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Exploring Moral Distress, Ethical Climate, and Psychological Empowerment Among New Registered Nurses

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This is to certify that the doctoral study by

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Walden University
2022

Abstract

Exploring Moral Distress, Ethical Climate, and Psychological Empowerment

Among New Registered Nurses

by

Luz Bruel Mauro

DNP, Fairleigh Dickinson University, 2019

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Moral distress in nursing has been an issue for decades and has consequences on nurses' physical, emotional, and psychological well-being. Nurses in different settings experience a high intensity and frequency of moral distress particularly in intensive care units (ICU), but few studies have examined the moral distress of non-ICU nurses. The purpose of this 3-manuscript dissertation was to assess the frequency and level of moral distress, ethical climate, and psychological empowerment among new registered nurses (NRNs) who work in non-ICU settings. The conceptual framework of Jameton's moral distress guided this study. Twenty-three NRNs with fewer than 3 years of experience completed the Measure of Moral Distress for Healthcare Professionals, Psychological Empowerment Index, and Hospital Ethical Climate Survey. Using MANOVA, the findings showed no difference in the level and frequency of moral distress, perception of ethical climate, and psychological empowerment among NRNs by age groups in various non-ICU settings, critical care units, and noncritical care units. The findings of this study may contribute to positive social change by encouraging improvement in nurses' job satisfaction by enhancing communication and teamwork among healthcare providers, which can improve the quality of patient care. Future studies need to focus on development of strategies aimed at improving moral distress, the ethical climate, and the psychological empowerment of nurses' workplaces for the benefit of both nurses and patients. Study replication with a larger population is warranted.

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Dedication

I dedicate this study to healthcare providers, especially to nurses who lost or risked their lives to COVID-19. The nurses continuously proved to be the icon of trust and value to the profession greater than their lives. The public witnessed the dedication and sacrifices each one of you made to endure in the time of crisis. Kudos to all nurses!!

Acknowledgments

There were so many people who have helped me throughout these five years and my deepest thanks to all of them. Foremost, I thank my advisor and chairperson of my dissertation committee, Dr. Leslie Hussey for your support, expertise, and encouragement. It has been a privilege to learn and work with you throughout this process. Thank you for inspiring me to succeed especially during the tough times with data collection. Your constant advice to "hold on" truly made a difference.

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I would like to express my deepest gratitude to the participants who spared their time to be part of the study. Thank you all!!

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Table of Contents

Part 1: Overview

Introduction

New registered nurses' (NRNs') transition into practice has been associated with both positive and negative feelings and experiences (Andersson & Edberg, 2010). Newly graduated nurses may be inadequately prepared for the transition to practice (Institute of Medicine, 2010). NRNs have reported difficulties in the role and have described the transition process as challenging, a "reality shock," and stressful (Duchscher, 2008; Kramer et al., 2013; Martin & Wilson, 2011). NRNs mostly prefer to work in acute care settings where practice could be stressful, rapidly changing, and where RNs have to work with advanced technology (Thomas et al., 2012). The common challenges NRNs face in the first year of practice are related to confidence in skill performance, lack of clinical knowledge, workload demands, relationships with colleagues, prioritization related to decision n making, and communication with physicians (Duchscher, 2008).

In addition to these transition challenges, moral distress is a negative emotional response that occurs when an individual knows what to do but is unable to act (Jameton, 1984). The complexity of the environment can be a source of conflict and disagreement with coworkers in the work setting, which can lead nurses to feel powerless and unable to fulfill their professional obligations. The three root causes of moral distress are (a) internal factors such as perceived powerlessness and lack of knowledge; (b) external factors such as inadequate staffing and lack of administrative support; and (c) clinical situations involving futile treatment, lack of informed consent, and lack of truth-telling (Hamric, 2012). In addition, nurses who cannot sufficiently integrate their own values

and norms into their daily practice may experience moral distress (Goethals et al., 2010). Nurses use their values and beliefs in ethics to justify right and wrong (Hutchinson, 2015). Rather than engaging in critical reasoning, nurses derive their moral decisions from their experiences and personal values (Goethals et al., 2010).

Problem Statement

Moral distress is a serious problem especially for NRNs when they feel they have limited power to respond appropriately. Failure to identify moral distress may lead to negative consequences. Moral distress is associated with burnout, job dissatisfaction, and nurse turnover (Allen et al., 2013; Asgari et al., 2019; Austin et al., 2017; Corley, 2002; Dzeng & Curtis, 2018; Fumis et al., 2017; Hamric, 2012; Henrich et al., 2016; Mauro, 2019; Neuman et al., 2018; Pereira et al., 2011). In addition, moral distress can lead to emotional withdrawal from patients (Kleinknecht-Dolf et al., 2015) and create anger, guilt, fear, withdrawal, silence, not taking risks, and frustration, which have all been linked to burnout, intention to leave a position, and turnover in nursing (Dodek et al., 2016; Epstein et al., 2019; Fumis et al., 2017; Hiler et al., 2018; Mauro, 2019; Neumann et al., 2018; Radzvin, 2011; Sajjadi et al., 2017; Shoorideh et al., 2015; Trautmann et al., 2015; Whitehead et al., 2015; Woods et al., 2015).

Most of the studies on moral distress have focused on intensive care units (ICUs) and acute care settings (Borhani et al., 2017; Browning, 2013; Corley et al., 2001; Dalmolin et al., 2014; Dyo et al., 2016; Ganz et al., 2013; Hamric & Blackhall, 2007; Henrich et al., 2016; Kleinknec-Dolf et al., 2015; Lamiani et al., 2017; Lawrence, 2011; Mason et al., 2014; McAndrew et al., 2011; Neumann et al., 2018; Pauly et al.,

2009; Rathert et al., 2016; Sauerland et al., 2014; Shoorideh et al., 2015; Silen et al., 2011; Sirilla et al., 2017; Varcoe et al., 2012). There are limited studies on moral distress in the medical surgical units in acute care settings. A survey of 260 nurses in a medical surgical unit at an adult acute tertiary hospital showed that the intensity of moral distress was high related to physician practice, nursing practice, institutional factors, futile care, deception, and euthanasia (Rice et al., 2008). The frequencies of moral distress were high especially with situations associated with futile care and deceptions (Rice et al., 2008). The purpose of this study was to assess the frequency and level of moral distress and explore the relationship between moral distress, ethical climate, and psychological empowerment among NRNs who worked in non-ICU settings.

Background

The healthcare system is complex and characterized by rapid advances in biomedical science, improved disease prevention, and management and is dominated by economic issues (Warner et al., 2020). In addition, regulatory mechanisms are aimed at ensuring the highest standards of ethics. In recent years, a variety of factors have converged to challenge the work environments of contemporary nurses. As a result, nurses are faced with ethical issues and must continue to adapt to the vast challenges in their practice.

Nurses are committed to providing quality nursing care (International Council for Nurses, 2019), which can be measured, evaluated, and defined (American Nurses Association [ANA], 2015). NRNs are required to demonstrate that they are able to identify ethical issues, apply theories and concepts to issues, understand the connection

among theories and concepts related to issues, and evaluate different positions on the issues. Nurses' ethical competencies are seen as a respect for patients' rights and as a responsibility of professional development (Poikkeus et al., 2013). Ethical decisions can affect all members of the healthcare team as they address the stressful and sometimes exhausting nature of working through ethical problems (Ulrich et al., 2010), though physicians have a bigger part than nurses when discussing moral problems, making the first intervention in the discussion, and determining the final solution (Georges & Grypdonck, 2002).

Ethical practice is a socially, personally, and professionally mediated process (Doane, 2002). NRNs need to acquire a range of clinical competencies (Memarian et al., 2007), including ethics, integrity, and compassion (Institute of Medicine, 2011). Good nursing practice needs to be reasoned, and ethical elements need to be considered and demonstrated in decision-making (Nursing and Midwifery Council, 2008). The dynamic combination of individuals' abilities, knowledge, and skills and the coordination of personal, professional, and social moral values that link the cognitive, affective, and psychomotor fields are reflected in ethical competency (Trobec & Starcic, 2015).

Conceptual Framework

Jameton's moral distress was the conceptual framework of this study. Jameton first introduced the concept of moral distress in 1984, describing it as feelings that are painful. Jameton (1984) contrasted moral distress with moral uncertainty and moral dilemmas. Moral uncertainty occurs when someone does not know which moral principles apply or cannot articulate what the moral problem is in a given situation. Moral

dilemmas arise when two or more moral principles or other moral standards apply to a morally problematic situation, but these are at odds with one another regarding which course of action each would support. Finally, moral distress occurs when someone knows the right thing to do but cannot do so because of constraints (Jameton, 1984). The presence of constraints preventing moral actions, either internal (personal) or external (institutional), is the hallmark of moral distress (Hamric et al., 2006; Nathaniel, 2006). Ethical dilemmas and conflicts are related to moral distress (Rathert et al., 2016).

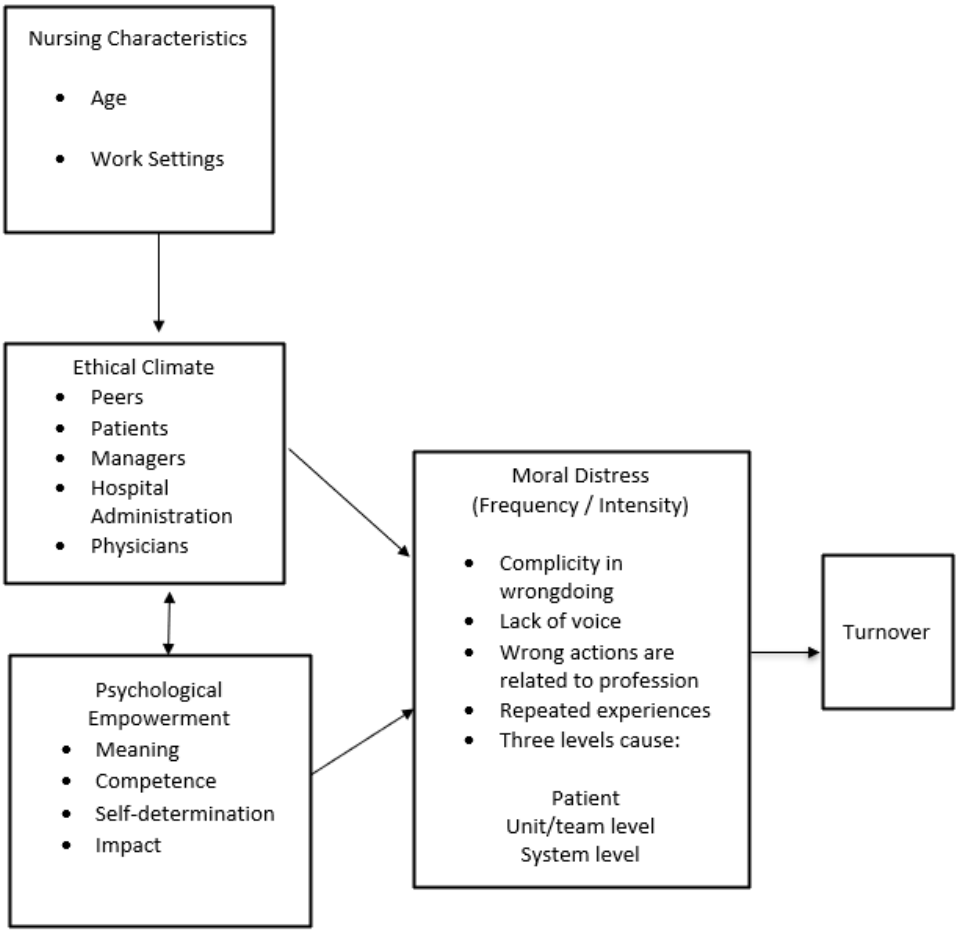
Moral distress is a psychological imbalance or disequilibrium that occurs when nurses find themselves in situations where they feel unable to do the right thing. For moral distress to happen, nurses must first display moral sensitivity (Corley, 2002). Moral sensitivity is an awareness of the moral as a guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession.

There are five components of moral distress (Epstein et al., 2019). First, feeling powerlessness for doing something ethically wrong contrary to beliefs. Second, knowledge about the situation, but having the feeling of not being heard. Furthermore, the wrong actions are related to the profession and are not personal. Fourth, in nursing moral distress can be due to three levels—patient, unit/team level, and system level. And, lastly, moral distress may repeatedly occur. Moral distress that is not dealt with can lead to what is called moral residue, which is described as the lingering feelings after a morally problematic situation has passed (Epstein & Hamric, 2009).

Nurses' experiences of moral distress could lead to frustration, burnout, and eventually leaving the position if not addressed. Thus, I investigated the relationships between the concepts of moral distress, the ethical climate, and psychological empowerment. To examine the associations, three instruments, the Measure of Moral Distress for Healthcare Professionals (MMD-HP), the Psychological Empowerment Index (PEI), and Hospital Ethical Climate Survey (HECS) were used. Each of the components listed in MMD-HP are conceptualized in terms of moral distress frequency and level of distress. The study integrated moral distress, ethical climate, and psychological empowerment to suggest that moral distress is a consequence influenced by the perceived ethical climate and psychological empowerment (see Figure 1).

Figure 1

Conceptual Framework for the Relationship Between Moral Distress, Psychological Empowerment, and Ethical Climate



Several studies have been done on what contributes to moral distress, but less attention has been given to nurses' perceptions of their environment that may affect their moral distress (Silen et al., 2011). Ethical climate is defined as the individual perceptions of the organizations that influence attitudes and serve as a reference for employee behavior (Olson, 1998). Nurses' perceptions of the ethical climate of the workplace is based on their relationship with peers, patients, managers, hospital administration, and physicians when faced with ethical problems or issues.

These relationships are influenced by the conditions of trust, inclusion, role flexibility, and inquiry that are necessary for ethical reflection, dialogue, and ethical problem-solving to occur as well as conditions of varying levels of power (Olson, 1998). It is important to determine the interactions between the individuals and the contextual aspects of organizations in order to assess how individuals respond and experience the situation (Olson, 1998). Individual attitudes and behaviors are influenced when they share common perceptions in their workplace (Schneider, 1987). When nurses perceive they have power and management is supportive, trustworthy, and flexible nurses can freely discuss their issues or concerns. Thus, the ethical climate is influenced by culture of the organization, which includes leadership, structure, policies, a reward system, and decision processes (Numminen et al., 2015). Studies have shown that the more positive an individual perceived the ethical climate they reported, the less moral distress (Lutzen et al., 2010; Pauly et al., 2009).

Psychological empowerment is the psychological state that employees must experience for managerial empowerment interventions to be successful (Spreitzer, 1995).

The four dimensions of psychological empowerment are meaning (individual goals, beliefs, or values), self-determination (sense of autonomy), competence (capability to perform work), and impact (making a difference), which must be combined to create psychological empowerment (Spreitzer, 1995). When all four dimensions are high, psychological empowerment enhances employee performance, positive attitude, and well-being (Hempel et al., 2012). A lack of any single dimension will deflate the overall degree of empowerment. Further, the psychological empowerment depends on the organization structure, team and individual characteristics, support of the organization, leadership, and work design (Kim & Lee, 2016). Thus, it is essential to identify conditions or situations within organizations that cause the sense of powerlessness (Conger & Kanungo, 1988).

Psychological empowerment in the conceptual framework refers to the nurses who have a sense of control in their practice. To empower nurses, their beliefs must be strengthened. Psychological empowerment is necessary so nurses feel in control in their work environment, can take initiatives, and are engaged and change oriented (Choi, 2007; De Sousa & Van Dierendonck, 2014; Laschinger et al., 2009; Spreitzer, 2008). The nurses' perceptions of their work settings and their attitudes and actions can influence their practices. The organizational support, job satisfaction, and role expectations can influence the negative attitudes and turnover. Psychological empowerment and ethical climate have been studied, but research on the relationship of psychological empowerment, ethical climate, and moral distress remains limited. These should be recognized as important contributors that may exacerbate or alleviate moral distress.

Overview of the Manuscripts

Reason for Three Studies

For this study, I wrote three separate manuscripts that individually address the level and frequency of moral distress, perception of ethical climate, and psychological empowerment among NRNs. Although the three variables (moral distress, ethical climate, and psychological empowerment) were the focus in all three studies, each manuscript approached the research problem individually and from a unique perspective. The first manuscript was focused on assessing the difference between the level and frequency of moral distress, perception of the ethical climate, and psychological empowerment among NRNs by age group. The second manuscript examined the effect of work environment for non-critical care units on the level and frequency of moral distress, perception of ethical climate, and psychological empowerment. Finally, the third manuscript compared the effect of the work environment (non-critical units versus critical care units) on NRNs, the level and frequency of moral distress, perception of ethical climate, and psychological empowerment.

Integration of Manuscripts

I conducted a comparative study using the MMD-HP, PEI, and the HECS to measure the moral distress. The data for the three manuscripts were collected simultaneously from the medical center in the United States and using nurses' Facebook groups. Each of the manuscripts focused on different knowledge gaps related to moral distress, ethical climate, and psychological empowerment. The purposes were to

determine (a) if there was a difference between the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs by age group; (b) the effect the work environment has on NRNs in stepdowns, medical/surgical units, emergency departments, ambulatory units, and procedure room units on the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs who work in non-ICU settings; and (c) the effect of the work environment of RNs in critical care units (ICUs and stepdowns) compared to RNs who work in non-critical care (medical/surgical, emergency department, ambulatory clinic, and procedure unit) on the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs with less than 3 years of nursing experience.

The three manuscripts offer a better understanding of NRNs experiences in clinical practices and their responses in relation to ethical issues in connection to the three variables. Further, the three manuscripts provide information on NRNs' characteristics, causes of moral distress, perception of ethical climate, and psychological empowerment that can be used to implement changes to mitigate moral distress and develop strategies to improve the ethical climate and psychological empowerment in work settings.

Manuscript 1

The first manuscript research question was "What is the difference between the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs by age group" This study was a quantitative research

comparative analysis, which required a multivariate analysis of variance to determine if there is a difference in the frequency and level of moral distress (dependent variable), perception of the ethical climate (dependent variable), and psychological empowerment (dependent variable) among NRNs by age group. In this study I examined the two age groups: those 30 years of age and below and above 31 years of age. The age group was the independent variable. The ethical climate was an important element affecting NRNs and practice. Ethical climate involves organizational practices and values related to practice issues and how these issues are managed and resolved (Shulter et al., 2008). Moral distress occurs when an individual is unable to fulfill the perceived obligation. I used convenience sampling to recruit NRNs who work either full time or part time, have fewer than 3 years of experience, are currently employed at a tertiary hospital, and are a member of a nursing Facebook group. The instruments used were MMD-HP, PEI, and HECS.

Manuscript 2

The second manuscript research question was "What effect does the work environment have on NRNs in stepdowns, medical/surgical units, emergency departments, ambulatory units, and procedure room units on the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment?" The nature of the study was descriptive, comparative, and quantitative. The study determined if there was a relationship between the frequency and levels of moral distress (dependent variable), perception of the ethical climate (dependent variable), and psychological empowerment (dependent variable) of NRNs who work in non-ICU settings (independent

variable). NRNs are defined as nurses with less than 3 years of nursing experience. I used convenience sampling. The inclusion criteria were RNs employed at a tertiary hospital in non-ICU settings and members of a nursing Facebook group who worked either full time or part time and had fewer than 3 years of experience. I used three questionnaires: the MMD-HP, the PEI, and the HECS.

Manuscript 3

The third manuscript research question was "What is the effect of the work environment of NRNs in critical care units (ICUs and stepdowns) compared to NRNs who work in non-critical care (medical/surgical units, emergency departments, ambulatory clinics, and procedure units) on the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs with less than 3 years of nursing experience?" This study was a quantitative comparative analysis study designed to assess the frequency and level of moral distress. I compared the frequency and level of moral distress (dependent variable), ethical climate (dependent variable), and psychological empowerment (dependent variable) of NRNs working in critical care units (ICUs and stepdowns) (independent variable) to NRNs who worked in non-critical care (medical/surgical units, emergency departments, ambulatory clinics, and procedure units) (independent variable), among NRNs with fewer than 3 years of nursing experience. I used convenience sampling. The eligibility criteria for the participants in the study are NRNs who worked either full time or part time with less than 3 years of experience.

Significance

Americans rate nursing as the most honest profession and indicate that nurses have the highest ethical standards (Gallup, 2015). Ethical practice is an embodied process and not just a function of rational thought (Doane et al., 2004). Based on the ANA (2015) the Code of Ethics for Nurses, nurses should display ethical behavior not only in times of crisis but in their daily interactions. However, ethical practice seems most problematic in situations that involve conflicting values or beliefs about what is the right or what is the best course (Ham, 2004). There has been a growing concern for moral distress in nursing practice (Hurst, 2017), which involves nurses not being able to carry out what they believe to be ethically appropriate actions (Jameton, 1984). Many studies have demonstrated how nurses go through stressful experiences when confronted with ethical problems (Baykara & Sahinoglu, 2014). Regardless of area of practice, nurses face a multitude of ethical dilemmas every day.

Studies have examined the correlation of demographics such as age, gender, education, and length of experience on moral distress with contradicting results. In terms of age, researchers have reported that there was a significant difference in moral distress across age groups, with younger nurses (25–34 years old) experiencing significantly higher moral distress (Woods et al., 2015). However, other studies have shown that age has no relationship to moral distress (Corley et al., 2001; De Villers & DeVon, 2012; Dodek et al., 2016; McAndrew et al., 2011; Ohnishi et al., 2010; Pauly et al., 2009; Silen et al., 2011; Sirilla et al., 2017). The lack of congruity between prior studies and current

studies regarding moral distress and age suggests moral distress can occur at any given time throughout nurses' careers.

In examining the years of experience, researchers have also shown conflicting results. For example, Sirilla et al. (2017) showed weak positive correlation between years of experience and moral distress. But several other studies showed a positive relationship (Dodek et al., 2016; Elpern et al. 2005; O'Connell, 2015; Rice et al., 2008; Shoorideh et al., 2015). Further, other studies showed no significant association between moral distress frequency and years of nursing experience (Cavaliere et al., 2010; Corley et al., 2001; McAndrew et al., 2011; Ohnishi et al., 2010; Pauly et al., 2009). Regardless of these results, experienced nurses tend to maintain an ethical perspective regardless of contextual constraints (Yarning & McElmurry, 1986).

In terms of environment, research has indicated that nurses, physicians, nurse practitioners, physician assistants, and medical residents who provide direct care have higher moral distress (Whitehead et al., 2015). Additionally, nurses working in critical care, perioperative services, and procedure areas have higher moral distress (Borhani et al., 2017; De Villers & DeVon, 2012; Iranmanesh et al., 2013; Sirilla et al., 2017; Whitehead et al., 2015). Similarly, ICU nurses have more moral distress than in geriatric settings (Piers et al., 2012). The common causes of moral distress for non-ICU nurses involve pressure from insurers or administrators to reduce costs, and for ICU groups, moral distress results from making decisions such as withdrawing life support for patients. Contradictory findings have shown that noncritical care nurses reported higher levels of moral distress than critical care nurses (Corley, 1995). However, others have

claimed no significant association between moral distress and type of settings and no difference in moral distress scores between critical care and non-critical care (De Villers & De Von, 2012; Mrayyan & Hamaideh, 2009).

Nurses continue to struggle and experience various distressing situations in their practice (Schluter et al., 2008). Nurses experience moral distress more frequently when they perceive a negative ethical climate in their care settings (Altaker et al., 2018; Corley et al., 2001; McAndrew et al., 2011; Neumann et al., 2018; Silen et al., 2011; Pauly et al., 2009; Hamric & Blackhall, 2007; Mrayyan & Hamaideh, 2009), work with incompetent staff (Beumer, 2008; Corley et al., 2001; McAndrew et al., 2011; Pauly et al., 2012; Piers et al., 2012; Rice et al., 2008; Silen et al., 2011), provide futile care (Cavaliere et al., 2010; Corley, 1995; Mauro, 2019; Mobley et al., 2007; Rice et al., 2008), when there are nursing shortages (Corley et al., 2001; Hamric, 2012; Mrayyan & Hamaideh, 2009; Mauro, 2019), and when patients and family members do not cooperate with care (Ganz & Berkovitz, 2012). Further, the ethical environment can be a positive or negative source of moral distress (Sirilla et al., 2017).

Moral distress has a lingering effect despite resolution of the distressing situation (Epstein & Hamric, 2009). Moral distress may impact quality of care (Ganz & Berkovitz, 2011; Gutierrez, 2005; Hamric & Blackhall, 2007). Quality care is defined in terms of obtaining maximum positive health outcomes and meeting patient needs (Naylor, 2003; Wichoewski et al., 2003). Moreover, nurses who are confronted with repeated ethical challenges causing moral distress may experience burnout and leave the profession, which contributes to a nursing shortage (American Association of Critical Care Nurses,

2008). The ANA (n.d.) reported that by 2022, there will be more than 100,000 RNs needed per year and more than 500,000 seasoned RNs are anticipated to retire. The U.S. Bureau of Labor Statistics (2018) also projected the need for 1.1 million new RNs for expansion and replacement of retirees to avoid nursing shortages. The high turnover rates and short periods of employment among NRNs are costly for healthcare organizations (Ching-Yu et al., 2014). The estimated cost of replacing a specialty nurse is $145,000 and $92,442 for a medical/surgical nurse (Bleich et al., 2006).

Moral distress in nurses is a major concern since it can lead to job dissatisfaction, burnout, turnover, declining engagement, depression, and problems with emotional and physical well-being (AMNHealthcare, 2017; Austin et al., 2017; De Veer et al., 2013; Mauro, 2019; Shoorideh et al., 2015; Wilkinson, 1989). The generational change in the nursing workforce is underway, and the baby boomer retirements among nurses are already in progress (AMNHealthcare, 2017). According to the American Association of Colleges of Nursing (2019), the workforce of nurses is expected to increase to 3.4 million in 2026 from 2.9 million in 2016, which is an increase of 438,100 or 15%. However, an additional 203,700 NRNs are needed each year through 2026. Support and education are needed from the leadership, institutions, and colleagues to assist them during their transition and to mitigate moral distress. Identifying the sources of moral distress could assist in creating programs to deal with moral distress leading to a healthier working environment (Browning, 2013). Hence, the findings of this study may contribute to positive social change to improve nurses' job satisfaction and the quality of patient care.

Summary

Based on the literature review, NRNs in different clinical settings experience various ethical dilemmas and moral distress. The frequency and level of moral distress depends on the specific source. Studies showed moral distress could be related to personal characteristics. In addition, there were negative psychological and physical consequences of moral distress. Thus, an effort should be made to decrease the level of moral distress. Further, there are inconsistent findings comparing levels of moral distress between settings and practice. Additional research is needed to identify the knowledge gap for moral distress of NRNs working in non-ICU units. These studies supported the importance of conducting this study.

Part 2: Manuscripts

Determinants of Moral Distress Among New Registered Nurses

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DNP, Fairleigh Dickinson University, 2019

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Nursing

Walden University

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Outlet for Manuscript

This study will be submitted for publication to the *Journal of Continuing Education in Nursing*, which is a monthly peer-reviewed journal publishing original articles on continuing nursing education that are directed toward continuing education and staff development of professionals, nurse administrators, and nurse educators in all health care settings (Journal of Continuing Education in Nursing, 2021). This journal was chosen because the nature of my study is aligned with the mission of the journal. The *Journal of Continuing Education in Nursing* supports continued career competence through continuing education, staff development, professional policy, and advocacy. Understanding moral distress has a relevance and impact to nursing practice. By evaluating the findings of this study, administrators and educators can create programs to address moral distress.

The manuscript must conform to the guidelines for manuscript preparation of the *Publication Manual of the American Psychological Association, 7th edition*. In addition, the length of manuscripts can range from six to 15 pages, including references, figures, and tables. All pages, including acknowledgments, abstract, text, references, figure legends, and tables, must be double-spaced, with 1-inch margins. References should focus primarily on work that has been published in the past 3 years. Older citations should relate to the original work in the field, classic work related to the topic, or, in rare cases, the only other relevant work.

Abstract

Purpose

The purpose of this study was to assess the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among new registered nurses (NRNs).

Method

In this quantitative study, the survey design for data collection included the Measure of Moral Distress for Healthcare Professionals (MMD-HP), the Psychological Empowerment Index, and Hospital Ethical Climate Survey was administered to NRNs in acute care hospitals and nurses Facebook groups. Jameton's (1984) moral distress was used for the conceptual framework. Multivariate analysis of variance was used for data analysis.

Findings

The findings showed that there were no differences in the level and frequency of moral distress, perception of ethical climate, and psychological empowerment among NRNs. The overall mean MMD-HP score was moderate to high.

Conclusions

NRNs are faced with ethical dilemmas and conflicts. Nurse leaders and institutions may assist in reducing moral distress by increasing the organizational ethics support.

Keywords: moral distress, ethical climate, psychological empowerment, nursing

Introduction

Nurses are often faced with ethical and stressing situations in their daily practice, moral distress is prevalent in the nursing profession in all areas of healthcare (Corley, 2002; Corley et al., 2001; Johnstone & Hutchinson, 2015; Pauly et al., 2012). Moral distress involves knowing the right thing to do but not being able to do it (Jameton, 1984). Nurses are among the direct care providers who have higher moral distress compared to healthcare providers who deliver indirect care such as a pharmacist, dietician, or social worker (Epstein et al., 2019). Nurses are often compelled to make ethical decisions that run counter to their professional and personal values (Randzvin, 2011). Thus, the inability to determine the right action may result in moral distress (Sirilla, 2014).

Moral distress can lead to emotional withdrawal from patients (Altaker et al., 2018; Hiler et al., 2018, Klienknecht-Dolf, et al., 2015). In addition, moral distress leads to emotional distress and physical symptoms among healthcare providers, which includes registered nurses (RNs) that have been identified in the literature (Corley, 2002; Elpern et al., 2005; Hanna, 2004; Mauro, 2019; Molazem et al., 2013; Silen et al., 2008; Rathert et al., 2016; Wilkinson, 1988, 1989). There is a strong correlation for nurses between moral distress, burnout, job dissatisfaction, and leaving the profession (Allen et al., 2013; Austin et al., 2017; Dyo et al., 2016; Goethals et al., 2010; Hamric et al., 2012; Mauro, 2019; Neuman et al., 2018; Pauly et al., 2012).

Significance

Moral distress is a problem affecting nurses in all health care systems, and it can be threatening the integrity of nurses (Johnstone & Hutchinson, 2015). Feelings of powerlessness are common with moral distress in addition to feeling disappointed, withdrawn, hopeless, and angry (Mauro, 2019). The physical effect of moral distress includes increased blood pressure, headache, tiredness, sweating, headaches, nausea, and diarrhea (Guiterrez, 2005; Mauro, 2019).

Some nurses may distance themselves to cope with their distress (Varcoe et al., 2012). Literature also supports the strong relationship between moral distress and burnout (Austin et al., 2017; Espeland, 2006; Fumis et al., 2017; Maslach et al., 2001; Neumann et al., 2018; Sajjadi et al., 2017). Moral distress is also related fatigue and poor patient outcomes (Allen et al., 2013; Austin et al., 2017; Dodek, et al., 2016; Epstein et al., 2019; Fumis et al., 2017; Hamric & Blackhall, 2007; Hiler et al., 2018; Mauro, 2019; Neumann et al., 2018; Sajjadi et al., 2017; Sauerland et al., 2014; Schluter et al., 2008; Trautman et al., 2015; Whitehead et al., 2015).

Studies have analyzed the demographic variables in moral distress (Corley et al., 2001; Ganz & Berkovitz, 2012; Piers et al., 2012; Radzvin, 2011), with conflicting results of age and number of years of experience with moral distress among nurses (Silen et al., 2008). Some studies have indicated that age of more than 33 years, nursing experience greater than 6 years, and more than 4 years in the critical care unit (Mobley et al., 2007; Rice et al., 2008) can lead to more moral distress. Other research has reported that older nurses had higher levels of moral distress (Oh & Gastmans, 2015). However, other

studies showed no significant correlation between moral distress frequency and age and years of experience among nurses (Cavaliere et al., 2010; McAndrew et al., 2011; Ohnishi et al., 2010).

Situations that give rise to moral distress often involve aggressive treatment, unnecessary tests, incompetent colleagues, power imbalance among health care providers, and lack of institutional support (Corley, 1995; Cronqvist et al., 2004; Liaschenko, 2004; Mauro, 2019; Nathaniel, 2006; Neumann et al., 2018). Most studies on moral distress have been focused on nurses working in the intensive care units (ICUs) or acute care settings (Altaker, 2018; Dalmolin et al., 2014; Dyo et al., 2016; Henrich et al. 2017; Kleinknecht-Dolf et al., 2015; Lamiani et al., 2017; Lusignani et al., 2016; Sirilla et al., 2017; Trautmann et al., 2015). There are few studies in non-ICU settings even though noncritical nurses are also involved in stressful situations related to ethical dilemmas that lead to moral distress.

My study was designed to bridge the gaps in the literature by determining whether other variables such as age and work settings influence moral distress. Studies on moral distress have largely focused on the experiences of ICU nurses or in acute care settings (Altaker et al., 2018; Browning, 2013; Cavaliere et al., 2010; Ganz et al., 2013; Green & Jeffers, 2006; Gutierrez, 2005; Hamric & Blackhall, 2007; Henrich et al., 2017; Hiler et al., 2018; Lamiani et al., 2017; Lawrence, 2011; Lusignani et al., 2017; Mason et al., 2014; McAndrew et al., 2011; Neumann et al., 2018; Pauly et al., 2009; Rathert et al., 2016). The purpose of this study was to assess the frequency and level of moral distress and to explore the relationship between moral distress, ethical climate, and psychological

empowerment among new RNs. A better understanding of moral distress among NRNs can lead to the development of programs or strategies to mitigate the negative effects of moral distress.

Conceptual Framework

Jameton's (1984) moral distress is the foundation of the conceptual framework of the study. Jameton's concept of moral distress was not initially defined; instead Jameton differentiated moral uncertainty, moral dilemmas and moral distress (Jameton, 1984). Jameton (1984) described moral uncertainty as not knowing what to do in a given situation. Moral dilemmas are the second category. This category involves two or more conflicting principles that could be applied to a single situation. Furthermore, Jameton described moral distress as feelings that are painful and as a psychological imbalance or disequilibrium that occurs when nurses find themselves in situations where they feel unable to do the right thing. Moral distress is due to institutional obstacles and can be an exercise of medical power, lack of time, legal limits or institutional policy (Jameton, 1984). According to Hanna (2004) Jameton viewed morals as personal values or beliefs that translate into private thoughts. He refers morals as "a set of values or principles to which one is personally committed" (p. 5) while ethics "refers to publicly stated and formal sets of rules and values, such as professional codes of ethics" (p. 5).

Moral distress is focused on negative psychological and emotional reactions (Jameton, 1984). Jameton further explored moral distress and identified two concepts: initial and reactive moral distress. In initial moral distress, the person experiences anger,

anxiety and feels frustration when confronted with institutional and interpersonal conflict about values.

Jameton (1993) defined reactive distress as “the distress that people feel when they do not act upon their initial distress” (p. 544). Jameton described reactive moral distress as the lingering effects of moral distress. Jameton’s view of moral distress, given the cause and effect of antecedent events, made researchers plausibly conclude that moral distress can be prevented by eliminating and controlling the antecedent events (Hanna, 2004).

The key element of moral distress occurs when the individual is unable to carry out actions perceived as ethically appropriate, which leads to powerlessness. There are four attributes to describe the concept of moral distress which include negative feelings, powerlessness, uncertainty and conflicting loyalties. Secondary attributes include ineffective advocacy, inability to reduce pain and suffering, and competing values (Russell, 2012)..

The presence of constraints preventing moral actions, either internal (personal) or external (institutional), is the hallmark of moral distress (Hamric et al., 2006). Studies revealed ethical dilemmas and conflicts are related to moral distress (Rathert et al., 2016) According to Corley (2002) for moral distress to happen, moral sensitivity somehow has to occur. Moral sensitivity is an awareness of the moral significance of one’s actions (Lutzen & Kvist, 2012). Moral sensitivity fosters commitment to patients and the ability to strategize in ethical decision making. The level of moral committed and

morally competence is directly linked to the level of moral comfort the nurse will experience and the less moral distress (De Viller & De Von, 2012).

The key element in moral distress is the "individual's sense of powerlessness, the inability to carry out the action perceived as ethically appropriate" (Jameton, 1993, p. 4). External constraints include power imbalances between members of the health team, pressure to reduce costs, fear of legal actions, poor communication between team members, lack of administrative support and hospital policies that conflict with patient care needs (Jameton, 1993). While internal constraints include fear of losing one's job, self-doubt, anxiety about creating conflict or lack of confidence (Hamric et al., 2006)

Moral distress that is not addressed can lead to what is called moral residue, described as the lingering feelings after a morally problematic situation has passed (Epstein & Hamric, 2009). Because moral distress has an impact on patient care and the nurse, studies are starting to focus on prevention of the antecedents of moral distress. Lutzen and Kvist (2012) emphasized "if we can identify the moral content of ethical problems, we can better understand stress relative to a particular content and situation" (p. 19).

Moral distress is a phenomenon that takes place when nurses are unable to implement ethical actions due to multiple constraints (Allen et al., 2013). Jameton's (1984) definition has been revised, whereby moral distress can also occur if a person attempts to perform what they believe to be the right actions (Gutierrez, 2005). The moral distress definition was expanded by Corley (2002) who identified the effects of moral distress on the patient, on the organization and on the nurse. Wilkinson (1989)

redefined the moral distress definition and argued the delivery of good patient care is threatened by moral distress. Furthermore, Wilkinson reported the key causes of moral distress are powerlessness and conflicting loyalties. Lutzen et al. (2003) suggested rather than embracing a single definition of moral distress, the development of a conceptual model is an approach to guide research.

Three instruments were used to assess the relationships between concepts, the Measure of Moral Distress for Healthcare Professionals (MMD-HP; Epstein et al., 2019), the Psychological Empowerment Index (PEI; Spreitzer, 1995), and the HECS (Olson, 1998). Figure 2 integrates moral distress, psychological empowerment, and ethical climate suggesting that the perceived ethical climate and lack of psychological empowerment can lead to moral distress. Moral distress occurs when nurses know the ethically right thing to do, but due to constraints, they are unable to take the course of actions that they believe to be right (Jameton, 1984). The constraints contributing to inability to act upon can be due to three levels, namely, patient level, unit/team level, or system level (Epstein et al., 2019). Epstein et al. (2019) identified the key components of moral distress, which include the complicity in wrongdoing, lack of voice, wrong actions related to the profession, repeated experiences, and the three-level cause.

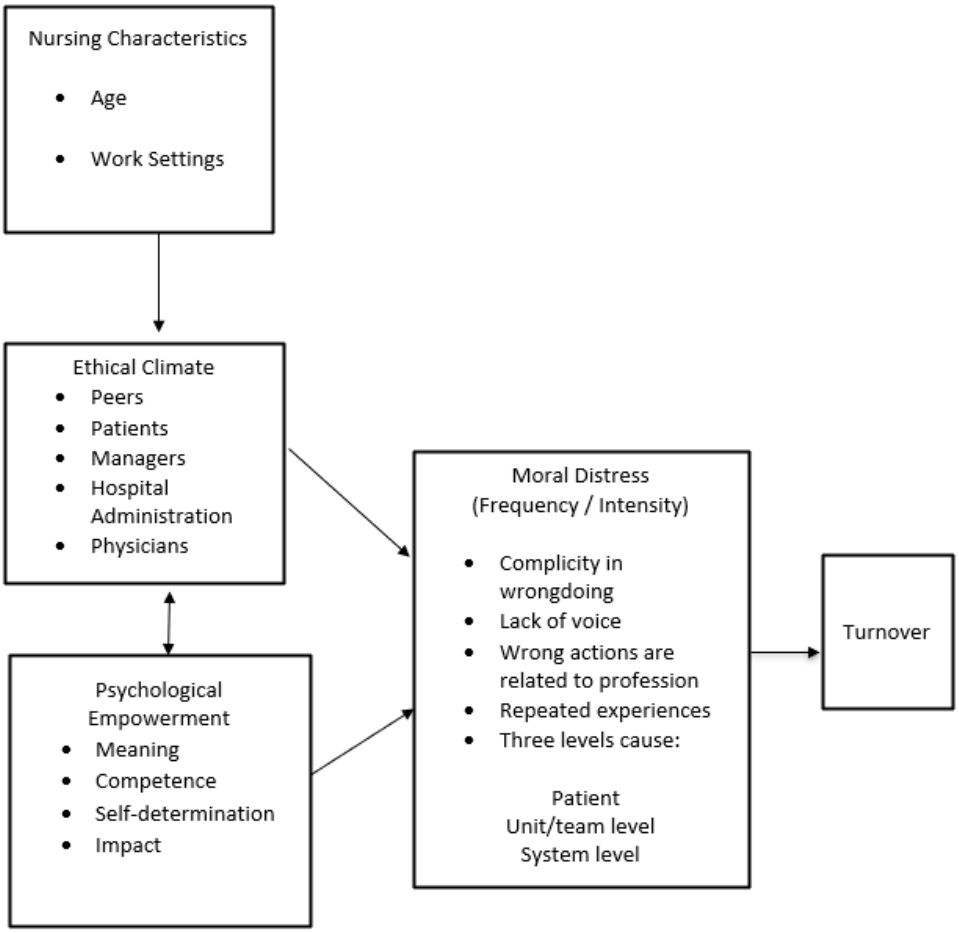
Ethical climate has several functions in the organization. The ethical climate is defined as the individual perceptions that influence attitudes and serve as a reference for employee behavior (Olson, 1998). The ethical climate assists nurses to identify the ethical issues within the work environment and assists them to handle the situation when faced with ethical dilemmas. Pauly et al. (2009) pointed out that the ethical climate influences

the nurses' quality of patient care and nurses' well-being. The ethical climate is perceived according to nurses' interactions among peers, patients, managers, hospital administrators, and physicians (Olson, 1998).

Psychological empowerment is defined as a psychological state that employees must experience for managerial empowerment interventions to be successful (Spreitzer, 1995). Psychological empowerment has four cognitions reflecting individuals' orientation to their work role, namely, meaning, competence, self-determination, and impact (Thomas & Velthouse, 1990). Nurses perceived themselves with limited or no power in their organization and also felt a lack of control regarding what is happening to them and to their patients (Ganz et al., 2012). The ethical climate and psychological empowerment both may influence ethical decision-making and may be the mediating factor affecting moral distress (see Figure 1).

Figure 1

Conceptual Framework for the Relationship between Moral Distress, Psychological Empowerment and Ethical Climate



Relevant Scholarship

In 1993, Jameton expanded the definition of moral distress to the following: “a nurse experiences moral distress when the nurse makes a moral judgment about a case in which he or she is involved and the institution or coworkers make it difficult or impossible for the nurse to act on that judgment” (Jameton, 1993, p. 542). Jameton also distinguished initial and reactive moral distress. Initial moral distress was defined as the feelings experienced when faced with institutional obstacles and conflicts with others regarding values (Jameton, 1993). In addition, Jameton mentioned that reactive moral distress is the feelings experienced if someone does not act upon initial distress. Moral distress was further expanded to be defined as the “painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institution policy, or legal considerations” (Corley et al., 2001, p. 250). Thus, the definition of moral distress had two essential elements, which involved the existence of moral phenomena and inconvenient psychological responses (Fourie, 2015).

Studies showed nurses facing challenges in daily practice may consider leaving their position in response to moral distress (Abbasi et al., 2018; Donkers et al., 2021; Mauro, 2019). The consequences for healthcare can affect productivity, recruitment costs, and training nurses. Ethical dilemmas in clinical situations challenge nurses in various settings. While nurses cannot control the actions of other healthcare providers, they must decide their own moral actions (Wilkinson, 1997). Nurses’ responsibilities to the patient, family, and healthcare team makes them vulnerable to experience moral distress.

Evidence on both qualitative and quantitative studies have suggested that NRNs transitioning into practice are challenged more today compared with decades ago. Dyess and Sherman (2009) conducted a qualitative study to examine how new graduate nurses with less than 1 year of practice experience transition into practice. The finding identified that new graduates often feel unprepared or unable to meet challenges. NRNs also reported they perceived themselves as being utterly alone in their role as nurse on multiple occasions and less than ideal communication with physicians and other interdisciplinary team members. Similarly, O'Shea and Kelly (2007) reported that the NRNs described their initial experience in the ward as stressful and unprepared in dealing with situations. The stress was primary related to multi-dimensional responsibilities associated with managerial/organizational/clinical skills deficits and new roles.

Ethical climate influences nurses' provision of quality of care as well as nurses' well-being (Storch et al., 2009). Studies showed that nurses' work environment can influence their attitudes towards ethical issues and decision-making, turnover, job satisfaction, and commitment (Abou Hashish, 2017; Goldman & Tabak, 2010; Malloy et al., 2009; Numminen et al., 2015; Parker et al., 2013). In Iran, Asgari et al. (2019) examined the relationship of moral distress and ethical climate to job satisfaction in critical care nurses. Using a descriptive-correlation study there were 142 critical care nurses (ICU and critical care unit) employed in five hospitals in Iran. Asgari et al. reported that there was no significant relationship between moral distress and job satisfaction while the relationship between ethical climate and job satisfaction was statistically significant. In Turkey, Atabay et al. (2015) surveyed 201 nurses in a single

hospital. They found positive correlations between the types of ethical climate (rules, individualism, or organizational interest) and the intensity of moral distress.

Another study was conducted by Pauly et al. (2009) with 374 nurses in acute care hospitals in British Columbia. They found that the demographic variables such as age, gender, years of experience, education, and employment status were not correlated with moral distress. In addition, Pauly et al. reported that ethical climate was negatively correlated with moral distress intensity and frequency. Thus, support is needed from leaders and administrators to implement programs for NRNs.

Additional research has suggested new graduates do not perform well when making clinical judgments. Etheridge (2007) reported participants were afraid they would not know what was going on with each patient including not knowing what the assessment data meant and the impact on the patient. Another finding was that new graduates recognized that taking responsibility appropriately is a significant part of being a nurse and found that knowing how to think critically was a larger issue than they initially thought. Critical thinking is an important component in nursing practice. NRNs must be able to identify the problem and determine the best interventions, which are part of the critical-thinking process. Adequate training among NRNs is essential to successfully implement holistic and effective nursing care.

The traditional Bachelor of Science in Nursing program takes 4 years. However, students have an option to become a nurse after they have completed a non-nursing undergraduate degree. For the several past decades, nursing institutions have offered accelerated fast-track programs for students who have completed a non-nursing degree.

NRNs starting nursing as a second degree could be older than the typical 22 years. Hence, there is a gap of knowledge as to whether age has a relationship to levels of intensity and frequency of moral distress, perception of moral distress, and psychological empowerment among NRNs.

The American Association American Association of Colleges of Nursing (2019) reported more than 17,725 students were enrolled in accelerated nursing programs in 2016. Woods et al. (2015) reported that there was a significant difference in moral distress across age groups. Ages 25 years to 34 years had significantly higher moral distress scores compared to other age groups. Thus, younger nurses were more susceptible to moral distress than older nurses.

Other studies showed age had no relationship to moral distress (Corley et al., 2001; De Villers & DeVon, 2012; Dodek et al., 2016; McAndrew et al., 2011; Ohnishi et al., 2010; Pauly et al., 2009; Silen et al., 2008; Sirilla et al., 2017). The lack of congruity between prior studies and current studies regarding moral distress and age is worth investigating. Studies have showed nurses less than 34 years old had higher moral distress compared to other groups. NRNs starting nursing as a second degree could be older than the typical college graduate of 22 years of age. Hence, there is a gap of knowledge as to whether age has a relationship to the frequency and level of moral distress, perception of ethical climate, and psychological empowerment among NRNs.

Research Question and Design

The research question was “What is the difference between the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment

among NRNs by age group?" I conducted a quantitative research comparative analysis, which required a multivariate analysis of variance (MANOVA) to determine if there is a difference in the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs by age group. I examined the two age groups, namely, ages 30 and below and ages 31 and above. The ethical climate was an important element affecting NRNs and practice. The data were collected with Likert-type questions with the three instruments, the MMD-HP, PEI, and HECS.

Methods

Participants

A convenience sampling of NRNs who worked both full time and part time with fewer than 3 years of experience currently employed at a tertiary hospital and members of nursing Facebook groups were recruited to participate.

Sample and Power

The study was conducted in a tertiary hospital in a metropolitan area in the northeastern United States. Institutional review board (IRB) approvals were obtained from the hospital and Walden University prior to initiation of the study. The MMD-HP, PEI, and the HECS were used to operationalize the concepts of moral distress and ethical climate. These three instruments are valid and reliable. Written permissions were obtained from Dr. Hamric (see Appendix A), Dr. Spreitzer (see Appendix B), and Dr. Olson (see Appendix C) to use their instruments. These instruments were not modified from their original format.

The study process and data collection were coordinated with the hospital's department of education and research. The recruitment letter was initiated via email, and a flyer was posted in the unit explaining the purpose of the study and describing the questionnaire. Participants interested were given a link for SurveyMonkey. Participation in the survey was voluntary and anonymity was ensured.

Each survey was coded with two letters and a number to identify the unit. The participants were given 2 weeks completion time. A second email was sent to participants at the beginning of the second week and a third email toward the end of the second week as a reminder to complete the survey. Each participant was asked to complete the informed consent, demographics data (see Appendix D), and the MMD-HP, PEI, and HECS.

The power analysis was calculated using G*Power software by Faul et al. (2019). Power analyses were done with two age groups who were 30 years and below and 31 years and above. Using an alpha of 0.05, a power of 0.80, a medium effect size of .0625, the desired sample size was 153.

Variables/Sources of Data

MANOVA was used to determine if there was a difference in the frequency and level of moral distress (dependent variable), perception of the ethical climate (dependent variable), and psychological empowerment (dependent variable) among NRNs with less than 3 years of nursing experience by age group (independent variable).

Instruments or Measures

The MMD-HP contains 27 items that measure moral distress by all healthcare providers in acute care, long-term acute care hospital, and outpatient clinical settings both for adult and pediatric patients (Epstein et al., 2019). The MMD-HP involves both the direct and indirect five key components of moral distress. These key features of moral distress are complicity in wrongdoing, lack of voice, wrongdoing associated with professional values, repeated experiences, and three levels of root causes. The root causes can be at the patient, unit, and system level.

The MMD-HP uses Likert scale to measure frequency of moral distress with a scale 0 = never, 4 = very frequently, for how often moral distress occurs in their practice and for how distressing it is when it occurs with a scale 0 = never, 4 = very distressing. The frequency score is multiplied by the level of distress score to calculate a composite score range from 0 to 16. The instrument overall composite score ranges from 0 to 432; higher scores indicate higher levels of moral distress. Write-in items are not included in the composite score. MMD-HP has a good reliability with Cronbach's alphas of .93. The MMD-HP is the most recent instrument on moral distress, and the authors recommended it to replace the Moral Distress Scale–Revised (Epstein et al., 2019).

To assess the reliability and validity of the MMD-HP a descriptive correlational study was used with 653 participants with a response rate of 92% at two medical centers working in different settings such as acute care, ICU, operating room, emergency department, long-term acute care hospital and outpatient clinic.

The survey was conducted for 3 weeks and was distributed electronically. The construct validity tested the four hypotheses, which were supported by previous studies. The four hypotheses include nurses have higher moral distress than physicians, participants considering leaving the position have a higher MMD-HP score, participants who have poor perception of ethical climate have a higher MMD-HP score, and, lastly, MMD-HP has three-level structures that include patient, team, and system. The group comparisons for continuous variables were analyzed by either a one-way analysis of variance (ANOVA) for three or more groups or two-sample *t* tests.

The exploratory factor analysis was used to test the fourth hypothesis (Epstein et al., 2019). The PEI includes 12 statements that measure the participants' perceptions of their work environment (Spreitzer, 1995). Spreitzer operationalized and measured PEI based on individuals' four subdimensions, which she derived from Thomas and Velthouse's concepts, as follows:

- Meaning – value of a work goal or purpose.
- Competence - self-efficacy.
- Self-determination – autonomy.
- Impact – making a difference.

Each item (statement) has a corresponding cognition measuring empowerment and was scored as: 7 = very strongly agree, 6 = strongly agree, 5 = agree, 4 = neutral, 3 = disagree, 2 = strongly disagree, and 1 = very strongly disagree. The calculated composite mean scores range from 1.00 to 7.00. The mean score for each subdimension is obtained by adding and averaging the three items with high scores indicating higher levels of each

subdimension. An overall psychological empowerment is obtained by adding and averaging the 12 items. A higher score reflects greater perceived psychological empowerment. The PEI reported has a strong reliability of approximately .80 (Spreitzer, 1995).

The validity of the study was assessed using 393 mid-level employees from a Fortune 50 industrial organization for the first sampling. There were 128 employees used for the second sampling, which was selected by stratified random sampling. The second-order confirmatory factor analysis was used to assess the convergent and discriminant validity of the empowerment in both samples (Spreitzer, 1995).

HECS is a 26-item Likert scale instrument with five domains relating to nurses' relationships with peers, physicians, patients, managers, and the hospital (Olson, 1998). Calculated composite mean scores range from 1.00 to 5.00. Positive ethical climate results in a score of greater than 3.50. The HECS has a score range of 26 to 130; the higher scores indicate a positive ethical climate. The reliability was 0.91 for the 26-item instrument, and 0.73 (peers), 0.68 (patients), 0.92 (managers), 0.77 (hospital), and 0.81 (physicians) for the subscales (Olson, 1998). Thus, the Cronbach's alpha values estimating internal consistency reliability range from 0.68 to .92 for subscales. The Cronbach's alpha should have a value of greater than 0.7 (Houser, 2008).

HECS tested the validity by using confirmatory factor analysis using the LISREL*7 statistical program. The samples were 360 RNs employed in two acute care hospitals in a midwestern city in the United States. The content validity was supported by literature review and Olson's concept analysis of ethical climate (Olson, 1998). In

addition seven content experts were engaged to assess the content validity. I calculated a Cronbach's alpha for the MMD-HP, PEI, and HECS. The reliability using Cronbach's alpha was 0.91 for the whole scale and 0.68 to 0.92 for the subscales (Olson, 1998).

Design and Analysis

The proposed Manuscript 1 was a quantitative comparative analysis study using a convenience sampling. A quantitative design is "intended to isolate and evaluate the effects of interventions, treatment, or characteristics (which are referred to as independent variables) on a specific outcome (referred to as the dependent variable)" (Houser, 2008, p. 397). A comparative analysis was conducted to examine the frequency and level of moral distress, perception of the ethical climate, psychological empowerment of two age groups, 30 years of age and below and 31 years of age and above, of NRNs in non-ICU settings.

I analyzed data with SPSS version 28. Demographic data were analyzed with descriptive statistics and MANOVA to examine if there is a difference in moral distress (dependent variable) and psychological empowerment (dependent variable) and ethical climate (dependent variable) by two age groups of nurses (independent variable). MANOVA is a test that compares multivariate sample means and is used when there are two or more dependent variables (Warner, 2013). According to Statistic Solution (2018), MANOVA compares whether or not the newly created combination differs by the different groups or levels of the independent variable. In addition, MANOVA essentially tests if the independent grouping variable simultaneously explains a statistically significant amount of variance in the dependent variable.

Results

Execution

This study was approved by the Walden IRB (0408200664796) and the facility's IRB (07092013). The responses from the facility were low, and I decided to add the nurse Facebook groups for data collection. Both the Walden and the facility IRBs were notified of changes in data collection and approved the changes. Responses from SurveyMonkey were entered into Mac SPSS Statistics. I summarized the demographics for the study participants and performed descriptive statistics and MANOVA for data analysis.

Results

A total of 68 nurses participated in the study that was conducted from March 2020 until August 2021. However, for the final analysis, only 33.8% (23 of 68) of participants completed the questionnaires. Most of the participants were female (n = 21, 91.3%) and most were above 31 years of age (n = 16, 69.6%). The largest age groups were 20 to 30 years of age (n = 6) and 61 to 70 years of age (n = 6). Most participants were White (n = 13, 56.5%), and the largest group was from the ICU (n = 9, 39.1%). Participants who completed a masters' degree (n = 9, 39.1%) was the largest group by level of education. Cronbach's alpha for the MMD-HP was .943, PEI was .894, and HECS was .938 indicating excellent internal consistency of the scales. Additional descriptive statistics are provided in Table 1.

Table 1

Demographic Characteristics of the Study Sample

Category	Sample with Complete Surveys ($N = 23$)		All Consenting Participants ($N = 68$)	
	Frequency	Percentage	Frequency	Percentage
Gender				
Female	21	91.3	61	89.7
Male	2	8.7	7	10.3
Race/Ethnicity				
White	13	56.5	38	55.9
Hispanic	1	4.3	7	10.3
Black or African American	2	8.7	5	7.4
Native Hawaiian or Other Pacific Islander	1	4.3	1	1.5
Asian	5	21.7	13	19.1
Missing	1	4.3	1	1.5
Age group				
20-30	6	26.1	18	26.5
31-34	0	0.0	1	1.5
35-40	1	4.3	14	20.6
41-50	3	13	8	11.8
51-60	3	13	12	17.6
61-70	6	26	8	11.8
>71	3	13	6	8.8
Missing	1	4.3	1	1.5
Nursing Education				
Diploma	1	4.3	4	5.9
Associate	4	17.4	16	23.5
BSN	8	34.8	28	41.2
Master's degree	9	39.1	19	27.9
Missing	1	4.3	1	1.5
Unit				
ICU	9	39.1	15	22.1
PACU/Recovery Unit	1	4.3	3	4.4
Stepdown	4	17.4	9	13.2
Medical/Surgical Telemetry	2	8.7	19	27.9
ER Department	2	8.7	5	7.4
Procedure Room	0	0.0	1	1.5
Ambulatory Unit	3	13	10	14.7
Missing	2	8.7	6	8.8

Prior to the analysis, the assumptions of the MANOVA were examined. The assumption of multivariate normality was assessed using the Shapiro-Wilk tests of normality. Table 2 shows that all Shapiro-Wilk tests of normality were not significant ($p > .05$) demonstrating that the data showed adequate univariate normality for the three dependent variables.

Table 2

Shapiro-Wilk Tests of Normality

Scale	Age Group	Shapiro-Wilk Statistic	*df*	*P*
Moral Distress	20-30	.94	6	.68
	31+	.96	16	.57
Psychological	20-30	.96	6	.79
Empowerment	31+	.97	16	.88
Ethical Climate	20-30	.93	6	.57
	31+	.96	16	.72

The assumption of no univariate or multivariate outliers was examined using Mahalanobis's distance and it was determined that there were no multivariate outliers in the sample (MD = .40 – 5.93). Values greater than 7.82 would indicate multivariate outliers in the sample. In Table 3, the assumption of homogeneity of variance was examined using Levene's test of Equality of Error Variances, all of which were not significant ($p > .05$) indicating the assumption was also met.

Table 3

Levene's Tests of Equality of Error Variances

Scale	Levene Statistic	*df1*	*df2*	*P*
Moral Distress	0.03	1	20	.86
Psychological Empowerment	3.04	1	20	.10
Ethical Climate	0.02	1	20	.88

Finally, the assumption of homogeneity of covariances was assessed using Box's test, which was not significant (p = .33), indicating that this assumption was met. To conclude, all assumptions were met, and data were appropriate for MANOVA analysis. The results of MANOVA showed there was no difference between age groups on the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs: Wilk's A = .702*,* F (3, 18) = 2.551, partial η^2 = .298, observed power .531. The MANOVA also showed no differences between the two age groups on the three measures: Pillai trace = .298, F (3, 18) = 2.55, p >.08*,* partial η^2 = .298*,* observed power = .531. Therefore, although the p value was not statistically significant because of the substantial effect size, follow up univariate ANOVAs were conducted to determine which of the three measures showed a difference among age groups. The null hypothesis was retained.

The ANOVA in Table 4 revealed that one of the measures, psychological empowerment, showed significant differences by age which explains 21.1% of the variability in scores.

Table 4

Univariate Tests of Differences Between Younger and Older Nurses

Dependent Variable	Source	*SS*	*df*	*MS*	*F*	*P*	Partial Eta Squared
Moral Distress	Contrast	3346.273	1	3346.273	0.422	.52	.021
	Error	158651.523	20	7932.576			
Psychological Empowerment	Contrast	2.761	1	2.761	0.335	.03	.211
	Error	10.351	20	0.518			
Hospital Climate	Contrast	0.028	1	0.028	0.064	.80	.003
	Error	8.656	20	0.433			

The majority of participants reported MMD-HP moderate (100–200) range and high (>200) range. The top three items that the participants identified as causing frequent and high level of moral distress were "Be required to care for more patients than I can safely care for" (M = 10.60, SD = 4.26), "Experience compromised patient care due to lack of resources/equipment/bed capacity" (M = 10.56, SD = 5.03), and "Experience lack of administrative action or support for a problem that is compromising patient care" (M = 10.8, SD = 5.98). The lowest factor identified causing less frequent moral distress was "Feel pressured to ignored situations in which patients have not been given adequate information to ensure informed consent" (M = 3.47, SD = 3.60). Other factors identified by participants who felt moral distress include: "No PPE during COVID, disagreements among family members, patient and caregivers regarding end-of-life practices, family members who do not want patients to know the diagnosis, critically ill patients moved out of the ICU too soon, pressure to meet metrics based on CMS payor requirements at the expense of safe patient care because of not enough resources, and physicians always expect you to back them up." See Table 5 for the MMD-HP level and frequency scores.

The last two questions of the MMD-HP address the intent to leave. The first question is: "Have you ever left or considered leaving a clinical position due to moral distress." Most participants (n = 13, 56.5%) responded "Yes, but did not leave." For the second question: "Are you considering leaving your position now due to moral distress?" Fifteen participants (65.2%) responded Yes.

Table 6 shows the HECS means ranged from 6.18 to 2.87. The item ranked highest was Item 1 (M = 6.18, SD = .59), which stated "My peers listen to my concerns

about patient care." The item with lowest score was Item 9, which stated "Physicians ask nurses for their opinions about treatment decisions" ($M = 2.87$, $SD = 1.10$).

Participants reported that the most important component of psychological empowerment was related to meaning stating "The work that I do is important to me." While the lowest scores reported were both related to impact stating "I have a great deal of control over what happens in my department" (See Table 7).

Table 5

MMD-HP Level and Frequency Score Per Item

Item	*N*	Min	Max	*M*	*SD*
1. Witness healthcare providers giving "false hope" to a patient or family.	22	.00	16.00	4.77	4.24
2. Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.	21	.00	16.00	8.90	4.89
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.	22	.00	16.00	6.09	4.88
4. Be unable to provide optimal care due to pressures from administrators or insurers to reduce costs.	22	.00	16.00	7.18	5.61
5. Continue to provide aggressive treatment for a person who is most likely to die regardless of this treatment when no one will make a decision to withdraw it.	22	.00	16.00	8.05	5.78
6. Be pressured to avoid taking action when I learn that a physician, nurse, or other team colleague has made a medical error and does not report it.	23	.00	16.00	4.09	4.08
7. Be required to care for patients whom I do not feel qualified to care for.	23	.00	16.00	5.61	5.14
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.	23	.00	16.00	6.83	4.88
9. Watch patient care suffer because of a lack of provider continuity.	23	.00	16.00	7.57	5.28
10. Follow a physician's or family member's request not to discuss the patient's prognosis with the patient/family.	23	.00	16.00	3.91	4.10
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.	23	.00	16.00	3.91	4.73
12. Participate in care that I do not agree with, but do so because of fears of litigation	23	.00	16.00	3.91	4.67
13. Be required to work with other healthcare team members who are not as competent as patient care requires.	23	.00	16.00	7.52	4.79
14. Witness low quality of patient care due to poor team communication.	23	.00	16.00	6.87	4.48
15. Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.	23	.00	12.00	3.48	3.60
16. Be required to care for more patients than I can safely care for.	23	1.00	16.00	10.61	4.26
17. Experience compromised patient care due to lack of resources/equipment/bed capacity.	23	1.00	16.00	10.57	5.03
18. Experience lack of administrative action or support for a problem that is compromising patient care.	23	.00	16.00	10.09	5.98
19. Have excessive documentation requirements that compromise patient care.	23	.00	16.00	9.26	6.11
20. Fear retribution if I speak up.	23	.00	16.00	6.48	6.40
21. Feel unsafe/bullied amongst my own colleagues.	23	.00	16.00	4.74	5.86
22. Be required to work with abusive patients/family members who are compromising quality of care.	23	1.00	16.00	8.61	5.16
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.	23	.00	16.00	8.09	5.69
24. Be required to care for patients who have unclear or inconsistent treatment plans or who lack goals of care.	23	.00	16.00	6.17	5.47
25. Work within power hierarchies in teams, units, and my institution that compromise patient care.	23	.00	16.00	4.91	5.26
26. Participate on a team that gives inconsistent messages to a patient/family.	23	.00	16.00	5.04	5.04
27. Work with team members who do not treat vulnerable or stigmatized patients with dignity and respect.	23	.00	12.00	4.13	3.82

Table 6

Means and SDs of Participants Perception on Ethical Climate

Item	*M*	*SD*
Peers		
My peers listen to my concerns about patient care.	6.18	.59
. My peers help me with difficult patient care issues/problems.	4.13	.76
I work with competent colleagues.	3.91	.67
Safe patient care is given on my unit.	3.91	1.04
Patients		
Patients know what to expect from their care.	3.64	.95
Nurses have access to the information necessary to solve a patient care issue/problem.	3.68	.78
Nurses use the information necessary to solve a patient care issue/problem.	3.96	.48
The patient's wishes are respected.	4.22	.67
Physicians		
Nurses and physicians trust one another.	3.55	.60
Physicians ask nurses for their opinions about treatment decisions.	2.87	1.10
I participate in treatment decisions for my patients.	3.22	.95
Nurses and physicians here respect each other's opinions, even when they disagree about what is best for patients. .	3.17	.98
Nurses and physicians respect one another.	3.61	.94
Nurses are supported and respected in this hospital.	3.35	.89
Hospitals		
Hospital policies help me with difficult patient care issues/problems.	3.05	1.21
A clear sense of the hospital's mission is shared with nurses.	3.61	1.16
The feelings and values of all parties involved in a patient care issue/problem are taken into account when choosing a course of actions.	3.22	.90
Conflict is openly dealt with, not avoided.	2.91	1.16
There is a sense of questioning, learning, and seeking creating responses to patient care problems.	3.43	.99
I am able to practice nursing on my unit as I believe it should be practiced.	3.52	.99
Managers		
When I'm unable to decide what's right or wrong in a patient care situation, my manager helps me.	3.23	1.30
My manager supports me in my decisions about patient care.	3.83	1.19
My manager listens to me talk about patient care issues/problems.	3.30	1.26
My manager is someone I can trust.	3.65	1.07
When my peers are unable to decide what's right or wrong in a particular patient care situation, I have observed that my manager helps them.	3.13	1.29
My manager is someone I respect.	3.95	1.09

Table 7

Means and Standard Deviations for Psychological Empowerment (N = 23)

Item	*M*	*SD*
Meaning		
The work that I do is important to me.	6.22	.92
My job activities are personally meaningful to me	5.87	1.22
The work I do is meaningful to me.	5.77	1.27
Competence		
I am confident about my ability to do my job.	5.82	1.03
I have mastered the skills necessary for my job.	5.13	1.42
I am self-assured about my capabilities to perform my work activities.	5.78	1.00
Self-Determination		
I have significant autonomy in determining how I do my job.	4.91	1.59
I can decide on my own how to go about doing my own work.	4.78	1.45
I have considerable opportunity for independence and freedom in how I do my job.	4.30	1.36
Impact		
My impact on what happens in my department is large.	4.70	1.52
I have a great deal of control over what happens in my department.	3.78	1.28
I have significant influence over what happens in my Department	3.95	1.21

Discussion

Interpretation

This study showed no difference between the level and frequency of moral distress, perception of the ethical climate, and psychological empowerment between participants 30 years of age and below and 31 years of age and above. This is similar to previous research that showed no significant correlation between moral distress frequency and age among nurses (Lusignani et al., 2017; Sirilla et al., 2017). However, other studies reported that perception on ethical climate and moral distress had positive correlation with age (Epstein et al., 2019; Lemmenes et al., 2018; Shoorideh et al., 2015).

My findings suggest that participants' age does not influence the level and frequency of moral distress, perception of ethical climate, and psychological empowerment.

The mean frequency for the level of moral distress for this study was moderate to high based on the maximum intensity score of 4. These findings indicated that the participants perceived and experienced an ethical dilemma, which caused them a high level of moral distress. The three situations that caused a high level of moral distress were: "Be required to care for more patients than I can safely care for" (M = 3.54, SD = .83), "Experience compromised patient care due to lack of resources/equipment/bed capacity" (M = 3.50, SD = .83), and "Experience lack of administrative action or support for a problem that is compromising patient care" (M = 3.41, SD = 1.02). The lowest score was "Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent" (M = 2.08, SD = 1.61).

Compared to the frequency score, the findings showed low to moderate scores. The most frequent situation that caused moral distress was "Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient" (M = 3.00, SD = 1.02), and the lowest score was "Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation" (M = 1.25, SD = 1.9). These findings indicate that participants did not perceive that the situations that occurred frequently did not cause the greatest distress. The individual scores showed variations for the level and frequency of moral distress ranging from low to high. For the 16 situations with mean frequency score above 2.0, some participants were very disturbed with the level of the situations. Despite the low to

moderate frequency scores, some participants may experience a troubling effect of moral distress. The mean for both groups, 30 years of age and below and 31 years of age and above ranged from moderate (100–200) to high (>200) for the level and frequency of moral distress. These findings indicate that the participants perceived and experienced the ethical dilemma of a great deal of moral distress.

My results also showed that 56.5% of the participants had left or considered leaving a position and 65.2% were considering leaving their present position because of moral distress. A similar study showed that 13.7% of the RNs left or considered leaving a position, and 50.5% considered leaving their present position due to moral distress (Lazzarin et al., 2012). The significant increases in the percentage of nurses experiencing moral distress indicates that moral distress needs to be addressed, particularly with the nationwide health crisis and nursing shortage due to COVID-19.

Other results reflected participants' positive views of their peers related to their willingness to listen, help, provide safe patient care, and work with competent colleagues. My findings show that the overall perception of the ethical climate was positive regarding the views of their peers, which was similar to previous studies (Lemmenes et al., 2018; Numminen et al., 2015, Ulrich et al., 2007). In the study by Numminen et al. (2015), physicians were perceived less positively because RNs felt less valued and less respected by physicians regarding the RNs' opinions about treatment.

In this study, the participants ranked *meaning* the highest dimension while *impact* had the lowest score. This showed that participants valued their work and had a sense of accomplishment for what they did. However, the low score on impact implied that they

were not appreciated for their level of expertise, and they perceived themselves as not as influential in their department.

The findings of the study support my conceptual framework that the cause of moral distress was linked with three levels: patient level, unit/team level, and system level. The participants' perceptions of moral distress, ethical climate, and psychological empowerment were exacerbated by organizations lack of support and policies and interprofessional conflict. Furthermore, my findings concluded that various situations experienced by RNs lead to dissatisfaction and poor retention.

Limitations

A limitation of the study is the low response rate of 23 participants. The post-hoc power was 0.154. There are several possible explanations for the low response rate. First, the time element involved to complete the three instruments and the demographic form. This study was conducted during the COVID-19 pandemic in which staffing and intense distress among nurses were at issue. Second, the survey might not be perceived as relevant or significant, although the study was conducted for 13 months. Reminders were given, but some nurse Facebook groups prohibited posting surveys after the initial posting. Lastly, the nurse Facebook group should have been expanded to international nurses and other social media should have been considered. This study was conducted in one medical center aside from nurse Facebook groups. Therefore, the results may not be generalizable to other medical centers or other members of nurse Facebook groups. The three instruments used in this study were well recognized. Cronbach's alpha for the study

were: MMD-HP was .943, PEI was .894, and HECS was .938 indicating excellent internal consistency of the scales.

Implications

The study has the potential to influence positive social change for nurses, institutions, and patients. Recognizing the sources of moral distress and enhancing communication and teamwork among healthcare providers can play an important role in reducing their stress and anxiety, increasing their self-confidence, decreasing turnover, and increasing retention and job satisfaction. Moral distress has been associated with increased job turnover, decreased caring ability, and affecting the well-being of the nurses (Austin et al., 2017).

Effective communication between nurses and physicians is critical for patient care. NRNs must be comfortable communicating with physicians and participating in the decision-making. The main effects of poor communication in healthcare are a reduction in the quality of care, poor patient outcomes, wastage of resources, and high healthcare costs (HIPAA Journal, 2021). Communication failures often have a negative effect on patient and staff satisfaction.

Failure to communicate the important information about patients' symptoms or conditions and poor documentation of patient information are the most common communication failures among clinicians (HIPAA Journal, 2021). These issues can result in incorrect decisions being made about treatment and delays to treatment when the severity of the patient's condition is not understood. Poor communications cost the U.S. healthcare system $1.7 billion in malpractice and nearly 2,000 lives between 2009 to

2013 (“Healthcare miscommunication cost $1.7B,” 2016). Additionally, the Centers for Medicare and Medicaid Services have stopped reimbursing hospitals for the cost of treating preventable adverse events and have implemented a reimbursement model more directly tied to patient outcomes and satisfaction (Hurtig et al., 2018).

Recommendations

This study adds to the understanding of moral distress, ethical climate, and psychological empowerment among NRNs and the ethical situations that cause it. However, there is a need to validate the findings of the study in a larger population. The high percentage of participants considering leaving their positions needs further investigation. Interventions can be considered to decrease and mitigate the moral distress. Future studies can be conducted including other healthcare providers, such as doctors, pharmacists, physical therapists, nurse practitioners, and physician assistants to measure moral distress and possibly identify the sources of moral distress.

The participants’ demographic characteristics, such as age, education, length of experience, settings, race, and ethnicity are worth further investigating to determine their impact on moral distress, ethical climate, and psychological empowerment. Ulrich et al. (2007) reported that Black nurses experienced more ethical distress and were three times more likely to leave their position compared with White nurses. A similar finding was reported by Lemmenes et al. (2018). Qualitative studies may be done on specific groups.

Conclusion

Examining NRNs’ moral distress, perceptions of ethical climate, and psychological empowerment allows nurses to identify the causes related to five factors

(peers, patients, mangers, hospitals, and physicians). These findings contribute to what is known about the three variables and the participants' characteristics.

NRNs have the academic preparation and basic skills required to enter the workforce. However, newly graduated nurses often have little trust in their own capabilities and experience, have a feeling of uncertainty, a lack of confidence, and are unable to appropriately communicate with other nurses, physicians, and patients (Duchscher, 2009; Kuokkanen et al., 2016; Numminen et al., 2015). The findings of this study showed the ethical climate and psychological empowerment were perceived as positive by the participants in the two age groups. Both groups experienced moderate to high levels of moral distress. A strategy for decreasing moral distress is through organizational ethics support (Rathert et al., 2016). Nursing leadership should pay attention to how well NRNs are being supported in dealing with moral issues and making sure they have access to ethics-related resources.

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Moral Distress, Ethical Climate, and Psychological Empowerment of New Registered Nurses in Non-ICU Settings

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Outlet for Manuscript

The target journal for Manuscript 2 is *Nursing Ethics: An International Journal for Health Care Professionals*. *Nursing Ethics* takes relevant issues and topics related to management/interprofessional relations and patient rights/public welfare ("Manuscript Submission Guidelines," n.d.). This manuscript is about moral distress, which has an ethical component and is the primary focus of this journal. The manuscript should be between 2,500 and 6,000 words (including abstract, text, and references, and excluding tables). The manuscript preferred format can be either Word or LaTeX files. *Nursing Ethics* adheres to a rigorous double-blind reviewing policy in which the identity of reviewers and authors are concealed from both parties. The manuscript will be reviewed by at least two referees within 4 weeks to 6 weeks from submission. The article abstract should be no more than 300 words with up to six key words.

Abstract

Purpose

The purpose of the study was to determine the relationship between the level and frequency of moral distress, perception of the ethical climate, and psychological empowerment among new registered nurses (NRNs) in non-intensive care unit (ICU) settings.

Method

A cross-sectional survey was conducted. The Measure of Moral Distress for Healthcare Professionals (MMD-HP), Psychological Empowerment Index, and Hospital Ethical Climate Survey were administered to 68 NRNs. Jameton's (1984) moral distress was used for the conceptual framework. Twelve NRNs completed the surveys at an acute tertiary care hospital or as members of nurse Facebook groups.

Findings

The level of moral distress was high in situations related to nursing practice. Overall, the study showed that there was no difference in the level and frequency of moral distress, perception of ethical climate, and psychological empowerment among NRNs in non-ICU settings.

Conclusions

Moral distress is common in NRNs in non-ICU settings and is caused by various situations experienced in their workplace. Although the sample was low, these findings can contribute to develop strategies to improve the moral distress, ethical climate, and psychological empowerment in work settings.

Introduction

Nurses from different practice areas encounter different types of ethical issues. Often, nurses encounter situations that may require them to make ethical decisions that go against their own personal beliefs and values. Moral distress was first described as knowing the right thing to do but not being able to act on it (Jameton, 1984, p. 6). This has been refined to express when nurses make moral judgments about situations that involve the institution and coworkers that make it impossible for the nurse to act (Jameton, 1993). Studies support correlation between moral distress, burnout, decreased job satisfaction, psychological distress, turnover, and intention to leave (Allen et al., 2013; Austin et al., 2017; Dzeng & Curtis, 2018; Espeland, 2006; Fumis et al., 2017; Hiler et al., 2018; Maslach et al., 2001; Mauro, 2019; Neumann et al., 2018; Sajjadi et al., 2017; Shoorideh et al., 2015).

The causes of moral distress vary, but certain themes across settings have been identified (Dyo et al., 2016). Futility of care for both critical care and non-critical care areas is a common source of moral distress (De Villers et al., 2012; Elpern et al., 2005; Wilson et al., 2013). In addition, the most frequently encountered issues across nursing units are conflicts in the nurse–patient relationship in providing care and staffing patterns that limit access to patient care (Park et al., 2015). Informed consent to treatment, autonomy, protecting patients' rights, staffing patterns, surrogate decision-making, and advanced care planning are also among the most common ethical issues that nurses face (Ulrich et al., 2010). An intervention study is necessary for a group, such as nurses in

ICUs who experience disturbing and more frequent ethical issues in daily nursing practice (Park et al., 2014).

Significance

Nurses are faced with ethical challenges when they think right actions and decisions are contradicting or in conflict with physician, nursing staff, and organizational policies. The ethical challenges can result in moral distress, which eventually lead to burnout, job dissatisfaction, and nurse turnover (Allen et al.,2013; Austin et al., 2017; Corley, 2002; Dzeng & Curtis, 2018; Hamric, 2012; Epstein et al., 2019; Fumis et al., 2017; Lutzen et al., 2003; Mauro, 2019). Consequences of moral distress have a negative impact on the well-being of nurses and patients. Thus, it is important to investigate the factors that could influence moral distress in order to prevent the occurrence or lessen the frequency and level of moral distress. For instance, the intensity of moral distress has been related to physician practice, nursing practice, institutional factors, futile care, deception, and euthanasia in a medical/surgical unit in an adult acute tertiary hospital (Rice et al., 2008). A recent study on moral distress and psychological empowerment in ICUs also revealed a negative correlation between psychological empowerment and frequency of moral distress in nurses (Browning, 2013). In addition, moral distress was high and positively correlated with age. Poor ethical climate, unintegrated palliative care teams, and lack of nurse empowerment have also been associated with increased moral distress (Altaker et al., 2018).

Most data on moral distress have been obtained from critical care nursing and acute care settings (Altaker et al., 2018; Browning, 2013; Darmolin et al., 2014;

Dekeyser Ganz & Berkovitz 2012; Dyo et al., 2016; Hamric & Blackhall, 2007; Henrich et al., 2017; Lamiani et al., 2017; Lawrence, 2011; Mason et al., 2014; Mauro, 2019; McAndrew et al., 2011; McCaffree, 2006; Pauly et al., 2009; Rathert et al., 2016; Sauerland et al., 2014; Silen et al., 2008; Silen et al., 2011; Sirilla et al., 2017; Wilson et al., 2013). But there are limited data on moral distress in the non-ICU settings. Further studies are needed to determine the level of moral distress outside of critical care settings. The purpose of the study was to determine, for new registered nurses (NRNs) in non-ICU settings, the relationship between moral distress, perceived ethical climate, and psychological empowerment.

Conceptual Framework

The conceptual framework I used to guide my study was Jameton's (1984) moral distress. Jameton first conceptualized moral distress in 1984 and has been regarded as the founder of the concept (Austin et al. 2005). Jameton (1984) differentiated moral distress from moral dilemmas and moral uncertainty. Moral uncertainty involves not even knowing what the problem is. Jameton (1984). Moral dilemma involves two or more conflicting principles that could be applied to a single situation. Furthermore, Jameton described moral distress as feelings that are painful and as a psychological imbalance or disequilibrium that occurs when nurses find themselves in situations where they feel unable to do the right thing.

The four core themes on moral distress that emerge in the literature are: (a) believes she knows what the ethical course of action to take is (b) is prevented in some way from following that course, (c) due to internal or external constraints. In doing so,

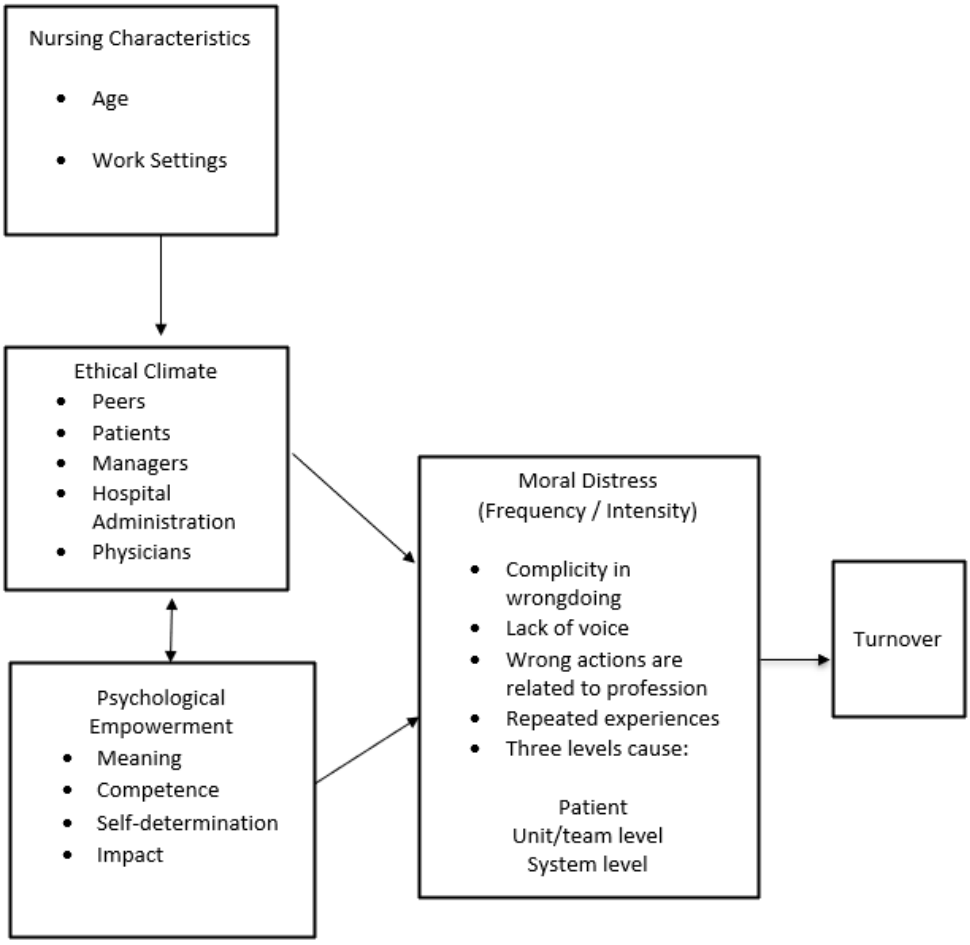
she (d) acts in a manner contrary to her personal or professional values, which undermines her integrity and authenticity (Kondrat, 2016.)

Moral distress is an outcome from interpersonal conflict which occurs when an individual must act in ways that are not in accordance with their personalities and values (Rathert et al., 2016). According to Hamric (2012) the unresolved moral distress can result in a crescendo effect. Moral distress that is not resolved completely can lead to moral residue which tends to build over time (Epstein & Hamric, 2009). According to McDaniel and Stumpf (1993), nurses often do not receive support from healthcare organizations, although nurses have identified that some organizational cultures are more positive than others (cited in Corley, 2005). When hospital administrators are unable to develop and implement policy and strategies for managing conflict that commonly arises between patients, families and peers over patient care, a nurse might feel powerless to resolve the controversy, which may lead to moral distress. The model posits that the administrator should enhance nurses' self-efficacy in order to improve job satisfaction among nurses. Improved self-efficacy will empower results either by strengthening individuals' beliefs or weakening belief in personal powerlessness (Conger & Kanungo, 1988).

Figure 1 shows the concept of moral distress that is linked to perceived ethical climate and psychological empowerment. Ethical climate and psychological empowerment interact to influence moral distress. Thus, the nature of ethical climate and psychological empowerment may be a predictor of the level of frequency and intensity of moral distress.

Figure 1

Conceptual Framework for the Relationship between Moral Distress, Psychological Empowerment and Ethical Climate



Relevant Scholarship

Moral distress has been largely focused on the experiences of ICU nurses or in acute care settings (Altaker et al., 2019; Browning, 2013; Cavaliere et al., 2010; Green & Jeffers, 2006; Gutierrez, 2005; Henrick et al., 2017; Lamiani et al., 2017; Hamric & Blackhall, 2007; Hiler et al., 2018; Lusignani et al., 2017). Most studies on moral distress have focused on the critical care environment because of widespread use of advanced medical technology at the end of life (Gutierrez, 2005; McCaffree, 2006). Studies on moral distress among medical and surgical nurses were limited (Corley et al., 2005; Ganz & Berkovitz, 2012; Rice et al., 2008). Rice et al. (2008) reported the intensity of moral distress was high in situations related to physician practice, nursing practice, institutional factors, futile care, deception, and euthanasia. The frequency of moral distress for situations associated with futile care and deceptions was particularly high.

Moral Distress and Psychological Empowerment

Increasing psychological empowerment could possibly lessen moral distress in non-critical care nurses. Leaders and institutions must identify situations within the organization that increase the sense of powerlessness among nurses. Conger and Kanungo (1988) pointed out it is essential to empower subordinates when subordinates feel powerless. According to Bandura's (1986) model, empowerment is a process where one's belief in self-efficacy is improved. Self-efficacy takes place when individuals' self-determination is enhanced (Bandura, 1986). NRNs may view themselves as unable to contribute to decision-making in their daily practice.

Empowerment has been positively related to autonomy and work effectiveness. The quality nursing care resulted when nurses perceived empowerment in their work environment (Laschinger, 1996). In the United States, DeVivo et al. (2013) examined the perceptions of 167 nurses in the emergency department and found that nurses had a moderate level of empowerment that was attributed to several opportunities and resources in their work environment, such as centers for learning and innovation, fellowship programs, mentoring, and collaborative care councils. Nursing leaders can enhance empowerment among nurses by examining and expanding these resources and supporting the nurses.

Browning (2013) conducted a study in the United States and surveyed 277 critical care nurses. The study showed a significant negative correlation between psychological empowerment and frequency of moral distress, thus indicating that nurses with higher perceived empowerment experienced less moral distress. Moral distress intensity and psychological empowerment were highly and positively correlated as nurses' age increased. When the years of critical care experience increased, nurses reported higher levels of empowerment related to competency.

Moral Distress and Ethical Climate

Ethical climate is defined as "the shared perceptions of what is ethically correct behaviour and how ethical issues should be handled" (Victor & Cullen, 1987, p. 52) within organizations. They introduced their ethical climate theory in the late 1980s, which serves as a descriptive map of ethical decision-making. Ethical climate mirrors the organization's policies and practices related to moral issues and their influence on

employees' behaviors and ethical beliefs (Martin & Cullen, 2006; Olson, 2002; Victor & Cullen, 1988). Ethical climate is associated with nurses' turnover, leaving the profession, job satisfaction, and organization commitment (Hart, 2005; Huang et al., 2012; Schluter et al., 2008). The literature described that nurses' overall perception of the ethical climate has been positive (Hwang & Park, 2014; Pauly et al., 2009; Silen et al., 2011).

Pauly et al. (2009) examined nurses' perception of moral distress and ethical climate. Using Corley's Moral Distress Scale and Olson's Hospital Ethical Climate Survey (HECS), 374 nurses who worked in acute care hospitals in British Columbia were surveyed. Moral distress intensity and frequency were correlated with the nurses' perceptions of ethical climate. The dominant issues associated with moral distress were levels of staffing and self-competency and the competency of other healthcare providers. Further, the HECS factors (patients, peers, managers, hospital, and managers) were also found significantly associated with moral distress. Similarly, Corley et al. (2005) studied 106 medical and surgical nurses in two medical centers located in a mid-Atlantic city. Moral distress intensity and ethical work environment were correlated with moral distress frequency. While the ethical work environment predicted moral distress intensity, Corley et al. (2005) also reported that age was negatively correlated with moral distress.

Nurses and physicians perceived moral distress and ethical climate differently. Hamric and Blackhall (2007) found that 196 nurses working in the ICUs had higher moral distress scores and lower perception of ethical environment than 29 attending physicians. Further, they reported that the highest moral distress situations for nurses and

physicians were situations where they both felt compelled to continue aggressive unwarranted treatment.

Nurses' perceived levels of moral distress differed significantly in various clinical settings. Nurses who provided direct patient care had a higher level of moral distress compared to nurses who provide indirect patient care (Whitehead et al., 2015). Organizational commitment has a relationship to strong enforcement of ethical rules and codes (Humphries & Woods, 2016). In addition, Humphries et al. (2016) reported that if individuals feel that the organizations' values conflict with their own ethical values, they are less committed to the organization. The purpose of the study was to assess the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs in non-ICU settings.

Research Question and Design

The research question for my study was "What effect does the work environment of stepdown, ambulatory, emergency room, procedure unit, and medical/surgical units have on the frequency and level of moral distress, perception of ethical climate, and psychological empowerment?"

Methods

Participants

The target population was RNs both full time and part time with fewer than 3 years of experience currently employed at a tertiary hospital and members of nurse Facebook groups working in the United States. Nurses working per diem were not eligible to participate in the study. I used the MMD-HP, Psychological Empowerment

Index (PEI), and HECS. Permission was obtained for instruments to be used from Dr. Hamric (see Appendix A), Dr. Spritzer (see Appendix B), and Dr. Olson (see Appendix C). These instruments were not modified from their original format.

Sample and Power

A convenience sampling was used for the study. The study was conducted in a tertiary hospital in a metropolitan area in the northeastern United States. Data were also collected from social media using nurse Facebook groups. Institutional review board (IRB) approval was obtained from the hospital (07092013) as well as from Walden University (040820064796). The list of participants were identified by department of nursing education and research, and the eligible participants were recruited via email (see Appendix D). The anonymity of the participants was ensured and protected by using a two-letter code and a number, for instance, ST for stepdown, AU for ambulatory, and MS for medical/surgical unit.

Power analysis was done using two levels of grouping independent variables stepdown, ambulatory, and medical surgical, and the three dependent variables (ethical climate, empowerment, and moral distress) (Faul et al., 2019). The G*Power software by Faul et al. (2019) was used for the power analysis. I used an alpha of .05, a power of .80, and a medium effect size of .0625, which yielded the desired sample size of 100.

Variables/Sources of Data

Data were analyzed with SPSS version 26. Demographic data were analyzed with descriptive statistics and multivariate analysis of variance (MANOVA) to examine the relationship between the frequency and level of moral distress (dependent variable),

psychological empowerment (dependent variable), and ethical climate (dependent variable) among NRNs in non-ICU settings (independent variables).

The recruitment of participants was coordinated and collaborated with the research department and department of nursing education. The recruitment process took 2 weeks. The recruitment letter was emailed to the participants through the research Department, and a flyer was posted in the unit. Participants who agreed to be part of the study were given the link for SurveyMonkey to access the three instruments and the demographic data (see Appendix D). Each participant was given an informed consent form and was kept anonymous using two letters and a number. Participants were informed the time commitment was 10 minutes to 20 minutes to complete the three instruments, including the demographic form.

Instruments or Measures

The MMD-HP has 27 items that measure moral distress by all healthcare providers in acute care, long-term acute care hospitals, and outpatient clinical settings both for adult and pediatric patients (Epstein et al. 2019). In addition, Epstein et al. mentioned the MMD-HP uses Likert scale to measure frequency of moral distress with a scale ranging from 0 = never to 4 = very frequently for how often moral distress occurs in their practice. Both the frequency and the level of moral distress each have a maximum score of 108. To obtain the overall composite score of moral distress, the frequency score is multiplied by the level of distress score. The MMD-HP overall composite score ranges from 0 to 432, and higher scores indicate higher levels of moral distress. The composite score excludes write-in items.

There are five key components of MMD-HP that include both direct and indirect causes of moral distress. These key features of moral distress are complicity in wrongdoing, lack of voice, wrongdoing associated with professional values, and repeated experiences. The root causes can be at the patient, unit, and system level. MMD-HP has a good reliability with Cronbach's alphas of .93. The MMD-HP is the latest instrument on moral distress, and the authors recommended it to replace the Moral Distress Scale–Revised.

The MMD-HP was a descriptive correlational study and used 653 participants at two medical centers working in different settings such as acute care, ICU, operating room, emergency department, long-term acute care hospital, and outpatient clinic. There were four hypotheses that tested the construct validity. These hypotheses were supported by previous studies and were tested using the exploratory factor analysis (Epstein et al., 2019).

The PEI included 12 statements that measure the participants' perceptions of their work environment (Spreitzer, 1995). Spreitzer (1995) operationalized and measured PEI based on individuals' four subdimensions, which she derived from Thomas and Velthouse's (1990) concepts of meaning, namely, value of a work goal or purpose, competence, self-efficacy, self-determination, autonomy, impact or making a difference.

The PEI addressed the four subdimensions measuring empowerment and were scored as: 7 = very strongly agree, 6 = strongly agree, 5 = agree, 4 = neutral, 3 = disagree, 2 = strongly disagree, and 1 = very strongly disagree. The calculated composite mean scores ranged from 1.00 to 7.00. A higher score reflected greater perceived

empowerment. The mean score for each subdimension was obtained by summing and averaging the three Items. A high score indicated a higher level of each subdimension. An overall psychological empowerment score was obtained by adding and averaging the 12 items. A high score indicated a high level of perceived psychological empowerment. The PEI had a strong reliability and reported validity estimated around 0.80 (Spreitzer, 1995).

The HECS was a 26-item Likert scale instrument with five domains relating to nurses' relationships with peers, physicians, patients, managers, and the hospital (Olson, 1998). The HECS had a score range of 26 to 130. The higher the HECS score, the more positive the ethical climate. The reliability was 0.91 for the 26-item instrument, and, for the subscales, was 0.73 (peers), 0.68 (patients), 0.92 (managers), 0.77 (hospital), and 0.81 (physicians) (Olson, 1998). Houser (2008) mentioned that Cronbach's alpha or the internal reliability had a value of 0.7 or greater.

To test the validity of the study, 393 participants from a mid-level industrial organization were selected for the first sampling. A stratified random sampling was used for the second sampling of 128 participants. The confirmatory factor analysis was used to provide a rigorous test of construct validity (Spreitzer, 1995).

The confirmatory factor analysis was used to test the validity of the study. There were samples of 360 RNs employed in two acute care hospitals in a Midwestern city in the United States. The content validity was supported by literature review and Olson's concept analysis of ethical climate (Olson, 1998). The study also used seven content experts to examine the content validity.

Design and Analysis

I conducted a quantitative comparative analysis study. Quantitative approach was recommended when the researcher intends to identify factors that determine outcome (Creswell & Creswell, 2018). The comparative analysis was used to assess and explore relationships between two or more variables by observing different groups. Comparative analysis was often used to explore and have a better understanding of the causal processes involved in the creation of an event or identifying the relationship between variables (Pickvance, 2005). A comparative study was performed to examine the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment of NRNs working in non-ICU settings.

I analyzed the data with SPSS version 28. Demographic data were analyzed with descriptive statistics. I used a MANOVA to examine the difference of the frequency and level of moral distress (dependent variable), perceptions of ethical climate (dependent variable), and psychological empowerment (dependent variable) in the five units, which are stepdown, ambulatory, procedure unit, emergency department, and medical/surgical units (independent variables). MANOVA can accommodate multiple groups and multiple dependent variables and is particularly useful when the researcher believes that multiple dependent variables are related to one another (Houser, 2008).

Results

Execution

This study was approved by both the Walden IRB and facility IRB. Because of the low responses from the facility, nurse Facebook groups were added to the data

collection. Walden IRB was notified and approved the changes to the data collection. Data collection began on July 2020 and concluded on August 2021. Sixty-eight respondents participated and 12 completed surveys. Responses from SurveyMonkey were entered into Mac SPSS Statistics. I summarized the demographics for the study participants and performed descriptive statistics.

Results

A total of 68 surveys were returned and 45 were incomplete. Twelve (18%) completed surveys were used for analysis. Cronbach's alpha for the study were MMD-HP was .943, PEI was .894, and HECS was .938 indicating excellent internal consistency of the scales. The age of the participants was not equally distributed. The largest group were 20 years to 30 years of age *(n* = 4; 33.3%). Most participants were female (*n* = 11; 91.7%), were White (*n* = 7; 58.3%), had a bachelors' degrees (*n* = 5; 41.7%) and worked in the stepdown unit *(n* = 4; 33.3%). See Table 1.

Table 1

Demographic Characteristics of the Study Sample

Category	Sample with Complete Surveys ($N = 23$)		All Consenting Participants ($N = 68$)	
	Frequency	Percentage	Frequency	Percentage
Gender				
Female	21	91.3	61	89.7
Male	2	8.7	7	10.3
Race/Ethnicity				
White	13	56.5	38	55.9
Hispanic	1	4.3	7	10.3
Black or African American	2	8.7	5	7.4
Native Hawaiian or Other Pacific Islander	1	4.3	1	1.5
Asian	5	21.7	13	19.1
Missing	1	4.3	1	1.5
Age group				
20-30	6	26.1	18	26.5
31-34	0	0.0	1	1.5
35-40	1	4.3	14	20.6
41-50	3	13	8	11.8
51-60	3	13	12	17.6
61-70	6	26	8	11.8
>71	3	13	6	8.8
Missing	1	4.3	1	1.5
Nursing Education				
Diploma	1	4.3	4	5.9
Associate	4	17.4	16	23.5
BSN	8	34.8	28	41.2
Master's degree	9	39.1	19	27.9
Missing	1	4.3	1	1.5
Unit				
ICU	9	39.1	15	22.1
PACU/Recovery Unit	1	4.3	3	4.4
Stepdown	4	17.4	9	13.2
Medical/Surgical Telemetry	2	8.7	19	27.9
ER Department	2	8.7	5	7.4
Procedure Room	0	0.0	1	1.5
Ambulatory Unit	3	13	10	14.7
Missing	2	8.7	6	8.8

The data were analyzed using SPSS (Version 26). Prior to analysis, assumptions of normality, equality of variance, and equality of covariance matrices were assessed. Normality was assessed using Shapiro-Wilk tests. All Shapiro-Wilk tests of normality were nonsignificant ($p > .05$) demonstrating that the data showed adequate univariate normality for the two of the three dependent variables. The emergency department group had only 2 data points and could not be assessed for normality (See Table 2).

Table 2

Shapiro-Wilk Tests of Normality

Scale	Unit	Shapiro-Wilk Statistic	*Df*	*p*
Moral Distress	PACU & Stepdown	.94	5	.66
	ED	--[a]	--	--
	Ambulatory & Medsurg	.92	5	.54
Psychological Empowerment	PACU & Stepdown	.91	5	.45
	ED	--	--	--
	Ambulatory & Medsurg	.91	5	.47
Ethical Climate	PACU & Stepdown	.95	5	.75
	ED	--	--	--
	Ambulatory & Medsurg	.93	5	.58

[a] Values are not calculable due to only 2 data points for this group.

The assumption of adequate sample size was not met. The sample size was too small ($n = 12$) with one cell having fewer cases ($n = 2$) than there were dependent variables (DV = 3). The assumption of no univariate or multivariate outliers was assessed but not met. Instead of using the five original groups, I used three groups—PACU and Stepdown, Emergency Room, and Ambulatory and Medical Surgical—to test the

hypothesis. I used MANOVA despite not meeting an adequate sample size assumption. A larger sample size would have been better, but I interpreted the data cautiously.

One extreme univariate outlier was noted on moral distress in the ambulatory and medical/surgical group. In Table 3, the homogeneity of variance was examined using Levene's Test of Equality of Error. Variances were not significant ($p > .05$), and the assumption was met.

Table 3

Levene's Test of Equality of Error Variances

Scale	Levene Statistic	*df1*	*df2*	*P*
Moral Distress	1.67	2	9	.24
Psychological Empowerment	2.20	2	9	.17
Ethical Climate	1.06	2	9	.39

The assumption of homogeneity of covariances was assessed using Box's test, which was not significant ($p = .15$) indicating that this assumption was met. The majority of participants ($n = 7$) reported moderate (100–200) and high range (>200) MMD-HP scores. The mean and standard deviation varied by type of units. The group of stepdown participants ($n = 4$; $M = 227.75$; $SD = 149.83$) had the highest mean and, those who worked in medical/surgical/tele ($n = 2$; $M = 160.54$; $SD = 5.0$) had the lowest mean scores.

Table 4

Means and Standard Deviations of MMD-HP, PEI and HECS Scores by Units

Scale	Unit	*M*	*SD*	*n*
Moral Distress	PACU/ Recovery Unit	211.00	----	1
	Stepdown	227.75	149.84	4
	Medical/Surgical Telemetry	160.54	5.00	2
	Emergency Room	189.00	155.56	2
	Ambulatory Unit	181.67	71.11	3
	Total	197.17	99.62	12
Psychological Empowerment	PACU/Recovery Unit	4.50	----	1
	Stepdown	5.10	.75	4
	Medical/Surgical Telemetry	5.04	1.83	2
	Emergency Room	4.96	.59	2
	Ambulatory Unit	5.39	.67	3
	Total	5.10	.77	12
Ethical Climate	PACU/Recovery Unit	3.81	----	1
	Stepdown	3.14	.38	4
	Medical/Surgical Telemetry	3.85	.28	2
	Emergency Room	4.04	.87	2
	Ambulatory Unit	4.13	.71	3
	Total	3.71	.63	12

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The MMD-HP scores ranged from 26 to 371 with a mean score of 197.17. Higher scores indicated greater distress. The PEI scores ranged from 3.75 to 6.33 (M = 5.09; SD = 0.77). Higher scores indicated greater perceived empowerment. The HECS scores ranged from 2.73 to 4.65 (M = 3.71; SD = 0.63). Higher scores indicated positive ethical climate. MMD-HP scores per item are presented in Table 5. The top three factors identified by participants as causing the most and frequent moral distress were "Have excessive documentation requirements that compromise patient care" (M = 11.17, SD =5.90), "Experience lack of administrative action or support for a problem that is compromising patient care" (M = 11.08, SD = 6.33), "Experience compromised patient care due to lack of resources/equipment/bed capacity" (M = 11.00, SD = 5.69), and "Follow the family's insistence to continue aggressive treatment even though I believe it

is not the best interest of the patient" (M = 11.00, SD = 4.94). "Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent" (M = 3.33, SD = 4.01) was the factor causing the least moral distress. Other factors identified by participants who felt moral distress include: "No PPE during COVID," "Disagreements between family members," "Patients and caregivers regarding end-of-life practices and decisions with family members who do not want patient to know the diagnosis," "Critically ill patients moved out of the ICU too soon," and "Pressure to meet metrics based on CMS payor requirements at the expense of safe patient care due to not enough resources and physicians who always expected you to back them up."

Table 5

MMD-HP Scores Level and Frequency Per Item

Item	*N*	Min	Max	*M*	*SD*
1. Witness healthcare providers giving "false hope" to a patient or family.	12	.00	12.00	4.75	4.11
2. Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.	12	1.00	16.00	11.00	4.94
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.	12	.00	16.00	7.33	5.43
4. Be unable to provide optimal care due to pressures from administrators or insurers to reduce costs.	12	.00	16.00	8.75	6.27
5. Continue to provide aggressive treatment for a person who is most likely to die regardless of this treatment when no one will make a decision to withdraw it.	12	.00	16.00	8.17	6.01
6. Be pressured to avoid taking action when I learn that a physician, nurse, or other team colleague has made a medical error and does not report it.	12	.00	16.00	5.25	4.71
7. Be required to care for patients whom I do not feel qualified to care for.	12	.00	16.00	6.67	5.66
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.	12	1.00	16.00	8.08	5.11
9. Watch patient care suffer because of a lack of provider continuity.	12	1.00	16.00	8.00	5.83
10. Follow a physician's or family member's request not to discuss the patient's prognosis with the patient/family.	12	.00	16.00	3.83	4.73
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.	12	.00	16.00	4.08	5.21
12. Participate in care that I do not agree with, but do so because of fears of litigation	12	.00	16.00	5.17	4.91
13. Be required to work with other healthcare team members who are not as competent as patient care requires.	12	.00	16.00	8.33	5.50
14. Witness low quality of patient care due to poor team communication.	12	1.00	16.00	7.83	5.18
15. Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.	12	.00	12.00	3.33	4.01
16. Be required to care for more patients than I can safely care for.	12	1.00	16.00	10.61	4.26
17. Experience compromised patient care due to lack of resources/equipment/bed capacity.	12	1.00	16.00	11.00	5.69
18. Experience lack of administrative action or support for a problem that is compromising patient care.	12	1.00	16.00	11.08	6.33
19. Have excessive documentation requirements that compromise patient care.	12	1.00	16.00	11.17	5.90
20. Fear retribution if I speak up.	12	.00	16.00	7.58	6.78
21. Feel unsafe/bullied amongst my own colleagues.	12	.00	16.00	4.58	6.33
22. Be required to work with abusive patients/family members who are compromising quality of care.	12	1.00	16.00	8.33	5.58
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.	12	1.00	16.00	9.33	6.43
24. Be required to care for patients who have unclear or inconsistent treatment plans or who lack goals of care.	12	.00	16.00	7.58	5.38
25. Work within power hierarchies in teams, units, and my institution that compromise patient care.	12	.00	16.00	5.33	5.66
26. Participate on a team that gives inconsistent messages to a patient/family.	12	.00	16.00	4.92	5.25
27. Work with team members who do not treat vulnerable or stigmatized patients with dignity and respect.	12	.00	12.00	4.75	3.98

There were meaningful responses to the question “Have you ever left or considered leaving a clinical position due to moral distress.” Participants (*n* = 5, 41.7%) responded “Yes, but didn’t leave,” and 41.7% (*n* = 5) left the position. Two participants (16.7%) responded “No.” For the second question, “Are you considering leaving your position now due to moral distress?” 7 participants (58.3%) responded “No.”

The participants’ perception of the ethical climate was positive. The most positive perception was related to peers, “My peers listen to my concerns about patient care” *(M* = 6.09, *SD* = 0.70), and the least positive perception of ethical climate was related to Physicians, “Physicians ask nurses for their opinions about treatment decisions” (*M* = 2.75, *SD* = 1.14) (See Table 6).

Table 6

Mean and SD of Participants Perception on Ethical Climate

Item	*M*	*SD*
Peers		
My peers listen to my concerns about patient care.	6.09	.70
. My peers help me with difficult patient care issues/problems.	4.33	.79
I work with competent colleagues.	4.08	.79
Safe patient care is given on my unit.	4.08	.90
Patients		
Patients know what to expect from their care.	3.64	.81
Nurses have access to the information necessary to solve a patient care issue/problem.	3.82	.75
Nurses use the information necessary to solve a patient care issue/problem.	4.00	.60
The patient's wishes are respected.	4.33	.78
Physicians		
Nurses and physicians trust one another.	3.64	.81
Physicians ask nurses for their opinions about treatment decisions.	2.75	1.14
I participate in treatment decisions for my patients.	3.08	1.00
Nurses and physicians here respect each others'opinions, even when they disagree about what is best for patients. .	3.58	.79
Nurses and physicians respect one another.	3.92	.79
Nurses are supported and respected in this hospital.	3.67	.78
Hospitals		
Hospital policies help me with difficult patient care issues/problems.	3.09	1.14
A clear sense of the hospital's mission is shared with nurses.	3.83	1.19
The feelings and values of all parties involved in a patient care issue/problem are taken into account when choosing a course of action.	3.17	1.12
Conflict is openly dealt with, not avoided.	2.91	1.16
There is a sense of questioning, learning, and seeking creative responses to patient care problems.	3.75	.75
I am able to practice nursing on my unit as I believe it should be practiced.	3.50	.78
Managers		
When I'm unable to decide what's right or wrong in a patient care situation, my manager helps me.	3.00	1.41
My manager supports me in my decisions about patient care.	3.92	1.24
My manager listens to me talk about patient care issues/problems.	3.25	1.36
My manager is someone I can trust.	3.65	1.07
When my peers are unable to decide what's right or wrong in a particular patient care situation, I have observed that my manager helps them	3.00	1.35
My manager is someone I respect.	3.83	1.03

Participants reported that the most important component of psychological empowerment was related to meaning, "The work that I do is important to me." While the lowest scores reported were both related to impact, "I have a great deal of control over what happens in my department" and "I have significant influence over what happens in my department" (see Table 7).

Table 7

Means and Standard Deviations for Psychological Empowerment (N = 12)

Item	Mean	SD
Meaning		
The work that I do is important to me.	6.17	.84
My job activities are personally meaningful to me	5.75	1.14
The work I do is meaningful to me.	5.83	1.27
Competence		
I am confident about my ability to do my job.	5.92	.79
I have mastered the skills necessary for my job.	5.00	1.48
I am self-assured about my capabilities to perform my work activities.	5.92	.79
Self-Determination		
I have significant autonomy in determining how I do my job.	4.83	1.47
I can decide on my own how to go about doing my own work.	4.75	1.42
I have considerable opportunity for independence and freedom in how I do my job.	4.42	1.38
Impact		
My impact on what happens in my department is large.	4.67	1.67
I have a great deal of control over what happens in my department.	3.92	1.17
I have significant influence over what happens in my Department	3.92	1.38

Due to the small sample size (n = 1) in one of the cells, the five original groups were combined into three groups to test the hypothesis; PACU and Stepdown, Emergency Room, and Ambulatory and Medical Surgical. A MANOVA was then used to assess the level and frequency of moral distress, perception of ethical climate and psychological empowerment among participants who worked in these three types of units. The results of the MANOVA showed there was not a statistically significant

difference between units on the level and frequency of moral distress, perception of ethical climate and psychological empowerment (Pillai's trace = .415, F (6, 16) = 0.69, p = .66, partial η^2 = .208. The null hypothesis was retained.

Discussion

Interpretations

My study results did not support findings of previous studies that showed the situations causing the most moral distress were related to pain management, provision of care, aggressive treatment, and unsafe staffing levels (Henrick et al., 2016; Lazzarin et al., 2012; Lusignani et al., 2017; Sirilla et al., 2017). In this study, 41.7% responded that they have left or considered leaving a position due to moral distress, and 58% were not considering leaving their position due to moral distress. These results were significant increases compared to the findings in the study conducted by Lazzarin et al. (2012) in which 182 nurses completed the Moral Distress Scale–Pediatric Version. In that study only 13.7% had changed their unit or hospital.

My findings also reflected the participants' less positive view of doctors in terms of them asking nurses for their opinions. Earlier studies have also reported that nurses felt silenced by physicians in ethical and clinical decision-making (Malloy et al., 2009; Newton et al., 2012). The findings of my study support the importance of positive and supportive environment among peers, managers, administrations, and physicians.

Additionally, psychological empowerment refers to an attitude reflected in a sense of control at the workplace (Mishra & Spreitzer, 1998). In this study, participants ranked the dimensions score as follows: meaning, competence, self-determination, and impact.

Having a high score in the *meaning* dimension reflected self-awareness of their purpose in nursing practice. Thus, their personal values would assist in the promotion of their nursing behavior in achieving positive outcomes. Conversely, when nurses perceived they are not being valued nor recognized for their work, this can lead to negative consequences. The psychological empowerment of nurses increases job satisfaction, enhances quality care, and helps to prevent burnout (Meng et al., 2014).

Limitations

This study had a low response rate, and it is difficult to generalize the findings to all nurses working in stepdown unit, ambulatory units, medical/surgical units, emergency departments, and procedure units. Furthermore, the generalization of the findings remains limited because the study was conducted in one medical center in the United States and using one social medium. The participants in the study did not represent the national sample of NRNs.

The low response rate may have been due to several factors. Participants had to complete three instruments and the demographic form, which can be lengthy. The timing of the study can also be an issue since the data collection took place during the COVID-19 pandemic. Participants may have not viewed the study as significant, and they may have preferred to be part of a study related to COVID-19. Lack of time can also be a cause of low response. There were participants who expressed their gratitude for conducting the study; however, participants also expressed that they could not find time to fill out the survey during working hours or spare time due to the nature of their work and staffing issues.

Implications

The study has the potential to influence positive change for nursing, institutions, and patients. Addressing the causes of moral distress offers the opportunity to assist NRNs to mitigate moral distress. Moral distress has been associated with increased job turnover, decreased caring ability, and the well-being of the nurses (Austin, et al., 2017).

Currently, in 2020, the turnover rate for staff RNs increased by 2.8% and currently stands at 18.7%. Institutions (35.8%) reported a vacancy rate exceeding 10%. (Nursing Solution Incorporated, 2021). Furthermore, Nursing Solution Incorporated reported that the average cost of turnover for a bedside RN is $40,038 and ranges from $28,400 to $51,700 resulting in the average hospital losing between $3.6 million to $6.5 million per year. The nurse managers and hospital administrators need to pay close attention to turnover and retention and to evaluate and identify the elements involved in moral distress, ethical climate, and psychological empowerment. Support and relationship of the nurses and nurse managers, administrators, peers, and physicians can influence the negative effects of the variables (Altaker et al., 2018).

Recommendations

Replicating this study in a larger sample would allow for generalizability of the findings. Exploring moral distress in other clinical settings, such as long term care, both urban and rural, would increase the understanding of the impact of environment on nurses. Also, further study of moral distress, ethical climate, and psychological empowerment seen in other healthcare providers, such as doctors, physician assistants, physical therapists, pharmacists, nurse practitioners, and nurses' aides would give us

insight into how other healthcare providers respond and would increase our understanding of the phenomenon of moral distress. Further research on the demographic information, such as race, sex, education, age, and unit or settings as potential contributing factors to moral distress would also be useful.

In August 2021, the American Association of Critical Care Nurses recommended some of the actions for healthcare institutions to address moral distress, included guaranteeing that nurses are included as decision-makers on all institutional ethics committees and monitoring the clinical and organizational climate to identify situations that could create moral distress. Further, the association recommended that clinicians be provided with tools to help them recognize the experience of moral distress, such as:

- Creating interdisciplinary forums to discuss patient goals of care.
- Discussing divergent opinions regarding those goals of care in an open, respectful environment.
- Ensuring institutional support systems that include easy access to ethics committees, critical stress debriefings, protocols for end-of-life care, and crisis and grief counseling.

Future study should be focused on programs to reduce moral distress across multiple types of nurses' jobs and settings.

Conclusion

Moral distress remains a complex phenomenon that needs continued study. This study adds to the understanding of moral distress, ethical climate, and psychological empowerment of NRNs for both critical care units and non-critical care units. Although

data showed that there was no significant difference in the three variables between settings, the level and frequency of moral distress were moderate to high in the sample studies. Building a healthy relationship between nurses and physicians will enhance communication and teamwork among clinicians. Newly graduated nurses often have little trust in their own capabilities and experience; lack confidence; feel uncertain; experience ethical distress and fear; and are unable to communicate appropriately to other nurses, physicians, and patients (Duchscher, 2009; Kuokkanen et al., 2016; Numminen et al., 2015). Continuous discussion of morally distressing situations that compromise the moral integrity of NRNs can ameliorate work-related tension.

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Comparison of Moral Distress, Ethical Climate, and Psychological Empowerment Among RNs in Critical Care Units Versus Non-Critical Care Units

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Outlet for Manuscript

The target journal for the manuscript is the *Journal of Nursing Administration*, which provides information on management and leadership development; human, material, and financial resource management; staffing and scheduling systems; staff development; labor-management relations; policy, legislation, regulations, and economics related to healthcare and program development; legal, ethical, and political issues; interdisciplinary collaboration; organization-wide projects; corporate issues; diversity management; community relations; innovations; and professional trends (*Journal of Nursing Administration*, 2021). The manuscript must be prepared according to the American Medical Association Manual of Style (10th edition), and double spacing using a 10-point type size with any font style. The length should be 3,600 words including abstract and references, not indenting paragraphs, and separating paragraphs with an extra return. Additionally, the abstract should be less than 150 words (including five headings—objective, background, methods, results, and conclusions). The institutional review board process and informed consent must be included. The review process starts on the first day of the month and the decision occurs within 16 weeks from the beginning of the review process.

Abstract

Purpose

The purpose of the study was to assess the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among new registered nurses (NRNs) who work in critical care units compared to non-critical care units.

Method

Sixty-eight NRNs working in critical care units and non-critical care units were recruited and 23 completed the Measure of Moral Distress for Healthcare Professionals (MMD-HP), Psychological Empowerment Instrument, and Hospital Ethical Climate Scale. Descriptive statistics and multivariate analyses were performed. Jameton's (1984) moral distress was used for the conceptual framework.

Findings

The highest intensity and frequency of moral distress situations were related to nursing practice. Overall, the study showed that there was no difference in the level and frequency of moral distress, perception of ethical climate, and psychological empowerment among NRNs in non-critical care units and critical care units.

Conclusions

Perceptions about moral distress, ethical climate, and psychological empowerment vary among NRNs. Understanding the causes can minimize moral distress and, in return, can enhance quality patient care, staff satisfaction, and retention.

Keywords: Moral Distress, Ethical Climate, Psychological Empowerment, Nursing, Ethical dilemma, Turnover, Practices, New Registered Nurses, Practices

Introduction

The perceived levels of moral distress have significant differences related to settings. Moral distress is higher among nurses compared to doctors (Epstein et al., 2019). Nurses who provide direct patient care also have a higher level of moral distress compared with those who provide indirect care (Whitehead et al., 2015). Ethical climate is another important element affecting nurses' behavior and practice (McGilles et al., 2008). The ethical climate involves the perception of how ethical issues are being managed in their work environment (Hojati & Azma, 2014). The ethical issues in the clinical setting include relationships among nurses and leadership, colleagues, and physicians and can be associated with moral distress (Whitehead et al., 2015). Addressing the ethical climate is important in the provision of quality of care and promoting safety. If individuals felt that the organizations' values are in conflict with their own ethical values, they are less committed to the organization (Humphries & Woods, 2016). Enhancing the ethical climate can result in better coping for nurses who are experiencing moral distress (Asgari et al., 2019). Empowerment is associated with moral distress since the perceived self-determination in the work setting is affected (Browning, 2013). Empowerment enhances employees' performance, well-being, and positive attitude (Hempel et al., 2012).

Significance

Nurses advocate for patients and are committed to providing care (International Council of Nurses, 2012). But there is a projected a shortage of nurses in 2030, with four states having a deficit of 10,000 including California, Texas, New Jersey, and South

Carolina. The nursing shortage creates ethical dilemmas in nursing practice (Health Resources and Services Administration, 2017). This shortage may be due to the transition to practice of new registered nurses (NRNs), which can be both a negative and a positive experience (Andersson & Edberg, 2010; Ching-Yu et al., 2014; Duchscher, 2008). NRNs feel frustrated and overwhelmed during their first year of practice (Thomas et al., 2012).

Additionally, moral distress occurs when nurses are unable to pursue the right actions due to constraints in spite of knowing exactly what to do (Jameton, 1984). Moral distress can lead to physical and psychological problems that can cause nurses to quit their jobs or consider leaving the nursing profession (Allen et al., 2013; Austin et al., 2017; Dyo et al., 2016; Hiler et al., 2018; Lamiani et al., 2017; Mauro, 2019; Neumann et al., 2018). Studies on moral distress have been mostly conducted on nurses who work in intensive care units (ICUs) and acute care settings (Abbasi et al., 2018; Altaker et al., 2018; Borhani et al., 2017; Browning, 2013; Darmolin et al., 2014; O'Connell, 2015; Ganz et al., 2013; Hamric & Blackhall, 2007; Hiler et al., 2018; Henrich et al., 2016; Iranmanesh et al., 2013; Kleinknecht-Dolf et al., 2015; Lawrence, 2011; Leggett et al., 2013; Mason, et al., 2014; McAndrew et al., 2011 McCaffree, 2006; Pauly et al., 2009; Sauerland et al., 2014; Silen et al., 2011; Pauly et al., 2009; Rathert et al., 2016; Shoorideh et al., 2015; Varcoe et al., 2012; Woods et al., 2015) and also in medical/surgical units (Rice et al., 2008; Sirilla, 2014). The purpose of this study was to assess the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs with fewer than 3 years of nursing experience working in non-critical care units and critical care units.

Conceptual Framework

Jameton's (1984) moral distress is the conceptual framework of my study. Moral distress is described as a negative emotional response that happens when a nurse knows morally what should be done but is prevented from taking an action because of the restrictions that do not allow for the appropriate ethical choice in the nurse's view (Jameton, 1984). Jameton defined moral distress as the inability of a moral agent to act according to his or her values and perceived obligations due to internal and external constraints.

The effect of moral distress can linger. Moral residue occurs when feelings ensue despite resolution of the event (Epstein & Hamric, 2009). Moral distress is recognized as a potential factor for burnout phenomenon (Rice, 2008). There are three independent moral values relevant to moral distress (a) the well-being of the patient, (b) the well-being of the health professional experiencing moral distress, and (c) the distribution of moral distress among groups of health professionals.

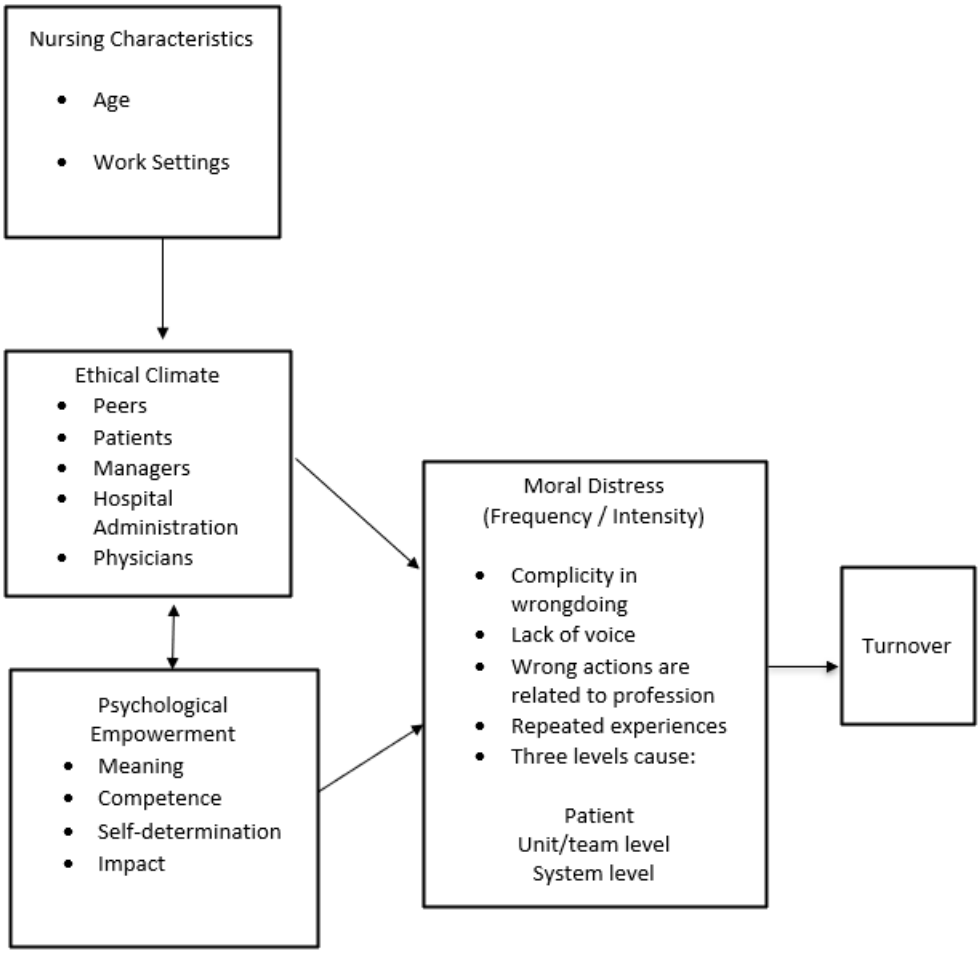
The study integrated moral distress, ethical climate, and psychological empowerment suggesting that moral distress is a consequence influenced by the perceived ethical climate and the experience of psychological empowerment. See Figure 1. There are three instruments used to examine the relationships between concepts: the Measure of Moral Distress for Healthcare Professionals (MMD-HP) and the Psychological Empowerment Index (PEI), and the Hospital Ethical Climate Survey (HECS). The framework suggests that the perceived ethical climate and psychological empowerment can lead to the negative impact of moral distress.

Nurses' decision-making is often influenced by the degree of empowerment. Nurses who have a sense of control in their practice lead to a positive psychological empowerment. Empowerment was a significant predictor of moral distress frequency (Browning, 2013). When nurses are unable to overcome ethical dilemmas due to their perception of the poor ethical climate, this can lead to frustration, burnout, and turnover. Contrary, the more positive an individual perceives the ethical climate, the less moral distress occurs (Lutzen et al., 2010; Pauly et al., 2009).

It is essential to determine how nurses interact with their peers, patients, managers, hospital administrators, and physicians when dealing with ethical dilemmas. Similarly, Olson (1998) pointed out how an individual responds in a given situation is dependent on the individual and the environment.

Figure 1

Conceptual Framework for the Relationship between Moral Distress, Psychological Empowerment and Ethical Climate



Relevant Scholarship

Studies showed moral distress takes place in all areas of healthcare (Dzeng, 2018). The most common causes of moral distress have focused on the critical care environment and include overly aggressive treatment, inappropriate use of healthcare resources, physicians giving incomplete/inaccurate information to patients and families, patient wishes being disregarded by physicians, disparate patient treatment goals among family members, disparate patient treatment goals between the patient and family, and lack of physician follow up. Other causes of moral distress were advanced medical technology at the end of life, ambivalence towards treatment and care, suffering resulting from a lack of ethical sensitivity, dilemmas resulting from nurses' limited autonomy in treatments, conflicts with physicians and conflicts with institutional policy (Choe et al., 2015; Gutierrez, 2005; McCaffree, 2006). The most difficult and common ethical challenge in the ICU that often leads to moral distress for both nurses and physicians was the perception of futile care (Dzeng et al., 2016; Mobley et al., 2006).

The root causes of moral distress can be at patient, team, and system level (Epstein et al., 2019). Moral distress is associated with burnout, retention, and intention to leave the position (Dodek, et al., 2016, Dzeng & Curtis, 2018; Epstein, et al., 2019; Fumis et al., 2017; Hiler et al., 2018; Mauro, 2019; Neumann et al., 2018; Sajjadi et al., 2017; Trautmann et al., 2015; Whitehead et al., 2015; Wilkinson, 1988; Wilkinson, 1989). Healthcare providers' responses to ethical concerns or issues may be to ignore or remain silent because of a culture of avoidance (Pavlish et al., 2015). Nurses' poor responses to ethical climate could negatively impact productivity, performance, and

relationships among healthcare providers. The ethical climate in the workplace may be linked to the occurrence of medical errors due to unsafe behaviors. Hwang et al. (2014) conducted a cross-sectional survey study of 1,826 nurses in 33 Korean public hospitals which examined the nurses' perceptions of the ethical climate of their workplace and the relationship to medical error experienced. Hwang et al reported 19% made at least one medical error during the previous year, and 25% intended to leave their jobs in the near future. Corley et al. (2005) conducted a study of 106 RNs working in medical/surgical units in two medical centers in a mid-Atlantic city. The study showed moral distress intensity and ethical work environment were correlated with moral distress frequency. Similarly, Pauly et al. (2009) reported that ethical climate was negatively correlated with moral distress intensity and frequency. Further, each factor in the Hospital Ethical Climate Scale (i.e., peers, patients, managers, hospitals, and physicians) was correlated with moral distress intensity and frequency except for the factor of peers. Thus, it is essential for nurses to assess and identify moral distress and be able to manage moral distress.

Few studies have examined the differences in moral distress experienced by nurses who work in ICU and those nurses who work in non-ICU settings. De Villers and DeVon (2012) conducted a descriptive, cross-sectional study to examine the similarities and differences in moral distress and avoidance between critical (n = 68) and non-critical care nurses (n = 28). The findings suggested there were no differences in moral distress between groups. In addition, there was a small positive correlation between moral distress and avoidance behaviors for both the groups. Hiler et al. (2018) studied 328 critical care

nurses in the United States and found that the highest level of moral distress frequency occurred when nurses perceived that the care provided was futile and not in the best interest of the patient. Further, they also reported that job satisfaction, practice environment, and age were predictors of moral distress.

In New Zealand, Woods et al. (2015) surveyed 1,500 randomly selected nurses through the New Zealand Nurses Organization and 412 were returned, giving a response rate of 27%. The Moral Distress Scale–Revised was used to study the variable. Subjects came from diverse clinical backgrounds – medical nursing 17.5%, surgical areas 18.2%, critical care 22.3.%, pediatric 9.2%, and 32.8% from other assorted areas such as oncology and gerontology. The study showed the highest moral distress scores were related to younger groups of nurses ages 25- 34 and nurses ages 55-64 had lower scores. The most frequent situations which caused moral distress were (a) having to provide less than optimal care, (b) working with others who are less than competent and (c) watching patients suffer due to lack of provider continuity.

Sirilla et al. (2017) also used MDS-R and reached similar results on 329 nurses who worked in inpatient units and ambulatory units. The aims of the study were to examine the level of moral distress among nurses and to compare the level of moral distress in nurses across specialty units. Sirilla et al. found that nurses in critical care, perioperative services, and procedure areas had the highest mean MDS-R score. Furthermore, they concluded that nurses experience moral distress in their practices while working in a complex environment.

However, Corley (1995) examined the differences in moral distress between critical care nurses and non-critical care nurses. The study showed the non-critical care nurses reported higher levels of moral distress related to aggressive care compared to critical care nurses. In medical/surgical units, the common cause of moral distress was inadequate pain control for the terminally ill (Rice et al., 2008). The nurses also reported a potential cause of moral distress was the nurses' comfort level with staffing and competence of other nurses and physicians as healthcare providers.

Moral distress has been studied, but few qualitative studies have been done. Robinson and Stinson (2016) conducted a phenomenological qualitative design using eight RNs in three different emergency departments in the South Central United States. The sources of moral distress were related to patient advocacy issues, professional behavior of other health care professionals, internal conflicts of doing the right thing, and guilt over their own feelings on patient care. The four themes identified in the study were (1) there was no face of the family, (2) asking God for forgiveness, (3) flipping the switch, and (4) it changes who we are.

Another qualitative study was conducted by Henrich et al. (2016) in British Columbia in 13 ICUs. There were 10 focus groups: three staff nurse focus groups, one clinical care leader focus group, three physician focus groups, and three other health professionals focus groups. Similar to Robinson et al. (2016), the common causes of moral distress were concerns about the care provided by other healthcare workers, the amount of care provided/too much care at end of life, poor communication, inconsistent care plans, and issues around end-of-life decision-making. Nurses reported that moral

distress was experienced as a consequence of inadequate care provided by other nurses and physicians. A common concern among nurses was physicians not responding fast enough to patients' needs.

Research Question and Design

The research question for my study was "What is the effect of the work environment of RNs in critical care units (ICUs and stepdown) compared to RNs who work in non-critical care (medical/surgical, emergency departments, ambulatory clinics, and procedure room units) on the frequency and levels of moral distress, perception of the ethical climate, and psychological empowerment among NRNs with less than 3 years of nursing experience?" The nature of the proposed Manuscript 3 was a quantitative comparative analysis study designed to assess the intensity and frequency of moral distress. I compared the frequency and level of moral distress, ethical climate, and psychological empowerment of NRNs working in critical care units (ICUs and stepdown) to RNs who work in non-critical care (medical/surgical, emergency departments, ambulatory clinics, and procedure units).

Methods

Participants

The nurses were recruited using convenience sampling. The inclusion criteria were full-time and part-time RNs with fewer than 3 years of nursing experience currently practicing in non-ICU and ICU settings in a tertiary hospital in a metropolitan area in the northeastern United States and members of nurses' Facebook groups. The exclusion

criteria are those nurses practicing in the operating room, a clinic, or having more than 3 years of nursing experience.

Data were collected using the three questionnaires MMD-HP, PEI, and the HECS. Consent was obtained from Dr. Hamric to use the instrument (see Appendix A), consent was obtained from Dr. Spreitzer (see Appendix B), and consent was obtained from Dr. Olson (see Appendix C). These instruments were not modified from their original format.

Sample and Power

Data were collected using a cross-sectional survey design. The study was approved by the facility and the Walden Institutional Review Board (IRB). Participants were informed that approximately 15 minutes to 20 minutes was needed to complete the surveys. Recruitment letters were emailed to potential participants and flyers were posted in the unit and on nurse Facebook groups. Follow-up emails were sent to participants as a reminder of the deadline of submission. Demographic data were collected, which included age, gender, race, education, years of experience and unit (see Appendix D). I calculated the sample size using G* Power software by Faul et al. (2019) using an alpha of 0.05, power of 0.80, and medium effect of .0625. This yields a desired sample size of 180.

Variables/Sources of Data

I compared the frequency and level of moral distress, ethical climate, and psychological empowerment of NRNs working in critical care units (ICUs and stepdown) to RNs who worked in non-critical care (medical/surgical, emergency departments,

ambulatory clinics, and procedure units) by the demographic characteristics and identified which NRNs were at high risk of moral distress.

Instruments or Measures

The MMD-HP is a 27-item Likert scale to measure frequency of moral distress with a scale ranging from 0 = never to 4 = very frequently for how often moral distress occurs in their practice (Epstein et al., 2019). The Likert scale for the level of distress ranged from 0 = none to 4 = very distressing. The maximum score for the level of moral distress was 108. This is same as the frequency of moral distress. To obtain the overall composite score of moral distress, the frequency score is multiplied by the level of distress score. A higher score indicates a higher level of moral distress. The calculated scores range from 0 to 432. The MMD-HP involves the five key components of moral distress both directly and indirectly. These key features of moral distress are: pressure to act wrongly, devalued professional insights, violations of ethical professional practice, and repetitive situations. The root causes can be at the patient, unit, and system level. Epstein et al. reported MMD-HP had a good reliability with Cronbach's alphas of .93. The smaller the amount of measurement error, the stronger the internal validity of a research study (Houser, 2008). The MMD-HP is the latest instrument on moral distress, and the authors recommended it to replace the Moral Distress Scale–Revised.

The validity of the instrument was tested using a descriptive study of 653 participants at two medical centers. The four hypotheses were tested using one-way ANOVA for three or more groups and two sample *t*-tests. The MDS-R combining 22 previous studies, examining 301 write-in items, and 209 root causes was updated. The

construct validity was tested using hypothesis testing. The group comparisons were analyzed using either two sample *t*-tests or a one-way analysis if three or more groups were compared. The exploratory factor analysis was used for the fourth hypothesis (moral distress occurs repeatedly over time) for construct validity.

The PEI is a reliable and valid instrument with reliability coefficients ranging from 0.62 to 0.74 (Spreitzer, 1995; Spreitzer, 1996). There were four cognitions or subscales to measure psychological empowerment, namely, meaning, competence, self-determination, and impact. The PEI addressed the four dimensions measuring empowerment and were scored as: 7 = very strongly agree, 6 = strongly agree, 5 = agree, 4 = neutral, 3 = disagree, 2 = strongly disagree, and 1 = very strongly disagree. An overall psychological empowerment score was obtained by summing and averaging the 12 items (four subdimensions) with a high score indicating a high level of perceived psychological empowerment. The subdimensions were measured individually by taking the mean of the three items measuring one dimension. A higher score reflected greater perceived empowerment. The PEI has a strong validity and reliability and reported validity estimated around 0.80 (Spreitzer, 1995).

The Cronbach's alpha and test-retest coefficients were used to examine the reliability of the empowerment measures. The second order confirmatory factor analysis was used on each sample to assess the convergent and discriminant validity of the hypothesis. The LISREL (linear structural relation) was used to examine the antecedents and consequences. The sample was 393 managers randomly selected from different units, and 128 employees were selected by stratified random sampling.

I assessed the ethical climate by using Olson's Questionnaire (HECS), which contains 26 items in five domains, including peers, patients, managers, hospitals, and physicians. Each item is scored using a Likert 5-point scale ranging from 1 (almost never true) to 5 (always true). The internal reliability reported using Cronbach's alpha for each of the five subscales were 0.73 (peers), 0.68 (patients), 0.92 (managers), 0.77 (hospitals) and 0.81 (physicians) (Olson, 1998). The possible score for HECS has a range of 26 to 130. The higher scores indicated a positive ethical climate.

The findings from both nursing and business studies dealing with ethical beliefs, employee behaviors, or the influence of environment on employees were the sources of items for the instruments. Thus, the content analysis was supported by literature reviews and Olson's concept analysis of ethical climate. In addition, there were experts in nursing ethics, a chief nurse executive in an acute care hospital, doctorally prepared faculty, and nurse researchers in ethics and organizational climate. The HECS construct validity used confirmatory factor analysis (Olson, 1998).

Design and Analysis

The study is a quantitative, comparative, cross-sectional survey design. The quantitative study is often used to measure relationships between variables (Houser, 2008). In this study, the variables included moral distress, ethical climate, psychological empowerment, and the settings (critical care unit and non-critical care unit). Comparative analysis was also used to identify relationships between two or more variables by observing different groups. Similarly, Richardson (2018) mentioned an attempt to identify and analyze similarities and differences between groups. I used

comparative analysis to explore the frequency and level of moral distress, perception of the ethical climate, and psychological empowerment among NRNs with less than 3 years of nursing experience between critical care nurses versus non-critical care nurses.

I analyzed the data with SPSS version 28. Demographic data were analyzed with descriptive statistics. I used the multivariate analysis of variance (MANOVA) to examine the difference of the frequency and levels of moral distress (dependent variable), perceptions of ethical climate (dependent variable), and psychological empowerment (dependent variable) in the two units, which were the critical care units and non-critical care units (independent variable). MANOVA is a test comparing multivariate sample means and is used when there are two or more dependent variables (Warner, 2013).

Results

Execution

This study was approved by both the Walden IRB (0408200664796) and the facility IRB (07092013). Because of the low responses from the facility, nurse Facebook groups were added in the data collection. Walden IRB was notified and approved the changes to the data collection. Data collection began on July 2020 and concluded on August 2021. Responses from the SurveyMonkey were entered into Mac SPSS Statistics. I summarized the demographics for the study participants and performed descriptive statistics.

Results

A total of 68 participants participated and 45 had incomplete surveys; thus, the response rate was 34% (n = 23). The Cronbach's alphas for the study were: MMD-HP

was .943, PEI was .894, and HECS was .938 indicating good to excellent reliability for the scales. Most participants were female (n = 21, 91.3%) and White (n = 13, 56.5%). The greatest percentage of participants held a masters' degree (n = 9, 39.1%) and worked in ICUs (n = 9, 39.1%). See Table 1. Table 2 shows the assumption of homogeneity of variance was examined using Levene's tests of equality of error variances and were not significant ($p > .05$) indicating the assumption was met. In Table 3 Shapiro-Wilk tests of normality were nonsignificant ($p > .05$) demonstrating that the data showed adequate univariate normality for the three dependent variables.

Table 1

Demographic Characteristics of the Study Sample

Category	Sample with Complete Surveys ($N = 23$)		All Consenting Participants ($N = 68$)	
	Frequency	Percentage	Frequency	Percentage
Gender				
Female	21	91.3	61	89.7
Male	2	8.7	7	10.3
Race/Ethnicity				
White	13	56.5	38	55.9
Hispanic	1	4.3	7	10.3
Black or African American	2	8.7	5	7.4
Native Hawaiian or Other Pacific Islander	1	4.3	1	1.5
Asian	5	21.7	13	19.1
Missing	1	4.3	1	1.5
Age group				
20-30	6	26.1	18	26.5
31-34	0	0.0	1	1.5
35-40	1	4.3	14	20.6
41-50	3	13	8	11.8
51-60	3	13	12	17.6
61-70	6	26	8	11.8
>71	3	13	6	8.8
Missing	1	4.3	1	1.5
Nursing Education				
Diploma	1	4.3	4	5.9
Associate	4	17.4	16	23.5
BSN	8	34.8	28	41.2
Master's degree	9	39.1	19	27.9
Missing	1	4.3	1	1.5
Unit				
ICU	9	39.1	15	22.1
PACU/Recovery Unit	1	4.3	3	4.4
Stepdown	4	17.4	9	13.2
Medical/Surgical Telemetry	2	8.7	19	27.9
ER Department	2	8.7	5	7.4
Procedure Room	0	0.0	1	1.5
Ambulatory Unit	3	13	10	14.7
Missing	2	8.7	6	8.8

Table 2

Shapiro-Wilk Tests of Normality

		Shapiro-Wilk		
Scale	Unit	Statistic	Df	Sig
Moral Distress	Critical Care	.97	13	.91
	Non-CC	.98	8	.96
Psychological Empowerment	Critical Care	.98	13	.98
	Non-CC	.90	8	.31
Ethical Climate	Critical Care	.98	13	.94
	Non-CC	.91	8	.34

Note. CC = Critical Care Unit.

Table 3

Levene's Test of Equality of Error Variances

Scale	Levene's statistic	*df1*	*df2*	*P*
Moral Distress	1.75	1	19	.20
Psychological Empowerment	.02	1	19	.88
Ethical Climate	.02	1	19	.90

Finally, the assumption of homogeneity of covariances was assessed using Box's Test, which was not significant ($p = .95$), indicating that this assumption was met. A MANOVA was used to assess the level and frequency of moral distress, perception of ethical climate, and psychological empowerment among participants who worked in critical care units (ICUs and stepdown) compared with non-critical care units. There were 13 participants who worked in critical care units and eight participants who worked in non-critical care units. The results of MANOVA showed there was no significant difference between the critical care units and non-critical care units on the level and frequency of moral distress, perception of ethical climate, and psychological

empowerment (Pillai's trace = .329, F (3, 17) = 2.78, p =.07, partial η^2 = .329. The null hypothesis was retained.

The MMD-HP scores ranged from 26 to 371 with a mean score of 183.98 (M = 183.98; SD = 85.75). Higher scores indicated greater distress. The PEI scores ranged from 3.75 to 6.58 (M = 5.03; SD = .83). Higher scores indicated greater perceived empowerment. The HECS score ranged from 2.35 to 4.65 (M = 3.62; SD =.63) with higher scores indicating more positive ethical climate. The MMD-HP scores per items are presented in Table 4. The situations causing frequent moral distress were ranked from the highest to lowest. The situation causing the highest moral distress was Item 16 ("Be required to care for more patients than I can safely care for) followed by Item 17 ("Experience compromised patient care due to lack of resources/equipment/bed capacity) with the lowest score was Item 15 ("Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent").

Table 4

MMD-HP Level and Frequency Scores per Items in Ranking

Item	*N*	Min	Max	*M*	*SD*
16. Be required to care for more patients than I can safely care for.	23	1.00	16.00	10.61	4.26
17. Experience compromised patient care due to lack of resources/equipment/bed capacity	23	1.00	16.00	10.57	5.03
18. Experience lack of administrative action or support for a problem that is compromising patient care.	23	.00	16.00	10.08	5.98
19. Have excessive documentation requirements that compromise patient care.	23	.00	16.00	9.26	6.11
2. Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient.	23	.00	16.00	8.90	4.89
22. Be required to work with abusive patients/family members who are compromising quality of care.	23	1.00	16.00	8.61	5.16
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care	23	.00	16.00	8.09	5.68
5. Continue to provide aggressive treatment for a person who is most likely to die regardless of this treatment	23	.00	16.00	8.05	5.78
9. Watch patient care suffer because of a lack of provider continuity	23	.00	16.00	7.57	5.28
13. Be required to work with other healthcare team members who are not as competent as patient care requires.	23	.00	16.00	7.52	4.79
4. Be unable to provide optimal care due to pressures from administrators or insurers to reduce costs	23	.00	16.00	7.18	5.61
14.Witness low quality of patient care due to poor team communication.	23	.00	16.00	6.87	4.48
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms	23	.00	16.00	6.83	4.88
20. Fear retribution if I speak up.	23	.00	16.00	6.48	6.40
24. Be required to care for patients who have unclear or inconsistent treatment plans or who lack goals of care.	23	.00	16.00	6.17	5.47
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments.	23	.00	16.00	6.09	4.88
7. Be required to care for patients whom I do not feel qualified to care for.	23	.00	16.00	5.61	5.14
26. Participate on a team that gives inconsistent messages to a patient/family.	23	.00	16.00	5.04	5.04
25. Work within power hierarchies in teams, units, and my institution that compromise patient care.	23	.00	16.00	4.91	5.26
1.Witness healthcare providers giving "false hope" to a patient or family	23	.00	16.00	4.77	4.24
21. Feel unsafe/bullied amongst my own colleagues	23	.00	16.00	4.74	5.86
27. Work with team members who do not treat vulnerable or stigmatized patients with dignity and respect	23	.00	12.00	4.13	3.82
6. Be pressured to avoid taking action when I learn that a physician, nurse, or other team colleague has made a medical error and does not report it.	23	.00	16.00	4.09	4.08
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.	23	.00	16.00	3.91	4.73
10. Follow a physician's or family member's request not to discuss the patient's prognosis with the patient/family.	23	.00	16.00	3.91	4.10
12. Participate in care that I do not agree with, but do so because of fears of litigation	23	.00	16.00	3.91	4.67
15.Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.	23	.00	12.00	3.48	3.60

The MMD-HP allows participants to write additional causes of moral distress. Identified causes were “Covid no PPE,” “Disagreements between family, patient, and caregivers regarding end-of-life practices/decisions,” “Family members do not want patient to know diagnosis,” “Critically ill patients moved out of ICU too soon,” “I often feel distressed when ambiguous DNR/DNI orders are in place.” Additional responses were, “Lack of concern from administration; level of expectations in relation to available resources,” “Physicians always expecting you to back them up, especially when they say patients have said rude things to them (that I have no knowledge of),” “Pressure to meet metrics based on Centers for Medicare and Medicaid Services payor requirements at the expense of safe patient care due to not enough resources and burden of proof,” and “Unsafe staffing that places pressure on nurses to miss breaks/meals, thus causing them great distress.”

The last two questions included in the MMD-HP ask about the intent to leave, “Have you ever left or considered leaving a clinical position due to moral distress?” The three answer options were (“No, I have never considered leaving or left a position,” “Yes, I considered leaving but did not leave,” and “Yes, I left a position”). Participants who considered leaving, but did not leave had the highest percentage (56.5%), 26.1% of participants left the position, and 17.4% did not leave. Sixty-five percent of participants also reported they did not consider leaving the position due to moral distress.

The HECS means ranged from 2.87 to 6.18. The item ranked highest was Item 1, “My peers listen to my concerns about patient care” (M = 6.18, SD = .59). The item with lowest score was Item 9 (M = 2.87, SD = 1.10). See Table 5. The mean score and

standard deviation of psychological empowerment is presented in Table 6. The findings indicate that the mean score for *meaning* was the highest while *impact* had the lowest mean score.

Table 5

Mean and SD of Participants Perception on Ethical Climate

Item	*M*	*SD*
Peers		
My peers listen to my concerns about patient care.	6.18	.59
. My peers help me with difficult patient care issues/problems.	4.13	.76
I work with competent colleagues.	3.91	.67
Safe patient care is given on my unit.	3.91	1.04
Patients		
Patients know what to expect from their care.	3.64	.95
Nurses have access to the information necessary to solve a Patient care issue/problem.	3.68	.78
Nurses use the information necessary to solve a patient care issue/problem.	3.96	.48
The patient's wishes are respected.	4.22	.67
Physicians		
Nurses and physicians trust one another.	3.55	.60
Physicians ask nurses for their opinions about treatment decisions.	2.87	1.10
I participate in treatment decisions for my patients.	3.22	.95
Nurses and physicians here respect each others'opinions, even when they disagree about what is best for patients.	3.17	.98
Nurses and physicians respect one another.	3.61	.94
Nurses are supported and respected in this hospital.	3.35	.89
Hospitals		
Hospital policies help me with difficult patient care issues/problems.	3.05	1.21
A clear sense of the hospital's mission is shared with nurses.	3.61	1.16
The feelings and values of all parties involved in a patient care issue/problem are taken into account when choosing a course of actions.	3.22	.90
Conflict is openly dealt with, not avoided.	2.91	1.16
There is a sense of questioning, learning, and seeking creative responses to patient care problems.	3.43	.99
I am able to practice nursing on my unit as I believe it should be practiced.	3.52	.99
Managers		
When I'm unable to decide what's right or wrong in a patient care situation, my manager helps me.	3.23	1.30
My manager supports me in my decisions about patient care.	3.83	1.19
My manager listens to me talk about patient care issues/problems.	3.30	1.26
My manager is someone I can trust.	3.65	1.07
When my peers are unable to decide what's right or wrong in a particular patient care situation, I have observed that my manager helps them.	3.13	1.29
My manager is someone I respect.	3.95	1.09

Table 6

Mean and Standard Deviation for Psychological Empowerment (N = 23)

Item	*M*	*SD*
Meaning		
The work that I do is important to me.	6.22	.92
My job activities are personally meaningful to me	5.87	1.22
The work I do is meaningful to me.	5.77	1.27
Competence		
I am confident about my ability to do my job.	5.82	1.03
I have mastered the skills necessary for my job.	5.13	1.42
I am self-assured about my capabilities to perform my work activities.	5.78	1.00
Self-Determination		
I have significant autonomy in determining how I do my job.	4.91	1.59
I can decide on my own how to go about doing my own work.	4.78	1.45
I have considerable opportunity for independence and freedom in how I do my job.	4.30	1.36
Impact		
My impact on what happens in my department is large.	4.70	1.52
I have a great deal of control over what happens in my department.	3.78	1.28
I have significant influence over what happens in my Department	3.95	1.21

Discussion

Interpretation

The overall finding of the study was that there was no difference in the level and frequency of moral distress, perception of ethical climate, and psychological empowerment among nurses working in critical care units and non-critical care units. However, participants of both groups reported moderate and high MMD-HP scores with a mean score of 183.98. The mean scores for the level of moral distress for this study were moderate to high based on the maximum intensity score of 4. The three situations caused high level of moral distress were “Be required to care for more patients than I can safely care for” (*M* = 3.52, *SD* = .85), “Experience compromised patient care due to lack of resources/equipment/bed capacity (*M* = 3.48, *SD* = .85), and “Experience lack of

administrative action or support for a problem that is compromising patient care (*M* = 3.35, *SD* = 1.03). The lowest score was for "Witness a violation of a standard of practice or a code of ethics and do not feel sufficiently supported to report the violation" (*M* = 1.22, *SD* = 1.20). Compared to the frequency score, the finding showed low to moderate scores. These findings indicate that participants did perceive that the situations occurring frequently did cause the great distress.

The findings of this study were not surprising since the study was conducted during the COVID-19 pandemic. Nurses are on the frontline promoting health and advocating and caring for patients. Nurses have experienced workplace hardships and have faced moral dilemmas. In a previous qualitative study, one nurse commented that "the absolute worst part is watching these patients die and there is no one. Their families do not get to come see them" (Robinson & Stinson, 2021, p. 238. During the surge of COVID-19, nurses were also struggling with high patient workloads and frequent operational failures including missing supplies and missing or broken equipment (Lasater et al., 2021). The mean staffing in medical/surgical units varied from 3.3 to 9.7 patients per nurse, and New York City had the worst mean (Lasater et al., 2021). The reasons for staffing shortages were due to healthcare personnel exposures, illness, or need to care for family members at home (Centers for Disease Control and Prevention, 2021).

Other studies have shown conflicting results. Sirilla et al. (2017) used the MDS-R and showed higher scores for nurses who worked in the perioperative services (*M* = 135), critical care (*M* = 130), and procedure areas (*M* = 127) compared to medical/surgical (*M* = 76). But in Lusignani et al.'s (2017) study, nurses who worked in medical/surgical

settings and intensive care settings had high levels of moral distress. Further, in a recent study that used the extended version of the MMD-HP, the highest distressing concern was “Be unable to provide optimal emotional support to anxious and distressed patients/family members,” and “Be required to care for more patients than I can safely care for” was ranked fourth (Donkers et al., 2021). The results of my study differed because participants who had the lowest moral distress stated “Feel pressured to ignore situations in which patients have not been given adequate information to ensure informed consent.” This may reflect that the institutions established informed consent policies and practices.

Although the nurses in my study had moderate to high moral distress, 65% were not considering leaving the position due to moral distress. It seems participants possessed moral resilience and had effective coping mechanisms. Moral resilience is the capacity of an individual to sustain or restore integrity in response to moral complexity, confusion, distress, or setbacks (Rushton, 2016). Furthermore, healthcare workers can learn to respond positively to ethically challenging situations by building their capacity for moral resilience, and organizations can support them by creating a culture of ethical practice (Rushton et al., 2017). Nurses need to have strong support to overcome the difficulties not only during pandemic and also in their daily practices (Donkers et. 2021).

The findings of this study on perception of ethical climate showed that participants ranked their relationships with peers and patients the highest followed by managers, hospitals, and physicians. Lemmenes et al. (2018) reported the same rank order. Pauly et al. (2009) reported similarly, except the lowest rank was hospitals

followed by physicians. Furthermore, Pauly et al. suggested that participants had a good working relationship with peers and can depend on them in ethical dilemmas and issues. My study had a similar finding where participants had positive views and a working relationship with peers. Bartholdson et al. (2016) reported that physicians had the lowest score. In the nurse-physician working relationship, it is essential to have trust, teamwork, and collaboration. NRNs must be given support to learn and be part of the team. The nurse managers must advocate for the NRNs to facilitate supportive and positive ethical climate.

Psychological empowerment enhances the ability to cope with stressful work and leads to workplace empowerment (Spreitzer & Misha, 2002; Knol & van Linge, 2009). Increasing psychological empowerment may lead to reduced mental pressures and work environment stressors, as well as, enhance the power of decision-making and performing moral behavior by the nursing staff (Chang et al., 2010; Khoshmehr et al., 2020). Thus, psychological empowerment results in having a sense of control, competency, autonomy, positive impact, and increased motivation in relation to work environment, NRNs can properly manage moral dilemmas.

In this study, participants ranked meaning the highest dimension score followed by competence and self-determination. Work impact had the lowest score. The result showed that the participants for both critical care units and non-critical care units had higher psychological empowerment, but the scores for the four dimensions were unequal. The high score for meaning reflected that participants had a good understanding of their purpose and value of their profession. The scores for self-determination and competence

indicated that participants were capable of working independently and had autonomy to make job-related decisions. However, the lowest score for impact implied that participants felt they had little influence in the decision-making process and were not well recognized.

The findings of the study support my conceptual framework that that moral distress is a common experience. The causes of moral distress were linked to three levels: patient, units/teams, and system levels. For moral distress to occur, moral judgment and the presence of various constraining situations prevented the participants from carrying out their moral judgements. The participants' perception to moral distress, ethical climate, and psychological empowerment were exacerbated by lacking organization support and policies and interprofessional conflict. Furthermore, my findings also concluded that poor job retention was a consequence of moral distress.

Limitations

This study has both strength and limitations. The sample was relatively small and was taken from only one institution and one social media platform. Therefore, the generalizability is limited. There are several potential explanations for the low response rate. First, this study was conducted during the COVID-19 pandemic. Nurses were dealing with unprecedented demands from their patients leading to physical exhaustion. Second, the three instruments were lengthy and took time, at least 10 minutes to 20 minutes to complete. Third, the study may have not been seen as relevant. COVID-19 was associated with death and suffering, and nurses would have preferred to see a study related to COVID-19.

Implications

The study has the potential to influence positive change for nursing, institutions, and patients. Nursing leaders have an important role in evaluating the competency of nurses, balancing the needs of nurses and patients, and minimizing the negative impact of moral distress. The Joint Commission (2021) mentioned that the staff must have competency, which has three attributes: *knowledge, technical skills, and ability* to deliver safe care and correctly perform technical tasks. The nurse leaders must have a competency program to evaluate each staff member within their roles.

Effective working relationships between nurses and physicians is critical for patient care. The Joint Commission (2008) pointed out that safety and the quality of care patients receive depend upon the quality of the practice environment. Organizations with a positive professional practice environment, characterized by healthy and respectful nurse-physician relationships, are better able to recruit and retain the best nurses. High levels of communication, respect, and collaboration between nurses and physicians contributes to a better environment for patients (Galletta et al., 2013; Siedlecki & Hixson, 2015).

NRNs must have a good rapport with physicians. The main effects of poor communication in healthcare are a reduction in the quality of care, poor patient outcomes, wastage of resources, and high healthcare costs (HIPAA Journal, 2021). The Institute of Medicine (2010) mentioned that verbal or physical abuse and intimidating or disrespectful behavior by doctors toward nurses impacts the healthcare practice environment in a negative way, affecting both nurse retention and patient outcomes. This

study supports that poor working relationships among nurses and physicians contribute to moral distress and have an impact on participants. The inability in ethical decision-making and coping with organizational constraints that may predispose to nurses' apprehension affect their quality of care (Taraz, et al., 2020). Thus, it is critical that the healthcare institution must monitor the nurse-physician relationship and have policies in place to monitor any form of abuse. Recognizing the sources of moral distress, enhancing a positive ethical climate, and identifying psychological empowerment can play an important role in reducing nurses' stress and anxiety and increasing their self-confidence.

Recommendations

The findings of this study suggest key areas for future research. Replicating the study in a large diverse population and different settings would increase the generalizability of the study. Future studies may be designed to examine the effectiveness of differing interventions on moral distress recommended by American Association of Critical Care Nurses (n.d.) 4A's moral distress approach. Moral distress can be a challenging experience by NRNs and complex situations can be unavoidable. NRNs must be equipped with certain virtues such as moral courage and moral resilience that are necessary to navigate around times of moral distress.

Future studies can be designed to explore concepts, such as moral courage, moral efficacy, and moral resiliency related to moral distress. Rushton (2016) mentioned moral resiliency can be cultivated through self-awareness, self-regulation capacities, and ethical competence, as well as vocalizing with clarity and confidence.

Research could also be conducted to explore the moral distress, ethical climate, and psychological empowerment of other healthcare providers, such as physician, physical therapist, pharmacist, and physician assistant. The ethical dilemmas encountered for each healthcare provider as well as their source of support might be different. Future research should also explore the correlation of these three variables on retention and burnout.

Conclusion

The study was designed to examine the difference between frequency of moral distress, perception of ethical climate, and psychological empowerment among NRNs in critical care units and non-critical units. My results have the potential to contribute to increased understanding of the relationship between and variables that influence the perception of moral distress, ethical climate, and psychological empowerment. Moral distress is common in both critical care units and non-critical care units. In order to address the moral distress, ethical climate, and psychological empowerment, institutions must provide a supportive environment. With the current shortages of nurses, attention to moral distress and development of positive ethical climate and psychological empowerment are critical to positive patient outcomes and nurses' job satisfaction. Thus, identifying the possible causes are crucial and preventing the negative effects of moral distress can lead to a healthier working environment.

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Part 3: Summary

Integration of Three Studies

Common Themes

The three manuscripts provide new knowledge on how new registered nurses (NRNs) experienced and perceived moral distress, ethical climate, and psychological empowerment in their practices. There were commonalities in the three manuscripts of this study in that NRNs experienced moderate to high moral distress and the NRNs expressed the causes of the intensity of moral distress. The situation that caused high levels of moral distress was being required to care for more patients than could be safely cared for. However, the causes of the frequency of moral distress were different. For Manuscript 1, the highest cause of distress was following the family's insistence to continue aggressive treatment even though it was not in the best interest of the patient, in Manuscript 2 it was having excessive documentation requirements, and in Manuscript 3, it was being required to care for too many patients. Further, the most positive perception was related to peers, and the least positive perception was related to physicians. Previous research has similarly indicated that nurses experience differences between the frequency and intensity of moral distress (Oh & Gastmans, 2015). The results of the three manuscripts on psychological empowerment was related to doing work they found important. Though the findings must be interpreted with caution because my sample size was small and presented limitations for my results, overall my findings indicated that NRNs experienced moral distress.

Relation to Conceptual Framework

These studies were guided by Jameton's (1984) concept of moral distress. It was evident that moral distress was due to three levels—patient level, unit/team level, and system level—though the level and frequency of moral distress varied. Studies on moral distress and ethical climate among healthcare providers have also shown that both were associated with an intention to leave the job (Lamiani et al., 2017; Maningo-Salinas, 2010; Van den Bulcke et al., 2020). Although it was not part of my study to determine the correlation between moral distress and turnover, the three manuscripts showed that 26.1% to 41.7% of NRNs quit their position due to moral distress. These findings were higher than a study where 15% of nurses quit their work (Corley, 2001) but slightly lower than a study in 2006 where 43% nurses quit their job (Nathaniel, 2006). Thus, moral distress of nurses can eventually lead to leaving the job.

The three manuscripts also highlighted the importance of institutional culture and effective communication for a positive ethical climate. Ethical climate is nurses' perceptions of how ethical issues were handled in their work environment (Olsen, 1995, p. 90). When nurses face constraints on their ability to practice ethically and are forced to compromise the standard of practice, these can contribute to unsafe patient care, decreased job satisfaction, and attrition (Koskenvuori et al., 2017). The nurses' decisions were influenced by various factors. Clinicians' decisions are embedded in a cultural milieu influenced by national policy, financial incentives, resource pressures, patient and family factors, and institutional leadership (Dzeng & Curtis, 2018). Fostering a positive

ethical climate can be achieved by allowing all members to be included in decision-making and to be included as part of the team.

Unanticipated Findings

In Manuscript 3, the findings showed no difference in the effect of the work environment of NRNs in critical care units compared to NRNs who work in non-critical care on the level and frequency of moral distress, perception of the ethical climate, and psychological empowerment. This was unexpected; however, since the sample size was small, this finding may not accurately reflect the levels of moral distress in these two groups. Additionally, critical care units provide advanced management and treatment especially with a high volume of COVID-19 cases. There were other issues surrounding the COVID-19 management, such as staffing, lack of supplies, family visiting policy, and bed capacity. The possible reason for no difference in the moral distress was that non-critical care units were used as ICU capacity beds. Regardless of settings, nurses faced the same challenges during the COVID-19 pandemic, which included risk of injuries, infection, and depression. Depression may be related to nurses' anxiety about their health due to infection and stress concerning the workload associated with patients with COVID-19 (Al Thobaity & Alshammari, 2020).

Implications for Positive Social Change

The participants' responses demonstrated significant scores for "have you left or considering leaving" or "are you considering leaving the current position." This indicated that NRNs need to immediately address the possible causes of moral distress and prevent the negative consequences such as burnout, decreased retention, and lower quality of

patient care. The findings of the three manuscripts contribute to the understanding of moral distress, ethical climate, and psychological empowerment, which can lead to better understanding of nurses' perceptions of the organizational practices and relationships in their work settings with peers, patients, families, and other healthcare providers.

My results have implications for positive social change. Participants' experiences of moderate and high level of moral distress have possible implications on the nursing workforce that could further affect the critical shortage of nurses. The two reasons most cited by nurses and midwives for leaving were related to poor staffing, high workloads, and disappointment with quality of care that nurses provided (Nursing and Midwifery Council, 2017). The findings of this study showed the highest cause of moral distress was related to workload. Considering the importance of nurses to healthcare and the effect of moral distress on nurses, implementing strategies that affect retention are essential for the benefit of nurses, patients, and institutions. Strategies that address moral distress and ethical climate include supportive engagement, a clear vision, good feedback to healthcare professionals from supervisors, regular and structural debriefing, and a need for better accessibility to psychosocial support (Donker et al., 2021).

Areas of Future Research

Future research may examine the effectiveness of interventional programs on moral distress. The organizational ethics support structures are most effective at reducing moral distress (Rathert et al., 2016), and this can be explored. Additionally, future research should examine the determinants of moral distress, ethical climate, and psychological empowerment among nurses or other healthcare providers.

This study has the potential to contribute to the understanding of moral distress, ethical climate, and psychological empowerment although the response rate was low. Future research should replicate this study in a larger population and not be limited to one institution or social media. These results may not be generalizable to other institutions, but repeating these studies in a larger population may strengthen the findings.

Research Lessons Learned

The lesson I learned on this journey was to have an open mind, be flexible, expect the unexpected, and be positive. It was a challenging process because of COVID-19. Although I anticipated that having three instruments in addition to the demographic data could be difficult for the participants, I created a plan to address the issue. Additionally, I initially chose two medical centers with high numbers of NRNs, but only one took part in the study. In collaboration with one facility's nursing education, it was planned to give potential participants an IPad during their residency training to answer the surveys. This did not take place because of COVID-19, as face-to-face trainings were cancelled. Instead, I relied on the participants to answer the surveys on their own time. For the second facility, there were issues beyond my control, and I waited almost a year for resolution of the issues. Eventually, I decided to drop the facility. I reached out to several facilities, but some of them were only doing COVID studies and for others the IRB was suspended.

Another barrier I encountered was uploading instruments to SurveyMonkey. I could not design the MMD-HP exactly like the original survey where the level and

frequency were side by side. Because the level of moral distress and frequency of moral distress had to be entered separately, the MMD-HP appeared long.

Further, obtaining the target population was difficult. To increase the sample size, I added nurses' Facebook groups with the approval of the Walden IRB, but I was still not able to get the target sample. I experienced a lack of support among nurses from social media who had no understanding of the importance of my study. Despite the challenges I experienced, I was satisfied that my studies were able to answer the three research questions. I have a better understanding and learned to apply MANOVA for data analysis. In addition, I discovered and learned the growing concepts related to moral distress, ethical climate, and psychological empowerment.

Conclusion

The moral distress among NRNs in this study was reported across different settings. This study gives further insight into various issues of moral distress, perceptions of ethical climate, and psychological empowerment. The level of moral distress was reported to be moderate to high. Thus, the possible ethical dilemmas in clinical settings should be addressed. Nursing leaders and researchers should aim at decreasing the moral distress and enhancing the ethical climate and psychological empowerment. This might lead to quality care and employee satisfaction. Ethics education facilitates a positive ethical climate leading to increased nurses' organizational commitment, job satisfaction, collaboration with physicians, and decreased turnover intention (Lemmenes et al., 2018). Though most of the studies on moral distress have been focused on nurses, future

research should also consider other healthcare providers and examine the phenomenon of moral distress, ethical climate, and psychological empowerment.

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Appendix A: Dr. Hamric's Permission to Use the Instrument

Dear Dr. Mauro,
Thank you for writing and for your interest in moral distress. We have completed a significant revision of the Moral Distress Scale-Revised (MDS-R) and are no longer recommending this older scale. The new instrument, the Measure of Moral Distress for Healthcare Professionals (MMD-HP), has been validated and our results just published in the following citation:
Epstein, E.G., Whitehead, P.B., Prompahakul, C., Thacker, L.R., & Hamric, A.B. (2019). Enhancing understanding of moral distress: the measure of moral distress for healthcare professionals. AJOB Empirical Bioethics. DOI: 10.1080/23294515.2019.1586008.
I have attached a copy of the article for your review. There are three Supplemental Tables available at the Taylor and Francis website; the first Table is the full MMD-HP, including guidelines for scoring and interpretation.
You are free to use the MMD-HP so long as you cite the full article in any use; you do not need formal permission. Please read the article and carefully review the MMD-HP to ensure that it is appropriate for your research or planned project.
Best wishes,
Ann Hamric

****

Ann B. Hamric, PhD, RN, FAAN
Professor Emeritus, School of Nursing
Virginia Commonwealth University
Richmond, VA

Appendix B: Dr. Spreitzer's Permission to Use the Instrument

Gretchen Spreitzer [redacted]
Thu 4/25, 8:53 AM
Luzviminda Mauro

12-item empowerment instrument.doc
320 KB

Download
Save to OneDrive - Laureate Education – ACAD

Hello, yes, you have my permission and here is the instrument.
Best wishes!

Luzviminda Mauro
Wed 4/24, 7:44 AM
April 24, 2019

Good morning Dr. Spreitzer,

I am a PhD in Nursing student at Walden University currently working on my 3 manuscript dissertation. My study involves exploring the moral distress, perception of ethical climate and psychological empowerment of new registered nurses in non-ICU settings.

I would like to ask your permission to use your instrument Psychological Empowerment Index for my study. Also could you please send me a copy of this instrument.

Thank you for your assistance.

Sincerely,
Luz Mauro, DNP, PhDc, MBA/HCM, MSN/Ed, CCRN, RN-BC
Walden University Student

Appendix C: Dr. Olson's Permission to Use the Instrument

August 17, 2019

Luz Mauro, DNP, RN, MBA/HCM, MSN, CCRN, RN-BC
PhD Student
Walden University

Dear Dr. Mauro:

I am writing to grant you permission to use the tool, the Hospital Ethical Climate Survey (HECS) in your research on the relationships among moral distress, psychological empowerment, and perceptions of ethical climate among new Registered Nurses.

I would appreciate your keeping me informed of your progress, and also of sharing your results when you have completed your research. This sounds like an exciting study.

Thank you for your interest in the Hospital Ethical Climate Survey.

Sincerely,

Linda L. Olson, PhD, RN, NEA-BC, FAAN

Appendix D: Demographic Data

Please provide the following information. Your responses will be kept confidential.

Sex
____ Female
____ Male

Race/Ethnicity
_____ White
_____ Hispanic
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ Asian
_____ Other (please specify)

Age group (Age on last birthday)
_____ 20-30
_____ 31-34
_____ 35-40
_____ 41-50
_____ 51-60
_____ 61-70
_____ >71

Nursing Education
_____ Diploma
_____ Associate
_____ Bachelor of Science

Unit
_____ICU
_____PACU or Recovery Unit
_____Stepdown
_____Medical/Surgical/Telemetry
_____Emergency Department
_____Procedure Room
_____Ambulatory Unit