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EXPLORING THE RELATIONSHIPS BETWEEN MORAL DISTRESS, MORAL COURAGE, AND MORAL RESILIENCE IN UNDERGRADUATE NURSING STUDENTS

by

ERIN GIBSON

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Nursing
Department of Nursing

Dr. Gloria Duke, Committee Chair

College of Nursing and Health Sciences

The University of Texas at Tyler
April 2019

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Dedication

This is dedicated to my husband Daniel, my children Bryson and Lainey, and my students.

Acknowledgements

First, I would like to acknowledge my heavenly father, God. Without Him, I would not have made it through the storms that got me to where I am.

Next, I want it to be known that without the support of my husband Daniel, none of this would have been possible. A husband that works so hard and even harder so that this would have been possible for me. I am forever grateful that I get to do life with you and can't wait to have our evenings back on the couch watching our favorite nonsensical television shows. You have made this process more bearable and I cannot thank you enough. I love you more.

Bryson and Lainey, my prayer is that while I went through this process, you were young enough that your memory stretched only as far as the day before. Most of all I pray that you know that you are loved. I dedicate this to you so that you may one day understand that you can dream big. You CAN be all the things that you wish if you work hard. Be a light in this world. Do not settle and be like others. Stay focused on the good and hard work you put into each day and you will bear fruit. You will fail and make mistakes, keep moving, God has a plan. I love you and I cherish each and every second I am with you.

Mom, thank you for supporting me through this journey. Thank you for teaching me to be strong, courageous, and bold in my opinions. Thank you for doing all the things when I couldn't. Laundry, dishes, and giving grace saved my sanity! One day, I hope to return the favor. I love you always.

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Last but not least, I dedicate this to all of my students who I am confident are making a difference in this world. Thank you for being my greatest teacher. It is my hope that you always remain courageous and stand up for what you believe is right.

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Abstract

EXPLORING THE RELATIONSHIPS BETWEEN MORAL DISTRESS, MORAL COURAGE, AND MORAL RESILIENCE IN UNDERGRADUATE NURSING STUDENTS

Erin Gibson

Dissertation Chair: Gloria Duke, PhD

The University of Texas, at Tyler
April 2019

The pervasiveness of moral distress in nursing can no longer be ignored. Moral distress can have devastating effects on a nurse and lead to burnout and/or cause the nurse to leave the profession. To mitigate these effects, strategies to decrease moral distress should be implemented as early as nursing school. Related concepts such as moral courage and moral resilience show favorable effects as strategies to combat moral distress. However, little evidence is known as to how these three moral concepts are related with one another.

Chapter 2, "Student Courage: An Essential for Today's Health Education" provides a concept analysis of student courage within nursing education. In order to enhance nursing knowledge, this concept is defined using language to help operationalize the term.

Chapter 3 provides an integrative review that summarizes empirical literature from 2012 to 2018 with a comprehensive understanding of moral distress in baccalaureate nursing students. This synthesis of the literature was conducted in consideration of Corley's (2002) Moral Distress Theory.

A descriptive correlational design was used to explore the interrelationships between moral

distress, moral courage, and moral resilience in nursing students. Quantitative data was collected using the Moral Distress Thermometer, the Connor-Davidson Moral Resilience Scale (CD-RISC), and the Moral Courage Scale for Physicians (MSCP). The data was analyzed using Pearson *r* correlations and multiple regression analyses to determine the relationship between these moral concepts. A multiple regression analysis was used to determine if one of the two moral concepts better predicted moral distress in students than the other.

Chapter 1

Overview of the Research

Moral distress was first introduced into the nursing literature by Dr. Jameton (1984) in 1984. Since then, a substantial amount of research has been done within the realm of practicing nurses. Recently, Jameton (2017) noted the drastic increase in publications since 2011 and implied that there is an increasing frequency, intensity, and/or extent of moral distress in various areas of healthcare. Because of the ongoing presence of moral distress experienced by nurses, one area growing in research is moral distress within nursing education. Nursing students experience moral distress and the subsequent emotional and physical effects (Ganske, 2010; Wojtowicz et al., 2014). Consequently, nursing education is responsible for supporting students as they circumnavigate through experiences such as moral distress. A knowledge gap regarding the presence of moral distress among nursing students was identified by Sasso and colleagues (2016) in their recommendation that future research be conducted to better understand this phenomenon.

Promising strategies to decrease the effects of moral distress include two other morally associated concepts known as moral courage and moral resilience. Moral courage occurs when an individual takes action to overcome any fear (Lachman, 2009). Moral resilience enriches or augments a person's capacity in such a way that their commitments to their own moral responsibility are deepened, allowing them to navigate challenging dilemmas (Rushton, 2016). Most nursing students lack moral courage despite knowing their role as a patient advocate. Furthermore, cultivating moral resilience in future nursing professionals is necessary in order to prepare them for imminent moral complexities they may face. While studies indicate these moral

concepts lessen the effects of moral distress, strategies that are evidence-based are scarce (American Nurses Association, 2017). Strategies for building moral resilience appear to fall under four domains: practice, education, research, and policy.

Given that moral dilemmas that lead to moral distress are inevitable, strategies to stimulate and teach moral courage and moral resilience so as to mitigate the effects of moral distress are imperative in nursing education. Before implementing evidence-based strategies that improve moral courage and moral resilience, examining how these three moral concepts are potentially related to one another is a crucial step in this research process prior to testing strategies to nurture them. Lastly, with the recent development of moral resilience, exploring these three moral concepts will test and validate current theoretical frameworks. The adapted theory that guided this study is Mary Corley's theory of moral distress with permission for use (M. Corley, personal communication, October, 2, 2018). Moral distress and moral courage are tested constructs within the theory with the addition of moral resilience that is not part of Corley's original model.

Purpose

The purpose of the study was to examine the relationships between moral distress, moral courage, and moral resilience in undergraduate nursing students.

Introduction of Articles

The first article included is a concept analysis of a newly developed term, student courage. Student courage was developed because nursing students need to be able to speak up when a moral dilemma arises. Using the Walker and Avant (2014) methodology, the concept analysis for student courage includes: (1) selection of concept; (2) determination of aim or purpose of

analysis; (3) identification of uses of the concept; (4) determination of defining attributes; (5) identification of a model case; (6) identification of additional cases; (7) identification of antecedents and consequences; and (8) definition of empirical referents. This concept analysis was published in the journal *Nursing Forum* in April of 2018. The purpose of developing student courage was to identify a concept regarding courage that precedes moral courage in the population of healthcare students, particularly nursing.

The next article presents an integrative review of moral distress in baccalaureate nursing students. Limited research exists regarding moral distress in nursing students, and the majority of those studies have used qualitative methodologies. In order to move the research forward, a synthesis of mixed methodologies was vital. Using the framework presented by Whittemore and Knafl (2004), various perspectives on moral distress in nursing students are discussed in Chapter 3. Qualitative and quantitative studies revealed varying sources of moral distress such as conflicting values between student and family wishes, informed consent dilemmas, subordinate role as a student, and unprofessional behavior exhibited by healthcare providers. Limited studies are available that provide intervention strategies towards mitigating the effects of moral distress. Potential strategies include generating evidence on moral courage and moral resilience.

Chapter 2

Student Courage: An Essential for Today's Health Education

Abstract

Aim: The aim of this concept analysis is to propose the new concept of student courage as it operates within the context of healthcare professionals' education.

Background: Nurses have a moral obligation that often requires courage. However, nursing students do not have the capacity to act with moral courage until they are close to licensure. Student courage is propositioned as a precursor to moral courage.

Design: The Walker and Avant approach is used to examine the attributes, antecedents, consequences, and empiric referents of student courage. Cases are provided to represent how student courage can be operationalized and to distinguish student courage from moral courage.

Results: The analysis demonstrates that the concept of student courage has four critical attributes: (a) persistence, (b) bravery, (c) overcoming fear, and (d) self-advocacy. Positive and negative consequences are associated with student courage and include: (a) moral distress, (b) criticism, (c) empowerment, and (d) self-knowledge.

Conclusions: This concept analysis helps fill the gap for nursing students transitioning into a professional role as well as clarifying a nursing student's role in patient care.

Keywords: moral development, moral duty, nursing student, nursing ethics

Student Courage: An Essential for Today's Health Education

Nurses have a duty to protect their patients from harm. This duty is outlined within the nursing *Code of Ethics* wherein safety of a patient should inform every aspect of care a nurse provides (American Nurses Association, 2017). One of the ways nurses and students entering the health professions can ensure patient safety is acting with moral courage. Acts of courage can be highly publicized, with examples being the nurse who was arrested for advocating patient rights or a mass shooting when off-duty nurses who risked their own lives to save others. However, not all acts of courage are broadcasted; most happen on a daily basis. Everyday examples of courage could be assisting a family member as they make the decision to end life support for a dying loved one, encouraging a physician to follow a patient's preferences, or stopping a nurse preceptor from administering an incorrect dose of pain medication. Nurses *and* nursing students are faced daily with moral dilemmas requiring acts of courage. Furthermore, nursing students, more than any other health professional student, nursing students are more likely to participate in or observe situations that threaten patient safety (Monrouxe, Rees, Endacott, & Ternan, 2014). Nursing students recognize the importance of speaking up for what they believe in is right, even if difficult (Bickhoff, Levett-Jones, & Sinclair, 2016). Although nursing students are notoriously taught to recognize their own their own morals and values, they do not always choose to be courageous and speak up about poor practices. Educators at all levels including undergraduate, graduate, doctorate, post baccalaureate, internships, fellowships and continuing education can serve to develop moral courage (Murray, 2010). Therefore, when moral courage is underdeveloped and students are in the process of recognizing their own morals and values, tools and strategies to first cultivate student courage are necessary. The concept of student courage is a new concept proposed

in this article and serves as a precursor to moral courage. The purpose of this article is to analyze and propose a warranted concept of student courage by using the Walker and Avant methodology (Walker & Avant, 2014).

Courage in Nursing

Courage is divided into four main types, 1) employment, 2) religious or patriotic, 3) social or moral, and 4) independent or family-based (Woodard & Pury, 2007). Moral courage is defined as the ability to rise above fear and take what is believed is the right course of action based upon one's own ethical belief; this is the specific type of courage required in nursing (Lachman, 2007). Due to more frequent and recent studies surrounding moral concepts, the American Nurses Association (2017) identified the necessity for all nurses in any role or setting to promote an environment that cultivates moral courage. Though literature demonstrating the importance and role of moral courage exists, including in nursing students, effective ways to foster moral courage has been understudied and underreported in the literature. In one analysis, Sadooghiasl, Parvizy, & Ebadi (2016) revealed that acquiring academic and professional qualification is an antecedent for moral courage. In other words, students may not exhibit moral courage until they have transitioned into their role as a licensed nurse. It has been suggested moral courage can be developed in nurses through repetition and regular application (Murray, 2010). However, in nursing students, one of the ways for educators to foster moral courage is to first emphasize the importance of student courage and its role in learning about delivery of quality, safe patient care.

Practicing student courage while in school could lead over time to active moral courage when new graduates enter the profession. Nash, Mixer, McArthur, and Mendola (2016) conducted a study with the intended outcome of instilling courage into nursing students by completing advance directives with homeless persons. Study findings revealed students' preceding fears

included acting inappropriately in front of the patient and fear of discussing dying and death with a homeless person (Nash, Mixer, McArthur, & Mendola, 2016). However, it was found that after interaction with homeless persons, none of the preconceived fears occurred; rather, they concluded students needed more courage in anticipation of such events (Nash, Mixer, McArthur, & Mendola, 2016).

Having moral courage as a nurse is a valuable characteristic, not only for patient safety but because of its recently established correspondence with preventing moral distress. (Bickhoff, Sinclair, & Levett-Jones, 2015). Moral distress occurs when a person knows the right action to take, but cannot take the correct action due to constraints (internal and external) (Jameton, 1984). Moral distress adversely effects job satisfaction and performance, physical and psychological well-being, turnover, and retention (Austin, Saylor, & Finley, 2016). Given that dilemmas causing moral distress are inherent in clinical and academic contexts, nurses *and* nursing students should be equipped with proper tools such as courage (Lindh, Barbosa de Silva, Berg, & Severinsson, 2010). In order to cultivate student courage, moral courage should be modeled and mentored (Aultman, 2008). Nursing students are still in the process of learning their role as a nurse and the assertive behavior required to go above and beyond to provide the highest quality care. Therefore, acknowledging and bringing awareness to student courage as a bridge to moral courage is crucial.

Moral Concepts Significant to Nursing and Nursing Education

Florence Nightingale emphasized the importance of moral disposition and considered it an essential attribute of a good nurse (Numminen, Repo, & Leino-Kilpi, 2016). Accordingly, it is imperative that the nursing profession recruit and retain nurses and students with proper moral comportment. Nursing education opens the doors for future nurses and, therefore, sets forth the professional behavioral expectations of nursing. Researchers sought to describe how nursing

students demonstrated moral courage and what factors inhibited or encouraged willingness to speak up. Bickhoff and others (2016) concluded that students who engage the journey to become a nurse begin to experience ethical dilemmas and may not be equipped to manage or prevent associated consequences. Moral distress as an associated consequence of not doing what is right in an uncertain circumstance, has been supported in healthcare research and specific to nursing students (Range & Rotherham, 2010; Renno, Ramos, & Brito, 2018; Sasso, Bagnasco, Bianchi, Bressan, & Carnevale, 2016; Wojtowicz, Hagen, & Van Daalen-Smith, 2014). In particular, nurses undergo moral distress more than any other healthcare discipline (Houston et al., 2013). Moral distress can lead to burnout and increased turnover (Hylton Rushton, Batcheller, Schroeder, & Donohue, 2015). Conversely, an increase in moral courage was shown to be effective in mitigating moral distress (Bickhoff et al., 2015). Murray (2010) suggests understanding the intrinsic and extrinsic factors surrounding the existence of moral courage also is crucial for leaders in the nursing profession.

Not only is having moral courage essential to mitigate moral distress, it is vital for nurses to preserve the public's trust in the nursing profession. According to a Gallup Poll, the nursing profession remains the highest ranking trusted public profession (Riffkin, 2014). Being an honest and ethical healthcare professional is valued by patients and their families because they expect nurses to be their biggest advocates. A student nurse who makes the intentional choice of employing student courage could prevent harm as exemplified in the case provided in this article. Quality patient outcomes and continuation of preserving trust from the public is fundamental for the nursing profession and the facilities in which they practice. Therefore, it is important to define the concept of student courage.

Concept Definition: Student Courage

Walker and Avant stress the importance of defining a concept so it is structurally sound (Walker & Avant, 2014). This is important so that the reading audience can understand the concept as intended. With a two-word concept such as student courage, both terms need analysis in order to explore all encompassing contexts. Lastly, courage is a complex concept and has many potential inferences in the literature as described below.

Student

To begin the process of analyzing the concept of *student*, English and American translations were used as a reference. Both translations refer to a student nurse in their meanings. The *Cambridge Online Dictionary* defines *student* in three different ways: 1) a person learning at a college or university; for example, a *student* nurse learning to become a nurse; 2) as primarily used in the United States, a *student* is someone who is learning at a school; and 3) a *student* of a particular subject, they know about it and are interested in it and such as a nurse may be a *student* of human nature ("Student," 2017). The *Merriam-Webster Online Dictionary* defines *student* as a scholar or someone learning who attends school, but also one who studies and is an attentive and systematic observer ("Student," 2017). The common aspect across these definitions is students are learning and acquiring knowledge in relation to their field of study. Nursing students have to learn to become a nurse, and included are the tools and skills required of a nurse.

Courage

The *Etymology Online Dictionary* describes *courage* in old French as *corage* meaning heart, innermost feelings, temper while in Latin the term *cor* means heart ("Courage," 2017). The *Merriam-Webster Online Dictionary* defines *courage* as a mental or moral strength to venture, preserve and resist fear, threat or struggle ("Courage," 2017). Courage is a term used for millennia

in religious contexts and other literature as a virtue to be extolled. Bible refers to *courage* as good cheer when God often times commands people to be of good cheer or to fear not. Tillich, a twentieth century theologian, defined courage in *The Courage to Be* as the self-affirmation of one's being in spite of a threat of non-being. Tillich contested that courage is related to anxiety; more specifically, anxiety is a threat and courage is what is used to resist the threat (Tillich, 1962). Given Tillich's notion and the established fact that nursing students experience significant amounts of anxiety, it is reasonable to conclude that student nurses must use courage to resist and overcome the threat of anxiety-hence the concept of student courage (Turner & McCarthy, 2017). Therefore, student courage is an intentional behavior in order to overcome anxiety. Courage has many inferences in the literature and has been interpreted in many different ways.

Aristotle laid the groundwork for establishing courage as a moral virtue (Aristotle, n.d.). He purported that cowardice is the opposite of courage and recklessness its unrestrained actualization. Courage, in its true from, Aristotle argued, should be a balance between these extremes. McCall (n.d.) extended Aristotle's definition of courage, describing the concept as the ability to *choose* between cowardice and recklessness in any circumstance. Accordingly, courage is an intentional choice of behavior positioned uniquely between being impulsive and being too fearful.

It is expected that student courage will lead to moral courage, which is also defined in this paper for its relevance in nursing literature and relation to the type of courage a nursing student would be aspiring to ascertain. Once student nurses are licensed registered nurses, their student courage shifts to full-fledged moral courage, which is the ability to overcome fear, to stand up for one's own values, and most importantly, to advocate for the values of the patient (Lachman, 2007; Lachman, 2016).

Antecedents to Student Courage

To help understand what lead to a concept, Walker and Avant delineated antecedents from attributes. Specifically, antecedents must occur prior to the anticipated concept (Walker & Avant, 2014). The antecedents of fear, confidence, and threat are proposed as necessary precursors to student courage. As a new concept, more antecedents may be discovered as further research around student courage develops.

Fear

First, fear must be present in order for student courage to emerge. Given that a defining attribute of student courage is to overcome fear itself, fear must initially exist within a student. The source of fear could be myriad. For example, students may fear that their level of knowledge about patient care is inadequate. Students may fear hierarchy or retaliation from preceptors or mentors. Furthermore, students may fear academic failure. Student nurses are realizing their professional role and learning that they have an obligation to act on behalf of the patient, which can produce fear of the above consequences of that advocacy (Bickhoff, 2017).

Threat

Threat is another antecedent of student courage. A threat is a danger or risk of well-being. A distressing threat internally or externally to one's morals, safety, values, or well-being must take place in order for student courage to occur. A threat must be present in order for a person to deliberately act with full knowledge of the implications of the threat, which could include ostracism, failure, or punishment. Sasso and others (2016) systematic review revealed commonly perceived threats or challenges in nursing students arose from dilemmas around end of life therapies, abortion, euthanasia, pharmacological and physical restraint, as well as healthcare inequalities and disparities.

Confidence

Confidence is a third antecedent for courage. Confidence or a feeling of self-assurance about a situation must be in place for courage to transpire. Without confidence, cowardice would take place rather than courage. In student courage, confidence includes the act of speaking up. For example, nursing students who exhibit courage are more likely to speak up and question substandard practice as confidence increases across their learning (Levett-Jones, Lathlean, Higgins, & McMillan, 2009). This precursor is in agreement with Aristotle's original thoughts that without confidence, negative traits would emerge more so than courage.

Critical Attributes of Student Courage

According to Walker and Avant, attributes are characteristics or qualities that define a concept (Walker & Avant, 2014). The critical attributes identified for student courage are persistence, bravery, overcoming fear, and self-advocacy (Reader, 2015; Salmela & Uusiautti, 2015). The attributes for student courage are defined in Table 1.

Table 1 Definitions of Attributes

ATTRIBUTE	DEFINITION IN RELATION TO STUDENT COURAGE
Persistence	The action or fact of persisting (persistence, 2017).
Bravery	The quality or state of having or showing mental or moral strength to face danger, fear, or difficulty (bravery, 2017).
Overcoming fear	To deal with fear successfully or prevail over it (overcoming fear, 2017).
Self-advocacy	The action of representing oneself or one's views or interests (self-advocacy, 2017).

Persistence

Student courage is exemplified by persistent advocacy for patients' best outcomes. Persistence as a personal characteristic can help students reach their professional as well as

personal goals (Stelnicki, Nordstokke, & Saklofske, 2015). For example, students may have to persist through barriers when communicating issues or concerns for their patients or for themselves with an instructor or preceptor. As an attribute of courage, persistence does not always result in the desired outcome. For example, a student who is communicating persistently about a patient issue with a good understanding and knowledge about facts pertaining to a particular issue, may not be successful in the endeavor, but without persistence, courage to advocate would be absent.

Bravery

Bravery and courage are similar but not the same. Given that an attribute is an inherent part of something, bravery coexists with student courage. Bravery differs from courage by the quality or state of having or showing mental or moral strength to face danger, fear, or difficulty (bravery, 2017). Bravery in a student can be specifically related to psychological courage when they are able to remain stable despite uncertainty and hardship (Putnam, 1997; Salmela & Uusiautti, 2015). A key component for student courage to transpire is students have the ability to exhibit bravery through moral or mental strength.

Overcoming Fear

Overcoming fear is when a person is able to successfully prevail over their fear. Also, overcoming fear consists of doing so despite consequences. Nursing students in particular are fearful of many clinical aspects such as death, examinations, and role conflict (Higginson, 2006). Speaking up or out is usually the action associated with courage, and in students the benefit of speaking out needs to outweigh the risk of not taking action. Students need to understand the importance of speaking up in an assertive respectful manner. Also, before speaking out, students need to first recognize if their fear is valid and not just a knowledge deficit. Once students validate their fears about patient safety for example, they need to proceed despite their fears and speak up in

order to avoid consequences. The consequences are also discussed in this article.

Self-Advocacy

Self-advocacy is vital for student courage. Self-advocacy is important in representing one's views in order to protect others. Self-advocacy can involve being an advocate for someone under their care and is necessary for justice or even doing what is morally right (Reader, 2015). Students can display courage by advocating for themselves in an academic setting or more importantly, advocating the core values of someone else.

Consequences of Student Courage

Consequences are the outcomes or results of an occurring concept as defined by Walker and Avant (Walker & Avant, 2014). The consequences of student courage can be positive or negative. A negative consequence of having or not having student courage could result in moral distress. When students know the right thing to do but do not act with student courage, they can be left with ongoing moral distress (Bickhoff et al., 2015; Hamric, 2010). Therefore, it would be reasonable to surmise students lacking student courage may enter the profession distressed or even abstain from entering the profession at all. Another negative consequence of courage may be criticism from others. In the model case provided, the student or nurse who displays courage could have been ridiculed by the physician as a form of defense or retaliation. However, in the model case provided, the benefits of acting with student courage exceed the risk of patient harm.

Positive effects of courage are empowerment and increased self-knowledge (Numminen et al., 2016). In nursing, moral courage can help nurses overcome barriers and promote trust, compassion, hopefulness, and patient safety (Sadooghiasl, Parvizy, & Ebadi, 2016). As apparent in the case provided, trust was established between the preceptor and student. Also, with an increase in self-knowledge and empowerment, a student becomes more confident and likely to act

when courage is necessary for patient safety.

Student Courage Model Case

This model case for student courage offers a window into understanding how defining attributes are actualized in a realistic scenario (Walker & Avant, 2014). M.K. is a 20-year-old female student who is in the middle of the third semester of a four semester upper division nursing program. M.K. has been working twelve-hour clinical shifts on a medical-surgical unit for the last five weeks in her clinical practicum for school. She has reached a milestone for her nursing program and been checked off by her nursing instructor on giving medications, which means she has been competent to administer medications under the supervision of her primary nurse (i.e., her preceptor). M.K. and her preceptor are assigned to a patient who is post-operative day six from a below the knee amputation. M.K. recognizes her patient's symptoms of phantom limb pain from a course lecture and book chapter she read and reports them to her preceptor. The surgery resident ordered Ketorolac for pain. M.K. specifically remembers from her pharmacology exam that Ketorolac is for short-term pain and should not be used longer than five days. M.K. notes that the patient has been receiving Ketorolac for six days and is still reporting pain. The preceptor advises M.K. that per the resident's order, the best action is to prepare the pain medication as prescribed and be ready to administer it. As M.K. is pondering what she should do, she considers the severe effects Ketorolac could have such as increased bleeding and kidney impairment.

M.K. expresses her concerns to her nursing instructor who concurs it is best to not follow the orders but to suggest and alternate pain medication to the resident. When M.K.'s preceptor asks if she is ready to administer the pain medication, M.K. voices her concerns about the appropriateness of the Ketorolac and offers Hydrocodone as an alternative. To substantiate M.K.'s concern, she shows her preceptor the information derived from her drug book and reviews the

medication record what shows the patient has consecutively taken Ketorolac for the last five days. The preceptor dismisses M.K.'s concerns and tells her that one more dose will be fine. While the preceptor prepares the medication herself, M.K. discusses the patient's kidney labs and asks about the implications of their steady increase over the last few days. At this point, the preceptor agrees with M.K.'s concern about the patient's safety and calls the surgery resident to discuss alternate pain medication options.

This case represents the defining attributes for student courage. Nursing students such as M.K. are vulnerable when caught between what is being taught and what they are seeing in practice. M.K. was able to overcome her fears of isolation or ill-treatment from her preceptor by knowing the risks involved for the patient. M.K. was persistent in her pursuit for patient safety and not only advocated for herself by not practicing unsafely; but ultimately advocated for her patient. Lastly, M.K. was brave by re-approaching the preceptor and was able to maintain psychological stability even after being rejected. As a result, M.K.'s self-knowledge became more evident and she felt empowered in her ability as a student to provide safe patient care as well as not having any feelings of moral distress.

Contrary Case

In continuing with the case above, the following scenario represents a contrary case where the attributes of student courage are absent (Walker & Avant, 2014). K.M. is a 20-year-old female student in the middle of the third semester of a four semester upper division nursing program. K.M. has been working twelve-hour clinical shifts on a medical-surgical unit for the last five weeks in her clinical practicum for school. She has reached a milestone for her nursing program and been checked off by her nursing instructor on giving medications, which means she has been deemed competent to administer medications under the supervision of her primary nurse (i.e., her

preceptor). K.M. and her preceptor are assigned to a patient who is post-operative day six from a below the knee amputation. K.M. recognizes her patient's symptoms of phantom limb pain from a course lecture and book chapter she read and reports them to her preceptor. The surgery resident ordered Ketorolac for pain. K.M. specifically remembers from her pharmacology exam that Ketorolac is for short-term pain and should not be used longer than five days. K.M. notes that the patient has been receiving Ketorolac for six days and is still reporting pain. The preceptor advises K.M. that per the resident's order, the best action is to prepare the pain medication as prescribed and be ready to administer it. As K.M. is pondering what she should do, she considers the severe adverse effects Ketorolac could have such as increased bleeding and kidney impairment.

K.M. considers expressing her concerns to her nursing instructor, and she considers voicing her concerns about the appropriateness of the Ketorolac with her preceptor. She considers using her drug book to substantiate her concern as well as the patient's lab values that indicate risk for kidney injury; however, as she considers these her fear grows that her preceptor will view her as incompetent or a trouble-maker. K.M. chooses to say nothing and proceeds to prepare the Ketorolac. She administers the properly dosed medication under the supervision of her preceptor. During the night shift, the patient continues to receive the medication as prescribed. The next morning, when K.M. and her preceptor did their morning assessment they find that the patient's surgical dressing is soaked with frank blood, his bleeding time increased, and his kidney labs are abnormally elevated. K.M. is devastated that she did not speak with her preceptor about the risk she knew about yesterday. She still chooses to keep quiet about it and listen to the dialogue among the nurses and other healthcare providers as they discuss the situation.

This case lacks the defining attributes for student courage. In this case, K.M. ignored the vulnerability that stemmed from being caught between she was taught and what she saw in

practice. K.M. chose to acknowledge her fears of isolation or ill-treatment from her preceptor and ignore the risks involved for the patient. K.M. may have questioned her own competence and knowledge base. K.M. did not advocate for her patient and therefore, did not exhibit student courage. She knew there was risk but acted on cowardice, putting her patient, the preceptor and her other nursing and interprofessional colleagues at risk by not choosing to bravely approaching the preceptor. As a result, K.M. was left with unresolved moral distress that she will carry throughout her nursing school career and possibly while entering the profession.

Empirical Referents

Using the concept analysis method described by Walker and Avant, empirical referents are measurable ways to validate the occurrence of a concept (Walker & Avant, 2014). No empiric referents were found for student courage. A surrogate measure that could be best adapted to measure student courage is the Moral Courage Scale for Physicians (MCSP) that was created in 2016 (Martinez, Bell, Etchegaray, & Lehmann, 2016). This nine item survey is based on a seven-point Likert scale from strongly disagree=1 to strongly agree=7 and measures moral courage in the context of patient care. Scores range from 0 (worst) to 100 (best). This scale was initially tested with a sample of 731 interns and residents who responded to the items about moral courage, empathy, and speaking up about patient safety breaches. In this psychometric study, all item-score correlations were significant $p<.001$, suggesting discriminant validity along with a Cronbach's alpha=0.90. The developers suggest that the MCSP can be used and modified in other healthcare professionals such as nurses who require moral courage.

Another potential scale to adapt in measuring student courage is the Professional Moral Courage Scale (PMCS) (Sekerka, Bagozzi, & Charnigo, 2009). Sekerka and others (2009) who developed the five-dimensional tool use a Likert scale and originally used the tool to study military

personnel. The scale assesses overall professional moral courage thematically to include moral goals, multiple values, enduring threats, going above and beyond compliance, and moral agency. Sekerka and others (2009) deemed the PMCS psychometrically sound and reported convergent and discriminant validity.

Lastly, other potential sources of measurement that could be adopted for student courage include: The Woodard Pury Courage Scale (WPCS-23) refined in 2007 using factor analysis suggested reliability and validity, and also the Moral Courage Questionnaire for Nurses (MCQN) (Dinndorf-Hogenson, 2014; Woodard & Pury, 2007). The MCQN was presented at an International Nursing Research Congress conference in 2014. The MCQN was initially tested by a randomized mail questionnaire to perioperative nurses across the Midwest, N=154. The MCQN was deemed sufficient with a Cronbach's alpha=0.81. With proper analysis these scales can be modified and adopted to measure student courage in nursing students or other healthcare professionals.

Conclusion and Recommendations

Student courage is a necessary characteristic for professionals entering healthcare. Nursing students are part of the interprofessional patient care team and are confronted with situations that require an intentional act of student courage. Students who are persistent and brave demonstrate courage by choosing to overcome their fears and fulfill their duty as advocates for themselves and others.

While nursing students are preparing for their professional role, educators can promote student courage by affirming and being approachable to concerns when situations arise. More importantly, in order for transference of the ethical obligations essential in nursing, curriculums should use pedagogies such as experiential learning to illuminate the importance of student

courage. Through increasing literature in academic distress, nursing can set precedence for bolstering the concept of student courage and how it operates in both academic and clinical settings.

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Chapter 3

Moral Distress Among Baccalaureate Nursing Students: An Integrative Review

Abstract

Background: At the forefront of patient care, nurses and students face a demanding and fluid healthcare system that can present overwhelming challenges. Moral distress is experienced by both students and nurses who encounter complex situations in which decisions are made that may conflict with their values. Having an understanding of the meaning and effects of moral distress in nursing students allows nurse educators to establish evidence-based protocols to improve outcomes.

Purpose: An integrative review of the literature was conducted to examine the sources of moral distress in nursing students as well as to synthesize what interventions have been effective in mitigating the effects of this phenomenon.

Design: An integrative review of the empirical literature (2012-2018) conducted by a search through online databases in nursing: PubMed, CINAHL, and SCOPUS.

Method: The methods described by Whittemore & Knafl (2005) were used to guide this review. A search from 2012-2018 produced 88 articles. Abstracts and full text were vetted for inclusion. Data were synthesized using the content method of analysis.

Findings: Nursing students experience moral distress from multiple sources. Limited studies are available that provide intervention strategies towards mitigating the effects of moral distress. Potential strategies include generating evidence on moral courage and moral resilience.

Conclusion: Knowledge gaps continue to exist regarding moral distress in nursing students. Future research on cultivating moral resilience and moral courage is warranted in order to provide best practice strategies.

Keywords: moral distress, nursing students, nursing ethics

Moral Distress Among Baccalaureate Nursing Students: An Integrative Review

The demands on new graduate nurses are rising with the growing complexities of today's healthcare system. The Bureau of Labor estimated the need for 1.05 million nurses due to growth and replacement by the year 2022 (United States Department of Labor, 2013). The nursing profession must remain diligent and proactive in efforts to recruit and retain nurses. However, complexities in healthcare such as moral distress, remain universal. Moral distress is experienced by nurses more than any other healthcare discipline (Houston et al., 2013) and strategies to diminish this could help retention efforts.

Moral distress affects nurses and aspiring nursing students in clinical practice (Sasso, Bagnasco, Bianchi, Bressan, & Carnevale, 2016), and occurs when a person knows the correct action to take but is constrained from taking it and can often involve feelings of frustration and anger (Jameton, 1984; Wilkinson, 1987). A majority of nurses experience moral distress in their nursing career (Oh & Gastmans, 2015). Experiences of moral distress may not happen often but the intensity of the experience can have significant impacts when they do occur (Oh & Gastmans, 2015). As a result job satisfaction and performance, physical and psychological well-being, turnover, and retention (Austin, Saylor, & Finley, 2016; Elpern, Covert, & Kleinpell, 2005) are adversely affected.

Nursing students experience moral distress in both clinical experiences *and* professional education (Range & Rotherham, 2010; Renno, Ramos, & Brito, 2018; Sasso et al., 2016). Nursing education is a pivotal time when students can learn to recognize and act when experiencing moral distress. Therefore, the purpose of this review is to determine the sources of moral distress in nursing students and to identify effective interventions in order for nurse educators to navigate

successfully the phenomenon of moral distress when it arises. The second purpose of this paper includes presenting Corley's Theory of Moral Distress to be able to adapt for future research in the context of nursing students.

Background and Significance

Moral distress is as relevant today as it was over thirty years ago when Jameton (1984) first defined the term as an experience where a person knows the correct action to take but does not take action due to constraints. Jameton then expanded the term and described that distress occurred in two phases, initial and reactive distress. Initial distress is what happens when a person does not take the correct action as they should. Reactive distress which accumulates over time became known as moral residue: feelings after a morally distressing event has occurred and after a person has lost moral integrity (Epstein & Hamric, 2009). Wilkinson (1987) expanded Jameton's definition of moral distress as "the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision" (p. 16). More recently, the American Nurses Association defined moral distress as a condition where although knowing the right thing to do, often institutional, procedural, or even social constraints hinder the ability to do the right thing (ANA, 2015).

Other associated moral concepts include moral courage and moral resilience. These concepts are relevant within the moral distress literature as potential resolutions for decreasing moral distress (Rushton, Caldwell, & Kurtz, 2016). Moral courage is the ability to be reactive and stand up for what is right, even against others' opinions (Murray, 2010), whereas moral resilience is the ability of a person to restore or withstand a distressing event that may be complex in nature and ultimately challenges one's own integrity (Rushton, 2016). These concepts remain unclear in the nursing literature and particularly in relation to nursing students.

Method

Design

This integrative review uses the Whittemore and Knafl (2005) methodology. An integrative review allows for the inclusion of various types of study designs in order to provide a more in-depth review for a complex concept such as moral distress. The approach to data in this review includes a constant comparison of data in order to identify patterns, themes, variations, and relationships (Miles & Huberman, 1994). Given moral dilemmas are inevitable and the focus is now minimizing moral distress before nurses start their professional career, this review is warranted.

Inclusion Criteria

Literature regarding moral distress in licensed nurses was readily available when compared to moral distress in nursing students. Therefore, selected studies to review included moral distress in nursing students and studies including moral distress in licensed nurses if they included nursing students. This allowed the researcher to provide a greater representation of the phenomenon. The author considered any type of qualitative or quantitative evidence, and not limited to, expert opinions, other reviews, analyses, and theoretical studies. Studies from 2012 to 2018 were included in this review. The inclusion criteria were also limited to the English language. In order to isolate moral distress in nursing students only, articles were excluded if they did not specify nursing students. Therefore, studies involving only medical or other healthcare professional students were excluded. Additionally, studies had to include moral distress specifically and not just distress in general.

Data Search Stage

A comprehensive one-step search strategy was done by using the keywords: *moral distress* and *nursing students.* This search in the PubMed database produced 37 results followed by an initial search in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) of the same keywords and no truncation produced 1,168 results. The CINAHL search was narrowed by subject of the major heading to students, nursing, baccalaureate which produced 17 articles. A search in SCOPUS using the same keywords produced 34 results. If abstracts were available, the researcher determined if the study met inclusion criteria. If no abstract was available, the full text of the article was read to determine its relevance to inclusion criteria. Of the 88 appraised studies, 72 were excluded for duplication and not meeting inclusion criteria, which left 9 full text articles included in the final review. Synthesis of the findings were aggregated into four main categories of moral distress within the clinical environment, moral distress within the academic environment, moral distress in licensed nurses compared to nursing students, and related interventions that also included associated moral concepts. The resulted studies are shown in Figure 1.

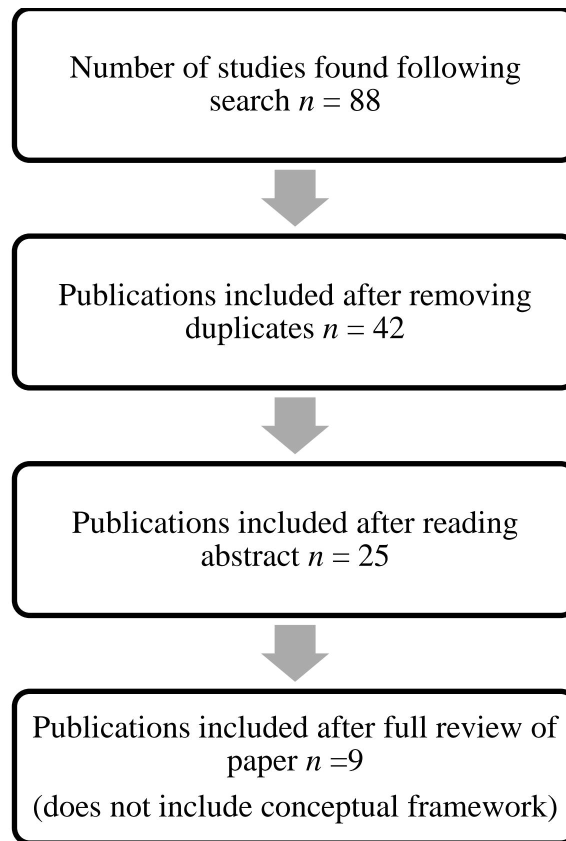

Figure 1. Data search (collection) process

Data Evaluation Stage

The evaluation of data stage involves evaluating the quality of the primary resources using a methodological approach that consists of using quality criteria appraisal tools in the evaluation process (Whittemore & Knafl, 2005). All of the literature that met inclusion criteria was included in the data analysis regardless of methodological rigor. Whittemore and Knafl (2005) emphasize the complexity of analyzing sources and therefore no gold standard exists. For this review, the author initially worked independently to review the titles and abstracts then proceeded to review the entirety of each full text. The full text was read to ensure that studies discussed moral distress in

nursing students. The nine articles included all levels of evidence and due to the gap in research in this area, all nine articles were included in this review. Of the nine articles two were quantitative (Escolar-Chua, 2016; Sinclair, Papps, & Marshall, 2016), and four were qualitative (Bordignon et al., 2018; Escolar Chua & Magpantay, 2018; Rees, Monrouxe, & McDonald, 2015; Wojtowicz, Hagen, & Van Daleen-Smith, 2014). Two of the studies were mixed method designs (Krautscheid et al., 2017; Theobald, 2013). A systematic review was also included in the study as it encompassed literature from 2004-2014 (Sasso et al., 2016).

Data Analysis Stage

During the data analysis review, articles were organized, categorized, and summarized by providing conclusive findings. The summary of findings for this review is outlined in Table 2.

Table 2 Summary of findings

Author/year	*Design*	*Sample population*	*Findings (excerpts from articles)*
Bordignon et al. (2018)	Qualitative Exploratory, Descriptive	21 student nurses in Brazil (19 female) Race: most white Age: 21-50 Semester: varied School: Different universities.	2 categories emerged: Strategies of resistance to MD: exercise of power and the non-resistance to MD: the disciplinary power in the moral fragilization of students. The findings illustrate their resistance and exercise of power differed among universities and how with more mastery of knowledge they felt more confident in protecting their own principles and values. Both positive and negative consequences of resistance were reported. Students demonstrated non-resistance, primarily in public institutions due to faculty relationships (obedience to hierarchy).
Escolar-Chua (2016)	Quantitative, Descriptive-correlational Instrument: Moral Distress Questionnaire 5-point Likert (0 = never occurred to 4 = frequently) Review Moral Sensitivity Questionnaire 9-items with six responses (1=total disagreement to 6= total	293 baccalaureate Filipino student nurses (75.4% female) Age: mean 19.01 Semester: 130 seniors and 163 juniors School: a 4-year Bachelor's degree University	Students frequently experienced morally distressing situations; however, depending on the intensity they may not have been able to demonstrate moral courage. Statistically significant findings between moral distress frequency and intensity and also moral distress and moral sensitivity.

	agreement) Professional Moral Courage Scale 15-items from 1=never true to 7=always true		
Escolar Chua & Magpantay (2018)	Qualitative Descriptive	14 students (94% female) Race: not reported Age: not reported Semester: senior School: not reported	Three central themes emerged from wherein moral distress stemmed from unprofessional behavior of some healthcare workers, sense of powerlessness, and differing values and mindsets of people they serve in community.
Krautscheid et al. (2017)	Mixed Method Descriptive cross-sectional Moral Distress Thermometer Single-item tool with 0 being no moral distress and 10 being worst possible distress	267 students (233 female) Race: majority (*n*=213) Caucasian Age: not reported School: three different campuses	Mean moral distress: 3.12 No significant effect of moral distress level and different institution. Top four reasons students did not take action during distressing situation: 1. Subordinate role 2. Desire to preserve relationship with preceptor/ faculty 3. Concerns due to incomplete knowledge or judgement 4. Didn't know how to respectfully speak up Situations contributing to moral distress: compromised best practices, disrespect for inherent human dignity, perceived constraints, navigating personal values and patient-centered care.
Rees, Monrouxe, & McDonald (2015)	Qualitative Interpretive through narrative survey	1399 healthcare students (*n*=756 nursing) Race: 97% white Age: 17-25 School: 20 Universities in the UK	Survey examined impact of professional dilemmas on moral distress Most common themes were patient care dilemmas by healthcare personnel or students, student abuse, and consent dilemmas.76.2% occurred in hospitals and 51.9% of perpetrators were nurses. Findings of the study compared to medical students narratives; however, nursing students more focused on emotional talk.
Sasso et al. (2016)	Systematic review	One quantitative study and three qualitative	Ethical dilemmas that cause moral distress include inequalities in health disparities, relationship with the mentor, students' individual characteristics. Gap remains in nursing education and interventions to minimize moral distress.
Sinclair, Papps, & Marshall (2016)	Quantitative Descriptive survey Moral Distress Scale 32-items 7-point Likert 1=low to 7=high Ethical Issues Scale 35-items	339 undergraduate nursing students in New Zealand 91% female Age: 61% between 18-29 Race: 69% European or New Zealander & 9% Maori Semester: first and second year School: multiple across New Zealand	Over 2/3 of students experienced breaches of a patient's right to confidentiality, privacy, dignity, or respect. 87% reported unsafe working conditions. Highest distressing situations involved patient safety, unsafe practices, suspected abuse or neglect. An open-ended question revealed the following themes: lack of support and supervision, bullying, and end of life issues.
Theobald (2013)	Mixed Method Moral Distress Scale 32-items 7-point Likert 1=low	160 nursing students Race: not reported Age: not reported	Students reported higher levels of distress as they progressed each semester. There was a positive correlation with moral

	to 7=high	Semester: all School: Public rural University in US	distress levels and frequencies. Main areas of moral distress included: 1.following family wishes when student didn't agree 2. student felt incompetent 3. unsafe staffing levels 4. patient's privacy 5. Incompetent nurses/aides.
Wojtowicz, Hagen, & Van Daalen-Smith (2014)	Qualitative Naturalistic inquiry	7 students in Canada All female Age: 21-38	Students experienced MD in mental health settings: nurse's poor communication with patients, hierarchical power structure, poor medication education, inability for advocacy from nurse educator.

Research Populations

Sociodemographic characteristics were examined in most of the studies. The majority of studies included students ages 18-29 (Bordignon et al., 2018; Escolar-Chua, 2016; Rees et al., 2015; Sinclair et al., 2016; Wojtowicz et al., 2014). In all studies the majority of participants were female. Race and ethnicity differed among the studies with participants reporting mainly Caucasian (Bordignon et al., 2018; Krautscheid et al., 2017; Rees et al., 2015). The systematic review included varying race and ethnicities (Sasso et al., 2016). Other studies reported European ethnicity (Sinclair et al., 2016), and Filipino (Escolar-Chua, 2016). The other three studies did not report ethnicity or race of their study participants (Escolar Chua & Magpantay, 2018, Theobald, 2013; Wojtowicz et al., 2014)

Contributing Factors of Moral Distress: Clinical Settings

The last decade of moral distress research increasingly demonstrates its existence in nursing students during their clinical experiences. Findings regarding particular ethical dilemmas that cause moral distress among students varied in the literature. A systematic review by Sasso and colleagues (2016) reported sources of moral distress in nursing students as being end-of-life therapies, euthanasia, pharmacological interventions, and physical restraint. For example, pharmacological sources of moral distress included nurses not verifying dosages on insulin and pushing intravenous pain medications faster than the recommended time-all errors that compromise patient safety. A

multisite descriptive study revealed other sources of moral distress in nursing students as compromised best practices, disrespect for human dignity, perceived constraints, and navigating personal values (Krautscheid et al., 2017). Nursing students also reported moral distress within the mental health setting because of over-emphasis on medications, staff infrequently talking with patients, and task-oriented rather than emotional support-oriented nursing care (Wojtowicz et al., 2014). Other sources of moral distress included: 1) following the family's wishes for a patient when the student did not agree with the wishes, 2) carrying out assignments when students did not feel competent themselves or felt that the provider or assistant was not competent for the care required, and 3) when patient privacy was not respected and no action was taken by care personnel (Theobald, 2013). Similarly, Sinclair and colleagues (2016) found moral distress was experienced when patient safety was being compromised and working conditions involved abuse or neglect. Additionally, in a qualitative narration, nursing students reported patient care dilemmas that contributed to moral distress including a nursing assistant as being "verbally abusive to dementia patients and mocking them for urinary incontinence" (Rees, Monrouxe, & McDonald, 2014, p.174). Similar findings in a study of Filipino nursing students were found when they reported moral distress when any aspect of patient care was diminished (Escolar-Chua, 2016). Comparably, varying situations such as lack of competence, poor quality patient care, inadequate communication, and collaboration among healthcare providers were seen as the most morally distressing events for student nurses (Escolar-Chua, 2016).

Contributing Factors of Moral Distress: Academic Settings

Studies of moral distress in academia are sparse despite anecdotal evidence of its existence in these settings. A systematic review presented specific sources of anecdotes of moral distress in education, such as "collective incivility of students, cheating and copying, bullying, the regulations

and procedures to access professional education, professional standards, and cultural concerns" (Sasso et al., 2016, p. 529). Additionally, studies show nursing students experience higher levels of distress as their education progresses (Theobald, 2013). A possible reason for high-level stressors may relate to increased clinical hours in senior nursing students compared to junior nursing students or transition of roles from student to graduate nurse. Nursing school is inherently stressful but a glimpse of the sources causing moral distress are new to the literature.

Moral Distress in Licensed Nurses As Compared to Nursing Students

Some of the studies compared the experience of moral distress between nursing students and nurses. Sinclair, Papps, and Marshall (2016) premised the importance of their quantitative study on the fact that nursing students experience moral distress differently than licensed nurses. Although nurses deal with moral distress from many of the same sources as nursing students, nurses report more organizational constraints and may even perceive these restraints as the norm (Sinclair, Papps, & Marshall, 2016). For example, staff ratios and nurse-physician relationships may serve as organizational constraints. Furthermore, nursing students are intentionally observing healthcare workers around them and felt morally distressed when nurses, aides, or physicians provided incompetent care (Krautscheid et al., 2017; Theobald, 2013). It is reasonable to surmise that nurses who are morally distressed could have an even greater adverse impact on the levels of moral distress in nursing students. Lastly, a common concept between nurses and nursing students related to experiencing moral distress was vulnerability (Sasso et al., 2016) or powerlessness (Sinclair, Papps, & Marshall, 2016). Vulnerability is a common theme in moral distress literature as students or nurses often describe a feeling of emotional vulnerability. On the other hand, powerlessness was described by nursing students due to their role in the clinical environment.

Consequences of Moral Distress

Nursing students who experienced moral distress in the mental health setting felt helpless and decided they would not pursue mental health nursing in their future career endeavors (Wojtowicz et al., 2014). Other students felt that the lack of support while experiencing moral distress had a detrimental effect on their learning and level of care offered to patients (Sinclair et al., 2016). Nurses and nursing students who experience moral distress can have physical and physiological symptoms such as sleep disorders, headache, anxiety, guilt, stomach upset, and emotional instability (Sasso et al., 2016). Perhaps the most significant consequences are those effects on patient care. Three dominant narratives within the compromised best practices theme involved infection control breaches, substandard medication administration, and unsafe work-arounds (Krautscheid et al., 2017).

Results of moral distress were also noted to be positive (Bordignon, 2017). Nearly all of the twenty-one participants in Bordignon and colleagues (2017) study stated that they were glad if they spoke up during a morally distressing situation. One student stated that after speaking up to the professor, she admitted she had made a mistake and apologized. Thus, some students who act as moral agents demonstrate moral empowerment despite feeling morally distressed (Bordignon et al., 2017).

Strategies to Decrease Moral Distress in Nursing Students

Awareness of negative consequences of moral distress in nursing students can be a driving factor for searching ways to mitigate this experience. Sasso and colleagues (2016) highlighted educational strategies in their systematic review. Useful strategies included incorporation of the following into nursing curricula 1) the important role nurses who oversee students have in facilitating students through difficult situations, 2) group debriefing sessions, 3) case study

discussions, and 4) meditative writing. Remarkably, not one study included in this review included an intervention to reduce moral distress among nursing students.

In order to analyze strategies that have been tested in research, the following evidence includes literature outside of the primary articles of review to include related concepts of moral courage and moral resilience. Reducing moral distress includes providing nursing student education centered on ethics so they are able to recognize ethical violations and make accurate observations of dilemmas in a hospital setting (Baykara, Demir, & Yaman, 2015). Monteverde (2016) demonstrated the value of ethics education to decrease moral stressors and promote moral resilience. The concepts of moral resilience or moral courage were commonly found to be future implications for research in most of the described studies. Lachman (2016) differentiated moral resilience from moral courage: moral resilience is the willingness to speak up about a concern; moral courage is demonstrated when one has the actual capacity to speak up (Lachman, 2016).

Moral courage is a growing concept within the context of nursing students. Two articles focused on the aspects of moral courage and how the virtue can be fostered or how moral courage is inhibited (Bickhoff, Sinclair, & Levett-Jones, 2015; Bickhoff, Levett-Jones, & Sinclair, 2016). The first was a literature review that found nursing students require moral courage for moral distress but do not exhibit courage when warranted (Bickhoff et al., 2015). To address the clear gap of how students can demonstrate moral courage, a qualitative study found nursing students identify themselves as patient advocates but will only act if severe consequences of poor practice would result (Bickhoff, Levett-Jones, & Sinclair, 2016). Nursing students also were aware of impacts such as moral distress and yet a mere 60% of students reported they would speak up if they continually witnessed poor practice. The remaining 40% reported they would only intervene if the benefit outweighed the risk (Bickhoff, Levett-Jones, & Sinclair, 2016).

Nash, Mixer, McArthur, and Mendola (2016) conducted a study with the intended outcome of instilling moral courage into nursing students by completing advance directives with homeless persons. Study findings revealed that prior to interacting with the homeless persons, the students had fears of acting inappropriately in front of the patient and of discussing dying and death with a homeless person. However, researchers found that after interaction with homeless persons, none of the preconceived fears occurred; rather, they concluded students needed more courage in anticipation of such events. Although this study relates to fostering moral courage, the vulnerability nursing students feel is evident. Nursing students reported the same vulnerable feelings when dealing with moral distress (Curtis, 2016). Curtis (2016) revealed the need to provide nursing students with strategies such as coping and relational skills in order to manage moral distress better.

Theoretical Models

Corley's (2002) Moral Distress Theory depicts what happens when a nurse is unable to advocate for patients and ultimately experiences feelings of moral distress. Corley's theory addresses internal psychological responses and external work environments. Some of the psychological processes consist of four components: moral sense making, moral judgment, moral intention, and moral competency. Another model comes from the environment in which professional practice is developed (Barlem & Ramos, 2015). Barlem and Ramos (2015) described the professional environment formed by various "micro-spaces" that are essentially connected to ethical-moral competencies. The conceptual model describes feelings in the realm of moral-ethical disturbances as a chain reaction based upon power games (Barlem & Ramos, 2015). Lastly, according to Benner's Novice to Expert theory, a nurse can learn proper ethical behavior through the "knowing how" and not necessarily the "knowing that" (Benner, 1982).

Although widely studied in licensed nurses, the literature regarding moral distress and

nursing students is gaining momentum. However, the author found no conceptual framework specific to nursing students. The author understands the importance of conducting a study grounded in theory, and it seems there is a dearth of theories associated with moral distress overall. Therefore, this deficiency has created a barrier for the development of strategies and interventions to decrease moral distress (Pauly, Varcoe, & Storch, 2012).

Implications for Nursing Practice, Education, and Research

Nurses in practice settings need to be more cognizant of their actions and the influence of those actions of moral distress in students. Practicing nurses, especially preceptors, need to be aware that students recognize ethically compromising practices being role modeled in the clinical environment (Sinclair et al., 2016). Not only could this awareness help the nurse and student, but could also improve patient safety and outcomes. Lastly, further training and education that center on ethical and professional behaviors may need to be integrated into continuing professional development for licensed nurses (Sinclair et al., 2016). For example, it may be helpful to have more nurses and nursing students involved in ethics committees so that mutual perspectives can be shared.

Nursing education plays a vital role in the in the experience of moral distress. Nursing students who experience moral distress in their education may enter the profession already experiencing compassion fatigue and apathy. Educators should promote open communication and be aware of issues occurring or causing concern in order to support, role model, and encourage the development of a healthier ethical nursing climate (Sinclair et al., 2016). Recommendations for nursing education include critical curriculum evaluation and revision to ensure a comprehensive, sustainable approach for teaching future nursing professionals how to circumnavigate moral distress (Krautscheid et al., 2017). This may include infusing didactic learning experiences with

constructivist activities such as unfolding case studies, problem-based learning, cognitive rehearsal, ethical dilemmas and role-play scenarios (Krautscheid et al., 2017).

The synthesis of these studies demonstrate the need for future research targeted towards interventions to minimize moral distress in nursing students. More rigorous studies are needed, particularly in the United States, with schools which represent more nursing student diversity. While studies exist that explore potential strategies such as moral courage and moral resilience, these studies do not directly examine moral distress levels in comparison. Furthermore, future research should incorporate nursing faculty, nursing students, and nursing preceptors in order to compare and contrast concurrent experiences of moral distress.

Gaps in the Literature

This review revealed a large gap in the literature surrounding moral distress specifically in the academic setting whereas most studies involved clinical settings. With new generations of nursing students, leaders in education need to be able to recognize and properly facilitate students through difficult dilemmas that may produce moral distress. More importantly, more strategies are needed to cultivate moral courage and moral resilience in nursing students. Although education around ethics is crucial and has demonstrated effectiveness, best practice, higher level experiences seems warranted here. For example, experiential learning through simulation may prove an effective pedagogy in contextualizing clinical imagination for nursing students.

In addition, conceptual frameworks to include nursing students are needed. Most of the conceptual frameworks and theories found were specific to licensed nurses. Provided nurses and nursing students experience moral distress somewhat differently, a theoretical foundation specific to nursing education is necessary to advance the body of knowledge surrounding this phenomenon.

Moral distress in the nurse education setting was the most understudied and underreported topic in the articles reviewed. Although the fundamental stressors of nursing school are clearly identified in the literature, moral distress has not clearly been linked as the relating phenomena. Perhaps future studies need to be aimed at this gap in order to improve student satisfaction.

Conclusion

This review illustrates the existence of moral distress among nursing students. Reported in the multiple studies reviewed in this paper, moral distress in nursing students has emotional and professional implications. It is reasonable that these symptoms could negatively affect academic performance and patient care. Additionally, the prevalence of moral distress has professional implications that include students abstaining from entering the nursing profession and in turn affects nursing shortages. Moral distress among nursing students is a multi-factorial phenomenon. Moral distress can occur after dilemmas involving end of life care, abortion, breaches in patient safety, and simply seeing things done differently than what was taught. Although moral distress in students is understudied, educational strategies centered on ethics have shown to be a valuable intervention for decreasing moral distress but lack empirical testing. Additionally, students exhibiting moral courage and who are more prone to speaking up during vulnerable situations may prevent feelings of distress. While moral courage is an effective characteristic that can be taught, further research is needed to determine extrinsic and intrinsic factors that form the foundations of this trait.

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Chapter 4

Exploring the Relationships Between Moral Distress, Moral Courage, and Moral Resilience in Undergraduate Nursing Students

Abstract

Objectives: To examine moral distress, moral courage, and moral resilience among undergraduate nursing students and their interrelationships.

Research question: Do nursing students with greater moral resilience and moral courage report less moral distress?

Methods: Using a descriptive correlational study design, a convenience sample of nursing students distributed among three sites were surveyed using three tools: the Moral Distress Thermometer (MDT), the Connor-Davidson Moral Resilience Scale (CD-RISC), and the Moral Courage Scale for Physicians (MSCP).

Results: Students reported mild levels of moral distress ($M = 2.73$, $SD = 1.9$). Moral resilience was significantly correlated with moral courage, age, and students having a previous degree. Moral questions added to the CD-RISC had significant relationships that contributes to the paucity of measuring moral resilience.

Conclusion: Interventions to cultivate moral resilience in nursing curricula is necessary. Valid instruments to measure moral resilience and moral distress in nursing students should also be investigated further.

Keywords: nursing students, moral distress, moral courage, moral resilience

Exploring the Relationships Between Moral Distress, Moral Courage, and Moral Resilience in Undergraduate Nursing Students

The large threat moral distress poses to nearly all healthcare professionals goes even beyond the healthcare realm (Jameton, 2017). Moral distress is a phenomenon that occurs when a person knows the correct action to take but is constrained from taking it (Jameton, 1984). A majority of nurses experience moral distress in their nursing career (Oh & Gastmans, 2015). However, moral distress can be an experience prior to entering the profession in nursing school (Sasso, Bagnasco, Bianchi, Bressan, & Carnevale, 2016). Experiences of moral distress may not happen often, but the intensity of the experience can significantly increase the negative impact of moral distress (Oh & Gastmans, 2015). In nurses moral distress adversely affects job satisfaction and performance, physical and psychological well-being, turnover, and retention (Austin, Saylor, & Finley, 2016; Elpern, Covert, & Kleinpell, 2005). With the complexity of healthcare and continued growth of ethical dilemmas encountered in nursing practice, eliminating moral distress entirely is not practical (Rushton, Schoonover-Schoffner, & Kennedy, 2017). Instead, the focus continues to center on ways to mitigate the effects of moral distress.

In order to reduce the harmful effects of moral distress, a call to strengthen moral resilience has been established (American Nurses Association, 2017). Moral resilience has gained more attention over the last few years and has been linked to lessening the effects of moral distress (Moss, Good, Gozal, Kleinpall, & Sessler, 2016). Another documented concept known to reduce moral distress is moral courage (Bickhoff, Sinclair, & Levett-Jones, 2015). Moral courage involves a person's capacity and readiness to speak up about a problem (Murray, 2010). In nursing students, one of the most frequent reasons for inaction occurs when students doubt their ability to speak up

(Krautscheid, DeMeester, Orton, Livingston, & McLennon, 2017). More commonly, when faced with moral dilemmas, nursing students do not show moral courage and would rather remain silent (Bickhoff, Sinclair, & Levett-Jones, 2017).

Moral distress and moral resilience have been studied extensively in licensed nurses, particularly those in acute care settings. However, the three moral concepts of moral distress, courage, and resilience are understudied in the context of nursing students. In addition, these concepts are not linked empirically but have commonalities that demonstrate the potential relationship between these concepts. This study investigated the relationships among moral distress, moral courage, and moral resilience in undergraduate nursing students.

Review of Literature

Studies surrounding moral concepts in nursing students are minimal. This section presents a review of literature surrounding moral distress, moral courage, and moral resilience in nurses and nursing students.

Moral Courage, Moral Resilience, and Moral Distress

Moral courage. A literature review by Bickhoff, Sinclair, and Levett-Jones (2015) revealed the importance of nursing students having moral courage as a necessary characteristic to prevent moral distress. Moral courage is also necessary in order to improve patient outcomes and patient safety (Dinndorf-Hogenson, 2015; Hawkins & Morse, 2014). One method a qualitative study took to reveal ways nursing students show moral courage was to identify the nursing student's role in patient advocacy (Bickhoff, Levett-Jones, & Sinclair, 2016). This study also revealed a multitude of consequences students face when questioning the practice of a nurse and the influence supervising or clinical facilitators had on their decision to speak up for patient safety. Nash, Mixer, McArthur, and Mendola (2016) conducted a study with the intended outcome of instilling courage

into nursing students by completing advance directives with homeless persons. Study findings revealed students' initial fears included acting inappropriately in front of the patient and fear of discussing dying and death with a homeless person (Nash et al., 2016). However, after interaction with homeless persons, study results indicated that none of the preconceived fears occurred; rather, they concluded students needed more courage in anticipation of interacting with vulnerable populations such as homeless persons (Nash et al., 2016). Furthermore, given that moral dilemmas causing moral distress are inherent in clinical and academic contexts, nurses and nursing students should be equipped with proper tools such as courage (Lindh, Barbosa de Silva, Berg, & Severinsson, 2010). While moral courage can be taught, nursing students are still in the process of learning their role as a nurse and the assertive behavior required to provide high quality care (Aultman, 2008). Studies surrounding moral courage in nurses are now targeting nurse leaders facilitating moral and ethical decision-making (Edmonson, 2010). Additionally, recent literature supports the notion of practicing moral courage as a way to develop moral resilience (Lachman, 2016). A concept analysis of moral courage claimed professional competencies had a vital role in the development of moral courage (Sadooghiasl, Parvizy, & Ebadi, 2018). In other words, without training on professional ethics, patient rights, or lack of work experience, moral courage may not be demonstrated (Sadooghiasl et al., 2018).

Moral resilience. A shift is underway regarding the use of moral resilience; current thinking suggests replacing *moral distress* with *moral resilience* (Rushton, Schoovner-Shoffner, & Kennedy, 2017). This shift aims to address healthcare problems not in terms of moral distress but in terms of moral resilience: “courage, cooperative speaking up, and persistent action" (Jameton, 2017, p. 20). Strategies that cultivate moral resilience include speaking up, courage, self-awareness, and self-regulation (Rushton, 2016). Moral resilience is perhaps the most understudied concept in the

literature in nurses and in nursing students. Currently no evidence can be found that tests specific strategies to foster moral resilience. However, Rushton (2016) provides anecdotal thoughts on cultivating moral resilience through self-awareness, having self-regulation capacities, ethical competence, speaking up with clarity and confidence, finding meaning in despair, engaging with others, participating in transformational learning, and contributing to a culture of ethical practice. Although the concept of resilience has been studied within the psychological realm, the specific concept of moral resilience is currently evolving in the nursing literature.

Moral distress. Moral distress is a concept that has been studied for nearly three decades in nursing and in nearly every other healthcare provider role. However, the literature in the last five years has noted an increase in nursing student moral distress. Nursing students experience moral distress in their clinical experiences and professional education (Range & Rotherham, 2010; Renno, Ramos, & Brito, 2018; Sasso et al., 2016). Sasso and others (2016) identified sources of moral distress in nursing students in mentor relationships, while taking care of patients with health disparities, and with interpersonal factors. According to Reader (2015), nursing students experience moral distress related to an overall feeling of disempowerment and lack of status. A similar study identified powerlessness as a key component to nursing student moral distress (Savel & Munro, 2015). Students are notoriously put in the middle of moral dilemmas and remain silent instead of questioning practice or patient safety due to their lack of ability to speak up and intervene (Bickhoff, Levett-Jones, & Sinclair, 2016). A descriptive, quantitative study comparing moral distress between nursing students and licensed nurses revealed all participants having moderately high levels of moral distress (Roberts & Holmberg, 2011). However, sources of distress in nursing students differed from that of licensed nurses. Students were most concerned about incompetent caregiving by either themselves, practicing nurses, physicians, or other health personnel. In

contrast, moral distress in licensed nurses derived from organizational factors such as understaffing (Roberts & Holmberg, 2011). A systematic literature review by Sasso and others (2016) found that sources of moral distress in nursing students consisted of inequalities and healthcare disparities, relationship with a mentor, and disparity of student nursing practices negatively effecting patient care decisions. Ultimately, Sasso and others (2016) concluded that a knowledge gap exists related to moral distress and suggested future research be directed at finding interventions to minimize the phenomena in undergraduate nursing students.

Identifying a Link between Moral Concepts

A clear connection between the concepts of moral distress, moral courage, and moral resilience in nursing students remains unknown. Journal articles describing the moral landscape in nursing reveal ambiguity and redundancy among moral concept definitions. Providing a clear distinction between moral distress, moral courage, and moral resilience may lead to a better understanding of how other terms such as moral complexity, moral sensitivity, moral competence, and moral strength may be either distinct or be a component of moral distress, moral courage, or moral resilience.

However, studies exist that highlight the importance of each within the context of nursing students. Moral distress has a dominant presence among nursing students (Krautscheid et al., 2017; Reader, 2015; Sasso et al., 2016). If moral distress remains unresolved, nursing students may suffer from moral residue (Epstein & Delgado, 2010), and fail to enter the profession (Ganske, 2010; Krautscheid et al., 2017). Moral residue may also lead to burnout and turnover during the first year of practice (Hamric, 2014). Building up moral courage in nursing students seems essential because nursing students are more likely than any other healthcare student to witness or participate in dilemmas that compromise patient safety (Monrouxe, Rees, Dennis, & Wells, 2015).

Research exploring the intrinsic factors of moral courage is warranted (Bickhoff et al., 2017). One potential intrinsic factor could be the necessary condition of having moral resilience (Young & Rushton, 2017). In 166 nursing students, a successful teaching intervention to decrease moral distress indirectly improved student moral resilience levels (Monteverde, 2015). However, a baseline moral resilience level was not directly measured in this study or in other available literature. On the other hand, one study with 293 baccalaureate Filipino nursing students measuring their moral sensitivity, moral distress, and moral courage revealed that the frequency of moral distress had a negative relationship with moral courage ($r = -0.13$, $p < 0.05$) suggesting that students do not act with moral courage when morally distressed (Escolar-Chua, 2016). Furthermore, findings regarding the influence of sociodemographic variables on moral distress in nurses and nursing students remain inconsistent (Oh & Gastmans, 2015, Sasso et al., 2016). In summary, moral distress, moral courage, and moral resilience lack relational congruency, particularly in context to nursing students.

Theoretical Framework

The theoretical framework guiding this study is derived from Corley's (2002) theory of moral distress (Appendix A) that illustrates moral concepts linked between moral distress and moral courage. This was the first theory aimed specifically at moral distress from a nurse's point of view as well as that of an organization. This theory has been used to study the physiological (internal) and organizational (external) variables that surround moral distress and has been utilized in the large body of knowledge in moral distress in nurses. For example, Corley's theory was used in a phenomenological study aimed at understanding moral distress in Korean nurses (Choe, Kang, & Park, 2015). Consistent with the theory, findings suggested the importance of nurses being aware and sensitive to ethical issues in order to take appropriate action (Choe et al., 2015). The theory

was also used in numerous doctoral dissertations (De Villers, 2010; Johnson Makiya, 2016; Powell, 2012). The theory in De Villers (2010) and Johnson Makiya (2016) studies was adapted to assess the concept of moral distress as experienced by critical care nurses when presented with unfamiliar dilemmas related to patient care. Powell (2012) used the theory for moral distress as a framework to assess the effectiveness of the American Association of Critical-Care Nurses (AACN) 4 A's to Rise Above Moral Distress in the workplace. Additionally, the model has been used outside of the United States to determine preceding factors of moral distress in a long term care setting (Green & Jeffers, 2006). Since studies of moral distress in nursing students are relatively new, the Corley theory can be adapted and expanded to research moral distress in nursing academia. Moral resilience will be added to this study's framework to determine the potential relationship with moral courage. Since nursing students are not excluded from the same environment in which nurses practice, this model will be used to assess the relational constructs between moral distress and moral courage. This theory helps better understand the relationships among moral concepts in order to gain a better comprehension of moral distress in nursing students. The findings from this study address the paucity of theoretically-based research and will inform the need to adjust the theoretical basis for understanding moral distress, moral courage, and moral resiliency in nursing students.

Conceptual and Operational Definitions

Major variables that are associated with the proposed study are defined below and

summarized in Table 3.

Table 3 Conceptual and Operational Definitions		
Variable	Conceptual definition	Operational definition
Personal Factors	Demographic factors describing nursing student (e.g. age, ethnicity, gender)	Demographic Survey
Moral courage	The capacity to overcome fear and stand up for one's own values and have the willingness to speak up about what is right (Lachman, 2007).	Moral Courage Scale for Physicians (MCSP) 9-item seven-point Likert scale from strongly disagree=1 to strongly agree=7 to measure moral courage in the context of patient care. Scores range from 0 (worst) to 100 (best) (Martinez, Bell, Etchegaray, & Lehmann, 2016).
Moral resilience	The ability and willingness to speak and take right and good action in the face of an adversity that is moral or ethical in nature (Lachman, 2016) and the capacity of an individual to sustain or restore their integrity in response to setbacks, distress, confusion, and ultimately moral complexity (Rushton, 2016). The ability to manage moral stressors confronted in clinical practice and to identify and frame ethical issues while building moral courage (Monteverde, 2014).	Connor-Davidson Resilience Scale (CD-RISC) 25-item scale used to measure hardiness, faith, support/purpose, and persistence factors by using a 5-point Likert scale. Total scores range from 0-100 with higher scores indicating greater resilience (Connor & Davidson, 2003).
Moral distress	Knowing the right thing to do but unable to act due to constraints despite the threat of moral integrity (Jameton, 1984).	Moral Distress Thermometer single item tool with an 11-point scale from 0-10 with verbal descriptors to help anchor the degree of distress in a meaningful way (Wocial & Weaver, 2013).

Research Questions

1. Do nursing students with greater moral resilience and moral courage report significantly less moral distress?
2. Do students with higher moral resilience have less moral distress?
3. Do students with higher moral courage have less moral distress?
4. Does moral courage predict moral distress more than moral resiliency?

Moral courage is thought to be more predictive because moral courage can be taught in nursing school whereas moral resiliency may require more experience with moral dilemmas (Krautscheid, 2017). Also, moral resilience underpins moral courage because when people are more resilient, they become more steadfast in their ability to show moral action or moral courage (Rushton, 2016). Lastly, moral resiliency is a concept that needs further exploration, particularly empirical data that targets attributes, antecedents, and consequences (Young & Rushton, 2017).

Methods

Design

This study uses a descriptive correlational design to examine moral distress, moral courage, and moral resilience among undergraduate nursing students in addition to investigating their interrelationships. Using a cross-sectional online survey method allowed the researcher to draw inferences regarding these moral concepts in nursing students (Creswell, 2014).

Population and Sample

The target population included third semester senior pre-licensure nursing students of the same cohort from three different campuses. A cohort of 125 nursing students in their NURS4602 Complex Concepts of Nursing Care II was targeted for this study. This population was selected

because their prior clinical experience had been simulation and community-based and in their third semester these students entered acute care settings where moral dilemmas and distress were more likely to be experienced. The convenience sample of pre-licensure baccalaureate nursing students took place at a large university setting and two satellite campus settings in the Southwest.

Participants were recruited through their student email. Participants showing interest were screened for eligibility. The criteria for participation included: (a) enrolled as a full-time undergraduate student in third semester of a pre-licensure BSN program, (b) age 18 and over, (c) able to read and speak English, (d) does not hold a nursing license, (e) no recent death of immediate family member within the last 6 months. Surveys for participation and eligibility vetting took place through the online survey site Qualtrics (Qualtrics, Provo, UT) in which only the researcher and dissertation advisor had password protected access.

A priori, a statistical power analysis was performed in G-Power Analysis 3.1 for sample size estimation (Faul, Erdfelder, Buchner, & Lang, 2009). An accepted minimal power level of 0.80 was utilized in order to avoid a Type II error (Cohen, 1988). With minimal literature having previous effect sizes, this study aims to achieve a medium effect of f=0.15. Therefore, using an alpha=.05 a total sample size of 68 is required. Allowing for 10% attrition, there will need to be 75 participants. Lastly, with a convenience sample that is not random, generalizability will be a limitation for this study. Participating students were entered into a random drawing and two Amazon gift cards were distributed.

Protection of Human Subjects

The study proposal was approved by the Institutional Review Board (IRB) at The University of Texas at Tyler. Finally, approval was also obtained from Texas Tech University Health Sciences Center IRB. Approval from both IRBs was completed prior to sample recruitment. The online

questionnaire included detailed information including the purpose of the study, responsibilities of participants, protection of student rights, and right to refuse participation without any retaliation. Because the data was anonymous, risks of student coercion were minimal. However, students may not have felt confident in the researcher and confidentiality of information. Participants may have been unfamiliar with the type of phenomenon being studied therefore full disclosure for the purpose of the study was provided. A risk might have included the researcher and participants establishing a rapport that goes beyond the faculty's (researcher) role. Benefits outweighed the risk as participants may have found appreciation that awareness of the phenomenon was being studied or addressed prior to entering the profession post-graduation.

Instruments

In order to interpret the results more meaningfully, demographic data (Appendix E) was collected at baseline to include the participant's age, gender, ethnicity, and prior or current healthcare experiences. Moral courage, moral resilience, and moral distress was assessed using the Moral Courage Scale for Physicians ([MCSP], Martinez, Bell, Etchegaray, & Lehmann, 2016), Connor-Davidson Resilience Scale ([CD-RISC], Connor & Davidson, 2003), and the Moral Distress Thermometer ([MDT], Wocial & Weaver, 2012).

The MCSP (Martinez et al., 2016) is a nine-item survey based on a seven-point Likert scale from strongly disagree = 1 to strongly agree= 7 and measures moral courage within the context of patient care (Appendix B). Scores range from 0 (worst) to 100 (best). This scale was used on 731 interns and residents who completed the survey anonymously regarding moral courage, empathy, and speaking up about patient safety breaches. In this study all item-score correlations were significant ($n = 731$, $p < .001$) along with a Cronbach's alpha = 0.90. The developers suggest that the MCSP can be used and modified in other healthcare professionals such as nurses who require

moral courage. The scale is available for public use and authors recommend the use of this instrument in other health professionals including nursing students. Permission from Dr. Martinez by personal communication was obtained on October 2, 2018.

The CD-RISC as a measure of moral resilience assesses hardiness, faith, support and purpose, and persistence aspects (Appendix C). It was originally used on patients who suffered from Post-Traumatic Stress Disorder (PTSD) in 2003 (Connor & Davidson, 2003). By using a 5-point Likert scale, total scores range from 0-100 with higher scores indicating greater resilience (Connor & Davidson, 2003). The CD-RISC is inarguably one of the best-known instruments in the field of resilience assessment (Arias González, Crespo Sierra, Arias Martínez, Martínez-Molina, & Ponce, 2015). It consists of 25 items with five response categories (0 to 4). The five main aspects include: eight items that reflect the notion of personal competence, high standards and tenacity, seven items reflecting trust in one's intuition, tolerance of negative affect, and the strengthening effects of stress, five items that reflect positive acceptance of change and secure relationships, three items reflecting control, and two items reflecting spiritual influences. In 2015, the CD-RISC scale was used to measure resiliency in nurses' characteristics within the context of burnout which was negatively correlated with resilience (Rushton, Batcheller, Schroeder, & Donohue, 2015). The CD-RISC has well-established psychometric properties (Cronbach's alpha= 0.89) in hundreds of studies including nursing. This scale is available for use upon a submission of agreement and terms of use. The usability of the scale continues to grow along with two shorter versions that have also been psychometrically tested for reliability and validity. Permission to use the instrument was obtained from the instrument author (J. Davidson, personal communication, September 24, 2018). Since the CD-RISC is the most valid scale to measure resilience, two questions were added to validate using the CD-RISC as a measurement of *moral* resilience. The two questions were derived from a

concept analysis of moral resilience (Young & Rushton, 2017): “I would/do keep to—at any cost—the moral principles I consider important, without veering from them in either actions or standards, under any condition” (Baratz, 2015) and “When faced with a morally difficult situation, I can cope with the situation through good ethical reasoning” (Monteverde, 2014).

The MDT (Appendix D) is a single-item tool with an 11-point scale from 0-10 with verbal descriptors to help anchor the degree of distress in a meaningful way (Wocial & Weaver, 2013). Initially developed to assess nurses’ moral distress in an inpatient setting, this scale is now used to describe how much moral distress one has been experiencing related to work in the past week including current day. It is noteworthy to mention one of the most widely used tools to measure moral distress is the Moral Distress Scale (MDS) (Corley, Elswick, Gorman, & Clor, 2001). Psychometric testing for the MDT showed a low to moderate convergent validity when compared to the MDS. However, unlike the MDS, the MDT is less time consuming and has a specific time point reference (Wocial & Weaver, 2013). An aim for this study is to examine moral distress in a current context rather than an accumulation which can be measured using the MDT. For this study, the wording of “how much moral distress you have been experiencing related to work" was modified with permission to "how much moral distress you have been experiencing related to your role as a student in the past month including today". A multisite descriptive study assessed 265 nursing students' level of moral distress using the MDT, and authors reported the tool simple to use (Krautscheid et al., 2017). A one-way between-subject ANOVA showed no significant effect of academic institution on moral distress ratings among students at all three sites (F [2,264] = 0.746, $p > .05$). Permission to use this instrument was obtained from the instrument author (L. Wocial, personal communication, September 25, 2018). The MDT does not provide specific examples of moral distress; therefore, the conceptual definition of moral distress was provided on the survey.

Data Collection

Following IRB approval from The University of Texas at Tyler and Texas Tech University Health Sciences Center (TTUHSC), data were collected from pre-licensure undergraduate nursing students. The students were enrolled at a large health sciences center university on three separate regional campuses. The participants were in their third semester (level three) of nursing school. The primary investigator first met with the level lead faculty member and Associate Dean of Student Affairs to determine the students' clinical rotation schedules and established the time frame for the survey link to be distributed. A recruitment letter along with the Qualtrics survey link was distributed through the student's TTUHSC email. The survey link remained open for two weeks with two email reminders sent by the Associate Dean of Student Affairs. Students were eight and nine weeks (out of fifteen) into their semester and immersed in acute care hospital rotations during the time of the survey. All questionnaires were completed anonymously and accessible only by the researcher and dissertation chair on a password-protected computer. Participants were instructed to contact the primary researcher and not the course faculty if there were any problems or questions concerning completion of the surveys. The survey completion time ranged from 10-20 minutes.

Data Analysis

Statistical analyses and instruments were selected to align with the study variables. Data was screened prior to analyses in order to address concerns regarding accuracy of data entry and missing data. Using SPSS version 24 (IBM Corporation, 2015), descriptive statistics was performed to summarize demographic data, moral distress, moral courage, and moral resilience. Additionally, Pearson *r* correlations and multiple regression analyses were performed to determine the relationship between the moral concepts. A standard entry multiple regression was used as there was no theoretical rationale regarding the relative importance of the variables to guide hierarchical

entry (Field, 2013). Demographic data was collected and is described in Table 3 and were analyzed using descriptive analyses.

In testing the research questions, the following assumptions were analyzed: (a) additivity and linearity, (b) normal distribution, (c) outliers, and (d) collinearity. Additionally, in order to perform a multiple regression analysis, the assumption of independence of errors and homoscedasticity was also required. Additionally, in order to rely on a confidence interval of 95% and produce more generalizability, a robust method known as bootstrapping was performed for correlation analyses (Field, 2013).

Procedures to Enhance Control

Threats to internal validity include diffusion of treatment, dropouts, and regression. Diffusion of treatment was minimized by selecting a time period when students were busy with clinical and had less time to discuss and communicate amongst each other during the time the survey was open. Also, in order to avoid the threat of regression, a student who may have been experiencing moral distress not related to nursing school was excluded from the study through vetting of eligibility criteria. For example, a student who had recently lost a family member may have witnessed or perceive the loss as being a result of poor practice that is unrelated to their school clinical experiences. Lastly, in order to reduce bias, the researcher considered factors that had potential to influence the results during the design and analysis phases. For example, measurement bias due to social desirability responses was controlled by clearly stating the purpose of the study during recruitment. Additionally, ensuring confidentiality was upheld and emphasizing the importance of honest and transparent responses.

External validity is the degree to which the treatment effects can be generalized across

populations, settings, measurement instruments, and treatment variables. The biggest factor for this threat is even though the sample may be diverse and was derived from three different campuses, the sample is still considered one cohort under the same curriculum at one school of nursing. However, provided that a robust method known as bootstrapping was used in analyzing the results of this study, generalizations to a like population will be made.

Results

Seventy percent of the students (n = 88) responded to the initial survey through the email link. However, 21% (n=19) of the respondents were ineligible due to reporting of a recent death of a family member within six months. Lastly, 27% of the students did not go on to take the Likert portions of the survey containing the MDT, MCSP, and CD-RISC scales. The final data set contained 45 nursing students resulting in a 36% response rate.

The demographic profile of the respondents is shown in Table 4. The respondents were primarily comprised of females (91.1%) with participant mean age being 22.15 (± 2.79) and a median age of 21. A majority of the respondents reported ethnicity as White (77.8%) while the second largest percentage of respondents being Hispanic or Latino (13.3%). The majority of participants did not report prior healthcare experience (62.2%) and also had not considered quitting nursing school (82.2%).

Table 4 *Descriptive Statistics, Frequencies, and Percentages of Demographic Characteristics*

Measure	Participants (*n*=45)
Age	
Mean *(SD)*	22.15 *(2.79)*
Gender*	
Female	41 (91.1%)

Male	4 (8.9%)
Ethnicity Origin or Race*	
Black or African American	1 (2.2%)
Asian/Pacific Islander	3 (6.7%)
White	35 (77.8%)
Hispanic or Latino	6 (13.3%)
Highest Degree*	
High School/GED	43 (95.5%)
Associates in General Arts	2 (4.5%)
Previous Healthcare Experience*	
Yes	17 (37.7%)
No	28 (62.3%)
Healthcare Experience Area*	
Anesthesia Technician	1 (40.7%)
Certified Nurse Aide/HUC	1 (49.2%)
Medical Assistant	1 (1.7%)
Dental Assistant	1 (1.7%)
Other	13 (28.8%)
Considered Quitting Nursing School*	
Yes	8 (17.8%)
No	37 (82.2%)

Note. *Format is *n* (%). HUC = Health Unit Coordinator

Table 5 presents a descriptive analysis of the main study variables of moral distress, moral courage, and moral resilience. Moral distress scores on the MDT ranged from 0 -7 with a "7" indicating a distressing and intense level. A majority of students reported moral distress ranging from mild to uncomfortable on the MDT ($M = 2.73$, $SD = 1.9$). A wide range of scores for moral courage (62.96-100) was elicited on the MCSP. Next, moral resilience was scored using the 25-item CD-RISC instrument. The students' average scores on moral resilience ($M = 78.44$, $SD = 11.6$) were lower than their average scores on moral courage ($M = 88.15$, $SD = 9.1$). Moral resilience scores ranged from 46-99. Lastly, the reliability for the instruments used in this study was analyzed and both the CD-RISC and MCSP had a Cronbach's alpha = 0.80. The reliability of the MDT as a single-item tool was unable to assess in this study.

Table 5 *Descriptive Statistics for Moral Distress, Moral Courage, and Moral Resilience*

Variable	Participants (N = 45)	Instrument Reliability
Moral Distress		
M (*SD*)	2.73 (*1.9*)	
Minimum	0	
Maximum	7	
Moral Courage		*a* = 0.8
M (*SD*)	88.15 (9.1)	
Minimum	62.96	
Maximum	100	
Moral Resilience		*a* = 0.8
M (*SD*)	78.44 (*11.6*)	
Minimum	46	
Maximum	99	

Research Question One

Research question one asked if nursing students with greater moral resilience and moral courage reported significantly less moral distress. A preliminary analysis using Pearson's product-moment correlation showed the relationships to be linear. Although not all variables were normally distributed, as assessed by Shapiro-Wilk's Test ($p < .05$), a Pearson's correlation is somewhat robust to deviations from normality (Field, 2013). There were no outliers. There was a small but non-significant negative correlation between moral distress and moral resilience $r(45) = -.21$, $p = .084$, 95% CI [-.47, 0.5]. Additionally, there was no statistically significant correlation between moral distress and moral courage $r(45) = .02$, $p = .44$, 95% CI [-.30, .35] (see Table 6). Therefore, students who reported higher moral resilience and higher moral courage did not report less moral distress. However, there was a statistically significant relationship between moral courage and moral resilience $r(45) = .37$, $p = .006$, 95% CI [.07, .62].

Table 6 Pearson Correlations for main study variables

	Moral Distress	Moral Courage
Moral Courage	.024	
Moral Resilience	-.209	.372*

*statistically significant at the 0.05 level (1-tailed)

Research Question Two

The second research question asked if students with higher moral resilience had less moral distress. The simple correlation between the two variable was $r(45) = -.21$, $p = .084$. A Pearson's partial correlation was conducted to assess the relationship between moral resilience and moral distress after adjusting for moral courage. Scatterplots showed linear relationships between moral resilience and moral distress. Pearson's partial correlation showed that the strength of this linear relationship was more after controlling for moral courage was $r_{partial}(45) = -.24$, $p = .062$, 95% CI [-.47, .05].

Table 7 Pearson Partial Correlations for Moral Resilience and Moral Distress

Control Variables		Moral Resilience
Moral Courage		
	Moral Distress	-.235

*statistically significant at the 0.05 level (1-tailed)

Research Question Three

Research question number three queried if students with higher moral courage had less moral distress The simple correlation between the two variables was $r(45) = .024$, $p = .44$. A Pearson's partial correlation was run to assess the relationship between moral courage and moral distress after adjusting for moral resilience. A Pearson's partial correlation established there was a weak, non-statistically significant linear relationship between moral courage and moral distress (see Table 6), $r_{partial}(45) = .112$, $p = .47$, 95% CI [-.22, .38].

Table 8 Pearson Partial Correlations for Moral Courage and Moral Distress

Control Variables		Moral Courage
Moral Resilience		
	Moral Distress	.470

*statistically significant at the 0.05 level (1-tailed)

Research Question Four

Research question number four dealt with moral courage being a predictor of moral distress greater than that of moral resiliency. A multiple regression was conducted to see if moral courage and moral resilience predicted moral distress. Table 9 presents a multiple linear regression analysis examining moral distress. Using the standard entry method, data indicated that the overall model was not statistically significant, $F(2,42) = 1.241$, $p = .30$. The model only explained 2% ($R = .056$, Adjusted $R = .011$) of the variance in the dependent variable moral distress. Therefore, moral courage does not predict moral distress more than moral resiliency.

Table 9

Summary of Multiple Regression Analysis for Variables Predicting Moral Distress (N = 45)

	B	*SE B*	*β*
Step 1			
Constant	1.936	5.163	
Moral Courage	.010	.062	.024
Step 2			
Constant	3.240	5.146	
Moral Courage	.048	.065	.118
Moral Resilience	-.043	.028	-.253

n = 45, R^2 = .001 for Step 1, ΔR^2 = .055 for Step 2 (p > .05)

Additional Analyses and Results

Using the CD-RISC instrument to measure moral resilience provided additional consideration for analyses. Two questions were added to the CD-RISC scale in order to establish correlation of the instrument for moral resilience specifically and not just resilience. The two questions added were: (a) I would/do keep to, at any cost, the moral principles I consider important, without veering from them in either actions or standards, under any condition and (b) When faced with a morally difficult situation, I can cope with the situation through good ethical reasoning.

A Pearson's product-moment correlation was run to assess the relationship between the original CD-RISC scale, the two new stand-alone questions, the CD-RISC with the additional two questions, moral courage, and moral distress. There were moderate to strong relationships that were statistically significant between the standalone questions, the modified CD-RISC (with the

standalone questions added), and the original CD-RISC score. There was a strong correlation between the standalone questions and the original CD-RISC $r(45) = .589$, $p < .001$ indicating moderate convergent validity of the two new questions. The standalone questions also had a statistically significant correlation with moral courage $r(45) = .445$, $p = .002$. The findings for correlations with the modified CD-RISC can be located in Table 10. These findings warrant further analyses with the new standalone questions for measuring moral resilience.

Table 10

Pearson Correlations for modified CD-RISC and main study variables

	Moral Distress	Moral Courage	Original CD-RISC	Modified CD-RISC	Standalone Questions
Moral Distress		.024	-.209	-.205	-.100
Moral Courage			.372*	.398**	.445**
Original CD-RISC				.995**	.589**
Modified CD-RISC					.666**

**statistically significant at the 0.01 level (2-tailed)

An additional Pearson's product correlation was run to analyze any relationships between the demographic variables and the main study variables. The data showed a statistically significant relationship between moral resilience and age $r(45) = .314$, $p = .04$, 95% CI [0.9, .54]. Additionally, a Chi-Square statistic was run to determine if there were differences in moral distress and moral resilience based on those who had a previous degree. There was a significant difference in moral resilience for those who had a previous degree, $x^2(1) = 28$, $p = .02$ indicating that moral

resilience was higher in those students who were seeking a second degree in nursing.

Discussion

The purpose of this study was to address a scientific gap by explaining moral distress, moral courage, and moral resilience among undergraduate nursing students and their interrelationships. Results of this study parallel findings from studies that support moral distress being a phenomenon experienced by nursing students (Krautscheid et al., 2017; Escolar-Chua, 2016; Renno et al., 2018). In fact, the average level of moral distress in this study mirrored a study (Krautscheid et al., 2017) with senior level nursing students that averaged a moral distress rating as 3.12, indicating a lower intensity level of moral distress. While there are more qualitative studies examining moral distress in nursing students than quantitative (Sasso et al., 2016), moral distress levels in this quantitative study supports the levels of moral distress among nursing students reported in other studies. Although specific sources of moral distress were not examined in this study, nursing students were provided examples that were extrapolated from the literature while rating their moral distress in the survey. The examples of moral distress provided to the nursing students in this study included feeling unable to act within the clinical environment, feeling powerlessness among the healthcare team, bullying between nurses or their peers, clinical experience in certain areas discourages them from entering those areas after graduation, and differing opinions between healthcare team and patients and/or their families. Given that these examples were provided to these students while simultaneously rating their level of moral distress, it is likely they had experienced something similar to one of these same dilemmas. Other sources or settings of moral distress in nursing students identified in the literature include patients with opioid use disorder (Lewis & Jarvis, 2019), disempowerment and status (Krautscheid et al., 2017; Reader, 2015), mental health settings

(Wojtowicz, Hagen, & Van Daalen-Smith, 2014), and teacher or preceptor as source of moral distress (Renno et al., 2018).

Moreover, in relation to moral distress, nursing students are among several other interprofessional healthcare students who are also experiencing moral distress as noted in the literature (Jameton, 2017). Curriculums providing education and training to future healthcare professionals should not underestimate the importance of keeping ethics and value based training. With the vast research on moral distress, resources are readily available to incorporate into curriculums such as a textbook titled *Moral Distress in Health Professions* written by Ulrich and Grady (2018). However, one of the underlying issues is that many gaps still remain in ethics education in nursing curricula (Hoskins, Grady, & Ulrich, 2018). Nonetheless, educators whether in practice or academia have a responsibility to prepare students for the workforce, particularly while the complexity of healthcare continues to increase. Another strategy to combat moral distress is the inclusion of emotional intelligence. Although no studies have been conducted on moral resilience and emotional intelligence, there are existing studies identifying the link between emotional intelligence and resilience. Given that moral resilience is a subgroup of resilience, it is plausible that emotional intelligence has an effect on moral resilience as an antecedent (Imani, Kermanshahi, Vanaki, & Lili, 2018). Ultimately, although fostering moral resilience is an important strategy, moral distress still needs to be addressed as the root cause as much as possible and may require a seismic shift in the way healthcare providers and future providers view their role as moral agents.

Furthermore, sociodemographic factors have been associated with moral distress such as ethnicity and age (Oh & Gastmans, 2015). A significant correlation between moral distress and

students who claimed a previous degree was demonstrated. The correlation was negative so those who were seeking a second degree had lower levels of moral distress. Also, this study had a statistically significant positive correlation between age and moral resilience implying that the older a person gets the higher moral resiliency they have. Similarly, there was a significant positive correlation between earning a second degree and moral resilience asserting that moral resilience went up for students claiming to be earning their second degree. This also suggests that as individuals age and experience adversity, their resiliency increases and therefore, they are already equipped with some of the tools and skills necessary to enter the nursing workforce.

Another interesting finding was that although students had mild moral distress, 82.2% had not considered quitting nursing school. Escolar-Chua (2016) had this same finding in Filipino nursing students who hardly considered quitting the nursing profession despite frequent morally distressing situations. Thus, claiming moral stressors to be the cause of new graduates leaving the profession may not hold weight. Perhaps the true reasons new graduates are leaving the profession are simply due to organizational factors such as workload, unsafe ratios, unsupportive administration, or stress that is not moral in nature. These findings highlight differences between licensed nurses and students whereas nurses who frequently experience moral distress are more likely to experience burnout and leave the profession (Rushton et al., 2015).

This study showed that moral resiliency had a greater effect on moral distress than moral courage for the nursing students in this study. For example, when moral courage was controlled for, there was a significant correlation between moral resilience and moral distress. However, although statistically significant, moral resilience as a predictor of moral distress was very low whereas moral courage had no contribution to the regression model. Furthermore, moral courage and moral resiliency together had statistically significant correlations but not in relationship with

moral distress. Given the fact that moral courage had no significant correlation with moral distress, perhaps less emphasis should be placed on moral courage with more emphasis on moral resilience.

Strengths and Limitations

A major strength for this study includes the use of valid and reliable instruments. Additionally, the inability to determine a causal relationship does not devalue the importance of a correlational design wherein moral values are characteristics that cannot easily be manipulated or predicted (Field, 2013). Therefore, determining the relationships between these moral concepts provided valuable evidence for nursing education and determining what characteristics are needed for nursing students prior to entering the profession. These factors yield results that are more valid and contribute to the body of knowledge surrounding moral concepts in the context of nursing students. Although this study examined nursing students within one nursing school, students of the same cohort and program were spread among three different campuses within the state of Texas and possibly exhibit diversity such as life experiences and personal beliefs.

Limitations of this study include a social desirability bias due to self-reported behaviors and self-assessment. The length of the questionnaires did pose completion issues where several students began to opt out as they progressed through the survey. College students are limited on time and have many responsibilities during their last year in nursing school. Also, a descriptive correlational design does not determine cause and effect and only indicates that a relationship exists. Furthermore, this study examined a small convenient sample of n=45 and had an unfavorable effect on the power for the hypothesis testing. This smaller sample could potentially have impacted the insignificant results for this study. Lastly, these senior level nursing students had been in the

hospital setting for one semester and may not have been aware of what moral dilemmas look like whereas a nursing student with more clinical hours could better identify a moral issue.

Recommendations

The findings of this study warrant further research in nursing students. A multi-site study with a large sample size would help generalize findings for transferability (Polit & Beck, 2010). However, based on the results, future research in both quantitative and qualitative realms as an embedded design and/or using a longitudinal design might help pinpoint and highlight specific moral dilemmas nursing students experience along with their reactions both intraprofessionally and interprofessionally. Furthermore, researching the psychometric properties of a new or modified moral resilience scale would be beneficial in quantifying moral resilience as this concept is widely under developed (Young & Rushton, 2017). As the conceptual definition of moral resilience is solidified, tools to measure it are necessary in order to determine where this concept occurs theoretically within ethical decision making, healthcare, nursing education, and other professional fields. Additionally, the reliability and validity of the MDT should be investigated further in comparison to the Moral Distress Scale.

In regards to Corley's Theory of Moral Distress, the outcomes of this study were somewhat dissimilar to the implications of the theory. The theory is somewhat weakened based on the results of moral courage and moral distress having no significant relationship. Current research, including this study, has broadened the phenomenon to include a more feasible concept being moral resilience. Further research such as a grounded theory design may be beneficial in understanding a more current state of concepts related to moral distress.

Although the purpose of this study was intended to be moral in nature, it may be possible that students were drawing from experiences that felt stressful, difficult, adverse, or uncomfortable.

Another moral concept that fits in regards to students not reporting experiences that were moral in nature could partly be due to their moral sensitivity. Without moral sensitivity, students may not be able to recognize ethical conflicts when they arise or they simply are not aware of the impact an ethical consequence may have on others (Borhani, Abbaszadeh, & Hoseinabadi-Farahani, 2016). It is certain nursing students are highly stressed; but this particular study yields these participants were not highly morally distressed. However, future studies should examine variables as to why nursing students have moral courage, moral resilience, and only mild moral distress. For example, in this study, age was a significant variable for moral resilience as most of the students were around twenty-two years of age. Variables such as faculty-student relationship, generational differences, clinical sites, preceptor attitudes, and curriculum content may have also contributed to a lack of intensity in moral distress.

Considering evidence-based practices for nursing education, further research may incorporate the use of simulation as effective teaching strategies to continue to foster moral courage and moral resilience. Specifically, the use of high-fidelity simulation as a pedagogical approach could provide experiential learning where students are better able to identify and circumnavigate moral dilemmas (Kim, Park, & Shin, 2016). Nevertheless, nursing curricula should continue to be steadfast in providing ethics education and remain diligent in teaching students to act as moral agents. Other strategies to enhance moral resiliency include self-care, and self-regulation or mindfulness. The importance of practicing self-care should be encouraged at the beginning of nursing school when challenges are likely to begin (ANA, 2017). As with nurses, if students are emotionally or physically depleted, they are more susceptible to adverse effects to distress including moral distress. Mindfulness has been linked to strengthening mental flexibility when moral conflict arises and can be beneficial for nursing students (Rushton, 2016). All of the above mentioned are

strategies that should not be overlooked in nursing curricula and have practical implications for use in nursing practice.

Lastly, the significant findings related to sociodemographic variables in this study have implications for nursing programs and their admission criteria. One factor to bear in mind is older students who are seeking second degrees may be more resilient when facing the challenges of nursing school.

Summary

The findings from this research study contribute to the gap in literature regarding the concepts of moral distress, moral courage, and moral resilience in nursing students. The purpose of this study was to explore the relationships among these concepts in order to better understand if nursing students possess moral courage and moral resilience along with experiencing moral distress. This study expands the literature in providing a baseline assessment of moral resilience in nursing students. Furthermore, while nursing students and nurses may experience moral distress differently, theoretical models may need revision or new development to provide a framework specific to nursing students and their experience with moral distress. This study can also be beneficial to nursing curriculums who suspect moral dilemmas among their students. Subsequently, best practice interventions to cultivate moral resilience and moral courage can be implemented within nursing curriculums. Lastly, despite the limitations, this study generated new knowledge that can facilitate further research in moral distress into positive outcomes around moral courage and moral resilience; and not remain stalled in the negative aspects of this phenomenon.

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Chapter 5

Summary and Conclusions

Moral distress has become well-known in the nursing literature and has seeped into nursing education literature within the last decade (Sasso et al., 2016). With increasing numbers of nurses leaving the profession, it is vital nurse educators prepare nursing students for real world practice with the inclusion of moral dilemmas in their curricula. Nursing students who have experiential learning in healthcare environments are at risk of experiencing moral dilemmas that result in moral distress and ultimately interrupt the learning process. The nursing literature points towards moral courage and moral resilience as being effective characteristics to cultivate in order to combat the effects of moral distress (Escolar-Chua, 2016; Monteverde, 2013; Stolt, Leino-Kilpi, Ruokonen, Repo, & Suhonen, 2018). While there is a larger body of knowledge regarding these moral concepts in licensed nurses and interprofessional team members (Jameton, 2017; Lamiani, Borghi,& Argentero, 2015), there are no studies examining how moral distress, moral courage, and moral resilience specifically relate to one another in licensed nurses or student nurses. Prior to this study, there was no research examining all three of these moral concepts in nursing students.

Nursing students should demonstrate moral courage when needed. However, as seen in this study, although students reported high levels of moral courage, they still experienced moral distress. As such, nurse educators should be unwavering in their strategies to teach moral courage while students are still grasping courage in their role as a student. Thus, the introduction of student courage and how that concept fits within the realm of healthcare students was provided in these chapters. Finally, while moral courage is important for patient safety, it may not have a direct correlation to moral distress as evidenced in this study. However, moral courage and moral resilience were significantly correlated in this study.

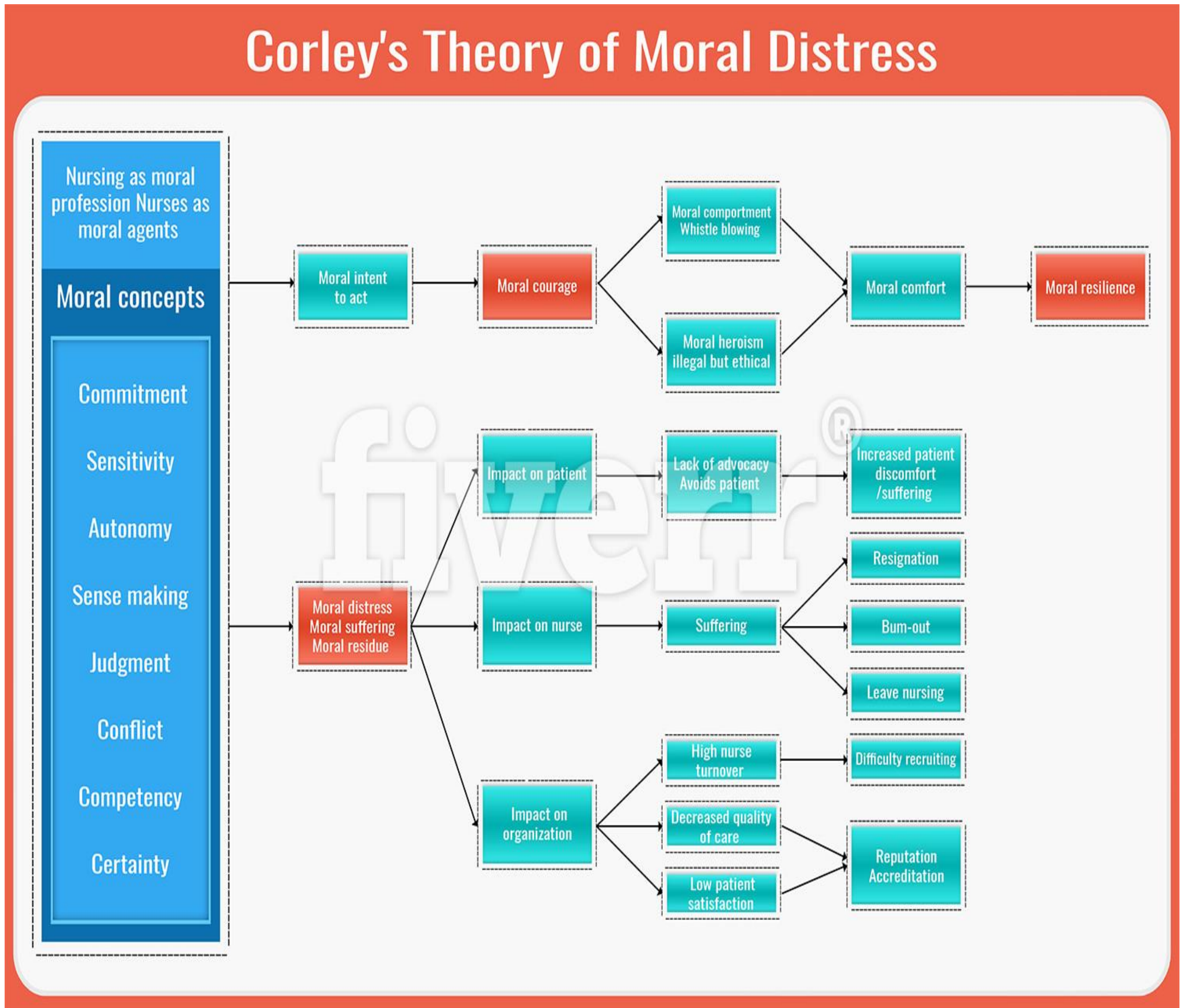
There is a larger shift towards the need for moral resilience that has emerged in the literature and was also evident in this study. Not only is moral resilience necessary in nursing students; but also in future healthcare providers and their organizations of practice. Academic institutions, healthcare facilities, and organizations need to cultivate resilience in individuals in order to face challenges, adversity, and distress and create a climate shift in the working environment. The inclusion of nursing ethics through simulation or other teaching pedagogies along with established competencies is crucial for preparing students for the nursing workforce. Lastly, other opportunities to enhance moral resilience include self-care, self-regulation, and mindfulness.

Sociodemographic factors also play a key role within these moral concepts. This study demonstrated that moral resiliency increases with age. Likewise, students who are pursuing advanced or second degrees also possess higher moral resilience. This certainly has an influence on nursing programs who admit non-traditional students that may be older than the average nursing student seeking a baccalaureate degree. Taking into consideration the results of this study, older students are more attractive candidates for nursing school as they may exhibit greater moral resilience.

Additional research is needed on quantifying moral resilience in nursing students. Using the CD-RISC or developing a new instrument that utilizes new moral resilience questions presented in this study are warranted. Likewise, strategies that enhance these moral concepts in nursing students is fundamental in preventing effects of moral distress such as burnout or leaving the profession shortly after graduation. Furthermore, development of theoretical models that include newly developed moral concepts such as moral resilience are needed. This study helped provide a baseline understanding of how moral distress, moral courage, and moral resilience are related that could be utilized in the development of theory construction.

Appendix A

Figure 1. Corley's Theory of Moral Distress*



*Orange boxes are constructs being tested in this study with permission to adopt from Mary Corley
** Moral resilience not part of original theory

Appendix B

Moral Courage Scale for Physicians (MCSP)

Instructions: Please indicate the extent of your agreement or disagreement with each of the following statements.

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1. I do what is right for my patients, even if I experience opposing social pressures (e.g., opposition from senior members of the healthcare team, medical guidelines, etc.).	☐	☐	☐	☐	☐	☐	☐
2. I use a guiding set of principles from my profession to help determine the right thing to do for my patients.	☐	☐	☐	☐	☐	☐	☐
3. My patients and colleagues can rely on me to exemplify moral behavior.	☐	☐	☐	☐	☐	☐	☐
4. I do what is right for my patients because it is the ethical thing to do.	☐	☐	☐	☐	☐	☐	☐
5. I go above and beyond what is required to do what is right for my patients.	☐	☐	☐	☐	☐	☐	☐
6. When faced with ethical dilemmas in patient care, I consider how both my professional values and my personal values apply to the situation before making decisions.	☐	☐	☐	☐	☐	☐	☐
7. When I do the right thing for my patients, my motives are pure.	☐	☐	☐	☐	☐	☐	☐
8. I do what is right for my patients, even if it puts me at risk (e.g., legal risk, risk to reputation, etc.).	☐	☐	☐	☐	☐	☐	☐
9. I am determined to do the right thing for my patients.	☐	☐	☐	☐	☐	☐	☐

Appendix C

Connor-Davidson Resilience Scale 25 (CD-RISC-25)

Connor-Davidson Resilience Scale 25 (CD-RISC-25) ©

*For each item, please mark an "**x**" in the box below that best indicates how much you agree with the following statements as they apply to you over the last **month**. If a particular situation has not occurred recently, answer according to how you think you would have felt.*

		not true at all (0)	rarely true (1)	sometimes true (2)	often true (3)	true nearly all the time (4)
1.	I am able to adapt when changes occur.	☐	☐	☐	☐	☐
2.	I have at least one close and secure relationship that helps me when I am stressed.	☐	☐	☐	☐	☐
3.	When there are no clear solutions to my problems, sometimes fate or God can help.	☐	☐	☐	☐	☐
4.	I can deal with whatever comes my way.	☐	☐	☐	☐	☐
5.	Past successes give me confidence in dealing with new challenges and difficulties.	☐	☐	☐	☐	☐
6.	I try to see the humorous side of things when I am faced with problems.	☐	☐	☐	☐	☐
7.	Having to cope with stress can make me stronger.	☐	☐	☐	☐	☐
8.	I tend to bounce back after illness, injury, or other hardships.	☐	☐	☐	☐	☐
9.	Good or bad, I believe that most things happen for a reason.	☐	☐	☐	☐	☐
10.	I give my best effort no matter what the outcome may be.	☐	☐	☐	☐	☐
11.	I believe I can achieve my goals, even if there are obstacles.	☐	☐	☐	☐	☐
12.	Even when things look hopeless, I don't give up.	☐	☐	☐	☐	☐
13.	During times of stress/crisis, I know where to turn for help.	☐	☐	☐	☐	☐
14.	Under pressure, I stay focused and think clearly.	☐	☐	☐	☐	☐
15.	I prefer to take the lead in solving problems rather than letting others make all the decisions.	☐	☐	☐	☐	☐
16.	I am not easily discouraged by failure.	☐	☐	☐	☐	☐
17.	I think of myself as a strong person when dealing with life's challenges and difficulties.	☐	☐	☐	☐	☐
18.	I can make unpopular or difficult decisions that affect other people, if it is necessary.	☐	☐	☐	☐	☐
19.	I am able to handle unpleasant or painful feelings like sadness, fear, and anger.	☐	☐	☐	☐	☐
20.	In dealing with life's problems, sometimes you have to act on a hunch without knowing why.		☐	☐	☐	☐
21.	I have a strong sense of purpose in life.	☐	☐	☐	☐	☐
22.	I feel in control of my life.	☐	☐	☐	☐	☐
23.	I like challenges.	☐	☐	☐	☐	☐
24.	I work to attain my goals no matter what roadblocks I encounter along the way.	☐	☐	☐	☐	☐
25.	I take pride in my achievements.	☐	☐	☐	☐	☐

Add up your score for each column 0 + _____ + _____ + _______ + ______

Add each of the column totals to obtain CD-RISC score = ______________________

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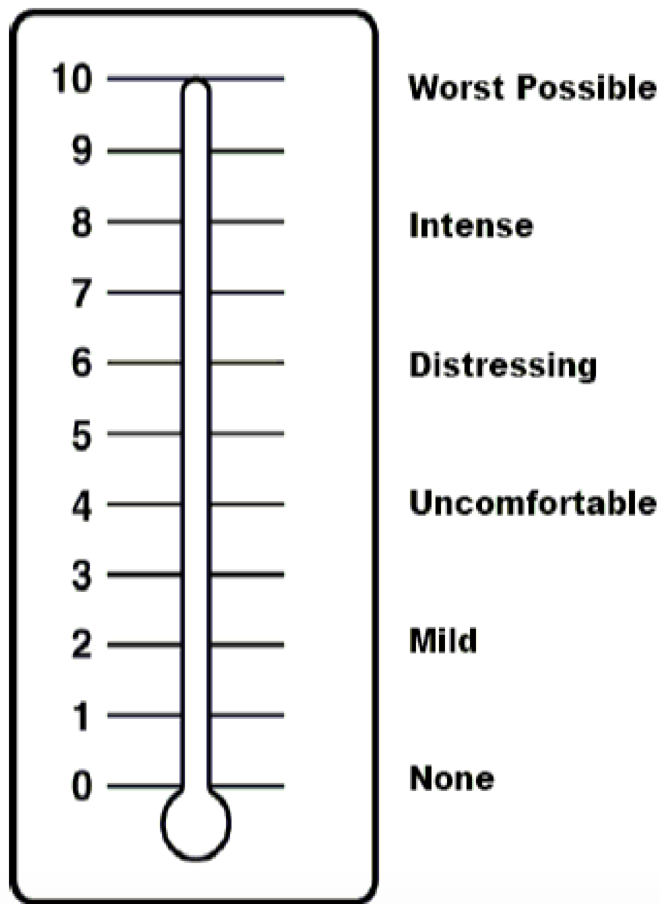
01-01-18

Appendix D

Moral Distress Thermometer

Moral Distress occurs when you believe you know the ethically correct thing to do, but something or someone restricts your ability to pursue the right course of action.

Please circle the number (0-10) on the Moral Distress Thermometer that best describes how much moral distress you have been experiencing related to your role as a student in the past month including today.



Appendix E

Demographic Survey

Please answer the following questions:

1. What is your age in years? (please list current age) _______

2. Gender ____Male ____ Female ____ Other (Please identify) ____Prefer not to answer

3. Ethnicity/Race
___African-American/Black ____American Indian/Alaskan Native ____Asian/Pacific Islander

___Caucasian (Non-Hispanic) ____ Hispanic ____ Other (Please identify) ____Prefer not to answer

4. Do you have previous healthcare provider experience? ____ No ___ Yes (If "yes" please indicate your area of experience) ____ CNA ____ LVN/LPN ____EMT _____Other (please identify)

5. Is this a second degree for you? ___No ___Yes ___ (If "yes", specify your highest degree) _____Associate ____Bachelor ____ Master's ____ Doctorate

In what area is/are your other degree(s)? _______

How long have or did you work in this capacity? ____ 1 year or less ____ Greater than 1 year

6. Have you had a recent death in your family or a close friend within the last 6 months?
____ No ____ Yes

7. Have you considered quitting nursing school? ___ No ____ Yes If yes, please elaborate on why you considered quitting and what influenced your decision to remain in school. ________

For Research Purposes Only:
Campus
Abilene ____
Lubbock ____
Odessa _____

Appendix F

Informed Consent

You have been invited to participate in this study, titled, “Exploring the Relationships between Moral Distress, Moral Courage, and Moral Resilience”. The purpose of this study is to explore the concepts of moral distress, moral courage, and moral resilience in nursing students. Your participation is completely voluntary, and if you begin participation and choose to not complete it, you are free to not continue without any adverse consequences.

If you agree to be in this study, we will ask you to do the following things:

- Complete the survey that should take 10 minutes or less

We know of no known risks to this study, other than becoming a little tired of answering the questions, or you may even become a little stressed or distressed when answering some of the questions. If this happens, you are free to take a break and return to the survey to finish it, or, you can discontinue participation without any problems. Potential benefits to this study are: Help the researcher learn about the relationships between moral distress, moral courage, and moral resilience in nursing students.

I know my responses to the questions are anonymous. If I need to ask questions about this study, I can contact the principle researcher, Erin Gibson at egibson@patriots.uttyler.edu or 806-535-4919 or, if I have any questions about my rights as a research participant, I can contact Dr. Gloria Duke, Chair of the UT Tyler Institutional Review Board at gduke@uttyler, or 903-566-7023.

I have read and understood what has been explained to me. If I choose to participate in this study, I will click “Yes” in the box below and proceed to the survey. If I choose to not participate, I will click “No” in the box.

Yes, I choose to participate in this study.

No, I choose to not participate in this study.

Appendix G

Dear student,

My name is Erin Gibson and I am a doctoral student at The University of Texas at Tyler. I am writing to invite you to participate in my research study about relationships between moral behaviors in nursing students.

If you decide to participate in this study, you will receive a link through your email. This link will verify your eligibility in addition to your consent. If you choose to participate, you will be entered into a drawing for an Amazon gift card. Participation in this study will provide information to help nurse researchers develop best practices to provide nursing students with the proper tools and skills required for the nursing profession.

Remember, this is completely voluntary. You can choose to be in the study or not. If you'd like to participate or have any questions about the study, please email or contact me at egibson@patriots.uttyler.edu

Thank you very much.

Sincerely,

Erin Gibson

egibson@patriots.uttyler.edu

Appendix H

BIOGRAPHICAL SKETCH

NAME: Erin Gibson, MSN, RN, CCRN-K

POSITION TITLE: Assistant Professor

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	Completion Date	FIELD OF STUDY
South Plains College Levelland, Texas	A.D.N.	05/2006	Nursing
Lubbock Christian University Lubbock, Texas	BSN & MSN	05/2010	Nursing
The University of Texas at Tyler Tyler, Texas	Ph.D.	present	Nursing Philosophy and Research

A. Personal Statement

My nursing career started in a level one trauma center. I staffed nights in the surgical trauma intensive care unit and took care of patients whose morbidity and mortality were higher than any other in the hospital. After moving to the day shift I was promoted to charge nurse where I assigned nurses to a 22 bed unit. Often times the ratio was not the ideal 1:2 and we were short staffed with highly acute patients. During my time as a charge nurse I worked very closely with my interprofessional team members and conducted our daily multidisciplinary meeting. Taking care of this patient population and their families often involved high levels of stress and moral distress. There were many conflicting parties while making life or death decisions for some of these patients. My next role was an Assistant Director of a Cardiovascular intensive care unit. The work environment was very different and did not have the nurse-physician relationships I was used to. This created a lot of moral distress as the hierarchy was tangible and disrupted patient care. During

the time in nursing management I served on the hospital ethics committee where we discussed many ethical dilemmas. Next I transitioned into academia where I found myself wanting to learn more about research. I had coworkers seeking their doctorates or had many years in research. After applying to PhD school I knew my research would involve nursing ethics and I was witnessing nursing students experience the same moral distress I had felt and wanted to change that for them.

1. Gibson, E. (2018). Longitudinal Learning Plan for Developing Moral Courage. *To appear in Teaching and Learning in Nursing*.

2. Gibson, E. (2018). Student Courage: An Essential for Today's Health Education. *To appear in Nursing Forum*. doi:10.1111/nuf.12254

B. Positions and Honors

Positions and Employment

2006-2010 Nurse/Charge Nurse Surgical Trauma ICU
2010-2014 Assistant Director CV/CICU
2014-2016 Associate Professor, Department of Nursing, Lubbock, TX
2016-2019 Assistant Professor, Department of Nursing, Lubbock, TX

Other Experience and Professional Memberships

2011-2015 Member, American Association of Critical-Care Nurses (AACN)
2014-present Member, American Nurses Association (ANA)
2015-present Member, The Honor Society of Nursing Sigma Theta Tau International (STTI)
2017-present Member, National League for Nursing (TXLN)

Honors

2015 Novice Faculty Award, Texas Tech University Health Sciences Center, Lubbock

C. Contribution to Science

Gibson, E. (2019). Longitudinal learning plan for developing moral courage. *Teaching and Learning in Nursing 2* (14), 122 – 24. doi.org/10.1016/j.teln.2018.12.012

Gibson, E. (2018). Student courage: An essential for today's health education. *Nursing Forum 3 (53)*, 369-375. doi:10.1111/nuf.12254