occurs when nurses judge they are prevented from carrying out care they believe to be ethically (morally) appropriate (1984)[1]. Jameton (1984, 1993) proposed that when a

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[1] Please note that generally in the nursing literature no distinction is made between the terms "moral" and "ethical" (College of Nurses, 2002; Johnstone & Hutchison, 2015; McCarthy & Deady, 2008). However, in general philosophy and bioethical literature, a distinction is made between the terms: "moral" refers to right or good conduct and "ethical" refers to the theory of right or good conduct. In this paper I will use the term "ethical" when referring to standards and "moral" when referring to conduct and the consequences of conduct. The consequence of relevance here is moral distress.

nurse is constrained in his/her efforts to provide patient care s/he deems is appropriate, moral distress arises. Moral distress is experienced when the nurse is unable to move from his/her preferred "moral choice to moral action" (Rodney, Brown, & Liaschenko, 2004, p. 162).

The Proposed Model for Moral Distress

The theoretical literature identified the following six constructs as being related to moral distress: structural empowerment, psychological empowerment, quality of care, interprofessional collaboration, compassion, and intent to leave. They mapped to moral distress as follows.

Structural Empowerment

Structural empowerment is the condition of having access to opportunity, resources, information, support, and sources of both informal and formal power (Laschinger, Finegan, Shamian, & Wilk, 2004).The six elements of structural empowerment include access to opportunity, resources, information, and support. The other two elements are access to sources of both informal and formal power (Kanter, 1993). Formal power occurs when jobs afford flexibility, adaptability, creativity, are relevant to the organization's purpose and discretionary decision-making is allowed. Informal power is created through a social network of alliances with sponsors, peers, subordinates and other groups.

Psychological Empowerment

Psychological empowerment is a psychological condition characterized by a sense of perceived meaning (feeling one's values and the organization's values are in alignment), competence (feeling capable of performing the work), self-determination (having a sense of autonomy), and impact (having autonomy and control over one's work) (Spreitzer, 1996).

Interprofessional Collaboration

The Canadian Interprofessional Health Collaborative (CIHC) defines interprofessional collaboration as "a process that includes communication and decision-making, enabling a synergistic influence of grouped knowledge and skills. Elements of collaborative practice include responsibility, accountability, coordination, communication, cooperation, assertiveness, autonomy, and mutual trust and respect" amongst all members of the health care team (CIHC, 2010, p.8). Interprofessional collaboration theory posits several underlying conditions for positive interprofessional team relationships: interdependency, dynamic processes, sharing partnerships, and sharing power (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). Sharing encompasses shared decision-making, responsibilities, philosophy, information, perspectives, and planning.

Compassion

Compassion is an emotion comprised of mindfulness, kindness, and a sense of common humanity (Gilbert, 2005; Neff, 2003). It arises when observing another's suffering and creates a desire to act to relieve the suffering. This movement to act differentiates compassion from empathy, sympathy and pity that do not move one to act (Armstrong, 2010; Goetz, Keltner, & Simon-Thomas, 2010). As compared to compassion, empathy, sympathy, and pity are not considered to have a moral direction [directed towards the good of the other] (Gilbert, 2005; Oman, 2011; Pommier, 2010).

Perception of Quality of Care

Perception of quality of care is defined as the nurse assessment of the quality of care patients are receiving.

Intent to Leave

Leaving may be voluntary or involuntary. Involuntary turnover includes termination, required retirement, layoff, and forced leave due to inability to work. Voluntary leaving occurs when a nurse decides to leave either his/her local work unit or the organization for whom he/she works.

Significance

Nursing is a practice grounded in ethics (Corley, 2002; Lutzen, Dahlqvist, & Norberg, 2006). Every nursing act is measured against requisite moral standards to do no harm, to promote justice, to be accountable, and to provide safe and competent care (Heikkinen, et al., 2006; Lutzen, Blom, Ewalds-Kvist, & Winch, 2010). Researchers speak of moral distress arising in environments where due to a lack of power nurses feel coerced into providing care they consider to be less than the best (Millette, 1994; Shepard, 2010). The effects of moral distress can be severe and long lasting. Just as the causes are internal or external so are the effects. Nurses may state they are burned out and disengaged from the patients and from the profession (Pendry, 2007; Peter, McFarlane, & O'Brien-Pallas, 2004). They may experience sleep disturbances, nausea, migraines, and gastrointestinal illness (Hamric, 2012; Hanna, 2004). They may choose to terminate their positions or leave the profession (Corley, Elswick, Gorman, & Clor, 2001). Even newly graduated nurses experience moral distress as self-doubt and self-blame, when they believe they might not be able to practice as they think they should (Kelly, 1998). They cope by leaving their units, working fewer hours, and becoming disengaged from the patients. The effects of moral distress can be severe and long lasting. With each experience of moral distress, a residual of the effect of the distress may persist. Not surprisingly, moral distress has been equated to psychological distress (also termed disequilibrium) (Corley et al., 2001; Zuzelo, 2007).

Integrated Article Format

This dissertation is organized in an integrated article format as regulated by the School of Graduate and Postdoctoral Studies at the University of Western Ontario.

Chapter 2 *"Understanding Moral Obligation and Moral Distress"*

This is the first of four articles. It is an article that traces how the concept of moral obligation arises in nursing and the possible sources of nurse moral distress. The groundwork is laid characterizing the nature of the nurse-patient therapeutic relationship. It is a relationship of moral obligation as it requires the nurse to act on the patient's behalf as determined by the patient. Given that the core of nursing practice is about enabling attainment of what is perceived to be best for a patient, the consequences are discussed when the nurse is not enabled to contribute effectively to that end. Jameton (1984, 1993) proposed that when a nurse is constrained in his/her efforts to provide patient care that s/he deems appropriate, moral distress arises. Predictors of moral distress are discussed (Hamric, 2012) and strategies to mitigate moral distress are put forward.

Chapter 3 *"Correlates of moral distress experienced by nurses: A scoping study"*

Article two is a scoping review of the literature of variables that have been correlated with moral distress. The theoretical literature on moral distress suggested the constructs structural and psychological empowerment, interprofessional collaboration, quality of care, and intention to leave to be associated with it. The concept compassion was also considered as it is deemed a core nursing attribute. The literature was reviewed from 2003 to 2015. Articles that examined a univariate or multivariate relationship of these concepts and moral distress were included - the intent being to understand how moral distress might arise. Appreciating that a cause of nurse moral distress may result from an inability to act on their moral decisions and that those decisions occur on a daily

basis, it may be possible to mitigate or alleviate the experience of moral distress. Given the current state of ambiguity, there may be some instances in which nurses do not even understand that what they are experiencing is moral distress (Beagan & Ells, 2008; Gold, Chambers, & Dvorak). Thus they may not understand that these are issues of a moral, not of a structural or organizational nature. This misunderstanding may lead nurses to be unable to articulate what they need. As such this article provided that understanding of the pathway to moral distress, which is urgently needed. Clarifying the concept and identifying the causes represent a hopeful opportunity for efforts to address the problems that ensue.

Chapter 4 *"Understanding compassion fatigue: Understanding compassion"*

Article 3 concerns itself with understanding what compassion fatigue is in a nursing context. This article has been published in the Journal of Advanced Nursing (Ledoux, 2015). The article describes how the concept of compassion fatigue arose and its current stature in nursing. Research and commentary on it is examined. What was discovered is the foundation of nursing research in compassion fatigue is based on a conception of vicarious trauma. Further, what was learned, vicarious trauma has been re-named compassion fatigue to be more acceptable to those who may suffer from it (Bride, Radey, & Figley, 2007; Figley, 2002). As the basis of compassion fatigue was uncertain, the literature was explored to understand the meaning of compassion. For if compassion could be understood, then analysis of what compassion fatigue is would be made easier. There was much commentary about compassion in the nursing literature but almost no research had been undertaken in nursing to understand its nature or prevalence (Graber & Mitcham, 2004; Schantz, 2007; von Dietze & Orb, 2007). However, research on compassion has occurred outside of nursing in the fields of neurobiology, psychology,

and sociology (Davidson & Harrington, 2002; Gilbert, 2005; Kahane, 2009; Pence, 1983). The article demonstrates the need to understand compassion in a nursing context and then move forward and re-examine the concept of compassion fatigue.

Chapter 5 *"Understanding the Correlates of Moral Distress"*

Article 4 reports the findings of a study conducted to examine the relationships of the variables structural and psychological empowerment, interprofessional collaboration, compassion, quality of care, and intent to leave with the variable moral distress.

Every nursing act is measured against requisite moral standards to do no harm, to promote justice, to be accountable, and to provide safe and competent care (Heikkinen et al., 2006; Lutzen et al., 2010). Nursing, being oriented to the promotion of the patient's needs in their entirety, can be considered a "moral practice" (Goethals, Gastmans, & Dierckx de Casterle, 2010). However, as nurses attempt to act, there may be obstacles to pursuing the course of care as agreed to with the patient. These include: inadequate staffing, cost-containment strategies, and policy constraints (Beagan, 2009; Corley et al., 2001).

First described by Jameton [a philosopher and qualitative researcher] in 1984, moral distress is a phenomenon that occurs when nurses are unable to carry out care they believe to be morally appropriate (1984). The constraints to care may be external or internal. They may include inadequate staffing, lack of time, hierarchies within the healthcare system, lack of collegial relationships, lack of administrative support, policies and priorities that conflict with care needs (such as in relation to providing other needed social services), lack of autonomy, fear of litigation, and compromised care due to pressure to reduce costs. Variables noted in the literature that align with the internal and external constraints to practice noted above have been studied in context with moral

distress: structural and psychological empowerment, interprofessional collaboration, the perception of the quality of care, and intention to leave. In addition, a relationship that had not been considered but one would have expected it to be, is the relationship between moral distress and compassion.

I proposed that as levels of structural and psychological empowerment increased, the perception of the quality of care would increase and nurses' moral distress decrease. Psychological empowerment would mediate the relationship between structural empowerment and quality of care. The model would demonstrate that interprofessional collaboration and nurses' degree of compassion would moderate the perception of quality of care. As interprofessional collaboration increased, quality of care would increase; as nurses' compassion increased, their perception of quality of care would decrease. As the perception of quality of care increased, moral distress would decrease. Quality of care would mediate the relationship between psychological empowerment and moral distress. I also hypothesized that as moral distress increased, the intent to leave would increase (Figure 1).
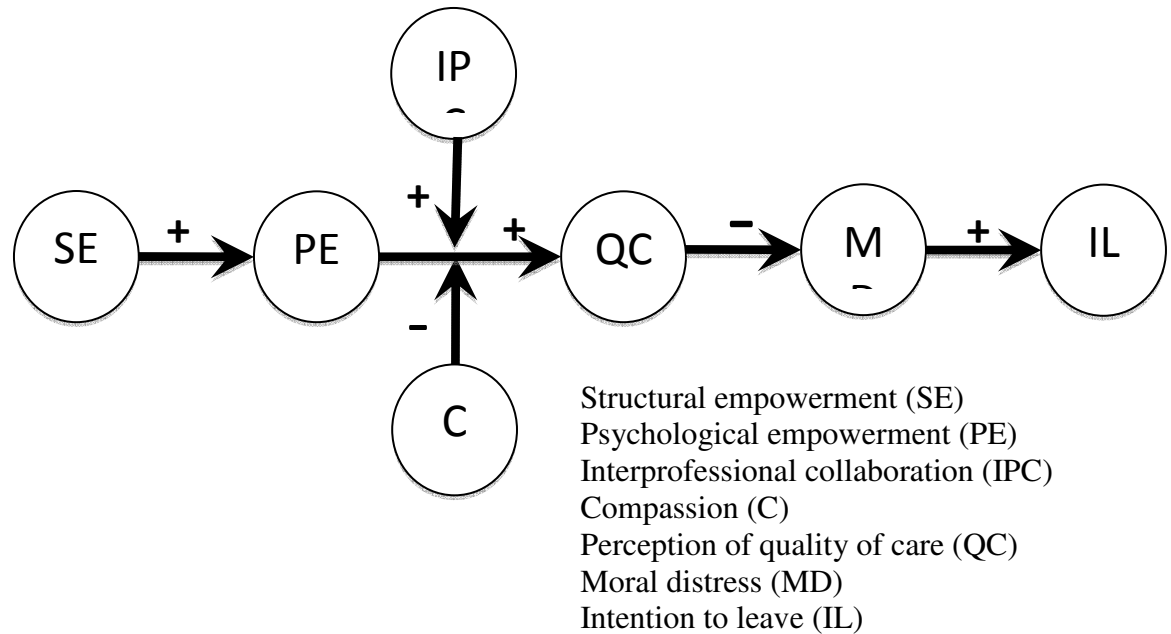
Figure 1. Model of the Relationships Amongst Variables

Surveys were sent to 900 randomly chosen registrants from the College of Nurses of Ontario Registry. A sample size of 200 was sought. Inclusion criteria were registered nurses: of any age, with any length of experience, in any inpatient or outpatient unit, in any hospital (community, long term care, and teaching) with any education level. Nurses who worked in any other setting, for example public health, were excluded. The data were initially analyzed using SPSS version 22. Partial Least Squares 3.1.9 (PLS), a component-based structural equation modeling technique, was used to test the model.

The study confirmed the hypothesized relationships between structural empowerment, psychological empowerment, quality of care, and moral distress. Quality of care was found to fully mediate the relationship between psychological empowerment and moral distress. No other mediating relationships were found. Neither compassion nor interprofessional care moderated the relationship between psychological empowerment and quality of care. There was not a significant pathway between moral distress and intent to leave.

Limitations of the study included inferences of causality were limited to the co-variation of the study variables and the a-priori theoretical relationships (Taris, 2000), the homogeneity of the respondents, and the exploratory nature of the study.

The implications for nursing include that organizations could look to enhance the determinants of structural empowerment, which are nurse access to information and power, managerial and collegial support of nurses, resources to enable the work to be done, and opportunity for skill development and challenging work. Knowing that psychological empowerment had a direct and significant relationship to quality of care, as structural empowerment increases, so would quality of care. As structural empowerment accounted for approximately a quarter of the variance of psychological empowerment, other known antecedents of psychological empowerment that would account for some portion of the remaining variance, could be enhanced, thus increasing quality of care even more. Personal (as opposed to the structural empowerment contextual) antecedents of psychological empowerment include having an internal locus of control, being self-efficacious, having self-esteem, and having emotional resilience (Seibert, 2011). Management practices could be such that these characteristics would be enhanced by, for example encouraging nurse autonomy. In turn, understanding that the elements of psychological empowerment are as described above, effort could be made to ensure there is alignment between the work that is required to be done and nurses' values, that nurses are decisional within their scope of practice, enable nurses to progress to higher levels of proficiency, and to engage nurses in discussions and decisions regarding organizational practices.

Chapter 6 *"Conclusion"*

This chapter is a summary of the articles. An understanding of nursing moral

obligation and moral distress is presented. A synopsis of the variables associated with moral distress, their proposed relationships and the subsequent findings of the research are presented. Implications for nursing are reviewed including a note that one of the variables, compassion, considering its iconic standing has been under-studied in nursing. A connection is also made that as moral distress may undermine the ability to form the nurse-patient therapeutic relationship, there is value in continuing research on this topic to determine the factors that make up moral distress.

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CHAPTER 2

UNDERSTANDING MORAL OBLIGATION AND MORAL DISTRESS

"That all that is said and done, will be said and done with a view to what is good

for those on whom he practises his art, so every art seeks not its own advantage,

but the wellbeing of the subject on whom it is exercised" argued Plato (Hamilton

& Cairns, 1969, p. 592).

Moral distress is a common experience of nurses (Hanna, 2004; McCarthy &

Deady; Zuzelo, 2007). A common source of moral distress occurs when nurses find

themselves unable to provide care as they judge they should (Hamric, 2012; Jameton,

1984, 1993, Wilkinson, 1988). Nurses may leave their place of work and the profession

because they cannot shape their professional practice in the ways they believe they

should (Gaudine & Thorne, 2012; Hamric & Blackhall, 2007; Thorne, 2010). The loss of

nurses from the work place and the profession has been described as a "quiet crisis" as

nurses' voices are not being heard (Canadian Nurses Association, 1998; Ceci &

McIntyre, 2001). Ceci and McIntyre (2001) state that nurses' moral distress deepens

when "what is of concern to nurses remains stubbornly invisible" (p. 123). I will attempt

to make visible what is of concern to nurses by first laying a groundwork characterizing

the nature of the nurse-patient relationship. This is a relationship of moral obligation, a

covenant between the two parties. Once that is understood, I will make visible what

happens when there is a rupture in this obligation. Moral distress ensues.

Moral Obligation

In order to understand the genesis of this source of moral distress one must first

understand the place of moral behavior in nursing. Not only is a moral perspective

expected of and assumed by nurses, nurses willingly accept this perspective as essential

to their role. However, it is this very perspective that leads to moral distress (Butts &

Rich, 2008).

Carper (1978), in a seminal work on the elements comprising nursing knowledge

suggests that there are fundamental ways or patterns of knowing in nursing. Carper lists:

empirics, esthetics, personal knowledge, and ethics. These patterns characterize the

cognitive space within which nursing occurs. They consitute "the kind of knowledge

[nursing] aims to develop … [and] what kinds of knowledge are held to be of most value

in the discipline of nursing" (p. 13). Later, Chinn and Kramer (2011) expanded Carper's

model with the addition of a fifth way of knowing: emancipatory knowing.

Empirics concerns itself with the scientific understanding of the care of patients.

Esthetics is the way in which individual nurses "design and provide nursing that is

effective and satisfying" (Carper, 1978, p. 17). Esthetics requires empathy which is the

ability to know what the patient is experiencing. As the nurse employs empathy, s/he

becomes more skilled in understanding the patient and thereby the meaning of a

particular situation the nurse and patient are in. This grasp of situational meaning makes

available a broader range of responses to the care needs.

Personal knowledge is the way in which nurses know and view themselves, as

well as how they view themselves in relation to others. This is the basis of the therapeutic

use of self in the nurse-patient relationship. Through personal knowledge, the nurse

endeavors to establish a trustworthy relationship with the patient. The ethical or moral

component of nursing arises from the "primary principle of obligation" (Carper, 1978, p.

20). This obligation concerns what ought to be done in the best interests of the patient as

determined by the patient. Emancipatory knowing is being aware of the social, cultural,

and political contexts of health care needs. It is about how and why the care needs arise, and how to address those needs in these contexts.

These ways of knowing are considered to be historical constants. In an analysis of Florence Nightingale's writing on nursing, Clements and Averill (2006) conclude that she too understood nursing to employ similar patterns of knowing. In *Nightingale's Notes on Nursing* regarding "Ventilation and Warming, Noise, Bed and Bedding, Light, Cleanliness of Rooms and Walls clearly address the empirical, aesthetic, ethical, personal, and sociopolitical ways of knowing" (p. 269). Each pattern of knowing is deemed necessary and together sufficient for nurses to be able to practice to the highest standard (Fawcett, 2006). For these reasons, nurses are taught and are expected to incorporate each of these patterns into their practice (Carper, 1978; Chinn & Kramer, 2011; White, 1995).

As this article is concerned with moral distress, I will focus on the moral pattern of knowledge of nursing. Much has been written about the requirement for moral knowing and moral comportment in nursing (Carper, 1978; Chinn & Kramer, 2011; Corley, 2002; White, 1995). Nortvedt (1998) considers nursing at its very foundation to be a moral practice. Caring for the vulnerable is an essentially moral undertaking. In the provision of care, a nurse should not simply apply a standard set of care processes to a patient. Each act to be considered a *caring* act must be evaluated as to its impact on the overall welfare of the patient. Each observation is more than strictly analytical or merely investigative. It is an observation of the effect, of what is being seen, on the patient. These vicarious judgements are morally significant judgements. "To be sensitive to a person's human experiences is the *sine qua non* of moral responsibility" (p. 386).

Nurses are educated to understand their specific moral responsibility. They are taught that the four fundamental responsibilities of nursing - the promotion of health, the prevention of illness, the restoration of health, and the alleviation of suffering are to be undertaken in light of specific patient requirements (Fry & Johnstone, 2002). Judgement and reasoning must always be applied to determine what is the best course of action to undertake. Choosing the best course of action as determined in consultation with the patient (recognizing that sometimes that is not what others consider the best course of action) is a moral not a technical determination. This is, of course a hallmark of professional practice: to perform nursing actions which enable and support a patient's well-being (Manojlovich, 2005; Millette, 1993; Rule, 1978).

Moral Distress

Moral distress can be differentiated from other similar phenomena such as moral dilemma, moral uncertainty, moral stress, moral sensitivity, and moral residue (Table 1). Moral distress is a phenomenon that was first noted in the literature in 1984 (Jameton, 1984). Jameton observed it occurs when nurses judge they are prevented from carrying out care they believe to be ethically (morally)[2] appropriate (Jameton does not claim that being constrained from providing care is the only source of moral distress for nurses but rather it is a frequently occurring cause) (1984). To understand the origins and effects of such obstructive situations, one must first understand the components and overall nature of the nurse-patient therapeutic relationship.

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[2] Please note that generally in the nursing literature no distinction is made between the terms "moral" and "ethical" (College of Nurses, 2002; Johnstone & Hutchison, 2015; McCarthy & Deady, 2008). However, in general philosophy and bioethical literature, a distinction is made between the terms: "moral" refers to right or good conduct and "ethical" refers to the theory of right or good conduct. In this paper I will use the term "ethical" when referring to standards and "moral" when referring to conduct and the consequences of conduct. The consequence of relevance here is moral distress.

Table 1

Definition of Phenomena Similar to Moral Distress

CONCEPT	DEFINITION
Moral distress	A form of psychological distress resulting from moral-conflict stressors (Jameton, 1984)
Moral dilemma	Occurs when two or more moral principles can apply to an issue at hand but at least two propose mutually exclusive courses of action. A moral dilemma may occur when a particular solution appears morally correct but other evidence suggests it is morally wrong (Dunwoody, 2010).
Moral uncertainty	Arises when one is uncertain what the moral problem is or what moral values apply (Jameton 1984)
Moral stress	A feeling generated when one is aware of moral obligations. It creates an alertness regarding deciding between what is considered right and wrong. Whereas moral distress is a negative outcome, moral stress may lead to a positive outcome through reflection and choice (Lutzen & Kvist, 2012).
Moral sensitivity	Being aware there are moral issues and decisions that will affect others (Rest, 1994).
Moral residue	A strongly felt and long lasting feeling that results from acute episodes of moral distress (Hardingham, 2004). The lingering feelings after the initial morally difficult circumstance has passed. This becomes the new and elevated baseline for moral distress. If new instances of moral distress occur, the distress experienced may be more intense (Epstein & Hamric, 2009).
Stress of conscience	Occurs as a result of conflict between personal and professional moral principles. Stress of conscience and moral distress may overlap but are not the same (Glasberg et al., 2006). There may be two conflicting value systems: the professional and the personal. The personal value system is the individual's conscience. The profession's values may create restrictions on the individual's conscience. When that is the case, guilt then ensues.

The nurse-patient relationship is described as the "crux" or essence of nursing (Peplau, 1962; Welch, 2005). The components of this relationship, shown in Table 2, include trust, respect, empathy, and intimacy (Canadian Nurses Association, 2003; College of Nurses of Ontario, 2009; Cutliffe & McKenna, 2005; Eldh, Ekman, & Ehnfors, 2006). This relationship requires that the power inherent in the nurse's role be used appropriately to meet patients' needs (College of Nurses of Ontario, 2009).

Table 2

Components of the Nurse-Patient Relationship

Components	Attributes
Trust	Reliance patients have on others that no harm will come to them and that they will be looked after. Trust supposes the ability and readiness, and the desire to act in the other's best interests (Rodney, Brown, & Liaschenko, 2004)
Respect	Acknowledging patients' individuality, autonomy, values, and worthiness. Respect in the nurse-patient relationship is the respect for human rights (Beauchamp & Childress, 2013; Curtin & Flaherty, 1982). Respect is found as a moral value in nearly all nursing codes of ethics (Tarlier, 2004).
Intimacy	May include physical, psychological, and spiritual nurse-patient contact for the purpose of knowing, understanding, and thus providing care for, the patient. In this sense it is a partnership based on determining each patient's unique needs (Tarlier, 2004). Without intimacy, the nurse would not know the patient and would therefore be unable to act on the patient's behalf.
Empathy	The ability to understand another person emotionally. In nursing it is the ability to understand the patient's perception of his or her health experience. This knowledge is necessary for ethical care. When nurses fail to have insight into the patient's meaning of their experience "bioethical problems are promoted" (Reynolds, Scott, & Austin, 2000, p. 236). Vetlesen (1994) posits empathy as a prerequisite to moral behavior. It is because of empathy or receptivity to another, that the nurse becomes aware of what is morally relevant; what it is that is of importance to the patient.

The duty to use power appropriately requires the nurse to be mindful that s/he has power and that s/he is obliged to use it on behalf of patients (Curtin & Flaherty, 1982). Typically, patients are vulnerable, through diminished ability, lack of knowledge, or due to the position implicit in the patient role. The nurse uses his/her power to act on the patient's behalf and in his or her best interests, as understood with the patient.

Moral behavior is acting to produce good outcomes or doing the "right thing" (Beauchamp & Childress, 2013). Moral choices are decisions about what is good or bad, right or wrong, better or worse (Tschudin, 1994). Thus, the necessary components of the nurse-patient relationship - trust, respect, empathy, and intimacy and the appropriate use of power individually and together are at the centre of moral nursing behavior. The nurse-patient relationship is a moral covenant: to act in the best interests of the patient. This covenant acts as a moral guide to assist the nurse in decisions where there could be harm and where there are choices to be made among alternatives (Fry & Johnstone, 2002).

The "crux" of nursing then is to know the patient and, once knowing, to act in his or her best interests as determined by and with the patient. Either the act may be to enable the patient to care for him/herself or it may be to provide care that the patient cannot provide for himself. "Acting for a patient is thus a matter of inherent ethical significance" (Liaschenko 1995, p.1). Every nursing act is measured against requisite moral standards to do no harm, to promote justice, to be accountable, and to provide safe and competent care (Heikkinen, et al., 2006; Lutzen, Blom, Ewalds-Kvist, & Winch, 2010). These standards are in keeping with the commonly understood principles of biomedical ethics: respect for autonomy, nonmaleficence, beneficence, and justice (Beauchamp & Childress, 2013). Thus, the foundation of nursing is the commitment to the relationship with the patient, and to act in the best interests of the patient. In this

sense, therefore, nursing is an inherently moral activity (Brown, Rodney, Pauly, Varcoe, & Smye, 2004; Goethals, Gastmans, & Dierckx de Casterle, 2010).

As demonstrated, the core of nursing practice is about enabling attainment of what is perceived to be best for a patient. What then are the consequences when the nurse is not enabled to contribute effectively to that end? Jameton (1984, 1993) proposed that when a nurse is constrained in his/her efforts to provide patient care that s/he deems appropriate, moral distress arises. Moral distress is experienced when the nurse is unable to move from his/her preferred "moral choice to moral action" (Rodney, Brown, & Liaschenko, 2004, p. 162). Wilkinson (1988) built on Jameton's description to describe moral distress as psychological disequilibrium. Corley et al (2001) then expanded this definition by defining moral distress as ''the painful psychological disequilibrium that results from recognizing the morally appropriate action, yet not taking it, because of obstacles such as lack of time, supervisory reluctance, an inhibiting medical [or other professional] power structure, institution policy, or legal considerations'' (pp. 250-251). Zuzelo (2007) describes moral distress similarly as a type of psychological distress characterized by anger, frustration, fear and guilt. Further, psychological distress (disequilibrium) may also result in emotional suffering characterized by symptoms of unhappiness and anxiety, lost interest, sadness, demoralization, restlessness, worry, feeling tense, and irritability (Mirowsky & Ross 2002). Somatic symptoms may also be experienced such as insomnia, headaches, gastrointestinal illness, lack of energy, and lack of appetite (Drapeau, Marchand, & Beaulieu-Prevost, 2012; Ridner, 2004).

Psychological distress thus occurs when a stressor creates an unmet need, when an individual feels a loss of control, and cannot effectively manage the emotional turmoil (Lazarus, 1998; Mirowsky & Ross, 1989; Ridner, 2004) Psychological distress is

eliminated when the stressor is removed or when the individual can cope effectively with the stressor (Ridner, 2004). In nursing, accordingly, a stressor may be a constraint on the nurse's ability to provide care s/he judges to be appropriate, with a subsequent loss of control over practice. This is a constraint on the nurse's ability to act on his/her moral choices. This is a threat to the nurse's moral integrity (Epstein & Delgado, 2010; Hardingham, 2004).

Building on Corley's work, and following a review of the literature on moral distress Hamric (2012) developed a model of predictors of nurse moral distress. She proposed that there are three root causes of moral distress: clinical situations, internal constraints, and external constraints (Table 3). Clinical situations include conflicting duties, disregard for patient wishes, and inappropriate resource utilization. Internal constraints include: perceived powerlessness, self-doubt, and lack of knowledge. External constraints include: inadequate staffing, lack of administrative support, and healthcare system hierarchies (i.e., operating systems wherein decisional control is dependent on relative status or rank). The predictors of moral distress are to be found in the "everyday" obligations of the provision of patient care. This is not surprising, as each nursing act requires knowing the patient and consequently acting in his/her best interest – the basis of moral obligation.

Table 3

Major Root Causes of Moral Distress

Root Causes	Predictors
Clinical Situations	·Providing unnecessary/futile treatment ·Prolonging the dying process through aggressive treatment ·Inadequate informed consent ·Working with caregivers who are not as competent as care requires ·Lack of consensus re treatment plans ·Lack of continuity of care ·Using resources inappropriately ·Providing care that is not in the best interests of the patient ·Providing inadequate pain relief ·Providing false hope to patients and families ·Hastening the dying process ·Lack of truth-telling ·Disregard for patient wishes ·Conflicting duties
Internal Constraints	·Perceived powerlessness ·Inability to identify the ethical problem ·Lack of understanding of the full situation ·Self-doubt ·Lack of knowledge of alternative treatment plans ·Increased moral sensitivity ·Lack of assertiveness ·Socialization to follow orders
External Constraints	·Inadequate communication among team members ·Differing inter- (e.g. RN to MD) or intra-professional (e.g. RN to RN) perspective ·Inadequate staffing and increased turnover ·Lack of administrative support ·Policies and priorities that conflict with care needs ·Following family wishes of patient care for fear of litigation ·Tolerance of disruptive and abusive behavior ·Compromising care due to pressure to reduce costs ·Hierarchies within healthcare system ·Lack of collegial relationships ·Nurses not involved in decision-making ·Compromised care due to insurance pressure or fear of litigation

Note: From Hamric, A. B., Borchers, C. T., & Epstein, E. G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Primary Research , 3* (2), 1-9.

Conclusion

Now understanding how moral obligation arises within the nurse-patient relationship, the experience of moral distress can be more easily understood. Moral distress arises from an inability of nurses to act on their moral decisions and those decisions occur on a daily basis. Given the current state of ambiguity, there may be some instances in which nurses do not even understand that what they are experiencing is moral distress (Beagan & Ells, 2008; Gold, Chambers, & Dvorak). Thus they may not understand that these are issues of a moral, not of a structural or organizational nature. This misunderstanding may lead nurses to be unable to articulate what they need. This article provides that understanding of the pathway to moral distress, which is urgently needed. Clarifying the concept and identifying the causes could represent a hopeful opportunity for efforts to address the problems that ensue. This opens the possibility to mitigate or alleviate the experience of moral distress. When nurses can give voice to what they are experiencing and what they need perhaps what is of concern to them will no longer be a "quiet crisis" but a meaningful discourse.

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CHAPTER 3

CORRELATES OF MORAL DISTRESS EXPERIENCED

BY NURSES: A SCOPING STUDY

Introduction

Nursing as a practice is grounded in moral obligation (Corley, 2002; Lutzen, Dahlqvist, & Norberg, 2006). Every nursing act is measured against moral standards[3]: to do no harm, to promote justice, to be accountable, and to provide safe and competent care (Heikkinen, et al., 2006; Lutzen, Blom, Ewalds-Kvist, & Winch, 2010). The nature of the nurse-patient therapeutic relationship requires acting on the patient's behalf (Liaschenko, 1995). This frequently gives rise to morally challenging situations which occur in the routine "everyday practice of individual nurses" (Park, 2009, p. 68). Nursing, thus oriented to the promotion of the patient's needs, is a "moral practice" (Goethals, Gastmans, & Dierckx de Casterle, 2010).

Nurses pursue the care as agreed to with patients. In that pursuit, they may encounter obstacles to acting: inadequate staffing, cost-containment strategies, and policy constraints (Beagan, 2009; Corley, Elswick, Gorman, & Clor, 2001). Nurses may experience moral distress (MD) when attempting to reconcile ethically determined practice expectations with what may be an opposing reality. First described by Jameton [a philosopher and qualitative researcher] in 1984, moral distress is a phenomenon that

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[3] Please note that generally in the nursing literature no distinction is made between the terms "moral" and "ethical" (College of Nurses, 2002; Johnstone & Hutchison, 2015; McCarthy & Deady, 2008). However, in general philosophy and bioethical literature, a distinction is made between the terms: "moral" refers to right or good conduct and "ethical" refers to the theory of right or good conduct. In this paper I will use the term "ethical" when referring to standards and "moral" when referring to conduct and the consequences of conduct. The consequence of relevance here is moral distress.

occurs when nurses are unable to carry out care they believe to be morally appropriate (1984). Jameton (1984) described both internal (within the individual) and external (within the environment) constraints to care. Some internal constraints are: lack of assertiveness, self-doubt, perceived powerlessness, socialization to follow orders, and not fully understanding the situation. Some external constraints are: inadequate staffing, lack of time, hierarchies within the healthcare system, lack of collegial relationships, lack of administrative support, policies and priorities that conflict with care needs (such as in relation to providing other needed social services), lack of autonomy, fear of litigation, and compromised care due to pressures to reduce costs. Moral distress arises in environments where due to a lack of perceived power nurses perceive themselves as being coerced into providing care they consider to be less than the best (Millette, 1994; Shepard, 2010). Cohen and Erickson (2006) identify sources of moral distress to be conflict among colleagues about job performance and patient care plans, power imbalances amongst health professionals, inadequate staffing, lack of support from leadership, inadequate orientation periods, and rationing of resources.

The effects of moral distress can be severe and long lasting. Nurses may state they are burned out and disengaged from patients and from the profession (Pendry, 2007; Peter, McFarlane, & O'Brien-Pallas, 2004). A nurse may experience sleep disturbances, nausea, migraines, and gastrointestinal illness (Hamric, 2012; Hanna, 2004). Nurses may even choose to terminate their positions or leave the profession (Corley et al, 2001). Newly graduated nurses, when they believe they might not be able to practice as they think they should, may experience moral distress as self-doubt and self-blame (Kelly, 1998). Nurses cope by leaving their units, working fewer hours, being absent from work, or becoming disengaged from the patients. McCarthy and Deady (2008) describe that the

failure to act due to constraints may create a "long term legacy of moral distress" (p. 257). There can be a feeling that one will never be the same due to the violation of one's integrity. These effects are significant risks for the nurse, the patient and the profession.

As the effects can be severe, it behoves nursing to understand the correlates of moral distress. Based on the literature, the theory, and my experience of moral distress, I hypothesize the nomological network of moral distress includes at least the following five constructs: structural empowerment, psychological empowerment, inter-professional collaboration, compassion, and quality of care. It could be expected that an outcome of the experience of moral distress would be an intent to leave the place of employment. The purpose of this paper is to (1) to understand the "extent, range, and nature" (Arksey & O'Malley, 2005, p. 21) of research conducted on these constructs affecting the experience of nurse moral distress and (2) to identify possible gaps in the research on moral distress. Following are a description of these constructs and how they may relate to moral distress.

Structural Empowerment

Structural empowerment is the condition of having access to opportunity, resources, information, support, and sources of both informal and formal power. Kanter's (1993) theory of Organizational Empowerment describes six elements that enable employees to be empowered to accomplish their work (Laschinger, Finegan, Shamian, & Wilk, 2004). The six elements of structural empowerment include access to opportunity, resources, information, and support. The other two elements are access to sources of both informal and formal power (Kanter, 1993). Opportunity reflects a chance to learn and develop. Resources are those elements necessary to be able to do one's job: people, time, equipment, supplies, and money. Information includes one's own expertise,

technical and professional, relevant data and formal and informal knowledge of the

organization and its goals. Support is the assistance, coaching and feedback received

from leaders, colleagues and subordinates. Formal power occurs when jobs afford

flexibility, adaptability, creativity, are relevant to the organization's purpose and

discretionary decision-making is allowed. Informal power is created through a social

network of alliances with sponsors, peers, subordinates and other groups.

Kanter's structural elements are conceptually similar to those organizational

elements noted above, that when missing, lead to moral distress (support, resources,

power). If Kanter's structural elements are in place (organizational barriers to care

removed) it could be hypothesized that nurses may experience few or no impediments to

pursuing quality care. If impediments to care are removed, nurses might then experience

little or no moral distress.

Psychological Empowerment

Psychological empowerment is a psychological condition characterized by a sense

of perceived: meaning, competence, self-determination, and impact (Spreitzer, 1996).

Kanter's structural empowerment theory describes the organizational elements that may

be in place. It does not however "describe the employee's reaction to these conditions"

(Laschinger et al., 2001, p.261). Spreitzer (1995) contends that a state of psychological

empowerment is established not merely by the presence of the structural elements but by

the individual's reaction to these organizational elements. Psychological empowerment is

the perception of: competence (feeling capable of performing the work), impact (having

autonomy and control over one's work), meaning (feeling one's values and the

organization's are in alignment), and self-determination (having a sense of autonomy).

These outcomes of psychological empowerment are conceptually similar but the converse

to those experienced when in moral distress: self-doubt, powerlessness, values misalignment, and conflict over autonomy.

Structural empowerment may confer psychological empowerment. However as nursing is never a solitary pursuit, the practice environment within which the nurse finds his/herself could influence his/her ability to act on this psychological empowerment. In particular, an environment supportive of nursing practice includes collegial relationships, the valuing of nursing, and allowing nursing decisional involvement in patient care (Lake, 2002). Aiken et al. (2001) state that support for professional practice consists of nurses being supported to make clinical decisions, managing their practice environments and having collaborative nurse-physician relationships. These characteristics of a positive professional practice environment are conceptually similar to the concepts identified in interprofessional collaboration theory.

Interprofessional Collaboration

The Canadian Interprofessional Health Collaborative (CIHC) defines interprofessional collaboration as "the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/ families and communities to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making, and partnerships." (Canadian Interprofessional Health Collaborative, 2010, p. 8).

Interprofessional collaboration theory posits several underlying conditions for positive interprofessional team relationships: sharing, partnerships, sharing power, interdependency, and dynamic processes (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005). Partnership is characterized by collegial relationships based on truthful and transparent communication, valuing the other, and having common

goals. Sharing encompasses shared decision-making, responsibilities, philosophy, information, perspectives, and planning. Power is understood to belong to all team members such that there is equality within the team. Interdependency is an awareness of the need to depend on others for goal completion. Dynamic process recognizes the extent of collaboration varies in various circumstances, is responsive to and transformative of each situation.

Where there is interprofessional collaboration, benefits acrue to the patients, to the healthcare organization, and to the individual practitioner (Petri, 2010; Rose, 2011). Better patient outcomes include decreased lengths of stay, enhanced coordination of care, decreased readmission rates, and increased patient satisfaction scores (Petri, 2010; Zwarenstein, Bryant, & Reeves, 2003). The most frequently observed organizational benefits are cost reductions such as reduced laboratory and pharmacy costs (Baggs, Norton, Schmitt, & Sellers, 2004). These benefits occur likely due to the enhanced coordination of care that results.

The benefit to individual providers arises in the form of enhanced job satisfaction (D'Amour et al., 2005). Job satisfaction is implied through "the presence of improved morale, increased enthusiasm, retention of personnel, and reduced burnout" (Petrie, 2010, p. 79) and reductions in absenteeism (Zwarenstein et al., 2003). In contrast poor nurse self-esteem, lack of job satisfaction, and moral distress have each been associated with a lack of nurse-physician collaboration (Larson, 1999; Pike, 1991). Team participation in patient care decision-making is supportive of the professional practice of all the participant professions. Where there is interprofessional collaboration nursing professionalism is faciltated and strengthened (Dechairo-Marino, 2001; Jordan-Marsh, Traiger, & Saulo, 2001).

The establishment of interprofessional collaboration does not mean that there will always be agreement about care decisions (Coeling & Cukr, 1997). It does mean however that each member of the team has made a commitment to other members of the interdisciplinary team so that together they can deliver quality patient care. This commitment is accomplished through setting shared goals, sharing power and information, engaging in respectful communication, and sharing decision-making. Thus when there is interprofessional collaboration nurses may still not always be able to provide the care they determine is ideal but they may have an understanding of the validity of currently existing barriers. When there are positive relationships within the interprofessional team, nurses may more fully understand the reasoning behind opposing decisions about care. This understanding might moderate any moral distress they might otherwise experience as a result of not being able to provide the care they judge should be given.

Compassion

There has been commentary on compassion since at least the time of Aristotle (Cassell, 2002). It is described as a response to human frailty that "informs and motivates our duties towards others" that by its very nature creates a desire to act on behalf of others (O'Connell, 2009, p. 3). This movement to act differentiates compassion from empathy, sympathy and pity that do not move one to act (Armstrong, 2010; Goetz, Keltner, & Simon-Thomas, 2010).

In colloquial speech compassion, empathy and sympathy are often used interchangeably. But in more careful analysis, distinctions can be made among them (Oveis, Horberg, & Keltner, 2010; Pommier, 2010). Keltner & Goetz (2007) say that empathy is a mirroring and understanding of another's condition. Eisenberg and Miller

(1987) say that when one has empathy one will feel the same or similar to another's state. Sympathy however, is a feeling of concern in response to another's emotional or physical state but it does not create the identical emotional feeling as empathy does. Closely related to sympathy is pity. Pity is a feeling of concern for someone weaker than one's self (Keltner & Goetz, 2007). Pity entails an acceptance of the situation with a reluctance to become personally involved. As compared to compassion, empathy, sympathy, and pity are not considered to have a moral direction [directed towards the good of the other] (Gilbert, 2005; Oman, 2011; Pommier, 2010). Compassion can also be differentiated from other similar concepts (Table 4).

Table 4

Definition of Phenomena Similar to Compassion

Concept	Definition
Altruism	A motivation to behave positively towards others by either helping those in distress or chastising anti-social behavior. It can be differentiated from other affects in that there can be a cost for altruistic behavior. In altruism, there is a notion of sacrificing something for another (Goetz, Keltner, & Simon-Thomas, 2010)
Compassionate love	The "giving of self for the good of the other" (Fehr, Sprecher, & Underwood, 2009, p. 4). Not always a response to suffering but rather may be an aid in the "flourishing" of others with, like altruism, a possible subsequent cost to self.
Compassion satisfaction	The satisfaction health care providers may feel when they can do their work well (Craig & Sprang, 2010)

Compassion is considered to have three components: common humanity, kindness, and mindfulness (Neff, 2003; Pommier, 2010; Wispe, 1991). Common humanity is the understanding that all humans share a universal experience. Being human, besides many positives, also means to be fallible and to suffer. Suffering being part of every human experience, is thus not a unique individual event. The understanding that suffering is a common denominator with all people creates an openness to or connection with others.

This connection of common humanity is hypothesized to be the impetus that moves a feeling of compassion to become an act of compassion (Wayment & Bauer, 2009). Action is the consequence of desire (Schueler, 1995). In the case of compassion the desire is to alleviate suffering. This desire arises from the understanding that everyone, like ourselves wishes to be free from suffering. Kindness is the expression of understanding and warmth towards others rather than of criticism or indifference (Gilbert, 2005). Mindfulness is a state of emotional equilibrium that prevents either "an over-identification [with] or a disengagement from the pain of others" (Pommier, 2010, p. 3). Mindfulness allows one to be open to others as one is not emotionally over or self-absorbed.

A consensus in the research is showing we each have the potential to express compassion; that it can be taught, learned, and nurtured (Gilbert, 2005, Kahane, 2009; Pence, 1983). However, although anyone can be compassionate, not everyone is compassionate (Goetz, Keltner, & Simon-Thomas, 2010; Schantz, 2007). One can do good for reasons of duty or reward.

So how might compassion affect the formation of moral distress? It is not surprising that compassion is important to nursing practice (Heffernan, Quinn Griffen,

McNulty, & Fitzpatrick, 2010; Perry, Dalton, & Edwards, 2009). Compassion, as thus understood, is being aware of other's suffering, opening oneself to that suffering and neither avoiding nor disconnecting from that suffering. Feelings of compassion, then, arise with a desire to ease the suffering (Neff, 2003). Compassion is characterized by acceptance, endurance, courage, and action (Lickerman, 2009; Morgan, 1996). Importantly compassion allows us to cross the chasm of "otherness". A hallmark of compassion is its ability to create an other-oriented attitude (Gilbert, 2005; Keltner & Goetz, 1998).

Compassion is frequently named as a guiding principle in nursing conduct (Milton, 2003; Roach, 2007). Both the Royal College of Nurses and the American Nurses Association assert nurses are to practice with compassion (American Nurses Association, 2008; Straughair, 2012). Similarly the Canadian Nurses Association declares the provision of safe, compassionate, and competent care to be a cornerstone of practice (Canadian Nurses Association, 2003). Considered a foundation of nursing compassion is inextricably linked to professional practice (Harrowing, 2011; Hem & Hegen, 2004; Horton, Tschudin, & Forget, 2007; Watson, 2006). Because of its nature, compassion gives the "context and direction to nurses' decisions and actions" (von Dietze & Orb, 2000). In turn, patients value compassion because it gives rise to a kind of nursing practice that permits patients to be understood, their will to be expressed, and suffering alleviated (Aita, 1995; Graber, 2004; von Dietz, 2007).

When compassion is present, one would expect the nurse's experience of moral distress to be greater. As the nurse more deeply understands the patient's suffering with the desire to alleviate it, then if constrained from acting to alleviate the suffering, the nurse's experience of moral distress would increase.

Perception of Quality of Care

Perception of quality of care is defined as the nurse assessment of the quality of care patients are receiving. A positive association between nurses' structural empowerment and their perception of the quality of patient care has been shown (Laschinger, Finegan, & Shamian, 2001; Laschinger & Wong, 1999; Leggat, Bartram, Casimir, & Stanton, 2010; Scotti, Harmon, & Behson, 2007). Indeed the elements of structural and psychological empowerment are similar to and in some instances the same as those elements which comprise a professional nurse practice environment. "A professional practice environment can be described as the system that supports nurses' control over the delivery of nursing care and the environment in which care is delivered and the characteristics of an organization that facilitate or constrain professional nursing practice" (Lankshear, 2011, p. 32).

A positive professional nurse practice environment values the work of nursing, encourages nurse accountability and autonomy, provides ongoing opportunities to learn and to advance clinically, values clinical competence, has leadership supportive of nursing, allows nurses to be engaged in local and organization-wide decisions, provides adequate patient care resources, and encourages collaborative relationships (Aiken & Patrician, 2000; Lake, 2002) . The elements of structural empowerment are access to opportunity, resources, information, support, and sources of both formal and informal power (Kanter, 1993). The elements of psychological empowerment are feeling competent, having your personal and organizational goals in alignment, and having a sense of autonomy (Spreitzer, 1995). As Lake (2007) says, the essential matter of nurses' work is the quality of the care. And it is the practice environment that supports quality care.

Thus, given the demonstrated association between empowerment and a positive professional practice environment, it would stand to reason that when empowerment is present nurses would perceive quality of patient care is present.

Intent to Leave

Intent to leave is defined as whether a working nurse intends to leave his/her place of employment. Leaving may be voluntary or involuntary (termed turnover). Involuntary turnover includes termination, required retirement, layoff, and forced leave due to inability to work. Voluntary leaving occurs when a nurse decides to leave either his/her local work unit or the organization for whom he/she works. Determinants of voluntary leaving have been hypothesized. They typically include socio-demographic and organizational variables (Hayes, et al., 2006; Tai et al., 1998). Socio-demographic variables may include age, gender, income, education, marital status, tenure, and role. Organizational factors may include the size, location, and quality of worklife of each organization.

The organizational factor, quality of work life as a predictor of intent to leave, has been well conceptualized. Gilmartin (2012) in a review of theoretical models of nurse intention to leave and subsequent research using these models, found job satisfaction is a strong predictor of intent to leave. In these models job satisfaction is defined as including autonomy and control over practice, professional satisfaction, and professional values fit. Repeatedly it has been shown that job satisfaction has greater impact on the intent to leave than any other individual or demographic variables such as pay, tenure, education, opportunity, and age (Brewer, Kovner, Greene, & Cheng, 2009). It is widely considered to be the major contributor to nurses' intent to leave (Borda & Norman, 1997).

Importantly intent to leave is the strongest predictor of actually leaving (Borda &

Norman, 1997; Brewer et al., 2009).

Nurse job satisfaction has been shown to occur when nurses are psychologically

empowered, they have autonomy and control over their practice, there is interprofessional

collaboration, there is leadership support and adequate staffing, and the organizational

policies and practices support nursing practice (Best & Thurston, 2004; Blegen, 1993;

Hayes, Bonner, & Pryor, 2010; Larrabee et al., 2003). As the lack of these elements are

predictors of moral distress, it stands to reason if nurses are experiencing moral distress

they are likely experiencing job dissatisfaction. When nurses experience job

dissatisfaction, they are more likely to have an intent to leave.

Method

A scoping study utilizing the framework proposed by Arksey and O'Malley

(2005) was conducted. A scoping study is undertaken to achieve clarity on a topic of

interest. Research and non-research literature is examined to identify gaps in

understanding, assess the need for systematic reviews, determine the need for policy, and

to summarize and disseminate results (Arksey & O'Malley, 2005; Levac, Colquhoun, &

O'Brien, 2010). Two of the four reasons for doing a scoping study express the purpose of

this study: (1) to understand the "extent, range, and nature" (Arksey & O'Malley, 2005,

p. 21) of research conducted on the constructs affecting the experience of nurse moral

distress and (2) to identify possible gaps in the research on moral distress. As per Arksey

and O'Malley (2005), the results will be demonstrated first in table format, then

discussed.

A review of the literature was conducted between the years 2000 - 2015.

CINAHL, Proquest Nursing and Allied Health Source, PubMed, PsychInfo, General

Business and Business Source, and Scopus were searched for primary sources using the keywords: empowerment, structural empowerment, psychological empowerment, nursing empowerment, nursing ethical/moral practice, nursing ethical/moral distress, interprofessional collaboration, quality of care, compassion, and intent to leave. Due to the broad nature of the concept of moral distress, this writer met with an academic librarian to appropriately frame the search. Literature from Canadian, European, American, African, and Australian writers across multiple disciplines (nursing, allied health, business, social sciences, and medicine) was reviewed. References cited in the retrieved literature were also reviewed. Key articles were used to conduct descendancy searches. Dissertations and theses were included.

Studies were included if they met the following criteria: (1) the respondents included nurses in any setting, (2) studies had either quantitative or qualitative research designs, (3) studies examined the relationship between the above seven constructs and moral distress either in a univeriate or multivariate relationship. Thirteen studies were included in the review. Most of the studies retrieved were cross-sectional in design. Two studies were longitudinal in design. This review has been organized to display the research on each of the above constructs as they relate to moral distress.

Results

Structural Empowerment

Table 5 provides an overview of research conducted which examines the relationship between structural empowerment and moral distress. The only study to date that has examined this relationship (Ganz, et al., 2012) did show a significant negative but weak association between these two variables ($r = 0.18$). Ganz hypothesizes, due to the weakness of the correlation, there may be a moderating variable. This weak finding

may also have occurred as the subjects were Israeli nurses and the tool used (MDS) was found to be culturally insensitive (Eizenberg et al., 2009). Eizenberg et al. (2009) conducted a qualitative study of 30 Israeli nurses to determine the Israeli-specific moral distress themes. A questionnaire was developed from the qualitative data. Factor analysis showed there are 3 relevant factors: work relationship problems, lack of resources, and time pressures. These factors are similar but not the same as the factors identified in the MDS: internal constraints, external constraints, and clinical situations. An examination of the items in each measurement tool confirms this difference.

Table 5

Structural Empowerment (SE) and Moral Distress (MD)

Author/Date/Country	Method/Aim	Sample	Results
Ganz et al., 2012 Israel	Cross sectional descriptive, correlational Aims: (1) determine levels of structural empowerment (SE), MD frequency & intensity, (2) and the association between them among intensive care nurses	n = 291 critical care Registered Nurses (RN) Israel	SE negatively correlates to MD but not to demographic variables

Psychological Empowerment

Table 6 provides an overview of research conducted which examines the

relationship between psychological empowerment and moral distress. Similar to structural empowerment, only one study was found which has examined this relationship (Browning, 2011). A statistically significant *positive* correlation was found between a subscale (deception) of MDS and psychological empowerment. This is an unexpected finding. The author speculates that although the respondents had an overall high psychological empowerment score they may have felt that they were unable to honestly address issues of patients' impending death. There was an expected significant negative relationship between psychological empowerment and the total moral distress *frequency* score. Browning's (2011) findings suggest that another variable may be moderating the relationship between psychological empowerment and moral distress.

Table 6

Psychological Empowerment (PE) and Moral Distress (MD)

Author/Date/Country	Method/Aim	Sample	Results
Browning 2011	Cross sectional, descriptive Aim: examine the relationship between MD and psychological empowerment (P E)	n = 277 critical care RNs USA	PE positively correlates to MD intensity, negatively correlates to MD frequency

Interprofessional Collaboration

Table 7 provides an overview of research conducted which examines the relationship between interprofessional collaboration and moral distress. Only three studies were found that examined this relationship (Hamric & Blackhall, 2007;

Karanikola, et al., 2013; Papathanassoglou et al., 2012). Only nurse-physician

collaboration was studied. Hamric and Blackhall (2007) surveyed 196 nurses and 29

physicians in 14 intensive care units (ICU) in two hospitals to examine the relationships

among collaboration, moral distress, and ethical (moral) climate in regard to end-of-life

care. Nurses who had high moral distress scores also had significantly lower

collaboration scores, lower satisfaction with quality of care scores, and lower ethical

climate scores than did nurses with low moral distress scores. There was insufficient

physician response to allow a similar assessment of the relationship between moral

distress and collaboration, satisfaction with quality of care, and ethical climate.

Papathanassoglou et al. (2012) surveyed 255 intensive care nurses from 17 European

countries to examine the relationships among nurse professional autonomy, collaboration

Table 7

Interprofessional Collaboration (IPC) and Moral Distress (MD)

Author/Date/Country	Method/Aim	Sample	Results
Hamric & Blackhall, 2007	Quantitative descriptive pilot study using survey design Aim: explore the relationships among MD, ethical climate, collaboration and satisfaction with care among critical care RNs and physician	n = 196 RNs and 29 physicians in critical care USA	RNs with high MD scores had lower IPC, patient satisfaction and ethical climate scores Insufficient Physician response to analyze results
Karanikola et al., 2013	Cross sectional correlational design Aim: explore the relationship between MD and (1) nurse–physician collaboration, (2) autonomy, (3) professional satisfaction, (4) intention to resign, and (5) workload among	n = 566 Italian intensive care unit RNs Cyprus	Negative correlation between the frequency and intensity of morally distressing events and collaboration Perception of

	Italian intensive care unit nurses		autonomy is positively correlated to collaboration
Papathanassoglou et al., 2012	Descriptive correlational design, self-administered questionnaire Aim: (1) explore levels of autonomy of critical care nurses (2) relationship of autonomy with RN-Physician collaboration, MD, and RN demographics	n = 255 European critical care nurses Greece	There is an inverse relationship between RN-Physician collaboration and RN MD Higher RN autonomy was associated with higher RN-Physician collaboration Frequency of MD events is inversely related to RN-Physician collaboration

with physicians, and moral distress. Individual country scores were not reported. Overall

autonomy scores had a positive association with collaboration scores; composite moral

distress scores [frequency times intensity] had a significant negative correlation with

collaboration scores. The study also found that the frequency of occurrence of morally

distressing events was significantly negatively correlated to collaboration scores. There

were similar findings in a secondary analysis done of the Italian respondents' data in

Papathanassoglou et al. (2012). Karanikola (2013) found there was a significant negative

correlation between both the frequency and intensity of morally distressing events and

collaboration and the intensity of morally distressing events and collaboration.

Compassion

Despite the standing compassion has in nursing, and the ample theoretical

literature, little empirical research has been done in nursing on the subject (Burnell, 2011;

Gilbert, 2005; Schantz, 2007; van der Cingel, 2009; von Dietze & Orb, 2007). Only one

published study with nurses as participants was found (Graber & Mitchum, 2004). No

studies were found which examined the relationship between compassion and moral

distress. There is only a small body of work on compassion to be found in nursing

dissertations and theses.

Graber and Mitchum (2004) used a qualitative approach to understand the nature

of compassion amongst a group of healthcare professionals including nurses, doctors and

any other "exemplary individuals" who were identified by hospital leadership as being

"really caring and compassionate in their interactions with patients" (p. 88). Twenty-four

clinicians were selected. They found compassion to be exemplified by a sense of the

humaness of the other, a unity with the patient, and an intention to help. They suggested

that compassion was found to be protective of the clinicians by increasing their resilience.

A total of seven studies on compassion were retrieved from nursing dissertations

and theses. The majority of them [4] were qualitative studies; one was a mixed methods

study and one a discourse analysis. In a discourse analysis of the nurse-patient

relationship in the USA in the 1950's Aita (1995) demonstrated that the then growing

scientific-bureaucratic [S-B] approach within nursing was stifiling the compassionate-

humanistic [C-H] approach to care. The discourse analysis included articles and books

published during this time, philosophical treatises on nursing and feminism,

conversations with nurses who had practiced during the 1950s, and correspondence and

private papers on nursing during that time. The S-B approach was in response to a

growing public dissatisfaction with the nursing profession. Assumptions were made that a

scientific, technical, objective, and bureaucratic dominant approach would increase

efficiency and consequently nursing status. However, as a result, the nurse's ability to

respond to patient's suffering was compromised. Nursing leaders of that time began to question the S-B paradigm. They wrote that compassion should be the "guiding principle for the nurse-patient relationship" (Aita, 1995, p. 158). They identified five elements which comprise compassion: a focus on the patient situation, responding to suffering, being personal and intimate, enabling what is of benefit to the patient, and humanizing of the technical aspects of care to the patient's individual needs.

Two studies examing the nurse-patient relationship sought to understand compassion from the patient's perspective (Burnell, 2011; Koerner, 2009). One study examined both the patient and the nurse's experience (Walker, 2009). In Burnell (2011) and Walker (2009) compassion was described as being an essential but not always present component of care. Patients described it was possible to be cared for without compassion. Compassionate nurses had warmth whereas others were "cool". Patients explained when nurses were compassionate, it enabled the nurse to better understand them. In Walker (2009) the 10 patients interviewed defined a compassionate nurse as being able to "discern the need, discomfort, or suffering of a patient without always being told or asked and [to] provide a level of care that surpasses basic requirements in such a way that the patient feels cared for, valuable, and safe" (p. 204). The nine nurses' experience of compassion was that it enabled them to recognize suffering and to go "the extra mile to meet a particular need or alleviate the suffering" (p. 191).

Three studies examined compassion from the nurse's perspective. In one study 18 students in a Masters of Nursing program were interviewed to determine what values guide their practice (McMillan, 1994). Ten values were identified: compassion, respect for the other, competence, commitment, inner harmony, patience, hope, courage, humility, and trust. The nurses spoke most frequently of compassion. They described compassion as

recognizing a shared humanity with patients, understanding their needs, suffering with the patient, and intending to alleviate the suffering. In another study, fourteen hospital-based nurses' lived experience of compassion was explored (Morgan, 1996). Four themes became apparent: human connection (respect for/valuing the person), encompassing emotion (feeling deeply about the needs of patients), benevolent intention (the desire to do good), and extraordinary generosity (more than usual care, extra measures). One study (Way, 2010) was undertaken to understand the experience of emotions of hospice workers - nurses, nursing assistants, social workers, and spiritual care providers. Compassion was cited as the most significant emotion experienced by this group, being experienced daily. In her analysis, Way (2010) conceptualized the subprocesses comprising compassion as recognizing, relating to, and responding to patient suffering.

As these studies of compassion point to compassion enabling nurses to understand patient suffering and to be moved to act to alleviate that suffering, it is noteworthy that no study has been conducted to test for a relationship between nurses' experience of compassion and moral distress.

Perception of Quality of Care

Table 8 provides an overview of research conducted which examines the relationship between perception of quality of care and moral distress. Three studies were found that sought to investigate this relationship (Ganz & Berkovitz, 2011; Gutierrez, 2005; Hamric & Blackhall, 2007). Ganz and Berkovitz (2011) in a study of 119 nurses who worked on surgical units in two Israeli hospitals found that perceived quality of care was significantly and negatively associated with the frequency of moral distress but was not significantly correlated with the intensity .

A study to explore the relationships of moral distress, ethical (moral) climate, and

satisfaction with the quality of care was conducted in 14 intensive care units in two

hospitals. Twenty-nine physicians and 196 nurses participated (Hamric & Blackhall,

2007). At both sites, nurses' perception of quality of care was significantly and

negatively correlated with their moral distress scores. There was no significant

correlation between physicians' moral distress and perception of quality of care.

The third study, rather than exploring the effect of the perception of quality of

care on moral distress, explores the converse: the experience of moral distress and the

effect it has on patient care. This phenomenological study of 12 critical care nurses found

that initially the nurses were reluctant to describe how moral distress affected the care

they provded (Gutierrez, 2005). However, with time the nurses did describe how moral

distress negatively impacted the quality of their care. Nurses described not wishing to

care for patients, when they were constrained from caring for them as they judged they

should. Respondents reported that there were instances of decreased interactions with

patients and families. The frequency of care decreased and became depersonalized.

Table 8

Perception of Quality of Care and Moral Distress (MD)

Author/Date /Country	Method/Aim	Sample	Results
Ganz & Berkovitz 2011	Quantitative – self report questionnaires Aim: describe RNs perceived levels of ethical dilemmas, moral distress and perceived quality of care and the associations among these variables	n = 119 RNs Israel	Perception of quality of care was inversely correlated to levels of MD
Gutierrez	Qualitative semi-structured	n = 12 RNs	Having MD negatively

| 2005 USA | interview Aim: to understand the experience of MD and effect of MD on care provided | USA | affects the quality of care provided |
| Hamric & Blackhall 2007 | Quantitative descriptive pilot study using survey design Aim: explore the relationships among MD, ethical climate, collaboration and satisfaction with care | n = 196 RNs, 29 Physicians USA | RN perception of quality of care was negatively correlated to their level of MD Physicians did not have a correlation between their level of MD and perception of quality of care |

Intent to Leave

Table 9 provides an overview of research conducted which examines the relationship between intent to leave and moral distress. Nine studies were reviewed which examined this relationship. Gaudine and Thorne (2012) conducted a longitudinal study of 410 nurses in four hospitals in four different regions of Atlantic Canada. Time one and time two were one year apart. Intent to leave was only measured at time 2 (time 1 measured absences). Three factors measured moral conflict: patient care values (meeting the needs of patients), value of nurses (collaboration and involvement in decision-making are supported), and staffing policy values (sufficient and appropriate staff are available). Intent to leave was negatively and significantly correlated to the factor patient care values of the moral conflict scale.

Table 9

Intent to Leave and Moral Distress (MD)

Author/Date/ Country	Method/Aim	Sample	Results
Gaudine & Thorne 2012	Quantitative longitudinal, 2 questionnaires completed 1 year apart Aim: to examine the relationship between nurse ethical conflict and organizational commitment, stress, intention to leave, absence, and leaving	n = 410 RNs Canada	Intent to leave was negatively associated with 1 factor of a moral conflict scale: sufficient and appropriate staff are available Actual leaving was inversely associated with 1 factor of a moral conflict scale: meeting the needs of patients
Hamric & Blackhall 2007	Quantitative descriptive pilot study using survey design Aim: explore the relationships among MD, ethical climate, collaboration and satisfaction with care among critical care RNs and physician	n = 196 RNs, 29 Physicians USA	There were 2 sites in the study. At site 1 1% of RNs had left a position due to MD, 23% had an intention to leave. At site 2 17% of RNs had left a position due to MD, 28% had an intention to leave
Thorne 2010	Quantitative longitudinal self-administered questionnaire Aim: examine the relationship between ethical conflict and employee stress, lack of organizational commitment, absenteeism, and intention to leave	n = 126 RNs Canada	A positive correlation (increased MD) was found between shared ethical priorities (SEP) and intent to leave. SEP is a measure of the employer's lack of commitment to safe patient care, family support, and appropriate staffing No correlation was found between ethical value congruence (agreement on values of caring, compassion, advocacy, and holistic care) and intent to leave
Tschannen,	Quantitative		Only RN results were

Kalisch, & Lee 2010	descriptive self-administered survey Aim: to examine the relationship between missed nursing care (inability to provide care) and intent to leave and leaving	n = 4,288 RNs, licensed practical nurses, nursing assistants USA	reported. RN intent to leave was positively correlated to missed care. Actual leaving was positively correlated to intent to leave
Strachota, Normandin, O'Brien, Clary, & Krukow 2003	Quantitative telephone survey Aim: determine reasons that (1) RNs voluntarily leave their jobs and (2) why nurses change to casual job status	n = 84 RNs USA	15% left due to inability to give the care they judged to be appropriate due to poor staffing and increased demands Reasons for changing to casual status were not reported
Fogel 2007	Quantitative self administered surveys Aim: explore relationships between (1) levels of MD and intent to leave and (2) the moderating effect of perception of ethical climate between MD and intent to leave	n = 100 RNs USA	A positive correlation was found between MD and intent to leave. Ethical climate was found to be a moderator between MD and intent to leave
Maningo-Salinas 2010	Quantitative self-administered surveys Aim: to examine the relationships between MD, perceived organizational support, and intent to leave	n = 180 RNs USA	A correlation was found between MD intensity and intent to leave A negative correlation was found between intent to leave and perceived organizational support
Papathanassoglou et al., 2012	Descriptive correlational design, self-administered questionnaire Aim: explore (1) levels of autonomy of critical care nurses and (2) relationship of autonomy with RN-Physician	n = 255 European critical care nurses Greece	MD was positively correlated to intent to leave

	collaboration, MD, and RN demographics		

In a study to assess the relationships among collaboration, moral distress, ethical (moral) climate and intent to leave, Hamric and Blackhall (2007) surveyed 196 critical care RNs and 29 critical care physicians at two hospital sites. At site one, 1% of the nurses had left a position due to moral distress and 23% had an intention to leave their current position. At site 2, 17% of the RNs had previously left a position due to moral distress and 28% were considering leaving. Nurses with higher moral distress scores were more likely to have an intention to leave or had previously left a position than nurses with a low score.

Thorne (2010) in a study of the correlation between moral conflict and intent to leave found a statistically significant correlation between shared ethical priorities and intention to leave. Shared ethical priorities is a measure of the extent to which a nurse disagrees with the ethical priorities and actions taken by his/her employer. As scores increase so does moral conflict. A significant correlation was not found between ethical value congruence and leaving intention. Ethical value congruence measures the degree to which a nurse and his/her employer agree on the values of caring, compassion, advocacy, and holistic care.

Tschannen et al., (2010) studied the relationship between missed nursing care (any aspect of care which nurses judged should be provided but could not be provided) and intention to leave and leaving rates on 110 units in 10 hospitals in the US midwest. Average amounts of missed care were calculated for each unit. Missed care was statistically significantly correlated to intent to leave and leaving. Larger amounts of missed care was statistically significantly correlated to greater intentions to leave and

intent to leave was statistically significantly correlated to leaving.

Strachota, Normandin, O'Brien, Clary, and Krukow (2003) surveyed 84 nurses who had voluntarily left employment at a large midwestern health care system, to ascertain their reasons for leaving. The most frequently given reason (50% of respondents) for leaving was hours of work (shift, holiday, and weekend work). Fifteen percent (15%) of respondents stated they left due to frustration with the quality of care. Nurses stated they could not give the care they judged to be required due to poor staffing and increased demands. They had "not become a nurse to give substandard care" (p. 114).

Fogel (2007) investigated the correlations among moral distress, ethical (moral) climate, and intent to leave of 100 critical care nurses in two hospitals. A positive correlation was found between some components of the moral distress tool (being asked to do work one is not competent to perform, being unable to give care deemed to be necessary, working with others who are not competent, and situations of injustice) and intent to leave. Ethical climate was found to be a moderator of the relationship between moral distress and intent to leave. The ethical climate scale measures nurses' perception of the relationships they have with peers, patients, managers, hospital administration, and physicians in relation to their ability to do their work.

In a study to examine the correlations among moral distress, perceived organizational support (the organization values nurses' work and cares about their well-being) and intent to leave Maningo-Salinas (2010) surveyed 180 inpatient and outpatient oncology nurses. A significant correlation was found between nurses who experienced more intensity of moral distress and intent to leave than nurses who experienced less intensity. A significant negative correlation was found between intent to leave and

perceived organizational support. Unlike the previous study, organizational support was not found to be a moderator between moral distress and intent to leave. Papathanassoglou et al. (2012) found that among 255 European critical care nurses, intention to leave was positively correlated to moral distress.

The research above on the relationship of moral distress and intent to leave suggests there is a positive correlation between these variables: as moral distress occurs, intent to leave and leaving occurs.

Discussion

Although the relationships among structural empowerment, psychological empowerment, interprofessional collaboration, compassion, perceived quality of care, moral distress, and intent to leave are intuitively apparent and evidence in the literature shows how these constructs may be linked, no study has yet looked at all of these relationships within the framework of a coherent model. Despite a nearly hand-in-glove fit among the items which comprise the constructs of structural and psychological empowerment and the antecedents of moral distress only one study each has been conducted to test for a relationship between them. Only three studies have examined the relationship between moral distress and interprofessional collaboration. This is surprising because for the most part, nurses work within teams to accomplish the goals of care. Another gap in this research is the failure to examine interprofessional collaboration including all members of the health care team, not only physicians.

No research was found that examined the relationship between compassion and moral distress. This is an interesting finding in itself as compassion enables the nurse to understand the patient and, thus, to know more clearly what his/her needs may be. Moreover, it moves the nurse to act to alleviate suffering by meeting those needs. If

obstructed from meeting those needs, nurse moral distress would be expected to follow. What is perhaps even more surprising is that there are only a handful of studies examining the experience of nurse compassion. As an iconic attribute of nursing it would be expected this would be a well-researched construct.

Two of the three studies (again, so few considering the inherent possible correlation) examining the perception of quality of care and moral distress clearly show an inverse relationship between the constructs (Ganz & Berkovitz, 2011; Hamric & Blackhall, 2007). The third study (Gutierrez, 2005), suggests that when a nurse has moral distress, his/her nursing care deteriorates. This creates urgency to be conducting more research to understand the relationship between these two variables.

Of all the relationships, the one between moral distress and intent to leave is the most well-studied. Even so, only nine studies were found. Although clearly suggesting a causal pathway between having moral distress and intent to leave, it is challenging to create strategies and policy with such limited data.

Finally, no research was found studying a more complex causal pathway that takes more than two variables into account. Moral distress is a complex construct (Lutzen et al., 2003; Pauly et al., 2009). It needs to be studied taking into consideration a nomological network (Corley, 2002; Hamric 2012; Lutzen & Kvist, 2012).

Conclusion

Moral distress may be experienced by any member of the inter-professional team (Carpenter, 2010; Brazil, Kassalainen, Ploeg, & Marshall; Forde, 2008; Ulrich et al., 2007). To limit the scope of this study, only the experience of nurse moral distress was explored. As identified at the start, the purpose of this scoping study was to (1) to understand the "extent, range, and nature" (Arksey & O'Malley, 2005, p. 21) of research

conducted on the constructs affecting the experience of nurse moral distress and (2) to identify possible gaps in the research on moral distress. An examination of the literature has revealed there are gaps and limitations in the research needed for an adequate understanding of the experience of nurse moral distress. As outlined earlier, the effects of nurse moral distress pose risks to patients, the nurse, and healthcare organizations, therefore there is a need to more deeply understand this construct. Once better understood, a more readily appropriate and effective effort can be made to mitigate moral distress.

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CHAPTER 4

UNDERSTANDING COMPASSION FATIGUE:

UNDERSTANDING COMPASSION

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Introduction

Compassion fatigue is not a new concept in nursing. Joinson (1992) characterized it as a unique form of burnout, calling it 'compassion fatigue'. She believed that because of it, nurses were experiencing forgetfulness, decreased attention span, exhaustion, physical illness, often leading to apathy and anger. Since then, attention to this phenomenon has grown. Compassion fatigue has been variously characterized as vicarious trauma, secondary trauma syndrome, occasionally post-traumatic stress syndrome and/or as a variant of burnout (Craig & Sprang, 2010; Joinson, 1992; Yoder, 2010). Valent (2002) writes that compassion fatigue may either have a place on a continuum before or after burnout, or burnout creates and then potentiates compassion fatigue. Thomas and Wilson (2004) postulate that compassion fatigue stands on its own. From their work with traumatized and suffering patients, they identify three distinct traumatoid outcomes: compassion fatigue, secondary traumatic stress and vicarious traumatization. Following a comprehensive conceptual analysis Coetzee and Klopper (2010) contextualize compassion fatigue as '…the final result of a progressive and cumulative process that is caused by prolonged, continuous and intense contact with patients, the use of self and exposure to stress.' (p. 237). Austin, Goble, Leir, and Byrne

(2009) sees compassion fatigue as resulting from feeling unable to provide the care that is judged to be appropriate.

Background: The Discourse on Compassion Fatigue

Nurses are fatigued. It is reported that not only are they physically fatigued they are also suffering from compassion fatigue (Sabo, 2011a). There is a growing concern not only about physical fatigue but also about psychological fatigue (Canadian Nurses Association, 2010), including compassion fatigue. The results of fatigue are devastating, negatively affecting the nurse, the patient, the organization and even society. The report cited calls for governmental, organizational and individual level changes to deal with this significant and mounting challenge to nursing practice (CNA, 2010). This topic is of relevance to many communities of nurses. Compassion fatigue has been discussed and studied in North America (Austin *et al*., 2009; Hooper, Craig, Janvrin, Wetsel, & Reimals, 2010; Perry, 2008; Potter *et al.,* 2010; Sabo, 2011a; Yoder, 2010), Europe (Laurenson, 2012; Lauvred, Nonstad, & Palmstierna*.,* 2009; Markaki, 2014; Mendes, 2014), Australia (Ainsworth & Sgorbini, 2010; Vann & Coyer, 2014), Asia (Cho & Jung, 2014; Fu & Chen, 2011; Sung, Seo, & Kim*,* 2012), Africa (Coetzee & Klopper, 2010; Harrowing, 2011) and the Mid-East (Zeidner, 2013).

Data Sources

A review of the literature was conducted. CINAHL, Proquest, Nursing and Allied Health Source, PubMed and PsychInfo were searched for primary sources using the keywords compassion and compassion fatigue. The literature from 1992-2014 on compassion fatigue was examined. The literature from 1998-2012 on compassion was examined. Literature from European, North American, Middle-Eastern, African, Asian and Australian writers was reviewed. Included in the review were articles referencing any type of nursing practice in any setting. References cited in the retrieved literature were

also reviewed. Key articles were used to conduct descendancy searches. Dissertations and theses were also searched.

The Literature

Some have taken an empirical approach to understanding compassion fatigue. Many of the quantitative studies have focused on the prevalence of compassion fatigue occurring within diverse nursing settings: hospice, emergency, oncology, nephrology, intensive care, medicine, surgery, mental health, pediatrics, home care and public health (Abendroth & Flannery, 2006; Hooper *et al*., 2010; Lauvrud *et al*., 2009; Meadors & Lamson, 2008; Robins, Meltzer, & Zelikovsky, 2009; Potter *et al*., 2010; Yoder, 2010). Compassion fatigue was found to be present in all of these nursing contexts. Some studies have looked at the relationship of demographic variables to the occurrence of compassion fatigue. The studies found no significant associations between compassion fatigue and the demographic variables of ethnicity, age, marital status, hours worked per week, years of experience, nurse specialty, gender, country of training, education, or years of employment at the study setting (Abendroth & Flannery, 2006; Frank & Adkinson, 2007; Frank & Karioth, 2006; Potter *et al*., 2010; Robins *et al*., 2009). Other studies have compared and contrasted the concepts of burnout, compassion fatigue, compassion satisfaction, job satisfaction and stress. Findings from all these studies were equivocal. For example, compassion fatigue was correlated with burnout, but was not statistically significant. However, in the same studies burnout was statistically significantly correlated with job satisfaction and work-related stress (Burtson & Stichler, 2010; Potter *et al*., 2010). In a national survey of American oncology nurses to determine what resources were available to mitigate compassion fatigue, compassion fatigue and burnout were not conceptually distinguished (Aycock & Boyle, 2009).

Qualitative studies to understand compassion fatigue are less common. One study (Austin *et al*., 2009, p. 201) linked it to the 'broader pre-determined structure (of) the healthcare environment' through the experience of five nurses who self-identified as having compassion fatigue. The study found that nurses experienced compassion fatigue when they perceived themselves as unable to fulfill their moral responsibility; that is, they could not provide the care they thought necessary. This suggested that compassion fatigue is moral distress. Ward-Griffin, St-Amant, and Brown (2011), in a study of nurses engaged in double-duty care-giving, suggest that the 'blurring of boundaries between professional and personal care work' (p. 1) predisposes to compassion fatigue. These two studies share the assumption that nurses are not at fault for experiencing compassion fatigue but rather it is the broader context which creates the circumstances and whithin which compassion fatigue arises. Other qualitative studies, with various tacit assumptions of what compassion fatigue is (e.g. burnout, secondary trauma syndrome or PTSD) have sought to identify the effectiveness of particular strategies to mitigate compassion fatigue (Harrowing, 2011; Maytum, Heiman, & Garwick, 2004) and how exemplary nurses might avoid compassion fatigue (Perry, 2008). But the strategies are as various as the assumptions.

All of these constructs of compassion fatigue share a conviction that there is a 'cost to caring' (Figley, 2002, p. 2). This cost, we are told, is borne by the nurse, the patient and the health care organization (Schantz, 2007; Najjar, Davis, Beck-Coon, & Doebbling, 2009; von Dietze & Orb, 2007). For nurses, the effects of compassion fatigue can include anxiety, fear, sadness, grief, anger, rage, uncertainty and persistent feelings of vulnerability (Thomas & Wilson, 2004). Nurses may become detached from their patients and withdraw emotionally to protect themselves. They may experience a physical and

mental fatigue that cannot be alleviated by a vacation (Burtson & Stichler, 2010; Schwan, 1998). The symptoms can become progressively worse to include questioning the meaning and purpose of their lives, isolating themselves from others, engaging in compulsive behaviours such as substance abuse, overspending, overeating, feeling apathetic, having difficulty concentrating and functioning in their roles (Compassion Fatigue Awareness Project, 2010; Sinclair & Hamill, 2007). Similarly Austin et al. (2009) found nurses may have difficulty sleeping, become distressed and may 'lose balance in their lives' (p. 206).

Whatever it is called and however it is understood, all authors describe the serious nature of compassion fatigue. In addition to the harm done to nurses, the authors speculate that nurses suffering from compassion fatigue are unlikely to be able to deliver quality patient care, placing patients at risk. Authors hypothesize because of disengagement from the patients and the health care team, apathy, anxiety and cognitive impairment, nurses are at increased risk of making errors, exhibiting poor judgment and being unable to establish or maintain positive inter-professional relationships (Alkema, Linton, & Davies, 2008).

<center>**Discussion**</center>

While all these studies examined the prevalence, possible relationships to other concepts and the resources available to mitigate it, they use substantially different views as to the nature of compassion fatigue. While many of the studies state compassion fatigue is the result of secondary traumatic stress syndrome (Abendroth & Flannery, 2006; Alkema et al., 2008; Burtson & Stichler, 2010; Hooper *et al.*, 2010; Potter *et al.* 2010; Robins *et al.*, 2009), others see it as arising from a combination of posttraumatic stress disorder and burnout (Meadors & Lamson, 2008; Yoder, 2010). Compassion

fatigue may also be understood to be vicarious trauma or secondary traumatic syndrome (Figley, 2002; Maytum *et al*., 2004). Lauvred *et al*. (2009), however, believe it arises solely from post-traumatic stress disorder, whereas Frank and Adkinson (2007) use a definition of compassion fatigue with attributes similar to, but not identical to secondary trauma syndrome: a holistic state of exhaustion and dysfunction due to the emotional strain and burden of the victims. Some authors use 'compassion fatigue' and 'burnout' synonymously (Valent, 2002); some acknowledge similarity (Keidel, 2002; Yoder, 2010), some say they are distinct phenomena. Alkema et al. (2008) for instance, defines compassion fatigue as 'the result of secondary exposure to traumatic events… burnout is a general construct describing a reaction to work-related stress' (p. 104).

Scholars note these different understandings of the nature of compassion fatigue (Aycock & Boyle, 2009; Perry, Dalton, & Edwards, 2010; Robins *et al*., 2009; Sabo, 2011b) and are clear that there is a failure to 'adequately differentiate it from other constructs' (Najjar *et al*., 2009, p.267). There is further muddying of the waters now with the appearance in the literature of two other concepts: empathy fatigue (Bush, 2009) and professional failure to thrive (Perry *et al*., 2010; Stamler & Gabriel, 2010).

Is compassion fatigue influenced by a prolonged exposure to patient suffering, to a single critical incident, or to an inability to provide the care one believes is necessary? Does it arise from burnout or is it influenced in some way by burnout? Does the degree of patients' ill health shape the incidence of compassion fatigue? Does compassion fatigue only occur with exposure to trauma patients? Hooper *et al*. (2010) were surprised to find nurses working in oncology were at greater risk for compassion fatigue than nurses in emergency departments. Equally surprising, the risk scores for compassion fatigue were relatively equal among inpatient and outpatient oncology staff (Potter *et al*., 2010). There

is clarity regarding the antecedents and attributes of physical fatigue but there is no similar clarity for compassion fatigue (CNA, 2010). In fact, the CNA report states it could not find an operational definition of compassion fatigue (2010).

Compassion

As demonstrated, there are markedly differing explanations of, even confusion about the ontology and etiology of compassion fatigue. Perhaps to understand compassion fatigue, we must first understand compassion. Turning to the nursing literature on compassion, interestingly here too there is a lack of clarity. Although considered a core attribute of nursing, there is only a limited literature on its attributes, antecedents and effects, measurements of its presence and prevalence, or the expected nursing practices (Gilbert, 2005; Graber & Mitcham, 2004; Schantz, 2007; von Dietze & Orb, 2007). What can be found are directives, exhortations, descriptions and expectations. Nurses are or must be compassionate and care is or is to be compassionate. Upon investigation 'compassion as a concept is hardly found' in nursing theories (van der Cingel, 2009, p. 134) and I could find no evidence that compassion is taught. That said, a discourse on compassion is beginning to appear in the UK literature. This is likely a result of the UK government (with support from the Royal College of Nurses) determining in 2008, that 'nursing care would be measured for compassion' (Bradshaw, 2011, p. 465) and nurses will be tested for compassion (Sellman 2012). The discourse however is not to establish what compassion is but to allege the elusive nature of compassion and thus the challenges in measuring it (Cooper 2012; Mooney 2009). How is it we claim compassion is an integral component of our practice when its nature is not known (Olshansky, 2007)? It seems we have an agreement, an understanding that nurses are compassionate, full stop. It would appear that nothing more need be said or known

about compassion. However, as it has only little been studied in a nursing context, we cannot presume to understand compassion or even to assume all nurses are compassionate (Graber & Mitcham, 2004; Hem & Heggen, 2004; von Dietze & Orb, 2007). It is clear though that compassion has iconic standing in nursing. Why is this? Why would senior nursing bodies exhort system change when compassion fatigue may be misapprehended and even compassion may not be understood? Why would there be an abundance of literature on compassion fatigue but a dearth on compassion?

As there was little in the nursing literature to guide me to understand the nature of compassion I turned to the philosophical literature. Compassion has been contemplated for several thousand years in philosophy and in the Buddhist tradition (Davidson & Harrington, 2002). The concept of compassion is derived from the philosophical theories of virtue and justice (van der Cingel, 2009). The philosophers Schopenhauer, Rousseau and Seneca each wrote that compassion is a fuel for social justice wherein the highest good is human well-being (Williams, 2008). Others agree there is a moral component to compassion, that to be affected and moved to action by another's distress is a basis for living a moral life and creates a framework for social order (Armstrong 2010, Doris, 2010). Compassion is a response to human frailty that 'informs and motivates our duties towards others' that by its very nature creates a desire to act on behalf of others (O'Connell, 2009, p. 3). This movement to act differentiates compassion from empathy, sympathy and pity that do not move one to act (Armstrong, 2010; Goetz, Keltner, & Simon-Thomas, 2010). From an evolutionary perspective it is postulated compassion emerged as an affect to protect vulnerable offspring and enable co-operation amongst non-kin (Oveis, Horberg, & Keltner, 2010).

Compassion as archetype. Compassion as understood as a motivation to act, to

alleviate the suffering of others, to nurture and to be moved towards social justice

resonates with the ideal or archetype of nursing. Perhaps this is why there is so little

discourse on compassion. Conceivably, at some subliminal level, nurses know

compassion. It is so integrated into our self-concept as nurses, it has not occurred to us to

study it. Jung, who proposed and developed the concept of *archetype*, postulated that all

things have their 'ideal' configuration that is universally known and understood. The

ideal becomes part of the collective unconscious and acts as a stereotype upon which

others following are copied. Jung believed archetypes provide a recognizable, typical

even comfortable pattern of behavior that has certain probable and predictable outcomes

(Stevens, 2001). We expect, even at an unconscious level, what the ideal to be and to act

in that way.

Nursing's archetype of the compassionate nurse is crystallized with Florence

Nightingale. She epitomizes the feminine, mother archetype, modeling behavior that is

nurturing, caring and even self-sacrificing for the greater good of others (Kaler, 1990).

Nightingale, in her notes addressing patient suffering writes, 'that nurses must strive to

alleviate this (suffering) through acts of compassion' (Straughair, 2012, p. 161). This

perspective of nursing was the driving philosophy of the time. In his hypothesis of

archetypes, Jung postulated that an archetype will persist consciously or subconsciously

in a culture as long as it provides a recognizable mental model of wholeness or fit with

expectations and norms (Stevens, 2001). It would seem this ideal has endured. As nursing

education developed, the ideal of compassion as a nursing virtue was incorporated into

curriculum (Bradshaw, 2011). In 1934, only 24 years following Nightingale's death,

Taylor (Dean of the Yale School of Nursing) in an address to the National League of

Nursing Education states that nursing has an obligation to select students who are

prepared to make sacrifices, have a sense of justice and can nurture patients when their need is the greatest (Taylor, 1934). Thirty years later in the mid-20th century in 1964 the nursing theorist, Virginia Henderson described being strongly influenced by Annie W. Goodrich, the Dean of the Army School of Nursing (her alma mater) who said that nurses required 'boundless compassion' (Henderson, 1964, p. 64). As the 20th century closed, in 1996, Henderson re-published her work without changes to her conception of compassion and nursing (Henderson, 1991). Newly into the 21st century, the archetype persists. Jean Watson another nursing luminary and theorist, describes a need to return to nursing's roots to re-awaken to an understanding of the nature of nursing practice. Watson describes the real nature of nursing as including the tasks of providing compassionate caring and healing service and the transformation of suffering. The 'raison d'etre (of nursing) is for compassionate service to humanity' (Watson, 2006). Watson cites Nightingale as believing nursing is a calling and considers nursing the 'sacred feminine archetype' of nurturing, self-sacrificing and serving (Warelow, Edward, & Vinek, 2008, p. 149).

Other authors and nursing professional bodies concur that it is a well-understood tenet that compassion is core to nursing (Heffernan, Quinn Griffen, McNulty, & Fitzpatrick, 2010; Perry *et al*., 2010). Echoing the earlier philosophers' discussions of compassion, the Canadian Nurses Association declares the provision of safe, compassionate and competent care to be a cornerstone of practice (Canadian Nurses Association, 2003). Compassion is thus inextricably linked to professional practice (Harrowing, 2011). Because of its nature, compassion gives the 'context and direction to nurses' decisions and actions' (von Dietze & Orb, 2000). Compassion is foundational in nursing (Hem & Hegen, 2004; Horton, Tschudin, & Forget, 2007; Watson, 2006).

Compassion is nursing's archetype.

A return to compassion fatigue discourse. Now understanding what compassion is and its preeminent place in nursing, it is more easily understood why there is such interest in the phenomenon of compassion fatigue. We heard the term compassion fatigue and we rallied. But were we premature in our reaction?

I would like first to return to the discourse on compassion fatigue. Beginning with Joinson (1992), compassion fatigue is often equated with burnout. As noted, the term 'compassion fatigue' first appeared in the nursing literature in that article, where Joinson offered a commentary on what she was observing amongst nursing colleagues: disengagement, feelings of helplessness, anger and apathy among other symptoms. Following, some authors simply took up Joinson's statement without apparent examination and have used it more or less verbatim (Craig & Sprang, 2010; Yoder, 2010). However, a careful examination of Joinson's (1992) original article, suggests she was not attempting to establish a causal relation between burnout and compassion fatigue. Writing as a nurse educator, she borrowed the term from a crisis counselor and *supposed* its cause to be burnout. Of course, there is no doubt that burnout exists in its own right. Schaufeli and Greenglass (2001), pre-eminent scholars on burnout, state it occurs when the employee (nurse) perceives that the employer lacks a commitment to the nurse and withholds organizational support, for example, failure to attend to resolution of workplace abuse, role conflict, role ambiguity, work overload and job insecurity. This would suggest then that burnout is associated more with a breakdown in the employer-employee relationship than with the nurse-patient relationship.

Of note, all but one (Meadors & Lamson, 2008) of the above studies used either

the Professional Quality of Life Elements Theory and Measurement tool (ProQOL) or the Compassion Fatigue Self-Test to measure compassion fatigue among nurses. Both are derived from Figly's work (Proqol.Org., 2010). Figley, a psychologist researcher (1995, 2002), like Joinson (1992), is often cited in the discourse of nurses and other healthcare providers' experience of compassion fatigue. Figley acknowledges Joinson (1992) in many of his writings as the source of the term compassion fatigue (an interesting turn as one might speculate the counselor from whom Joinson took the term was perhaps a psychologist or social worker). He asserts that the source of compassion fatigue is not burnout but vicarious or secondary exposure to trauma. Like burnout, vicarious trauma is a real condition and it is possible that nurses might suffer from it. However, the question is whether or not Figley is correct in finding that vicarious trauma to be the cause of compassion fatigue in the context of nursing.

Although often cited in discussions related to nursing, Figley's research does not actually include nurse participants. His work is based on the experiences of therapists and counselors who work with clients traumatized by physical or psychological assault, violent crimes, natural disasters, combat and the like. Although nursing researchers have invariably used the ProQOL and Compassion Fatigue tools to quantify the degree of compassion fatigue, the tools do not appear to measure the construct of compassion as described earlier. In addition, Figley notes that he chose the term 'compassion fatigue' only because it is a 'more user-friendly term for vicarious and secondary trauma' to reduce the stigmatization of being diagnosed as traumatized (Figley, 2002, p. 3). Later Figley tells us that although secondary traumatic stress/compassion fatigue and vicarious traumatization have 'distinctions' in terms of 'theoretical origin and symptoms' they will all be referred to as compassion fatigue (Bride, Radey, & Figley, 2007, p. 156). Bride,

Radey and Figley (2007) go on to warn researchers to exercise caution in interpreting any scores obtained from the above tools as they have been given a low threshold to pick up the variable of interest ('compassion fatigue') to prevent any false negatives. The authors go on to say that it is possible respondents could show high levels of compassion fatigue as per the measurement tool, when 'in fact (the respondents) are not experiencing compassion fatigue' (p. 162). The authors advise the tools should be used for screening purposes only. The plausibility then of the findings being applicable to nursing is doubtful. In all, it would seem that the discourse on compassion fatigue rests on a most fragile foundation.

Implications for Nursing

Current Discourse Challenges

The discourse thus far on compassion fatigue is perplexing. The multiple viewpoints about the nature of compassion fatigue are confusing and the methods used to measure it may be neither reliable nor valid. With this in mind, I see significant implications. As noted above, a national nursing body is calling for system-wide policy and practice changes to mitigate compassion (and physical) fatigue. This creates a risk that recommended strategies and policies may be ill conceived and not address the targeted phenomenon. If compassion fatigue is essentially different from other kinds of fatigue such as burnout or secondary traumatic syndrome, then nurses and health care organizations may need to devise different strategies and programs to deal with it than those they use to manage burnout. Perhaps of even greater concern in this discourse is the notion of 'the cost of caring'. Authors suggest that compassion fatigue arises due to caring (using the terms compassion and caring synonymously). 'Caregivers are at risk for emotional exhaustion from their work, in any level or all degrees described by the

constructs (of compassion fatigue) proposed in the literature' (Bush, 2009, p. 26). This implies that being engaged in the act of caring creates risk for the nurse. If this is true the risk is great. Caring is extensively cited in the literature as a core value that guides and sustains nursing practice (Harrison, 2006). As Watson (2006) states, it is the caring relationship that often calls individuals into nursing in the first place. Could it be possible that caring itself is the source of nurse suffering? Now knowing more about this discourse, I would suggest caution in implementing strategies to mitigate compassion fatigue and in propagating the hypothesis that there is a cost to caring. I suggest that there is a need to clear a space and re-build the foundation of our understanding of compassion fatigue.

Alternate Discourse Opportunities

Although there is inconsistency in the use of and conceptual ambiguity about the term 'compassion fatigue', its potential for expressing something of core importance to nursing practice has been demonstrated in the readiness with which the term is used and the phenomenon studied (Coetzee & Klopper, 2010; Najjar *et al.*, 2009; Perry, 2008). How then might we comprehend compassion fatigue? Let me again take you back, but this time to *compassion* because how we understand the meaning of compassion in nursing will guide us to understand compassion fatigue.

There is ample discourse about compassion, theoretical and empirical, occurring outside of nursing. The Stanford Centre for Compassion and Altruism Research and Education defines compassion as 'a process that unfolds in response to suffering. It begins with the recognition of suffering, which gives rise to thoughts and feelings of empathy and concern. This, in turn, motivates action to relieve that suffering' (Centre for Compassion and Altruism Research and Education, 2011). The research is showing that we have an

innate potential to express compassion; that it can be taught, learned and nurtured (Gilbert, 2005; Kahane, 2009; Pence, 1983). When practiced its presence can even be demonstrated in images of neuronal pathways (Davidson & Harrington, 2002). The presence and practice of compassion can decrease the experience of burnout, increase resilience and enable one to more easily handle conflict (Van Dam, Sheppard, & Forsyth, 2011). Compassion we have learned is the complement to the fight or flight response as when in a compassionate state oxytocin is secreted and when in fight or flight mode cortisol is excreted (Keltner & Goetz, 1998). Interestingly, the physiological signature for compassion is the same as for willpower (McGonigal, 2012). Compassion is characterized by acceptance, endurance, action and courage (Lickerman, 2009). Importantly it allows us to cross the chasm of 'otherness'. A hallmark of compassion is its ability to induce an other-oriented attitude (Gilbert, 2005; Keltner & Goetz, 1998). As compassion enables one to enter into a relationship, open oneself to another and know the other, might we then understand compassion as a mediator of the successful nurse-patient therapeutic relationship? Compassion fatigue might, then, be a symptom of an interruption in the relationship, when the act of caring has been impeded or obstructed. It follows then, that in such cases it may not be caring (the manifestation of compassion) which creates suffering but rather the inability of nurses to relieve suffering, the inability to provide care.

It is noteworthy that the qualities of compassion are mirrored in the Canadian Nurses Association Code of Ethics, within which nurses are required to practice (2008). The Code declares that nurses will promote health, well-being and justice, will respect informed decision-making and will preserve dignity. Like the CNA's Code of Ethics, compassion requires that suffering be alleviated, the irreducible value of every person is honoured and that all are treated with justice, equity and respect. As the values expressed

in the Code of Ethics are the same as the characteristics of compassion, when unable to enact one, then perhaps, *de facto* one is unable to enact the other. In a situation of moral distress, the nurse is unable to exercise the now professionally/legally obligatory virtue of compassion. When nurses are unable to practice ethically 'they may feel guilt, concern, or distaste as a result.' (Canadian Nurses Association, 2003). There can be both a profound physical and emotional impact. Similarly, feelings of anxiety, disappointment, despair and physical effects arise when a nurse is frustrated in his or her obligation to exercise compassion (Austin *et al*., 2009). These are similar to the effects of compassion fatigue noted earlier. Thus when the imperatives of compassion cannot be fulfilled what ensues, which we have named compassion fatigue, may perhaps, be moral distress.

Conclusion

To understand what compassion fatigue might be, I would argue we must first study compassion in nursing. We must raise compassion from an iconic or symbolic status in nursing to a real and measurable attribute. Once compassion's nature, prevalence and contribution in nursing are known then we might understand what effect there is for nurses when compassion is not present or is thwarted. As compassion motivates action to alleviate suffering under what circumstances might compassion fatigue occur? In this new discourse we might reconceptualize the concept of the 'cost of caring'. Perhaps it isn't caring which creates nurse suffering but when care is obstructed. I would also argue we use the term compassion fatigue cautiously. It connotes a lessening of, rather than the impediment to, the expression of compassion. Do we understand compassion as an economic model? Does one only have so much compassion, then one becomes compassion fatigued or depleted? In fact, do we know if all nurses are compassionate? It would seem that as yet, we don't know.

The current discourse on compassion fatigue has served us well by illuminating compassion is an essential concept in nursing and by making known that nurses are suffering (Jezuit 2003). It has also served to illuminate that we have taken much for granted. We believe we know what compassion is when it would appear we may not; that we argue for compassion but may not educate or nurture nurses in expressing it; that we use the term loosely and synonomously with care when they may or may not be the same construct; that we may not appreciate that opening to another's suffering may eliminate 'otherness' which could be a key variable in the nurse-patient relationship; and importantly that we misapprehend that compassion may leave us vulnerable when in fact it appears to give us the strength to act, increases resilience and sustains and supports us. I would thus argue we continue this discourse by determining what compassion is in nursing: its antecedents, effects and prevalence. When that is known we might then understand what compassion fatigue is. Ultimately, in understanding both phenomena we will more deeply understand the nurse-patient relationship.

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CHAPTER 5

UNDERSTANDING THE CORRELATES OF MORAL DISTRESS

Nursing is a practice grounded in ethics (Corley, 2002; Lutzen, Dahlqvist, & Norberg, 2006). Every nursing act is measured against requisite ethical standards to do no harm, to promote justice, to be accountable, and to provide safe and competent care (Heikkinen, et al., 2006; Lutzen, Blom, Ewalds-Kvist, & Winch, 2010). Nursing, being oriented to the promotion of the patient's needs in their entirety, can be considered a "moral practice" (Goethals, Gastmans, & Dierckx de Casterle, 2010). [4]

The knowledge that ethical considerations are a core component of nursing practice is not new. The first modern study exploring ethical standards and moral practice issues in nursing was conducted in 1935. Since then there have been many more studies exploring moral practice. As the nature of the nurse-patient therapeutic relationship requires acting on the patient's behalf, it is to be expected that these studies found moral situations arising frequently in nursing. Moral decisions occur in the "everyday practice of individual nurses" (Park, 2009, p. 68).

However, as nurses attempt to act, there may be obstacles to pursuing the course of care as agreed to with the patient such as inadequate staffing, cost-containment strategies, and policy constraints (Beagan, 2009; Corley, Elswick, Gorman, & Clor, 2001). In attempting to reconcile ideals of practice with what may be an opposing reality, nurses may experience moral distress. First described by Jameton [a philosopher and

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[4] Please note that generally in the nursing literature no distinction is made between the terms "moral" and "ethical" (College of Nurses, 2002; Johnstone & Hutchison, 2015; McCarthy & Deady, 2008). However, in general philosophy and bioethical literature, a distinction is made between the terms: "moral" refers to right or good conduct and "ethical" refers to the theory of right or good conduct. In this paper I will use the term

qualitative researcher] in 1984, moral distress is a phenomenon that occurs when nurses are unable to carry out care they believe to be morally appropriate (1984). Jameton (1984) described both internal (the individual) and external (the environmental) constraints to care. The internal are: lack of assertiveness, self-doubt, perceived powerlessness, socialization to follow orders, and not fully understanding the situation. The external are: inadequate staffing, lack of time, hierarchies within the healthcare system, lack of collegial relationships, lack of administrative support, policies and priorities that conflict with care needs (such as in relation to providing other needed social services), lack of autonomy, fear of litigation, and compromised care due to pressure to reduce costs.

Subsequent researchers speak of moral distress arising in environments where due to a lack of power nurses feel coerced into providing care they consider to be less than the best (Millette, 1994; Shepard, 2010). Cohen and Erickson (2006) identify sources of moral distress to be conflict amongst colleagues about job performance and patient care plans, power imbalances amongst health professionals, inadequate staffing, lack of support from leadership, inadequate orientation periods, and rationing of resources.

Studies have been undertaken to understand the correlates of nurse moral distress. Variables noted in the literature that align with the internal and external constraints to practice noted above have been studied in context with moral distress: structural and psychological empowerment, interprofessional collaboration, the perception of the quality of care, and intention to leave. However, each of these variables has been studied singly in relation to moral distress. A more complex causal pathway has not been

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"ethical" when referring to standards and "moral" when referring to conduct and the consequences of conduct. The consequence of relevance here is moral distress.

contemplated in the research literature. In addition, a relationship that has not been considered, although expected, is the relationship between moral distress and compassion. Considered an iconic attribute of nursing, this variable has in fact been little studied in nursing.

The purpose of this study was to examine how structural empowerment, psychological empowerment, interprofessional collaboration, compassion, and the perception of the quality of care affect nurses' perceptions of moral distress. Additionally, this study, examines the relationship between moral distress and intention to leave.

Theoretical Framework

The guiding framework used in this study is Kanter's expanded theory of structural empowerment (Laschinger, Finegan, Shamian, & Wilk, 2001). The current conceptualization of the concept moral distress has been integrated into this framework. I will describe in the following section each concept in the hypothesized model with its associated current empirical literature.

Moral Distress

Moral distress has been well examined in the nursing literature. Studies have been conducted to measure its prevalence and antecedents (Corley, Minick, Elswick, & Jacobs, 2005; Elpern, Covert, & Kleinpell, 2005; Mobley, Rady, Verheijde, Patel, & Larson, 2007; Pauly, Varcoe, Storch, & Newton, 2009). Nurse participants were from a broad range of clinical settings. All participants reported moderate to high levels of moral distress intensity with low to moderate levels of frequency of morally distressing events. These studies found the antecedants to moral distress were organizational barriers to care such as: poor staffing patterns, poor working conditions, an inability to protect patients'

rights (Rice et al., 2008; Zuzelo, 2007); an inability to control events affecting care, overwork (Corley et al., 2005); feeling powerless when dealing with physicians and administrators (Elpern et al., 2005; Mobley et al., 2007); and a lack of resources (Pauly et al., 2009). Other research has found moral distress was experienced when there were insufficient resources, when forced to act against professional guidelines, when there were insufficient supporting structures (Kalvemark, Hoglund, Hansson, Westerholm, & Arnetz, 2004), and when participants felt subordinate to physicians and unsupported by leadership.

Structural Empowerment

The organizational constraints that may lead to moral distress are similar but contrary to the constructs necessary for empowerment. A premise across the definitions of empowerment is the "notion of individuals having the power to accomplish their work in a meaningful way" (Laschinger, Gilbert, Smith, & Leslie, p. 5, 2010). Kanter's theory of Organizational Empowerment describes six elements that are required by employees to be empowered so that they can more effectively accomplish their work. They are: access to information, resources, support and development, and exercising informal and formal power.

Empowerment is a well-researched concept in nursing. Studies have validated Kanter's model of empowerment in a nursing context. Perception of empowerment has a strong effect on nurses' perception of control over their practice (Laschinger, Sabiston, & Kutszher, 1997; Manojlovich, 2005); a positive effect on the reported provision of quality, individualized care (Caspar & O'Rourke, 2008); a positive correlation with work satisfaction (Laschinger et al., 2001; Laschinger et al., 2004) and a correlation with positive nurse-physician relationships (Laschinger, Almost, & Tuer-Hodes, 2003). The

effect of being empowered then seems the opposite of the effect of moral distress: increased self-esteem and self-worth, inner confidence, well-being and a sense of personal and social responsibility (Shearer & Reed, 2004). Thus if Kanter's structural elements are in place (organizational barriers removed) nurses might experience few or no impediments to pursuing quality care. With control over their practice they might effectively accomplish their work and thus might experience little or no moral distress. Based on Kanter's theory, it would stand to reason that if nurses were empowered they would be less likely to experience moral distress.

The only study to examine the relationship between structural empowerment and moral distress (Ganz, et al., 2012) did show a significant negative association between these two variables.

Psychological Empowerment

The constructs of psychological empowerment include: self-determination or having autonomy over one's work, impact or the ability to have influence, competence or the belief in one's capacity to do the work, and perceiving meaning or value in the work (Spreitzer, 1995). In a meta-analytic review of research utilizing Spreitzer's model of psychological empowerment all the predicted antecedents were significantly and positively correlated to psychological empowerment: information-sharing, extensive training, decentralization, participative decision-making, material, social, and psychological resources, supportive leadership, task significance, and autonomy. These antecedents map back to Kanter's structural empowerment factors (Seibert, Gang, & Courtright, 2011). The experience of psychological empowerment would seem to be the inverse of the experience of moral distress: rather than autonomy, impact, competence, and meaning, nurses when in moral distress may experience a lack of assertiveness,

powerlessness, self-doubt, and being at odds with the organization's values (Hamric, Borchers & Epstein, 2012; Lutzen, Cronqvist, Magnusson, & Andersson, 2003). Only one study was found which had examined the relationship between psychological empowerment and moral distress (Browning, 2011). A negative relationship between psychological empowerment and moral distress was found.

Interprofessional Collaboration

Three studies were found that sought to find a relationship between interprofessional collaboration and moral distress (Hamric & Blackhall, 2007; Karanikola et al., 2013; Papathanassoglou et al., 2012). Nurses who had high moral distress scores also had significantly lower interprofessional collaboration scores (Hamric & Blackhall, 2007). Papathanassoglou et al. (2012) and Karanikola (2013) found moral distress scores had a negative correlation with collaboration scores and the frequency of occurrence of morally distressing events was negatively correlated to collaboration scores. Karanikola (2013) also found there was a negative correlation between the intensity of morally distressing events and collaboration.

Compassion

Despite the standing compassion has in nursing, and the ample theoretical literature, little empirical research has been done in nursing on the subject (Brunell, 2011; Gilbert, 2005; Schantz, 2007; van der Cingel, 2009; von Dietze & Orb, 2007). Only one published study with nurses as participants was found (Graber & Mitchum, 2004). No studies were found which examined the relationship between compassion and moral distress. Graber and Mitchum (2004) found compassion to be exemplified by a sense of the humaness of the other, a unity with the patient, and an intention to help and suggested compassion was found to be protective of the clinicians by increasing their resilience.

However, research into compassion is being conducted beyond nursing. Again, surprisingly, despite compassion being a well theorized construct, it is only within the last twenty years or so that it has had a research focus.

In a review of research on compassion spanning these 20 years, Goetz, Keltner, and Simon-Thomas (2010) found compassion is a distinct "affective state" (p. 354) as compared to sadness, distress, love, empathy, sympathy, or pity and as such has a different purpose which is to reduce suffering. It is described as a response to human frailty that "informs and motivates our duties towards others" that by its very nature creates a desire to act on behalf of others (O'Connell, 2009, p. 3). This movement to act differentiates compassion from empathy, sympathy and pity that do not move one to act (Armstrong, 2010; Goetz, Keltner, & Simon-Thomas, 2010). The research suggests, "a sense of self-efficacy…increases the likelihood of experiencing compassion" (p. 358). This could be similar to psychological empowerment, two of which elements are self-determination and competency. Cassell, 2002; Schantz, 2007; Valdesolo and DeStano, 2011 found that compassion is not felt by all people and not at all times. Despite those findings, all nurses are expected to demonstrate compassion. As the purpose of compassion is to reduce suffering, and if nurses are compassionate, it would be expected they would experience moral distress if they were unable to act to relieve patient suffering.

Perception of Quality of Care

Three studies were found that investigated the relationship between moral distress and the perception of the quality of care (Ganz & Berkovitz, 2011; Gutierrez, 2005; Hamric & Blackhall, 2007). Ganz and Berkovitz (2011), in a study of 119 nurses who worked on surgical units in two Israeli hospitals found that perceived quality of care was

significantly and negatively associated with the frequency of moral distress. A phenomenological study of 12 critical care nurses' experiences of moral distress and its effects on patient care in a large teaching hospital, found that initially the nurses were reluctant to describe how moral distress affected the care they provded (Gutierrez, 2005). However, with time the nurses did describe how moral distress negatively impacted the quality of their care. Nurses described not wishing to care for patients, when they were constrained from caring for them as they judged to be appropriate. Subjects reported that there were instances of decreased interactions with patients and families. The frequency of care decreased and the care became depersonalized. A study to explore the relationships of moral distress, moral climate and satisfaction with the quality of care was conducted in 14 intensive care units in two Virginia hospitals (Hamric & Blackhall, 2007). At both sites, nurses' perception of quality of care was significantly and negatively correlated with their moral distress scores.

Intent to Leave

Studies have been conducted looking at the relationship between intent to leave and moral distress. Gaudine and Thorne (2012) found the "patient care values" factor of the moral conflict scale was negatively and significantly correlated to intent to leave. Hamric and Blackhall (2007) found in a two-site study that at one site, 1% of nurses had left a position due to moral distress and 23% had an intention to leave their current position. At site 2, 17% of the RNs had previously left a position due to moral distress and 28% were considering leaving. Nurses with higher moral distress scores were more likely to have an intent to leave or had left a position than were nurses with a low score. Hart (2005) investigated the relationships between hospital moral climate and intent to leave the current position and the intent to leave the profession. There was a statistically

significant correlation between a positive moral climate and intent to stay and intent to remain in the profession. Thorne (2010), in a study of the correlation between moral conflict and intent to leave found a statistically significant correlation between the extent to which a nurse disagreed with the moral priorities and actions taken by his/her employer and intention to leave.

Tschannen et al., (2010) studied the relationship between missed nursing care (any aspect of care which nurses judged should be provided but could not be provided) and intention to leave and leaving rates. Missed care was statistically significantly correlated to intent to leave and leaving. Larger amounts of missed care was statistically significantly correlated to greater intentions to leave and intent to leave was statistically significantly correlated to leaving.

Hypothesized Model

The paths between structural empowerment, psychological empowerment, interprofessional collaboration, compassion, perceived quality of care, moral distress, and intent to leave are intuitively sound and although evidence in the literature shows how these constructs may be linked, no study has yet looked at all of these relationships as a coherent model. As moral distress is a complex construct (Lutzen et al., 2003; Pauly et al., 2009) it needs to be studied taking into consideration its nomological network (Corley, 2002; Hamric 2012; Lutzen & Kvist, 2012). In consideration of that I proposed the following model: structural empowerment will lead to psychological empowerement. When nurses are psychologically empowered, they perceive themselves as able to provide good quality of care. And perceiving that ability, they experience less moral distress. Interprofessional collaboration and compassion moderate the relationship between psychological empowerment and the perception of the quality of care. When

there are positive relationships within the interprofessional team, nurses should more fully understand the reasoning behind opposing decisions about care. This understanding might moderate the perception of the quality of care. As a nurse's level of compassion rises his/her ability to understand the suffering of patients and his/her desire to alleviate suffering will also rise. This should create the perception of the need to deliver a higher standard of quality of care thus influencing the perception of the quality of care. There is a direct, positive relationship between moral distress and intent to leave. As moral distress decreases so will the intent to leave.

Hypotheses

1.   Structural empowerment is positively related to psychological empowerment.

2.   Psychological empowerment mediates the relationship between structural empowerment and nurses' perception of quality of care.

3.   Psychological empowerment is positively related to the perception of quality of care.

4.   Interprofessional collaboration positively moderates the relationship between psychological empowerment and the perception of quality of care.

5.   Compassion negatively moderates the relationship between psychological empowerment and perception of quality of care.

6.   Perception of quality of care is negatively related to moral distress.

7.   Quality of care mediates the relationship between psychological empowerment and moral distress.

8.   Moral distress is positively related to intent to leave.

Method

Design and Sample

A predictive, non-experimental cross-sectional design was used to explore the

relationships among the variables of structural and psychological empowerment,

interprofessional collaboration, compassion, quality of care, and the dependent variable

moral distress as well as intent to leave. Using a modified Dillman (2007) approach,

surveys were sent to 900 randomly chosen registrants from the College of Nurses of

Ontario Registry. A sample size of 200 was sought. Hair, Hult, Ringle, and Sarstedt

(2014) state a minimum sample size of 158 is required to achieve a statistical power of

80% with a .01 significance level (2014). Inclusion criteria were registered nurses: of any

age, with any length of experience, in any inpatient or outpatient unit, in any hospital

(community, long term care, and teaching) with any education level. Nurses who worked

in other settings, for example public health, were excluded. Two hundred and eighteen

(218) surveys were returned for a response rate of 24.2%. After data cleaning, 191

surveys were able to be included. Seventeen (17) surveys were excluded as the

respondents failed to answer the quality of care question. This question was located in the

middle of a page and it is assumed that respondents simply "missed" it when answering

the survey. The other 10 surveys were discarded due to pages of the survey being missed

or sections of a survey being incomplete.

Sample Characteristics

The mean age of the nurses was 46 (SD = 10.84) years. The percentages of nurses

in grouped ages were similar to the national profile of nurses by age group (Canadian

Nurses Association, 2012). The majority of nurses were female (95.8%) and diploma

prepared (55.5%). Nearly the same percentage of nurses worked in community hospitals

as did in teaching hospitals (44% and 43.5% respectively). Most nurses were employed

full time (66%) and averaged 22.4 years of employment (SD = 11.97). The nurses

reported they had worked at their current hospital an average of 16.4 years (SD = 10.62)

and an average of 11.4 years on their current unit (SD = 8.66). The largest percentage of

respondents worked in critical care (14.1%), emergency (12%), medicine (9.9%), and the

surgical suite (8.4%). The remaining respondents ranged from 7.3% (surgical units) to

1% (complex continuing care and cardiac care). As shown in Table 10, the demographics

of the study nurses was nearly the same or similar to the national and provincial profile of

nurses.

Table 10

Demographic Characteristics

Demographic		Frequency	Percent	National Average	Provincial Average
Sex	Male	6	3.1	5.8	4.5
	Female	183	95.8	94.2	95.5
Employment Status	Full time	126	66	58	65.8
	Part time	48	25.1	30	26
	Casual	13	6.8	11.9	8.2
Education	Diploma	106	55.5	57.6	
	Baccalaureate	72	37.7	38.8	
	Masters	10	5.2	3.3	
Type of Nursing	Critical Care	27	14.1	8.3	
	Emergency	23	12	7.5	
	Medicine	19	9.9		
	Surgical Suite	16	8.4	5.4	
	Surgery	14	7.3		
	Labour & Delivery	13	6.8	6.4	
	Geriatrics	8	4.2	10.9	
	Pediatrics	5	2.6	3.1	
	Cancer Care	5	2.6	1.5	
	Rehabilitation	5	2.6	1.7	

	Mental Health	3	1.6	5.7	
	Nephrology	3	1.6		
	Cardiac Care	2	1		
	Complex Continuing Care	2	1		
	Other	30	15.7	9.8	
Type of Hospital	Community	84	44		
	Teaching	83	43.5		
	Long Term Care	11	5.8		
Demographic		Mean	SD	National Average	Provincial Average
	Age	46.4	10.8	45.4	46.5
	Years in Nursing	22.4	11.9		
	Years Current Hospital	16.4	10.6		
	Years Current Unit	11.4	8.6		

Instruments

All variables measured the respondents' reports or their perceptions of, structural empowerment, psychological empowerment, interprofessional collaboration, quality of care, moral distress, and intention to leave.

Structural empowerment. Structural empowerment was measured using the Conditions of Work Effectiveness Questionnaire – II (CWEQ – II) (Appendix A). It consists of 19 items designed to measure the six empowerment dimensions in an individual's work setting: opportunity, information, support, resources, formal power and informal power (Laschinger et al., 2001). The CWEQ-II is a modification of the original CWEQ developed by Laschinger et al., (Laschinger et al., 2001). The instrument uses a 5 point Likert scale ranging from 1 = never to 5 = a lot. Three indicators are used for five of the dimensions; four indicators are used for the sixth dimension. A high score indicates

a high perception of structural empowerment. Cronbach's alpha was .89 in this study. Cronbach's alpha reliabilities in other studies have been reported from 0.79 to 0.82 (Laschinger et al. 2001). Face and content validity have been established (Laschinger et al, 2001). Construct validity of the CWEQ-II was established through confirmatory factor analysis (Laschinger, et al., 2001).

Psychological empowerment. Psychological empowerment was measured using the Psychological Empowerment Scale (PES) (Appendix B) (Spreitzer, 1995). Psychological empowerment is described as a feeling or sense of empowerment with four cognitive dimensions: meaning, competence, self-determination, and impact. The scale consists of 12 items, three items per dimension, on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate that an individual feels more psychologically empowered. The PES has been found to be highly reliable and valid. Convergent and divergent validity has been established and reliability coefficients ranging from 0.62 to 0.74 have been reported (Browning, 2011). The test-retest co-efficients have been 0.72 with an industrial sample and 0.62 for an insurance sample (Ohnishi, 2012). Ohnishi (2012) in a study examining the relationships amongst organizational support, psychological empowerment and organizational citizenship behavior reported a test-retest coefficient of 0.76 and a Cronbach alpha of 0.83. Other studies have found similar validity and reliability results. In a study amongst nurses in the Netherlands to examine the relationship between structural and psychological empowerment and innovative behaviour, the PES Cronbach alpha was 0.87 (Knol & van Linge, 2009). Laschinger, Almost, Purdy & Kim (2004) have reported Cronbach alpha's ranging from 0.87 to 0.92.

Interprofessional collaboration. Interprofessional collaboration was measured

using the Relational Co-ordination Scale (Appendix C) (Gittell, 2009). The Relational

Coordination Scale (RCS) is a seven-item instrument that measures the perception of the

quality of collaboration between individuals and other team members (Canadian

Interprofessional Health Collaborative, 2012). The 5-point Likert-type scale measures

four elements of communication (timeliness, frequency, accuracy, and problem-solving)

and three relational elements (shared knowledge, shared goals, and mutual respect).

Higher scores are an indication of greater collaboration. This study's Cronbach's alpha

was 0.96. The RCS has been found to have a reliability index (Cronbach's alpha) of 0.80,

0.85 and 0.86 in earlier studies (Gittell, 2001; Gittell, 2008; Gittell, et al., 2000; Nadolski

et al. 2006). Exploratory factor analysis (no cross-loadings between questions greater

than 0.4) and item-to-total correlations (0.4 or greater) suggest construct validity.

Compassion. Compassion was measured using the Compassion Scale (Pommier,

2010). The Compassion Scale is a 24-item six-factor instrument developed to measure

the three dimensions of compassion: mindfulness, kindness, and common humanity

(Appendix D). Scoring is based on a 5-point Likert scale with answers ranging from

"almost never" to "almost always". A higher score indicates a higher level of

compassion. This study's Cronbach alpha was 0.84. Cronbach's alpha in previous studies

has ranged from 0.87 to 0.90 (Pommier, 2010). Content validity was determined by

having a panel of 8 experts (6 researchers and 2 counselors/practitioners) in compassion

review 118 items. Some items were re-written and 38 items were deleted. Final items

were determined through a factor analysis with 439 participants. Only items that

exceeded a loading of greater than 0.5 were retained. The scale demonstrated it had

adequate goodness-of-fit (CFI = 0.97, NNFI = 0.96, SRMR = 0.05, RMSEA = 0.05). A

higher-order factor analysis indicated adequate fit that a single higher order factor

(compassion) explained the inter-correlations amongst the 6 factors (CFI = 0.96, NNFI = 0.95, RMSEA = 0.06, SRMR = 0.06).

Perception of quality of care. Quality of care was measured by a single item: "In general, how would you describe the quality of nursing care for patients in your unit?". The response selection is poor, fair, good, and excellent (1 – 4) (Aiken, Clarke, & Sloane, 2002) (Appendix E). Nurse perception of the levels of quality of care has been significantly correlated to the actual quality of care (McHugh & Stimpfel, 2012).

Moral Distress. Moral Distress was measured using the Moral Distress Scale - Revised Nurse Adult Questionnaire (Appendix F). The revision was to meet "three objectives: (1) include more root causes of moral distress; (2) expand its use in non-ICU settings; and (3) make it appropriate for use by multiple healthcare disciplines" (p. 3). Six versions of the scale were developed: one for each of nurses, physicians and other healthcare providers who practice in each of two settings, adult and pediatric. The respondents score each item on frequency or how often the event occurs (never to frequently) and on intensity or how disturbing the event was (none to great extent) of each event. Each of the frequency and intensity scores can be summed and analyzed. The MDS-R has added a new composite score: the frequency and intensity scores for each item are multiplied which creates a new "fxi" score, ranging from 0-16. Rarely experienced or minimally disturbing events will have a low score; more frequently occuring or disturbing events will have a higher score. The respondent's composite score of moral distress is then obtained by summing all fxi scores. The composite score range is 0-336. Construct validity was tested and confirmed (Hamric et al., 2012). In a previous study, the Cronbach alpha for the MDS-R, Nurse Adult Questionnaire was 0.89 (Hamric et al., 2012) and in this study the alpha was 0.93.

Moral distress was also measured using the Moral Distress Thermometer (MDT) (Appendix G). The MDT is a visual analogue scale that measures respondents' current (within the past 2 weeks) level of moral distress (Wocial & Weaver, 2013). It is a single item tool with an 11 point scale from 0-10. Six verbal descriptors from none to worst possible are used to determine the degree of moral distress. Construct validity has been estimated by testing the MDT against the *original* Moral Distress Scale (MDS). The MDT to MDS correlation coefficient was moderate (r = .40, p < .001). This study's correlation coefficient between the revised Moral Distress Scale (MDS-R) and the MDT was .53 (p < .01).

Intent to Leave. Intent to leave was measured by the Job Turnover Intentions scale (Kelloway, Gottlieb, & Barham, 1999) (Appendix H). Job Turnover Intentions is a 4 item scale. Scoring is based on a 5-point Likert scale with responses ranging from 1 (strongly disagree) to 5 (strongly agree). A score is obtained by averaging the item response. This study's Cronbach alpha was 0.87. Cronbach's alpha has been reported in other studies ranging from 0.92 to 0.93 (Kelloway et al., 1999).

Data Analysis

The data were entered into SPSS version 22 for initial analysis. Following, the data were entered into SmartPls version 3.1.9 for path analysis. The means, standard deviations, ranges, and reliability coefficients of the study's major variables were determined (Table 11). Missing data were handled as follows. Each question was examined and had less than 5% missing data. Given the small percentage of missing values (Schlomer, Bauman, & Card, 2010) they were coded as "99" and indicated in SPSS and PLS that these data were missing. SPSS does calculations ignoring the missing values. PLS does a mean substitution for these data.

Most data were approximately symmetric. As non-normal data does not have an influence on the findings in SmartPLS, all data were retained for the analysis. Bootstrapping, which was performed, also mitigates any non-normal data (Kelly, 2005). To create the constructs, the mean scores of the items measuring the constructs were used. A correlation matrix was then completed to analyze the relationships between continuous variables (Table 12); T tests and ANOVA were performed to measure the significant differences between the means of the categorical variables of education, type of nursing, type of hospital worked in, and employment status and the model variables. Pearson correlations were used to analyze the continuous variables of age, years of nursing experience, years at current hospital, and years on current unit. Sobel's test of mediation in conjunction with bootstrapping, was used to examine the significance of hypothesized mediated relationships (Preacher & Hayes, 2008). SmartPLS version 3.1.9 was used to test the measurement and structural models of the hypothesized model.

Table 11

Mean, Standard Deviation (SD), Range, Reliability (α) of Variables

Variable	Mean	SD	Range	α
Structural Empowerment	3.09	0.58	1.75-4.68	0.89
Psychological Empowerment	3.80	0.51	2.25-5	0.84
Interprofessional Collaboration	3.51	0.53	1.97-4.94	0.96
Compassion	4.20	0.43	3-5	0.84
Quality of Care	3.16	0.65	1-4	Single item
Moral Distress Thermometer	3.17	2.56	0-10	Single item

Moral Distress MDS-R	77.56	46.61	0-336	0.93
Turnover	2.4	1.13	1-5	0.87

Table 12

Correlation Matrix

	1	2	3	4	5	6	7	8
1. Structural Empowerment	1							
2. Psychological Empowerment	.440**	1						
3. Interprofessional Collaboration	.536**	.337**	1					
4. Compassion	.148*	.225**	.225**	1				
5. Quality of Care	.349**	.234**	.328**	.208**	1			
6. MDS-R	- .121	.007	-.204**	- .086	- .195**	1		
7. MD Therm	- .263**	-.086	- .271**	- .115	-.353**	.525**	1	
8. Intent to Leave	- .329**	- .266**	- .219**	- .068	- .444**	.246**	.395**	1

** Correlation is significant at the 0.01 level (2 tailed)

Results

Descriptive Results

The mean structural empowerment score was moderate (M = 3.09, SD = 0.58). Similar results were found in a study of nurses working in the same province as this study's respondents (M = 3.28, SD = 0.82) (Wong & Laschinger, 2012). The respondents' psychological empowerment mean score was moderate (M = 3.8, SD =

0.51). Moderate psychological scores were also found in a study of nurses working in urban tertiary care settings (M = 3.58, SD = 0.86) (Laschinger, Finegan, Shamian, & Wilk, 2001). The mean interprofessional collaboration score was moderate (M = 3.51, SD = 0.53). Moderate interprofessional collaboration scores were also found in a study of nurses in an academic health care setting (M = 3.61, SD = 0.84) (Nadolski et al., 2006). The mean score of quality of care was also mid-range at 3.16 (SD = 0.65). This is similar to the findings of Laschinger (2008) (M = 3.45, SD = 0.59). The mean compassion score however, was high (M = 4.2, SD = 0.43). Pommier's finding of compassion (2010) in a study of undergraduate students, was closer to mid-point (M = 3.57, SD = 0.61). The mean moral distress thermometer (MDT) response was less than mid-point (M = 3, SD = 2.56). Wocial and Weaver (2013) had similar results using the MDT (M = 2.9, SD = 2.5). The mean moral distress scale – revised (MDS-R) score was low (M = 77.56, SD = 46.61). The highest possible score is 336. In study by Hamric, Borchers and Epstein (2012) nurses' mean MDS-R score was also low (M = 91.53, SD = 44.24). The mean intent to leave score was also low (M = 2.4, SD = 1.13). Laschinger (2012) in a study of years 1 and 2 new nursing graduates had similar findings (M = 2.72, SD = 1.26 and M = 2.61, SD = 1.28).

Relationship of Demographic Variables to Model Variables

No significant relationships were found between years worked on unit, education, sex, employment status, type of nursing, and the model variables. Age and years of nursing experience correlated significantly and negatively to structural empowerment (r = - .18, $p < .01$ and r = - .17, $p < .02$ respectively). Years worked at current hospital correlated significantly and negatively to intention to leave (r = - .22, $p < .003$). There was a significant effect of type of hospital on structural empowerment: F (2, 175) =

8.498, p ≤ 0.00. Post hoc comparisons using the Tukey HSD test (Pallant, 2010) indicated

the mean score of teaching hospital (M = 3.27, SD = 0.58) was significantly different

than community hospital (M = 2.94, SD = 0.55) and long term care hospital (M = 2.76,

SD = 0.68). The effect size, calculated using eta squared was large (.09) (Cohen, 1988).

There was also a significant effect of type of hospital on interprofessional collaboration.

Post hoc comparison indicated the mean score of teaching hospital (M = 3.59, SD = 0.54)

was significantly different than community hospital (M = 3.34, SD = 0.51). The effect

size was medium (.05).

Measurement and Structural Model Assessment

Partial Least Squares (PLS), a component-based structural equation modeling

technique, was used to test the model. PLS was chosen as these study variables have only

been examined for the most part in a univariate manner and theory development for a

more complex model has not been explored before. PLS is "appropriate for early stage

research models where the emphasis is on theory exploration and prediction" (Neufeld,

Dong, & Higgins, 2007). In a PLS analysis, one first assesses the measurement model.

When satisfied with the, the structural model is then assessed (Hair, Hult, Ringle, &

Sarstedt, 2014).

Measurement model assessment. Individual item reliability, internal

consistency, convergent validity, and discriminant validity are used to assess the

measurement model. Loadings are used to assess individual item reliability. Loadings are

the degree to which that indicator's variance is explained by the latent construct.

Loadings of 0.708 explain at least 50% of the variance in the item. As a rule, that is the

threshold an indicator must reach in order to be retained (Hair et al., 2014). Seven

indicators (of 104 indicators) were found to have low factor loadings (0.033 – 0.271).

The 7 indicators were removed from the model. Three other indicators had factor

loadings less than 0.708 but were retained (0.51 – 0.58) (Table 13). The items were

retained as there is theory fit, deletion did not improve average variance extracted (AVE)

or composite reliability (Hair et al., 2014), and in previous studies loadings are similar

(Laschinger, Finegan, Shamian, & Wilk, 2001).

Table 13

Low Factor-loading Items

Instrument	Lower order construct	Item (question)	Loading
Items deleted			
Structural Empowerment (Appendix A)	Access to information	1. The current state of the hospital	- 0.07
	Formal power	3. The amount of visibility of my work-related activities within the institution is	0.03
	Informal power	4. Seeking out ideas from professionals other than physicians	0.12
Psychological Empowerment (Appendix B)	Competence	4. I am confident about my ability to do my job	0.09
	Self-determination	8. I can decide on my own how to go about doing my work	0.15
		9. I have considerable opportunity for independence and freedom in how I do my job	0.19
Intent to Leave (Appendix H)		4. I don't intend to be in this organization much longer	0.27
Items retained			
Structural Empowerment (Appendix A)	Support	2. Specific comments about things you could improve	0.58
		3. Helpful hints or problem solving advice	0.58
Psychological	Competence	6. I have mastered the skills	0.51

Empowerment (Appendix B)		necessary for my job	

Historically internal consistency is tested using Cronbach's alpha. A value of greater than 0.7 is acceptable (Warner, 2013). The range of Cronbach's alpha for the scales were all acceptable (Table 11). However, in PLS Cronbach's alpha is less often used since it "generally tends to underestimate the internal consistency reliability" (Hair, 2014, p. 101). The measure of reliability used in PLS is composite reliability. Both measure internal reliability but use different techniques to measure for it. Cronbach's alpha assumes the indicators are equally reliable while composite reliability takes into account the differing outer loadings of the indicators. Composite reliability ranges between 0 and 1, again with values of 0.7 indicating acceptable reliability. All composite reliabilities ranged between 0.85 – 0.86.

Convergent validity is established by assessing the average variance extracted (AVE). The AVE is performed to see if the latent variable has captured at least 50% of the variance in the items in relation to the amount of variance explained by measurement error (Hair et al., 2014). An AVE of 0.5 or greater indicates there is acceptable convergent validity. All were greater than 0.5.

Discriminant validity is a test to determine the extent to which each construct is distinct from other constructs in the model. This indicates that each construct is unique and measures phenomena not measured by other constructs in the model. Discriminant validity is measured in two ways: by assessing the cross-loadings of the indicators and by the Fornell-Larcker test (Hair, et al., 2014). An indicator's loadings should be greater on its associated construct than its loadings on any other constructs in the model. These loadings on other constructs are the cross-loadings. In this model all cross loadings were

less than the loadings on the associated construct. The Fornell-Larcker test is a more

conservative test of discriminant validity (Hair et al., 2014). This is a test to determine if

the construct shares more variance with its associated indicators than with indicators of

other constructs. It is measured by comparing the latent variable correlations to the square

root of the AVE. The square root of the AVE should be greater than the correlation with

any other construct. In this model all the AVE square roots are larger than all correlations

with other constructs (Table 14).

Table 14

Discriminant Validity: AVE Square Roots

	1	2	3	4	5
1. Moral Distress	1				
2. Psychological Empowerment	.023	.633			
3. Quality of Care	-.195	.190	1		
4. Structural Empowerment	-.130	.461	.359	.545	
5. Intention to Leave	.102	-.068	-.226	-.184	.810

Structural model assessment. The results of the tests of hypotheses are shown in

Figure 2 and Figure 3. Hypothesis 1 postulated that structural empowerment is positively

related to psychological empowerment. This hypothesis was supported ($\beta = 0.46$; t =

7.02; p < 0.001). Mediation amongst the variables was assessed using Sobel's test

(Preacher & Hayes, 2008). Psychological empowerment was not a mediator between

structural empowerment and quality of care (hypothesis 2) (Sobel test statistic 0.09; p =

0.92). The relationship between psychological empowerment and quality of care was not

statistically significant (hypothesis 3) ($\beta = 0.07$; t = 1.06; p = 0.289). Hypothesis 4

posited that interprofessional collaboration positively moderates the relationship between

psychological empowerment and quality of care. This hypothesis was not supported ($\beta =$

0.07; t statistic 0.20; p = 0.84). Hypothesis 5 stated compassion will negatively moderate the relationship between psychological empowerment and quality of care. Again, there was no moderation (β = -0.48; t statistic 0.90; p = 0.37). When the moderators were removed the path between psychological empowerment and quality of care was significant (β = 0.189; t statistic 2.610; p < 0.001) (Figure 4 and Figure 5). An additional finding was that both compassion (β = 0.135; t statistic 2.26; p = 0.014) and interprofessional care (β = 0.24; t statistic 3.69; p < 0.00) had direct significant paths to quality of care.

Hypothesis 6 stated that quality of care would be negatively related to moral distress. This was supported (β = -0.19; t statistic 3.04; p < 0.001). Quality of care fully mediated the path between psychological empowerment and Moral Distress (Sobel's test -1.99; p < 0.05). Moral distress did not mediate the relationship between quality of care and intention to leave (Sobel's test -0.95; p = 0.34). Finally, hypothesis 7 stated that moral distress is positively related to intention to leave and this was not supported (β = 0.10; t statistic 1.43; p = 0.15).
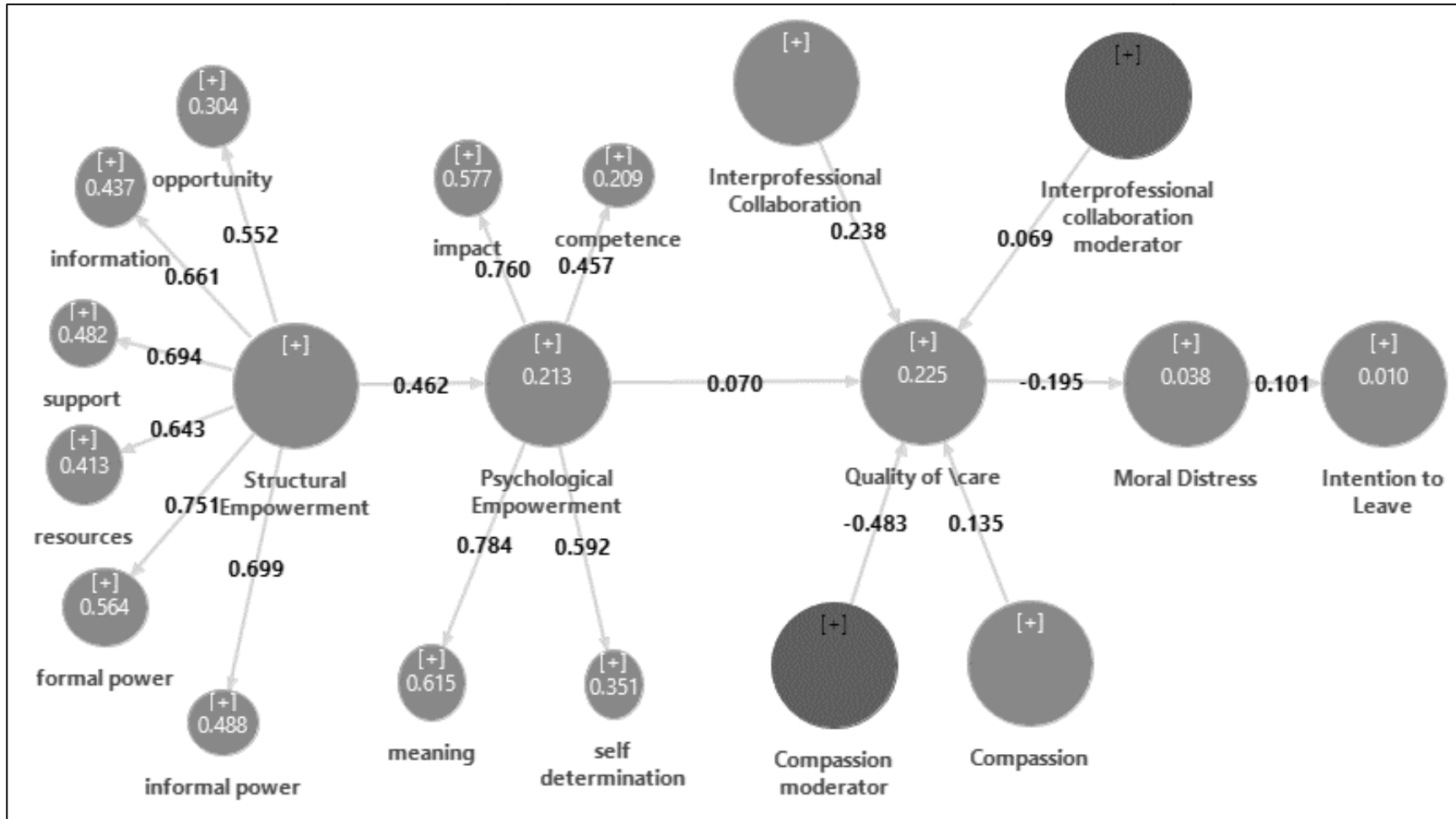
Figure 2. Path Coefficients (with moderators)
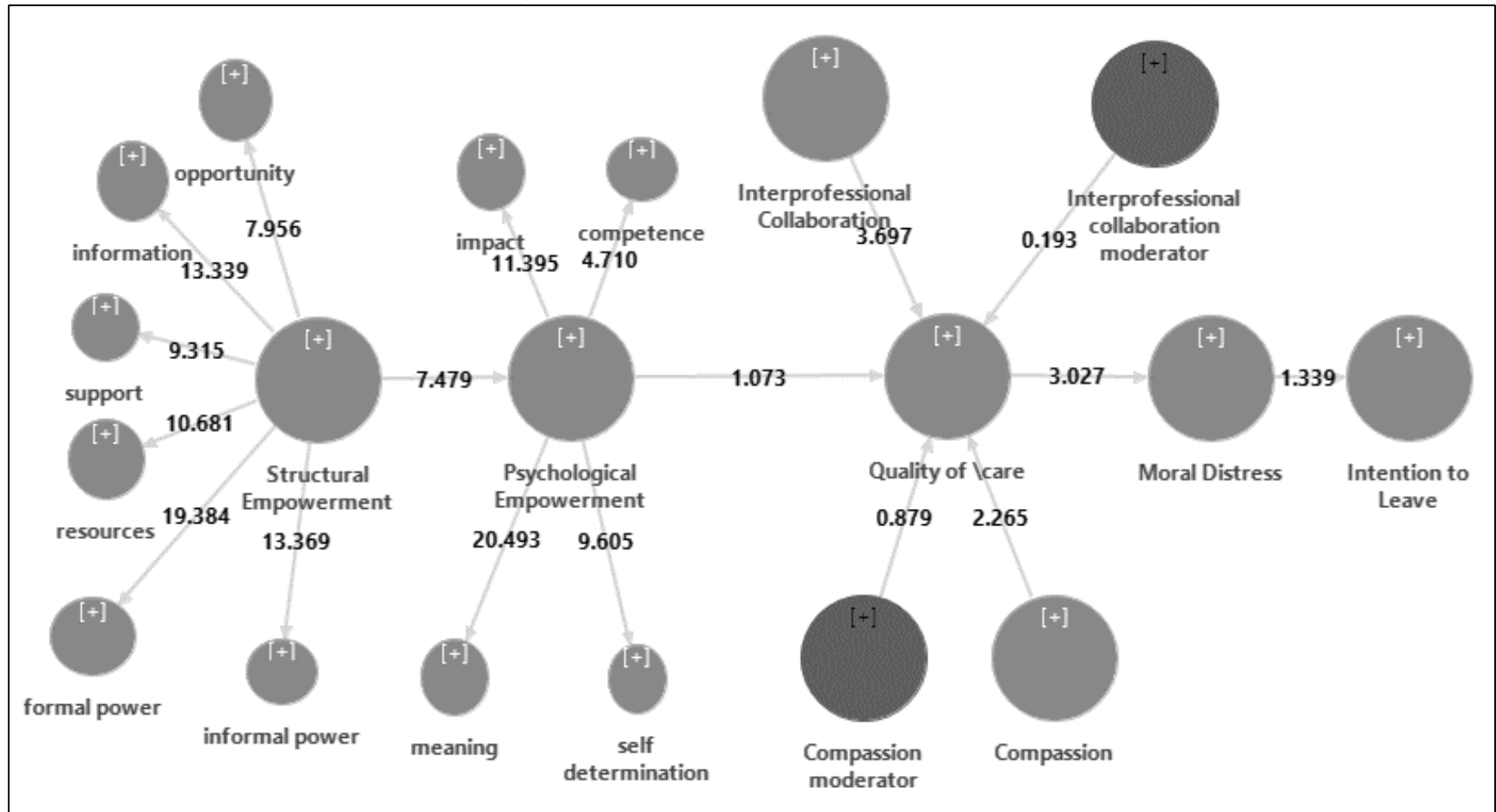
Figure 3. T Statistic (with moderators)
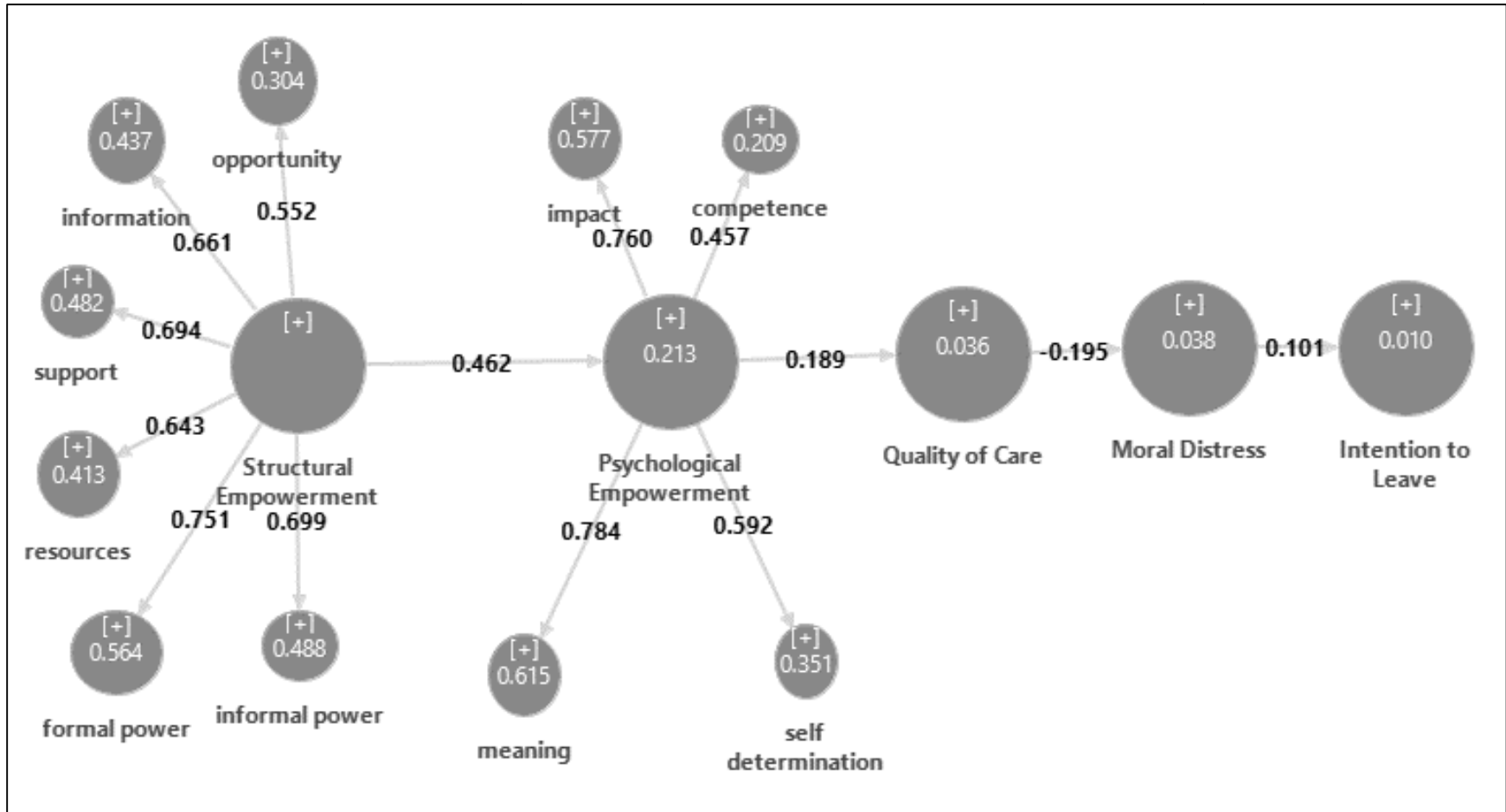
Figure 4. Path Coefficients (without moderators)
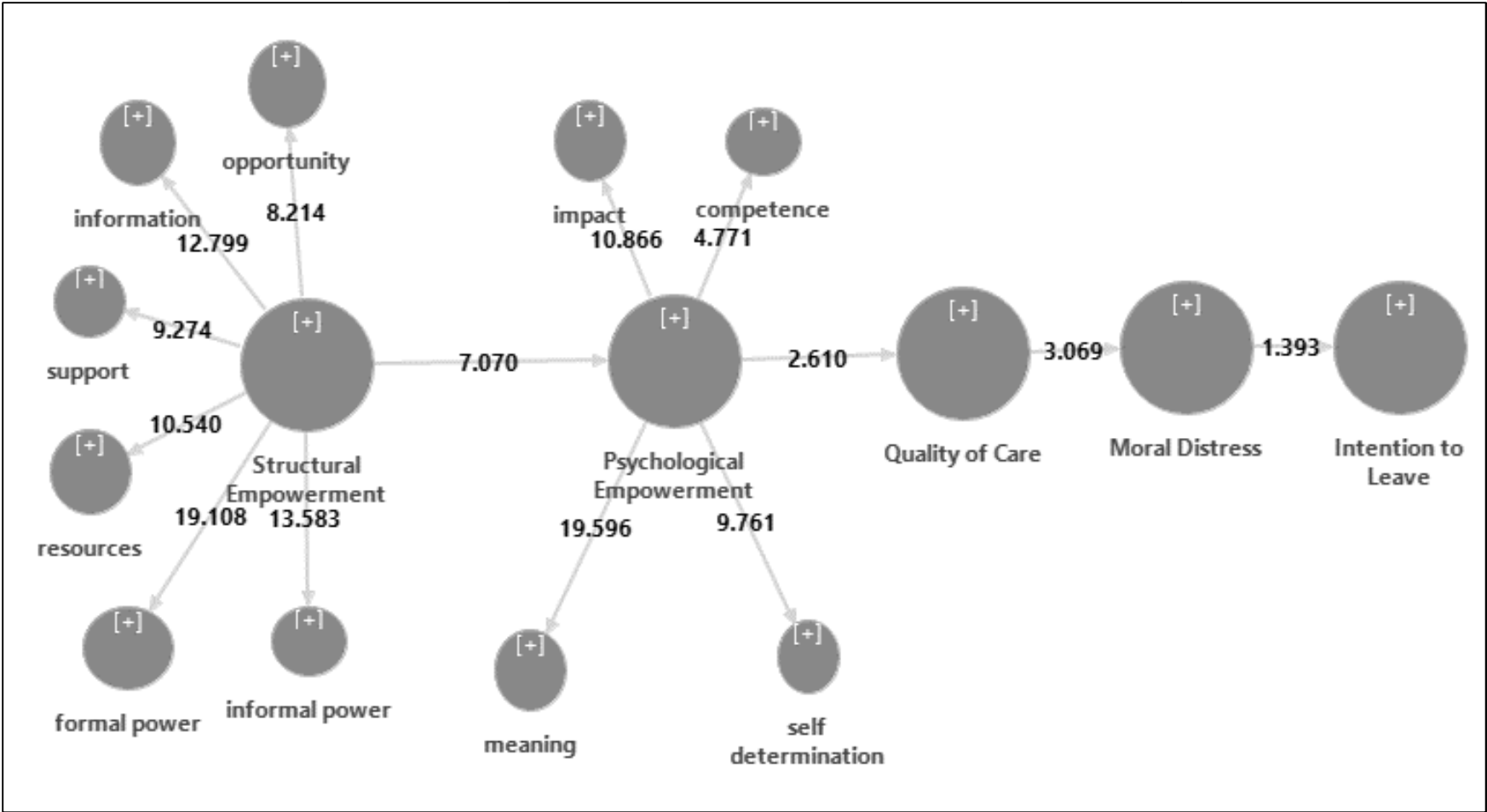
Figure 5. T Statistic (without moderators)

Discussion

Previous research has identified several relationships pertaining to the concept moral distress. On the basis of these findings, a more comprehensive model was constructed and tested to explore the multivariate genesis of moral distress relative to structural empowerment, psychological empowerment, interprofessional collaboration, compassion, quality of care, and intent to leave. In most cases this model confirms previous research, in some cases it does not. Based on my experience and the literature, the model provides a testable structure for a plausible understanding of the relationships among the selected variables.

This study confirms the relationship between structural empowerment and psychological empowerment. In a meta-analytic review of research utilizing Spreitzer's model of psychological empowerment, all the predicted antecedents were significantly and positively correlated to psychological empowerment: high performance managerial practices (open information-sharing, extensive training, decentralization, participative decision-making), socio-political support (material, social, and psychological resources), supportive leadership, and work design characteristics (task significance, autonomy). These antecedents map back to Kanter's structural empowerment factors (Seibert, Gang, & Courtright, 2011). Maynard, Gilson, and Mathieu (2012) state there is solid significant evidence of the positive relationship between structural empowerment and psychological empowerment. In support of their claim, Wagner et al., (2010) following a systematic review of the literature also found a significant association between structural empowerment and psychological empowerment.

This study also supports the finding of a significant positive relationship between psychological empowerment and quality of care. Bonias et al. (2010*)* surveyed 541

hospital staff in an Australian health system, including management, physicians, nurses, other clinical, and non-clinical support staff and found that psychological empowerment was significantly correlated to perceptions of the quality of care. Leggat, Bartram, Casimir, and Stanton (2010) investigated the relationships between psychological empowerment, job satisfaction, and quality of care in an Australian regional hospital; 201 nurses responded. Psychological empowerment was significantly positively correlated to the perception of quality of care.

Knowing that structural empowerment accounts for 21% of the variance of psychological empowerment, organizations can look to enhance the determinants of structural empowerment, which are nurse access to information and power, managerial and collegial support of nurses, resources to enable the work to be done, and opportunity for skill development and challenging work. Knowing that psychological empowerment has a direct and significant relationship to quality of care, as structural empowerment increases, so will quality of care. As structural empowerment accounts for approximately a quarter of the variance of psychological empowerment, other known antecedents of psychological empowerment that would account for some portion of the remaining variance, could be enhanced, thus increasing quality of care even more. Personal (as opposed to the structural empowerment contextual) antecedents of psychological empowerment include having an internal locus of control, being self-efficacious, having self-esteem, and having emotional resilience (Seibert, 2011). Management practices could be such that these characteristics would be enhanced such as enabling nurse autonomy, providing positive reinforcement, and encouraging reflective practice. In turn, understanding that the elements of psychological empowerment are as described above, effort can be made to ensure there is alignment between the work that is required to be

done and nurses' values, that nurses are decisional within their scope of practice, enable nurses to progress to higher levels of proficiency, and to engage nurses in discussions and decisions regarding organizational practices.

Neither compassion nor interprofessional collaboration moderated the relationship between psychological empowerment and quality of care. This means they did not influence the direction nor the strength of the relationship between the predictor and criterion variables. Moderating effects are challenging to show unless the effect is large (McClelland & Judd, 1993). In addition, compassion is as yet poorly conceptualized in nursing. However, both compassion and interprofessional care had direct and significant relationships to quality of care. Compassion's effect on quality of care is interesting. I hypothesized that as a moderator as compassion rose, the perception of the quality of care would fall. With this direct effect, as compassion rises, so does the perception of the quality of care. This might indicate that nurses do have an understanding of the context of health care; that they have compassion for the system within which they work. Or it might mean that with compassion they have a deeper understanding of the patients' needs and thus know how to care for them. Regarding the direct significant relationship between interprofessional collaboration and quality of care, there is ample research that demonstrates positive collegial relationships does positively affect patient outcomes and processes (Baggs, Norton, Schmitt, & Sellers, 2004; Hamric & Blackhall, 2007; Martin, Ummenhofer, Manser, & Spirig, 2010).

Quality of care did have a significant negative correlation with moral distress. Previous research supports this finding. Ganz and Berkovitz (2011) found that perceived quality of care was significantly and negatively associated with the frequency of moral distress. A study of critical care nurses' experiences showed how moral distress

negatively affected the quality of their care. Nurses described not wishing to care for patients, when they were constrained from caring for them as they judged to be appropriate. Nurses reported the frequency of care decreased and the care became depersonalized (Gutierrez, 2005). Hamric and Blackhall (2007) found nurses' perception of quality of care was significantly and negatively correlated with their moral distress scores. The single item quality of care scale used in this study does not allow a determination as to what specifically created moral distress. Future research could explore what elements nurses consider to make up the construct quality of care. It would then be possible to identify the specific elements correlated with moral distress.

Psychological empowerment did not mediate the relationship between structural empowerment and quality of care. Other studies have shown that psychological empowerment is a mediator between structural empowerment and quality of care (Leggat et al., 2010). Those studies however, measured the nurses' perception of the quality of the nurse's care. This study measured the nurses' perception of the *unit's* quality of care, not the *nurses'*.

This study's different questions and results may help us to understand psychological empowerment more fully. In both studies psychological empowerment does have a significant effect on quality of care. When nurses are asked about his/her *own* care, psychological empowerment mediates. But when asked about the *unit's* quality of care, the nurse may not see that s/he has a relationship with what the organization provides and the unit's quality of care. The nurse may be assessing quality of care differently when perceiving him or herself as contributing independently of the quality of care generally prevailing in the unit.

Perceptions of quality of care however fully mediated the relationship between

psychological empowerment and moral distress. Psychological empowerment reflects "the individual's orientation towards work" (Wagner et al 2010, p. 449) and his or her wish to be engaged in and influence that work. As the work of nursing is to care for the vulnerable (de Chesnay, 2012; Nortvedt,1998) it is not surprising that when care is perceived to be poor, nurses would experience moral distress. Even though the nurse may not feel a strong association with the unit quality of care, if the quality is poor, it may still create a feeling of moral distress.

Finally, moral distress did not mediate the pathway between quality of care and intention to leave. This is consistent with the finding that there was not a significant relationship between moral distress and intention to leave (Baron & Kenny, 1986). Other research has found a significant correlation between moral distress and intention to leave. Hamric and Blackhall (2007) studying two sets of respondents found with one set, 1% had left a position due to moral distress and 23% had an intention to leave their current position. With the second set, 17% of the RNs had previously left a position due to moral distress and 28% were considering leaving their current roles. Nurses with higher moral distress scores were more likely to have an intention to leave or had left a position than nurses with a low score. Thorne (2010) found a significant correlation between shared ethical priorities and intention to leave. Shared ethical priorities is a measure of the extent to which a nurse disagrees with the ethical priorities and actions taken by his/her employer. As scores increase so does moral conflict. Tschannen et al. (2010) studied the relationship between missed nursing care (any aspect of care which nurses judged should be provided but could not be provided) and intention to leave and leaving rates. Average amounts of missed care were calculated for each unit. Missed care was statistically significantly correlated to intent to leave. Larger amounts of missed care was statistically

significantly correlated to greater intentions to leave and intent to leave was statistically significantly correlated to leaving. Strachota, Normandin, O'Brien, Clary, and Krukow (2003) surveyed 84 nurses who had voluntarily left employment. Fifteen percent (15%) of respondents stated they left due to frustration with the quality of care. Nurses stated they could not give the care they judged to be required due to poor staffing and increased demands.

There is evidence though that intention to leave is dependent on age, job status, and tenure. Nurses with full time employment are significantly less likely to have an intention to leave (Medina, 2012). Sixty-six percent (66%) of this study's respondents were employed full time. Longer tenure in a role and in an organization as well as increasing age is also a predictor of nurses not intending to leave (De Geiter, 2011; Nei, Snyder & Litwiller, 2014). Nurses in this study had on average been in their current role 11 years and had worked in their current organization 16 years. Their average age was 46. These factors suggest that intent to leave would be less probable. But in addition, current economic factors affecting the availability of options need also to be considered. Healthcare in Ontario (where this study took place) is government run under the direction of a Ministry of Health (MoH). Hospital funding from the MoH has, in recent years had yearly decreases to its funding base (Ontario Hospital Association, 2011). As a result healthcare agencies have, among other fiscal restraint strategies, been laying off nurses (Canadian Federation of Nurses' Unions, 2010; Mulligan, 2015). In addition, the general economic environment is only now beginning to recover from the global downturn experienced in 2008-9 which has affected nurses' intention to leave (RNAO, 2015) . Having fewer opportunities to find new roles and an uncertain economic environment may combine to make intention to leave less likely notwithstanding the experience of

moral distress.

Even if the risk of intention to leave is lessened due to these larger social-economic factors, moral distress still poses challenges to the individual, the organization, and the profession. The effects of moral distress can be severe and long lasting. Nurses may state they are burned out and disengaged from the patients and from the profession (Pendry, 2007; Peter, McFarlane, & O'Brien-Pallas, 2004). They may experience sleep disturbances, nausea, migraines, and gastrointestinal illness (Hamric, 2012; Hanna, 2004). Even newly graduated nurses experience moral distress as self-doubt and self-blame, when they believe they might not be able to practice as they think they should (Kelly, 1998). They cope by working fewer hours and becoming disengaged from the patients. McCarthy and Deady (2008) describe that the failure to act due to constraints may create a "long term legacy of moral distress" (p. 257). There can be a feeling that one will never be the same due to the violation of one's integrity. With each experience of moral distress, a residual of the effect of the distress may persist. Then with each subsequent experience of moral distress, the experience may be felt more severely; the distress may be more profound (Epstein & Hamric, 2009). Alarmingly, in order to self-preserve, nurses may chose to be pragmatic and abandon their principles and trivialize their decisions (Hanna, 2004). These effects may create significant risks for the nurse, the patient and the profession.

Limitations

Due to the study's non-experimental, cross-sectional design inferences of causality are limited to the co-variation of the study variables and the a-priori theoretical relationships (Taris, 2000). A second limitation is the exploratory nature of this study. Most studies examining moral distress have examined that variable in relation to single

other variables. This study was a first step to understand a more complex pathway to moral distress and was thus necessarily exploratory in nature. This study therefore cannot infer causal relationships. A third limitation is that only hospital nurses were studied. Examining a more heterogeneous sample would possibly disclose more of the nature of nurse moral distress. A fourth limitation is the sole focus on constraints-to-practice as an antecedent to moral distress. Nurses may experience moral distress for other reasons not explored in this study. A fifth limitation is generally a longitudinal study is required to test mediation. This study occurred at a single point in time. A sixth limitation is alternate models were not tested. A final limitation is concern regarding the validity of the MDS-R tool. The tool measured moral distress as experienced at any time in the respondents' practice. The other tools measured respondents' more immediate experiences. In addition, the placement of the descriptors "Very Frequently" and "Great Extent" over the numbers in the Likert scale may have biased responses.

Conclusion

Nurses are experiencing moral distress, at least in part due to their inability to give care as they professionally judge to be appropriate. This is not new to nursing and that it persists despite decades of study is to say the least, worrisome. With these findings and with those from other studies there is an opportunity to begin the work on studies to evaluate strategies to mitigate moral distress as it relates to the nurse-patient therapeutic relationship. And finally, to the best of my knowledge this is the first quantitative examination of the construct "compassion" in a nursing context. Although compassion did not turn out to be a moderator of the pathway between psychological empowerment and quality of care, this is hopefully but the first of more studies to continue to learn about the little understood (in the context of nursing) construct of compassion.

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CHAPTER 6

CONCLUSION

This research was derived from my interest in understanding how moral distress in nursing might arise. As my particular interest is in understanding the nurse in organizations, I proposed a model (Figure 6) that would demonstrate how levels of structural and psychological empowerment, compassion, interprofessional collaboration, and the perception of the quality of care might increase or decrease nurses' experience of moral distress. I also hypothesized and tested a relationship between moral distress and intent to leave.

The paths between structural empowerment, psychological empowerment, interprofessional collaboration, compassion, perceived quality of care, moral distress, and intent to leave are theoretically sound. Evidence in the literature shows how the variables are linked singly. However, no study had yet looked at all of these relationships as a coherent model. As moral distress is a complex construct (Lutzen, Cronqvist, Magnusson, & Andersson, 2003; Pauly, Varcoe, Storch, & Newton, 2009) it needs to be studied taking into consideration its nomological network (Corley, 2002; Hamric 2012; Lutzen & Kvist, 2012). I proposed the following: structural empowerment would lead to psychological empowerment. When nurses are psychologically empowered, they perceive themselves as able to provide good quality of care. Perceiving that ability, they will experience less moral distress. Interprofessional collaboration and compassion would moderate the relationship between psychological empowerment and the perception of the quality of care. When there are positive relationships within the interprofessional team, nurses would more fully understand the reasoning behind opposing decisions about care. This understanding might moderate the perception of the quality of care. As a nurse's

level of compassion would rise his/her ability to understand the suffering of patients and

his/her desire to alleviate suffering would also rise. This might create the perception of

the need to deliver a higher standard of quality of care thus influence the perception of

the quality of care. There would be a direct, positive relationship between moral distress

and intent to leave. As moral distress decreases so would the intent to leave.
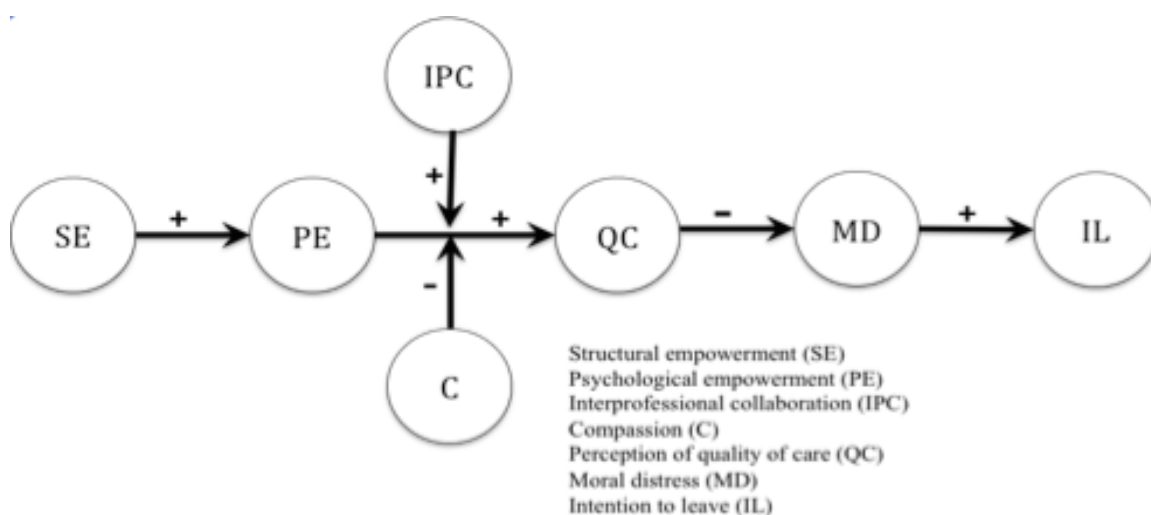
Figure 6. Hypothesized Model

   A predictive, non-experimental, cross-sectional design was used to explore the

relationships among the variables. Surveys were mailed to 900 randomly selected

registered nurses from the College of Nurses of Ontario registry of nurses, who had

indicated their willingness to participate in research. The inclusion criteria were

registered nurses: of any age, with any length of experience, in any inpatient or outpatient

unit, in any hospital (community, long term care and teaching) with any education level.

The hypothesized model was tested using PLS structural equation modeling.

Implications and Future Research

This study did support, as other studies have before, that there is a positive significant relationship between structural and psychological empowerment. And similarly, there is a significant positive relationship between psychological empowerment and quality of care. Psychological empowerment was found not to be a mediator between structural empowerment and quality of care. This could reflect that psychological empowerment is a measurement of the individual's perspective and both structural empowerment and quality of care measures organizational attributes. The respondents may not see they play a role (mediate) between the organization's infrastructure and the overall unit quality of care. This may be a naïve view. It suggests the respondents may not see themselves as part of the overall health care system but rather apart from it. This would be a worthwhile relationship to research. Understanding how nurses view themselves in relation to the unit and to the organization could deepen the understanding of how moral distress arises. As structural empowerment does have an effect on moral distress, as Austin (2012) suggests, there is a need to understand the practice setting's "moral habitability". Research regarding organizations' policies and their effect on moral distress could be conducted. As Storch, Rodney, Pauly, Brown, and Starzomski (2002) found, absence of policies, policies that are too binding, and/or vague policies may all cause moral distress.

Neither interprofessional collaboration nor compassion were moderators of the relationship between psychological empowerment and quality of care. However, both variables had a direct effect on quality of care. The direction of the effect of compassion was not anticipated. I hypothesized that as a moderator, as compassion would rise, the perception of the quality of care would fall. This, I thought would be due to compassion

sensitizing the nurse to patient suffering. The finding that as compassion rises, so does the perception of the quality of care, may suggest as nurses are compassionate, they understand the patients more deeply and the care they may require. Knowing this, they provide that care. So little research has been done on compassion in nursing. More research is certainly warranted to understand nurses' experience of compassion, its prevalence, and effect. Although, there is little known about compassion in the practice of nursing, compassion is a well-understood construct outside of nursing. I think it is timely then to be educating nurses about compassion. As compassion can be learned, consideration could be given to teach nurses how to be compassionate. The direct effect of interprofessional collaboration on the perception of the quality of care has also been found in other studies (Baggs, Norton, Schmitt, & Sellers, 2004; Hamric & Blackhall, 2007; Martin, Ummenhofer, Manser, & Spirig, 2010).

Not surprising, there was a significant and inverse relationship between quality of care and moral distress. It may be time now to try to understand what factors make up nurse moral distress and to what degree are they found to be distressing? I would suggest that most nurses understand that it is not possible to give all care to all patients at all times. Knowing that, what specific gaps in care or particular contexts might trigger moral distress? Similarly, what are the factors that nurses would describe constitute quality care? There are many requirements and standards that are to be met. Failure to meet which of these is more likely to create moral distress? There are also practices that have no standard or requirement but may be considered core to practice: having time to spend with patients, having uninterrupted time to complete work, ready access to fellow health care providers, and so on. Such an analysis and subsequent findings would be worthwhile

to determine what strategies an organization and a nurse could implement that would be most successful in mitigating moral distress.

The lack of a significant relationship between moral distress and intent to leave may be understood by examining the demographic profile of the respondents. This profile and the economic environment may be inconducive to an intent to leave. On average, the respondents were within nine years of retirement and had been on their current unit 11 years. The cost of replacing a nurse is significant (Hayes, et al., 2006). However, if nurses aren't leaving does nurse moral distress matter? Emphatically, yes it does matter. There is ample evidence that nurses who do experience moral distress are at risk of physical and emotional illnesses. They are at risk of becoming disengaged - at the very least from the organization, and at the very worst from the patients for whom they care (Pendry, 2007; Peter et al., 2004). A nurse disengaged from patients cannot be engaged in the nurse-patient therapeutic relationship. This relationship is the very crux or essence of nursing (Peplau, 1962; Perraud et al., 2006; Welch, 2005). It enables the nurse to know the patient and thus meet the obligation of acting in the best interests of the patient, as determined by the patient. When nurses are not engaged in a therapeutic relationship, they are not able to know the patient. When the patient's needs cannot be known, the moral obligation of caring for the vulnerable cannot be met.

From an educational perspective, it may be helpful to educate nurses about the construct of moral obligation and not only about ethical standards. I would suggest that nurses might not understand how moral obligation arises and therefor might not understand that they may be experiencing moral distress as opposed to burnout or perhaps job dissatisfaction. It would be helpful as well for them to understand that moral issues arise in the everyday practice of nursing, not just in the critical, dramatic moments.

These must be navigated as carefully as the larger dilemmas (Pauly, Varcoe, & Storch, 2012). In order not to be reliant on external loci of control (i.e., organizations' moral habitability), nurses could be educated about, and develop competence in, moral agency. This could permit principled thinking and in turn enhance the ability of nurses to be articulate about moral issues. As O'Connell (2015) alludes, the purpose of studying moral distress is not to "undermine principles of autonomy, independence in practice, and self-governance" but the opposite (p. 39). It is (or should be) to determine what elements of professional practice can be enhanced to mitigate moral distress?

In the current curricula devoted to understanding ethical practice, it may also be helpful to teach about differing philosophical perspectives. Different philosophies have different determinants of right and good moral behaviour. For example utilitarianism holds that a behaviour is right according to the consequences of the behaviour whereas communitarianism would say that a behaviour is right when the communal values have been upheld (Beauchamp & Childress, 2001). These differing perspectives lead to different decisions and expectations about how care should be delivered. Nurses may not even know what philosophy they are using when making judgements about appropriate care.

For nearly three decades there has been research on moral distress (Pauly et al., 2012). Now may be the time to take the understandings we have gained over those thirty years to undertake longitudinal and controlled studies in order to begin to make causal interpretations.

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Appendices

Appendix A: Conditions of Work Effectiveness Questionnaire-II (CWEQ-II)

Appendix B: Psychological Empowerment Scale

Appendix C: Relational Coordination Scale

Appendix D: Compassion Scale

Appendix E: Perception of Quality of Care Scale

Appendix F: Moral Distress Scale – Revised Nurse (Adult)

Appendix G: Moral Distress Thermometer

Appendix H: Job Turnover Intentions

Appendix A

Conditions of Work Effectiveness Questionnaire-II (CWEQ-II)

(Laschinger 2000)

CWEQ-II-OPPORTUNITY

HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Challenging work	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Tasks that use all of your own skills and knowledge.	1	2	3	4	5

CWEQ-II-INFORMATION
HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?

	No Knowledge		Some		A Lot Knowledge
1. The current state of the hospital.	1	2	3	4	5
2. The values of top management.	1	2	3	4	5
3. The goals of top management.	1	2	3	4	5

CWEQ-II-SUPPORT
HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Specific information about things you do well.	1	2	3	4	5
2. Specific comments about things you could improve.	1	2	3	4	5
3. Helpful hints or problem solving advice.	1	2	3	4	5

CWEQ-II-RESOURCES
HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Time available to do necessary paperwork.	1	2	3	4	5
2. Time available to accomplish job requirements.	1	2	3	4	5
3. Acquiring temporary help when needed.	1	2	3	4	5

JAS-II
IN MY WORK SETTING/JOB:

	None				A Lot
1. The rewards for innovation on the job are	1	2	3	4	5
2. The amount of flexibility in my job is	1	2	3	4	5
3. The amount of visibility of my work-related activities within the institution is	1	2	3	4	5

ORS-II

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR
PRESENT JOB?

		one				A Lot
1.	Collaborating on patient care with physicians.	1	2	3	4	5
2.	Being sought out by peers for help with problems	1	2	3	4	5
3.	Being sought out by managers for help with problems	1	2	3	4	5
4.	Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dieticians.	1	2	3	4	5

GLOBAL EMPOWERMENT		Strongly Disagree				Strongly Agree
1.	Overall, my current work environment empowers me to accomplish my work in an effective manner.	1	2	3	4	5
2.	Overall, I consider my workplace to be an empowering environment.	1	2	3	4	5

Appendix B

Psychological Empowerment Scale (Spreitzer, 1995)

Please circle the number that reflects the extent to which you agree or disagree with each statement.

		Strongly Disagree	Disagree		Agree	Strongly Agree
1.	The work I do is very important to me.	1	2	3	4	5
2.	My job activities are personally meaningful to me.	1	2	3	4	5
3.	The work I do is meaningful to me.	1	2	3	4	5
4.	I am confident about my ability to do my job.	1	2	3	4	5
5.	I am self-assured about my capabilities to perform my work activities.	1	2	3	4	5
6.	I have mastered the skills necessary for my job.	1	2	3	4	5
7.	I have significant autonomy in determining how I do my job.	1	2	3	4	5
8.	I can decide on my own how to go about doing my work.	1	2	3	4	5
9.	I have considerable opportunity for independence and freedom in how I do my job.	1	2	3	4	5
10	My impact on what happens in my department is large.	1	2	3	4	5
11	I have a great deal of control over what happens in my department.	1	2	3	4	5
12	I have significant influence over what happens in my department.	1	2	3	4	5

Appendix C

Relational Coordination Scale

1. How frequently do people in each of these groups communicate with you about patient care?

	Not nearly enough	Not enough	Just the right amount	Too often	Much too often
Physicians	1	2	3	4	5
Nurses	1	2	3	4	5
Social Worker	1	2	3	4	5
Physiotherapist	1	2	3	4	5
Occupational Therapist	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

2. Do they communicate with you in a timely way about patient care?

	Never	Rarely	Occasionally	Often	Always
Physicians	1	2	3	4	5
Nurses	1	2	3	4	5
Social Worker	1	2	3	4	5
Physiotherapist	1	2	3	4	5
Occupational Therapist	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

3. Do they communicate with you accurately about patient care?

	Never	Rarely	Occasionally	Often	Always
Physicians	1	2	3	4	5
Nurses	1	2	3	4	5
Social Worker	1	2	3	4	5
Physiotherapist	1	2	3	4	5
Occupational Therapist	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

4. When there is a problem with patient care, do people in each of these groups blame others or work with you to solve the problem?

	Always blame	Mostly blame	Neither blame nor solve	Mostly solve	Always solve
Physicians	1	2	3	4	5
Nurses	1	2	3	4	5
Social Worker	1	2	3	4	5
Physiotherapist	1	2	3	4	5
Occupational Therapist	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

5. Do people in each of these groups share your goals for patient care?

	Not at all	A little	Somewhat	A lot	Completely
Physicians	1	2	3	4	5
Nurses	1	2	3	4	5
Social Worker	1	2	3	4	5
Physiotherapist	1	2	3	4	5
Occupational Therapist	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

6. Do people in each of these groups know about the work you do with patient care?

	Nothing	A little	Some	A lot	Everything
Physicians	1	2	3	4	5
Nurses	1	2	3	4	5
Social Worker	1	2	3	4	5
Physiotherapist	1	2	3	4	5
Occupational Therapist	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

7. Do people in each of these groups respect the work you do with patient care?

	Not at all	A little	Somewhat	A lot	Completely
Physicians	1	2	3	4	5
Nurses	1	2	3	4	5
Social Worker	1	2	3	4	5
Physiotherapist	1	2	3	4	5
Occupational Therapist	1	2	3	4	5
Other	1	2	3	4	5
Other	1	2	3	4	5

Appendix D

Compassion Scale

HOW I TYPICALLY ACT TOWARDS OTHERS

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost Never				Almost Always
1	2	3	4	5

_____1. When people cry in front of me, I often don't feel anything at all.

_____2. Sometimes when people talk about their problems, I feel like I don't care.

_____3. I don't feel emotionally connected to people in pain.

_____4. I pay careful attention when other people talk to me.

_____5. I feel detached from others when they tell me their tales of woe.

_____6. If I see someone going through a difficult time, I try to be caring toward that person.

_____7. I often tune out when people tell me about their troubles.

_____8. I like to be there for others in times of difficulty.

_____9. I notice when people are upset, even if they don't say anything.

_____10. When I see someone feeling down, I feel like I can't relate to them.

_____11. Everyone feels down sometimes, it is part of being human.

_____12. Sometimes I am cold to others when they are down and out.

_____13. I tend to listen patiently when people tell me their problems.

_____14. I don't concern myself with other people's problems.

_____15. It's important to recognize that all people have weaknesses and no one's perfect.

_____16. My heart goes out to people who are unhappy.

_____17. Despite my differences with others, I know that everyone feels pain just like me.

_____18. When others are feeling troubled, I usually let someone else attend to them.

_____19. I don't think much about the concerns of others.

_____20. Suffering is just a part of the common human experience.

_____21. When people tell me about their problems, I try to keep a balanced perspective on the situation.

_____22. I can't really connect with other people when they're suffering.

_____23. I try to avoid people who are experiencing a lot of pain.

_____24. When others feel sadness, I try to comfort them.

Coding Key:
Kindness Items: 6, 8, 16, & 24
Indifference Items: 2, 12, 14, & 18 (Reversed Scored)
Common Humanity: 11, 15, 17, & 20
Separation: 3, 5, 10, & 22 (Reversed Scored)
Mindfulness: 4, 9, 13, & 21
Disengagement: 1, 7, 19, & 23 (Reverse Scored)

To reverse-score, change the following values: 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1
To compute a total Compassion Score, take the mean of each subscale (after reverse-scoring) and compute a total mean.

Please remember that if you plan to examine the subscales separately, you should not reverse-code. Before reverse-coding, for example, higher indifference scores represent more indifference, but after reverse-coding higher indifference scores represent less indifference. This is why the subscales of indifference, separation, and disengagement are reverse-coded before taking an overall compassion mean.

Pommier, E. A. (2011). The compassion scale. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 72*, 1174.

Appendix E

In general, how would you describe the quality of nursing care for patients on your unit?

1 Poor	
2 Fair	
3 Good	
4 Excellent	

Appendix F

MDS-R Nurse Questionnaire (ADULT)

Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints. The following situations occur in clinical practice. If you have experienced these situations they may or may not have been morally distressing to you. Please indicate how frequently you experience each item described and how disturbing the experience is for you. If you have never experienced a particular situation, select "0" (never) for frequency. Even if you have not experienced a situation, please indicate how disturbed you <u>would</u> be if it occurred in your practice. Note that you will respond to each item by checking the appropriate column for two dimensions: *Frequency* <u>and</u> *Level of Disturbance*.

	Frequency					Level of Disturbance				
	Never		Very Frequently			None			Great Extent	
	0	1	2	3	4	0	1	2	3	4
1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.										
2. Witness healthcare providers giving "false hope" to a patient or family.										
3. Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.										
4. Initiate extensive life-saving actions when I think they only prolong death.										
5. Follow the family's request not to discuss death with a dying patient who asks about dying.										
6. Carry out the physician's orders for what I consider to be unnecessary tests and treatments.										
7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.										
8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.										

	Frequency					Level of Disturbance				
	Never				Very Frequently	None				Great Extent
	0	1	2	3	4	0	1	2	3	4
9. Assist a physician who, in my opinion, is providing incompetent care.										
10. Be required to care for patients I don't feel qualified to care for.										
11. Witness medical students perform painful procedures on patients solely to increase their skill.										
12. Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.										
13. Follow the physician's request not to discuss the patient's prognosis with the patient or family.										
14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.										
15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.										
16. Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.										
17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.										
18. Witness diminished patient care quality due to poor team communication.										
19. Ignore situations in which patients have not been given adequate information to insure informed consent.										
20. Watch patient care suffer because of a lack of provider continuity.										
21. Work with levels of nurse or other care provider staffing that I consider unsafe.										

	Frequency					Level of Disturbance				
	Never				Very Frequently	None Extent				Great
	0	1	2	3	4	0	1	2	3	4
If there are other situations in which you have felt moral distress, please write them and score them here:										

Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

     No, I've never considered quitting or left a position _____
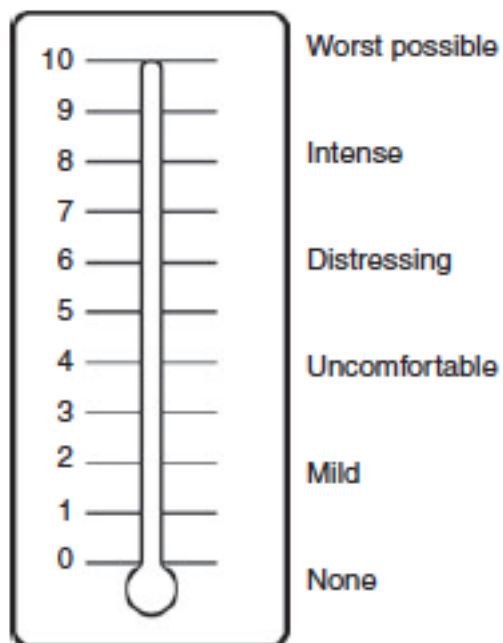   Yes, I considered quitting but did not leave _____
     Yes, I left a position _____

Are you considering leaving your position now?   Yes   No

Appendix G

Moral Distress Thermometer

Moral Distress Thermometer

Moral distress is a form of distress that occurs when you believe you know the ethically correct thing to do, but something or someone restricts your ability to pursue that course of action.

Please circle the number (0–10) on the thermometer that best describes how much moral distress you have been experiencing related to work in the past 2 weeks including today.

Appendix H

Job Turnover Intentions

Please indicate the extent to which you agree with the following statements.

1= Strongly Disagree	2= Disagree	3= Neither Agree nor Disagree	4= Agree	5= Strongly Agree

1. I am thinking about leaving this organization.   1   2   3   4   5

2. I am planning to look for a new job.   1   2   3   4   5

3. I intend to ask people about new job opportunities.   1   2   3   4   5

4. I don't intend to be in this organization much longer.   1   2   3   4   5

CURRICULUM VITAE

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       Journal of Advanced Nursing. Advance online publication. doi:
       10.1111/jan.12686