

Moral distress in public health practice: Case studies from nursing education

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Abstract

Moral distress in critical care nursing has been well studied; however, there is a gap in the literature related to moral distress among nurses and nursing students practicing in the community. This paper describes moral distress experienced during participation in the Interprofessional Care Access Network, a community-based nurse-led education and practice program providing longitudinal care coordination for underserved individuals and families in rural communities and urban neighborhoods. Two case studies represent client situations resulting in moral distress for nursing faculty and students. Contributing factors include unaddressed social determinants creating barriers to health and health care; inexperience and discomfort with people living in extreme poverty; lack of access to critical services for the most vulnerable; and powerlessness to influence discriminatory systems. Strategies are described to reduce moral distress and build moral resilience among students and faculty practicing in the community. Research is needed to expand understanding of causes, interventions, and consequences of moral distress in public health nursing.

KEYWORDS

moral distress, moral resilience, public health nursing, undergraduate nursing education, underserved populations

1 | INTRODUCTION

Moral distress is a familiar and common concern among nurses. This paper describes moral distress experienced by undergraduate nursing students and faculty participating in a clinical program requiring community-based placements and longitudinal engagement with underserved and disadvantaged clients. Included are a program description, case studies that caused moral distress among students and faculty, supportive approaches to address moral challenges, and recommended strategies for nursing education that build moral resilience.

Moral distress has been described as the response to a challenge to personal and professional integrity when persons are in violation of their core moral values and feel powerless to meet their perceived moral obligations. This definition presupposes institutional or rela-

tional constraints to taking the “right” action (Peter & Liaschenko, 2013; Rushton & Carse, 2016; Rushton et al., 2016). Individual responses to moral distress can be emotional, spiritual, behavioral, and physical, and over time affect the quality of patient care and job satisfaction (Rushton et al., 2016). While moral distress can contribute to professional burnout, in some situations it may be positive—calling attention to ethically troubling situations and facilitating personal and professional growth and institutional change (Rushton et al., 2016, 2017). Over time and with intention, nurses can build moral resilience allowing them to stay true to their values while remaining flexible enough to navigate the reality of clinical practice (Rushton & Carse, 2016).

Consistent with studies related to nursing education and practice, developmental researchers and experts suggest that resilience can be developed. Recommended strategies for health professions students

include encouraging lifelong learning, realistic self-assessment, moving out of ones' comfort zone and participating in new experiences, and learning to embrace challenges (Duckworth et al., 2007). It is incumbent on nurse educators to integrate these and other evidence-based practices into curricula to better prepare students for the challenges ahead.

2 | LITERATURE REVIEW

In nursing, much of the research and conceptual analyses on moral distress has focused on acute and critical care practice related to patient suffering, use of advanced technology, and end of life care (Bickhoff et al., 2017; Henrich et al., 2017; Rushton & Carse, 2016; Traudt et al., 2016; Wolf et al., 2016). Very few papers have been published regarding moral distress among nurses in public health practice. Issues related to end-of-life care, team conflict, and organizational culture likely cross the spectrum of professional nursing environments, although related concerns may be qualitatively different in the community. Additional moral challenges may be exclusive to community-based practice specialties (Mendes, 2017).

Nursing students and new nurses are especially vulnerable to moral distress. Students see themselves as low on the health professions' hierarchy, and frequently stay silent when faced with moral conflict (Bickhoff et al., 2017). Disempowerment contributes to their moral distress, which is commonly focused on unjust and disrespectful treatment of the students themselves (Thomas & Burk, 2009) and patient care issues, including observation of substandard practice, hierarchy, and interprofessional conflict, and systems deficiencies (Bickhoff et al., 2017; O'Mara et al., 2014; Krautscheid et al., 2017; Rees et al., 2014; Renno et al., 2016). Students come to their academic life with differing coping capacities, and faculty have the opportunity to build on individual strengths and teach how to effectively address moral challenges and manage adverse responses. Novice nurses are particularly vulnerable to moral distress as they transition to practice because they lack confidence, frequently encounter new situations, and may not understand available resources in their practice environment (Rushton & Carse, 2016).

Because moral distress is so common in health care work, moral resilience is an essential characteristic. Moral resilience has been defined as "the capacity of an individual to sustain or restore, or deepen integrity in response to moral adversity", and characteristics include personal and professional integrity, the ability to recover from disappointment, "self-regulation, self-stewardship, and moral efficacy" (Holtz et al., 2018, p. e489; Rushton, 2016). Studies have identified strategies for building moral resilience, including transformative ethics education; self-reflection, and mindfulness (Traudt et al., 2016); creation of moral community; interprofessional collaboration, and ethical discourse; and attention to institutional moral climate and resources (Rushton & Carse, 2016; Rushton et al., 2016; Ulrich et al., 2010). For nursing students developing moral resilience, Bickhoff et al. and Levett-Jones (2017) recognized that supportive relationships with faculty or mentors are critical for developing strategies to deal with moral chal-

lenges. Broad social support and confidence in their ability to accomplish goals have also been shown to reduce moral distress and increase resilience among students (Krautscheid et al., 2019).

Moral agency and moral courage are important factors contributing to the development of moral resilience and are foundational as students learn to advocate for patients (Bickhoff et al., 2017). Moral agency has been defined as "the ability to live one's values and moral commitments" (Rushton, 2016) and relies on values identification, the ability to be responsive and flexible, and the capacity to find meaning and recover from distressing and disappointing situations in practice (Holtz et al., 2018; Rushton, 2016). In nursing education, moral agency can be developed through robust ethics education including identification and integration of personal and professional values with clinical practice (Peter & Liachenko, 2013).

Like moral agency, moral courage can be taught. The most effective strategies include role modeling, mentorship, and reflection (Gibson, 2019). If students do not have the courage to take action when confronted with poor practice or other morally distressing situations, they are vulnerable to ongoing moral distress (Bickhoff et al., 2017). Without tools to cope, new nurses may burn out early in their careers and even leave nursing practice (Krautscheid et al., 2019).

Nurse educators have an opportunity and an obligation to prepare students for the moral dimensions of practice. The program described below provides undergraduate nursing students with meaningful engagement with underserved individuals and communities. Students are exposed to new and morally challenging situations, supported and coached through responses and decision-making, and participate in learning activities designed to build moral agency and courage, and ultimately, moral resilience.

3 | PROGRAM DESCRIPTION

A collaborative academic-practice model was developed to provide nursing students with authentic and meaningful clinical experiences in communities that also benefit partner agencies. The Interprofessional Care Access Network (I-CAN) is a nurse-led community-based clinical education and practice program in which supervised teams of health professions students focus on social determinants of health (SDH) and health equity to provide care coordination for marginalized people and populations in four underserved urban neighborhoods and three rural communities (Wros et al., 2015). The program provides high value population health placements using an innovative nurse faculty practice model and longitudinal engagement with community partners, including clinics and social service agencies that refer clients based on established criteria. Students and faculty develop relationships with clients and learn from and with them over weeks and months through home visitation focused on achieving health outcomes identified and prioritized by clients. Students see first-hand how chaos, instability, racism, and adverse SDH affect clients' health and ability to navigate the health care system. In many cases, students are faced with the futility of client situations and frustrated by gaps in health care and social service systems that create barriers. They often feel inadequate to intervene

because of their student status, the traditional scope of health care, and system complexity.

Over 1700 nursing, dental, medical, pharmacy, and nutrition students have participated in I-CAN; this paper focuses on concerns related to moral distress for the 1055 undergraduate nursing students. Student teams have provided longitudinal care coordination for more than 755 clients over the past 8 years. An early and unexpected response to participation in the program was the high degree of moral distress experienced by both students and faculty. Exemplars causing moral distress are described, along with strategies implemented to reduce moral distress and build moral resilience.

3.1 | Clinical case studies

Case studies were identified by nursing faculty who serve as faculty-in-residence, maintain a clinical practice providing care coordination for disadvantaged clients in collaboration with local clinics and agencies, and supervise students rotating through the neighborhoods or community placements. Specific situations were identified that caused significant moral distress for nursing students and faculty. Keep in mind that moral distress is dependent on the conflict between professional ethical codes, individual perspectives, and values-based life experiences; it also presumes the perception of powerlessness to act ethically. The I-CAN protocol, including dissemination, has been approved by the university institutional review board.

3.1.1 | Case study A

A 66-year-old man with end-stage multiple organ failure who wanted to die at home was referred by a clinic provider. He could not manage independently but did not want to be hospitalized or receive aggressive end-of-life medical interventions. He wanted help controlling pain and transferring belongings to his estranged daughter.

Initially, the I-CAN team connected with the client by phone since he was fearful of home visiting but too sick to leave his house. Weekly calls were made for check-in and follow-up communication with the provider. The team identified that he had intermittent confusion, shortness of breath, difficulty with mobility, and learned that he had stopped taking his medications. After 2 months, he agreed to meet at the local senior center. Students observed that he suffered from respiratory distress, muscle wasting, jaundice, abdominal distention, peripheral edema, and leg ulcers. After meeting the team, the client allowed regular home visitation. An environmental assessment exposed an unsafe and unsanitary home. Trash and collections were piled shoulder-high around the entrance through a structurally unsound garage. The client used an open lit oven to heat his home; food and garbage littered the kitchen. Towering accumulations of belongings lined walking paths and obstructed windows on the first floor. He dragged an oxygen tank and nasal cannula behind him through the house. The client's hygiene was poor, and his clothing dirty. He was unsteady on his feet and unable to

balance with his cane. He mistrusted people, but had one friend who visited occasionally.

The client was diagnosed with multiple chronic health conditions, including heart disease, COPD, urinary tract infections, prostatitis, methicillin-resistant staphylococcus aureus, diabetes with cellulitis, and ulcerations, pancytopenia, and hepatitis C. He described past experiences contributing to his poor health, including motor vehicle accidents, lifestyle choices, industrial exposures, and incarceration. The I-CAN team visited weekly, providing resources and services to manage at home, performing weekly assessments, and connecting with medical and social service providers.

Students experienced moral distress because of the hopelessness of the situation—realizing that they could not solve all the identified problems. They could not connect with the client's daughter and despite their interventions, he was not completely safe in his home. They were concerned that he would not be able to remain at home as requested and felt powerless to change the outcome. Eventually, nursing students and their faculty were instrumental in getting the client enrolled in home hospice, but he died in the hospital—against his wishes. The team had some measure of moral resolution because they knew he stayed home as long as possible and died in relative comfort without aggressive medical treatment.

3.1.2 | Case study B

A 38-year-old woman with tuberculosis-induced lung damage resulting in COPD and pulmonary hypertension was referred by a community partner. The woman was a refugee from a remote Middle Eastern region and spoke only Arabic. Her migration story was traumatic; government militants destroyed her village and she fled with her family to a refugee camp, where she met her husband and gave birth to three children. Conditions at the camp were desperate, and the family was fortunate to receive refugee status with subsequent resettlement in Oregon.

Although living in the United States was safer, it was challenging to adjust to a new culture and language without many resources. The client's husband worked in a factory and their children attended elementary school. The client had severe dyspnea and the portable oxygen tanks kept running out. No one in the family spoke English so they could not contact the medical supply company; consequently, she went for days without oxygen until the students taught her how to order refills. They discovered that the client had a complex medication regimen with prescription medication bottles labeled in English that were incomprehensible to her. The inhalers, critical to her well-being, were empty and she did not know how to tell when they ran out. Over several weeks, students helped her understand and manage her medications using a sectioned pillbox and basic translated Arabic instructions.

Despite the hardship of managing a chronic and deteriorating medical condition in an unfamiliar culture, this woman demonstrated inspiring resilience and strength. Her prognosis was poor, despite improved medication management. The pulmonologist recommended a lung



transplant, which was unavailable in Oregon. The I-CAN team and the refugee resettlement social worker partnered to prepare the family to move to another state for the surgery—arranging for housing, case managers, and new employment for the husband, and back-up caregivers.

I-CAN team members experienced moral distress when they learned that the client did not qualify for a transplant because of her poor English, lack of stable income, inadequate support network, and history of missing appointments. Citing the history of missed appointments was especially distressing since the medical transportation system had failed to pick her up on multiple occasions—even though students had confirmed appointments. Poverty, low English proficiency, and lack of social support are typical challenges for newly arrived refugees and due to circumstances out of their control. It was morally distressing for the I-CAN team to witness her Herculean efforts to succeed in America and yet be denied life-saving treatment. Students had developed a relationship with the family and were invested in the outcome, only to find that the selection process for the transplant program seemed biased against the most vulnerable—including newly arrived refugees. The students felt powerless and there was nothing they could do to change the decision of the transplant program.

The client's provider tried to adjust medication dosages to effectively treat her health conditions, but was unaware that the medications were not consistently taken as prescribed because she could not read the label or remember verbal instructions. Although technology is available to print medication labels in languages other than English, the service is generally used by pharmacies only if required by state legislation. The client was ultimately referred to palliative care, with some clinical improvement. She was not going to receive a transplant, but felt better and would be able to enjoy her remaining life with her young family. This resolution was a compromise that was difficult to accept for the students, who felt that they did not have the expertise or influence to impact biased systems.

4 | DISCUSSION

Critical care nurses most often report moral distress related to end-of-life situations and futility of care (Traudt et al., 2016). In contrast, these cases situated in public health nursing illustrate different stressors causing moral distress for faculty and students. Factors contributing to the development of moral distress were identified from I-CAN chart notes, team huddles with community partners, post-conferences, and student reflections. The themes included unaddressed SDH challenges, inexperience and discomfort with extreme poverty, lack of access to critical services, and powerlessness to affect discriminatory systems. Because of the paucity of published information about moral distress among public health nurses or students in community rotations, it is unknown whether similar experiences affect those providing nursing care for vulnerable people in underserved neighborhoods and communities.

4.1 | Unaddressed SDH challenges

People seen in health care settings are typically seen out of their context. Vulnerable people may not disclose barriers to the plan of care, even when asked, and critical SDH issues such as unsafe housing, food insecurity, and lack of access to transportation can be invisible to nurses and other team members. Because of misunderstandings between providers and patients, people can be labeled “non-compliant” when, in fact, their multiple barriers are unaddressed. Instead of attributing poor intent or making assumptions, care could be improved by asking “what happened?” and assessing patients' home and community circumstances. I-CAN teams were often able to gain additional and essential information about clients' situations and life stories through longitudinal home visitation and building relationships. One critical role has been to relay more accurate and compassionate narratives about clients' lives to health care providers and their interprofessional teams to inform and improve care planning.

4.2 | Inexperience and discomfort with extreme poverty

While many students come to nursing school from disadvantaged backgrounds, the considerable level of poverty in the community was unfamiliar and uncomfortable for most. Lack of financial resources gave clients limited or no options to address their most pressing needs. Although clients were not always accessing available resources and may have been limited by ineffective health care behaviors, a lifetime of poverty, and related disempowerment was difficult to overcome. Many nursing students identified an overwhelming sense of hopelessness and helplessness on behalf of clients, but used persistence and creativity to advocate and identify services to help achieve client goals despite the barriers.

4.3 | Lack of access to critical services

As team members became aware of resource needs for clients, they also became aware of systemic gaps in health and social services. Moral distress occurred when clients could not access critical services due to complex requirements and processes or because resources did not exist. Students worked with people who were houseless, assisting with the complicated steps of obtaining identification and medical testing, and completing multiple housing applications—only to learn that units had special requirements or years'-long waitlists. A developing body of evidence demonstrates the positive impact of housing on physical and mental health outcomes and cost reduction for health care services (Fenelon et al., 2017). The tension between students' academic understanding that people who are housed have better health outcomes and the experience with barriers for getting housed was morally challenging.

4.4 | Powerlessness to influence discriminatory systems

The cases highlight federal, state, and local policies and systems that were often discriminatory and complex to navigate. Evidence of systemic racism and xenophobia were embedded in many client situations. Laws and norms in many communities have been established without considering the diverse needs of the population, such as non-English speakers or low-income families that do not often have a political voice. For example, students working with immigrants and refugees learned that families consistently had challenges with medication management and errors because they were not able to read prescription labels written in English. Clients were confused about dosing, medication storage, refilling prescriptions, and following up with the provider; students and faculty were dismayed at this gap in the system that regularly caused harm.

Working with individual clients and families in neighborhoods over time allowed students and faculty to identify and understand the broader population health issues. Some concerns could be addressed by I-CAN teams, community organizations, and activists, or brought to the attention of public authorities. However, many seemed intractable—requiring significant social and political change. I-CAN students' frequent and personal confrontation with these issues combined with their perceived powerlessness contributed to their moral distress.

4.5 | Lessons learned

Early in the program, I-CAN leadership realized that close engagement with marginalized individuals, families, and populations was resulting in symptoms of moral distress among students and faculty. Faculty felt overwhelmed, exhausted, and overloaded, and some did not continue to teach in the community. Some students indicated they would not consider public health nursing as a career because it was so disheartening and stressful. These responses were in part symptomatic of unaddressed moral distress. The undergraduate nursing curriculum includes comprehensive ethics education, including bioethical principles and approaches, the ANA Code of Ethics, problem-solving models, organizational ethics, microethics, and reflection about personal and professional values. For students practicing in the community, additional focused activities were designed to provide tools for managing moral distress in public health practice.

4.6 | Faculty moral community

The I-CAN team began addressing moral distress proactively when community-based faculty shared stories about the impact of client situations. Consistent with recommendations by Traudt et al. (2016), the faculty group dedicated regular time for their own confidential debriefing. The opportunity to develop a moral community and share the circumstances of their practice, get support and feedback, and provide

learning for team members was critical for developing resilience among faculty serving as student role models.

4.7 | Student reflection and discussion

Faculty incorporated learning experiences related to moral conflict into I-CAN student orientations. As recommended by Rees et al. (2014), faculty provided students with safe spaces to make sense of clinical situations and consider responses and actions. They helped them understand health care culture and adjust expectations. Formal guided discussions and informal conversations provided regular and intentional outlets for students to reflect on their experiences, normalize their feelings, find support for “doing the right thing”, and consider ways to manage moral distress. Students had the opportunity to hear from other students with similar experiences and feelings and engaged in planning next steps for themselves and their clients.

4.8 | Focused learning activities

When engaged in longitudinal clinical experiences such as I-CAN, students have opportunities to practice supported moral courage—an important step towards development of moral resilience (Bickhoff et al. 2017; Gibson, 2019; Holtz et al., 2018; Rushton, 2016; Young & Rushton, 2017). A concept-based learning activity (Nielsen, 2016) entitled *Moving from Moral Distress to Moral Courage* was developed in the population health course to support structured discussion. A study guide required for I-CAN students included readings about best practices for managing moral challenges. Students reflected on a clinical situation that created moral conflict and identified a plan for mitigating moral distress. Faculty also encouraged students to ask public health professionals about their own coping skills. These activities and interviews provide students with the start of a toolkit for managing moral conflict that they will experience in practice.

4.9 | Empowerment for action

Students were empowered to advocate for clients with community and health care agencies and providers. They contacted social service agencies to explore benefits, participated in planning meetings with community partners, and accompanied clients to appointments. Taking action helped them to address moral concerns, develop professionally, and make progress toward client goals and outcomes. In response to repeated encounters with systemic barriers causing moral distress, student teams identified, developed, and implemented population-based strategies to address community concerns, including organizational and policy solutions. They collaborated with community partners to prioritize and develop interventions—sometimes over many months by subsequent clinical groups. Faculty provided opportunities for activities such as attending state legislature public health advocacy days, meeting with political leaders, and learning

equity organizing principles. Political activism equipped students with powerful tools for action motivated by moral distress. In one example, students responding to the concern about medication errors in refugee populations worked with faculty for over 2 years to bring a bill to the Oregon legislature to require pharmacies to label prescription drugs in a person's primary language. ORS 698 was passed for the benefit of non-English speakers in the state and helped students understand the impact that nurse advocates can make on the health of a population.

4.10 | Implications for nursing education in community settings

Innovative ethics education and moral learning in the curriculum relies on affective, cognitive, and psychomotor domains. Students can prepare for moral conflict in the community through targeted learning activities, such as case studies, role-playing, or guided reflections. Clinical faculty are situated to develop trusting relationships with students individually and in groups to explore moral challenges, guide value-laden debriefs to manage moral complexity, discuss unconscious biases and systemic inequities, support students to act courageously and build resilience. With the support of a network of faculty, peers, and preceptors, students have opportunities to respond appropriately and professionally to distressing situations and emerge with new commitment and abilities to navigate and even change existing systems on behalf of underserved and vulnerable people.

High quality, authentic community-based placements provide opportunities to engage in experiences that challenge nursing students' developing professional values and build capacity for moral resilience. Supported experiences in teamwork, community partnerships, and community and political activism teach students to think and act upstream. Empowered students can directly address problems causing moral conflict by advocating for people, questioning policy, or practices, and developing resources and services to address systemic gaps.

Given the described experiences, it is likely that the causes and resolutions of moral distress for public health nurses are different from those previously identified in acute care. There remain significant gaps in understanding of the causes, interventions, and consequences of moral distress among students, faculty, and nurses practicing in underserved communities. While there may be consistent patterns regarding moral distress and resilience across practice settings, our experiences indicate there may also be unique factors that could affect students' interest in careers in public health and contribute to the burnout of nurses and faculty engaged with this work. Additional study of the causes and impact of moral distress among public health nurses is a necessary next step that has the potential to improve their well-being and resilience, advance effective practice, and reduce attrition.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study

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