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Moral Courage and the Nurse Leader

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Abstract

Today's nurse leaders practice in very complex environments. This complexity leads to value conflicts and creates the potential for moral distress. Jameton's sentinel work framed the concept of moral distress as arising when one knows the morally right thing to do, but cannot do so because of organizational constraints. In this article the author reviews sources of moral distress among nurse leaders, discusses the nurse leader's responsibility for demonstrating and supporting moral courage, identifies threats to moral courage among nurse leaders, offers strategies to promote moral courage, and makes recommendations for the continuing development of moral courage.

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Today's nurse leaders practice in very complex environments. This complexity leads to value conflicts and creates the potential for moral distress. Jameton's (1984) sentinel work framed the concept of moral distress as arising when one knows the morally right thing to do, but cannot, due to organizational constraints. Jameton observed that moral issues are defined not by the scientific how-to's, but by questions of ought-to's, adding that knowing 'how' to provide care is different from deciding 'what' care to provide and 'to whom' we should provide care. Jameton has suggested that nursing is the moral center of healthcare and provides the true image and inspiration of ethical care and compassion.

In 2002, Corley expanded on Jameton's (1984) work to include conflict arising when nurses' commitment to the organization and/or physician is misaligned with their duty to patients. Repenshek (2009) reported that this continuing conflict eventually leads to chronic stress for patient care providers. Moral distress can lead to burn out, 'hardening,' disengagement, and lack of focus on the primary work of nursing. Rashotte (2004) referred to the inability to

successfully resolve moral distress as the “stories that haunt us.” These stories often describe situations related to patient advocacy, end of life, futile treatment, and role conflict based on values.

Corley (2002) noted that because nurses act as moral agents in the healthcare system, the patient, nurse, and organization all benefit from nurses’ acts of moral courage. These acts have the potential to increase nurse retention, promote patient comfort, relieve patient suffering, and enhance the reputation of the organization.

Although moral distress among direct-care nurses has been well explored, the experience of moral distress among nurse leaders is virtually absent in the nursing literature. The stories that haunt nurse leaders often emerge from the same situations as those that haunt direct-care nurses. It is important that nurse leaders support direct care nurses in facing these situations and address these situations in their own work by demonstrating moral courage.

Sekerka, Bagozzi, and Charnigo (2009) have described the concept of ‘professional moral courage’ as a managerial competency. Although not specific to nurse leaders, their work is easily applied to the work of nurse leaders. Sekerka, Bagozzi, and Charnigo found that the leader who considers more than rules and policies, who demonstrates hardiness and determination, and who is self directed toward the good or what is right and moral routinely displays acts of moral courage. They added that education and training greatly improve a leader’s will to proceed in the face of difficult situations.

Although finding, utilizing, and evaluating a specific model to decrease moral distress by bolstering moral courage in today’s nurse leaders remains elusive, nurse leaders must develop, role model, and practice moral courage as the first step to decreasing moral distress in the profession. In this article I will review sources of moral distress among nurse leaders who hold formal leadership positions within a healthcare organization, discuss the nurse leader’s responsibility for demonstrating and supporting moral courage, identify threats to moral courage among nurse leaders, offer strategies to promote moral courage, and make recommendations for the continuing development of moral courage.

Sources of Moral Distress among Nurse Leaders

Moral distress in nursing arises from a variety of sources. These sources may include a nurses’ reaction to the situation, continuation of the situation causing the distress, complexity of the environment in which the distress occurs, and characteristics of the nurse and the situation producing the distress. Each will be described below.

Moral distress among nurses is seen in two different dimensions, described by Jameton (1984) as the initial dimension and the reactive dimension of moral distress. Initial moral distress is the distress nurses experience when they are faced with interpersonal value conflicts. It is experienced as feelings of frustration, anxiety, anger, and an inability to act as one sees fit due

to organizational constraints. Reactive moral distress is the distress nurses experience when they do not act upon the initial distressing situation to bring about resolution.

These acute manifestations of moral distress, if not acted upon and resolved, lead to moral residue, or the additional development over time of regret, anger, and frustration. An example may be that of nurse leaders who value excellence in care and believe the staffing standard for their unit is not appropriate to the patient population being cared for, thus interfering with quality outcomes, yet who chooses to 'live with the standard' instead of speaking up and actively working to change the target. These feelings of anger and frustration may be turned on themselves in the form of low self-esteem, self-hate, and job dissatisfaction, or turned on others resulting in horizontal violence directed at peers or the offending source (Corley, 2002). Repetition of this 'moral action paralysis' creates what Levi, Thomas, Green, Rentmeester, and Genevia (2004) have referred to as 'jading,' which is the worn-out state that results from consistent and prolonged pressure to perform distressing tasks in relation to the moral position of the nurse (leader). Coles (2010) added to the observations of Levi et al. by suggesting that the cost of sustained moral distress can be absenteeism, morale issues, and poor productivity for the organization along with emotional exhaustion for direct-care nurses and nurse leaders.

Moral distress permeates nursing due to the nature of the profession, especially in light of the increasing complexity of the healthcare environment that may include performance expectations, finite resources, technology advancement, aging of the population, and the competitive globalization of healthcare. The healthcare environment is characterized by emotionally charged issues for patients, families, and providers, creating fertile ground for reasonable people to disagree on the decisions as to what is 'right' and what is 'morally right' (Nathaniel, 2006).

Mohr and Horton-Deutsch (2001) offered two explanations for action/inaction on the part of the nurse, namely the nurse's dispositional status (characteristics), and the nurse's situational status. Dispositional status represents the individual psychological characteristics of the nurse regarding personal beliefs, values, and convictions that influence the decision to act. Situational status represents the characteristics of the situation, i.e., the extent to which they meet a threshold for action to be taken by the nurse. Mohr and Horton-Deutsch contended that it is likely that neither explanation is singularly responsible for action or inaction. It is more likely that an interaction effect is occurring with cultural ideology as a context.

Nurse Leader Responsibility

Our nursing leaders and professional organizations have made it clear that nursing leaders are responsible for creating cultures that support acts of courage in nursing. The American Organization of Nurse Executives has advocated for the creation of healthful work environments that support moral courage by identifying nine elements/principles for nurse leaders to integrate into member organizations. Principle Five calls for leadership to be competent, credible, visible, and expert. These behaviors are seen in leaders who demonstrate

moral courage. Other nursing leaders, and also professional organizations, have issued calls for leaders who are able and willing to demonstrate moral courage as described below.

Corley (2002) described the 'courage to take action' in a morally distressing situation as verbally acting to alleviate the initial moral distress felt by nurses in morally conflicted situations. This may be thought of as using one's voice to express or advocate for an action to alleviate or reduce moral distress experienced by self and/or others. Buresh and Gordon (2006) shared that nurses must find their 'voice of agency' to act with courage, conviction, and capacity. Such courage to speak up is supported by many state nurse practice acts that require nurses to act out their professional duty as agents of patient safety, maintain professional practice boundaries, and protect patient rights. Lachman (2007) described moral courage as the individual ability and capacity to overcome fear and openly support one's core values. Acts of moral courage occur in public and private settings within healthcare organizations that provide not only the context but also the channels for these acts to occur. Nurse leaders need to develop the ability to role model 'speaking up.'

Ketefian (2001), in her work with the Midwest Nursing Research Society, addressed the need to develop moral reasoning as a pre-requisite to demonstrating moral courage. She also noted that there has been too much of a focus in the moral courage literature on the individual characteristics of the nurse, and not enough focus on the environment created by nurse leaders in the organization. Ketefian (1980, 2001) has identified the need to increase research that will enhance our understanding of environmental and organizational factors that impact a nurse's ability to act in a morally courageous manner.

The American Nurses Association (ANA) in the Code of Ethics for Nurses (2001) has called for nurses to act when a patient's or nurse's rights are violated through decisions made by others. Nurse leaders experience moral distress related to patient care much the same as do direct-care peers. However, the uniqueness of the combined, and often conflicting roles of nurse and leader create additional opportunities for leaders to experience moral distress due to the added responsibility of leaders to both self and the organization. Grossman and Valiga (2009) have described this leadership challenge as one of being morally fit and also creating healthy disorder to challenge hierarchy, tradition, cultures, and norms that mitigate against healthful work environments for the purpose of providing quality care for patients. In Nursing Administration: Scope and Standards of Practice (ANA, 2009), nurse leaders are directed to define ethical frameworks for administrative practice and provide leadership in establishing an ethical culture at the bedside for the direct-care nurse, a culture that is inter-professional in nature. This standard includes a commitment to self-care for nurse leaders through stress management and connections with self and others.

Threats to Moral Courage for Nurse Leaders

Jameton (1984) described how the nature of nursing practice can create moral distress due to differences between actual and expected experiences. This process begins during the pre-licensure education of nurses and continues throughout their professional career. These

differences occur because nursing emphasizes prevention and humanizing of the individualized care provided, using high-touch, relationship-oriented care that often conflicts with the curative, standardized nature of hospital-based care that values high-tech, production-based, and efficient care. These differences contribute to the value conflicts that plague the healthcare system. The authority gradient and the clinician-organization conflict can both contribute to these differences.

Authority Gradient

The authority differences in healthcare organizations that are related to differences in roles and positional power between physicians and nurses, administrators and nurses, and nurse leaders and nurses can create repression of personal values. The authority gradient (AG) is the command hierarchy of power, or the balance of power, measured in terms of steepness. The authority gradient can influence both patient care and organizational decisions by repressing those in subordinate positions, keeping them from influencing or making decisions they consider to be the most appropriate. Speaking truth to power must be encouraged and developed in nursing professionals to mitigate the negative consequences of the AG and to improve healthcare systems.

Nurse leaders need to understand how this gradient affects their professional decision-making power within the organization. Strong shared governance models and positioning of nursing within the organization provide mechanisms to reduce the steepness of the authority gradient. Examples of organizational positioning of nursing include arranging for the chief nursing officer to hold membership and voting privileges on the Board of Trustees and developing nursing committees that report directly to the Board, bypassing traditional hierarchical positions that might not support initiatives proposed by nursing.

The Clinician-Organization Conflict

Nurse leaders desire to, and are expected to balance diverse and competing interests of patients, families, physicians, employees, and organizations while maintaining a moral environment. Nurse leaders are different from many other healthcare leaders in that they move between the clinical and administrative/organizational domains in healthcare settings. Their decisions need to be multilayered and contain increasingly scaffolded elements of risk to themselves as nurses and as leaders. Rashotte's hermeneutic-phenomenological study (2004) suggested that acute moral distress, unresolved by moral action, creates moral residue or stories that haunt us and continually resound within us. The concepts of 'looking back"' or 'moral regret,' as described by Wurzbach (2008), emphasize the influential role of moral certainty as predecessor to and sustainer of the ability to act. Moral certainty, as defined by Wurzbach (2008) is the inner conviction to such a high degree that it is sufficient for action. In her research Wurzbach found that nurses who exhibited moral uncertainty regarding a situation and those who had very little time to plan a response were more likely to experience moral regret. Increasing moral certainty and allowing for planning, discussion, and anticipation of outcomes may prevent moral regret and subsequent moral residue in nurse leaders.

Nurse leaders are not exempt from the need to plan ahead in their work so as to find moral certainty in the decisions they make. Nurse leaders who intentionally provide for and invite open discussion of decisions from a moral perspective and who avoid last minute, rushed, and unplanned decisions have the greatest opportunity to assist others in avoiding moral regret. Email, although efficient from many perspectives, may not be the most effective way to deliver or discuss decisions with potential to contribute to moral distress. In-person and phone conversations allow for generative discussion, planning, and moral decision making through active dialogue. They allow the nurse leader to consider both the clinical and organizational demands of the situation.

Nurse leaders work in inter-professional teams that often include non-clinicians having limited or no experience in providing direct patient care. These team members may have backgrounds in finance, organizational operations, and/or administration but not in clinical endeavors. Bringing the clinical perspective to the team often means educating the team on care processes by describing how specific types of care can create specific outcomes and addressing the specific ethical conditions in a given situation.

To influence inter-professional teams nurse leaders must translate the work of nursing into familiar terms and paint a picture for their colleagues describing how their colleagues' actions and/or areas of responsibility impact clinical providers and patient outcomes. Nurse leaders who obtain knowledge outside of the clinical domain and broaden their experience to include knowledge of ancillary operations and financial processes can better influence their organizational colleagues for the betterment of patient care. Nurse leaders may 'level their playing field' by becoming members of, and fellows in healthcare-related organizations, such as the American College of Healthcare Executives (ACHE). Nurse leaders who learn and apply the ACHE code of ethics in discussions with their colleagues may better influence the moral decisions of those having decision-making authority.

Conflict is inherent in the nurse-leader role in healthcare organizations. Nurse leaders who invest in mastering the skills of negotiation, mediation, conflict resolution, and expert communication will possess the necessary skills for an effective and meaningful career in nursing leadership. For most nurse leaders this requires both education beyond the baccalaureate level and also participation in professional workshops, retreats, and continuing education offerings.

Strategies to Promote Moral Courage

At times a nursing leaders' moral compass, i.e., the moral and ethical values they use to guide their decision making, may appear to be directionally challenged. This challenge frequently results from the leader's conflict between their nursing values and the values of the organization in which they lead. These conflicts may occur in areas such as organizational finances, staffing, care delivery, and/or research studies. As nurses advance into leadership positions, the complexity of the decisions they need to make increases, as does the potential for moral distress. Grady et al. (2008) and Ulrich et al. (2007) both found that nurses and social

workers who had participated in educational offerings focusing on ethical decision making utilized ethics resources more frequently than did their counterparts who had not received classes in ethical decision making. These findings suggest that providing advancing nurse leaders with education related to ethical decision making will increase their chances of job satisfaction and success. The strategies below are designed to help nurse leaders develop moral courage.

The 4 A's Framework

The American Association of Critical-Care Nurses (AACN) has identified the prevention/alleviation of moral distress as one of the greatest areas in need of resolution in healthcare. In 2004 this Association published a model for decreasing moral distress among critical care nurses utilizing a framework called The 4 A's. These 'A's' include: Ask, Affirm, Assess, and Act. Although the model was created primarily for critical-care nurses, the generalist nature of the 4 A's provides a solid foundation upon which a nurse leader can draw when confronting moral distress.

The initial step of 'Ask' provides nurse leaders an opportunity to look internally for the manifestations of stress in their physical, emotional, behavioral, and spiritual domains. The goal of the first step is awareness of the moral distress in oneself. Identifying distress in oneself requires introspection, reflection, and honesty coupled with a willingness to view situations and responses through a different lens.

After identifying the presence of distress, the nurse leader must 'Affirm' the responsibility to oneself and profession to address the source of the moral distress. Affirming involves the validation of one's feeling and the situation. This can be facilitated through social networking and discussing the situation with colleagues who form a support network for the leader. Nurse leaders may also seek out a peer or mentor to discuss their responsibility in a given situation.

After validating moral distress the nurse moves through the familiar process of 'Assess.' Assessing draws upon the leader's higher reasoning and critical assessment skills to locate, label, and prepare to act on the source of the distress. This step involves understanding the risks and benefits of acting, the goal of the plan to act, and one's willingness to act.

'Acting' may represent the most difficult step. It requires the greatest amount of moral courage. Acting involves creating both the opportunity and the environment that have the greatest probability of success. Acting requires the nurse leader to understand and control the fear associated with the act. Roberts (1984) postulated that one needs to resist any impulse that may prevent action and reshape fear into a more constructive emotion, both of which may be accomplished by the leader who has a high level of self-efficacy and the ability to frame the act as one of intense caring.

Every act of courage creates opportunity for risk and benefit. Nurse leaders must themselves become comfortable in confronting and effectively resolving moral distress through models

such as the 4 A's. Assessing the practice environment, both formally and informally, looking for acts of courage, and identifying factors that bolster the use of, or serve as barriers to moral courage, is a natural beginning for any nurse leader.

Developing Collaborative Partnerships: A Research Exemplar

Some activities may be especially prone to contribute to moral distress. Research is an example of such an activity. One of the nurse leader's duties to the organization involves protecting the organization from legal, reputational, ethical, and/or financial risk by doing all that is possible to mitigate risk to the organization. However, one of the nurse leader's duties to the nursing profession is to facilitate the expansion of nursing knowledge so as to improve patient outcomes.

Supporting a research study may place the nurse leader at risk when the research study has the potential for negative findings in terms of public relations. An undesired outcome could impact the organization's reputation and/or financial stability. When involved with a potentially risky research study, it is important that the nurse leader works early on to find a middle ground to mitigate risk to the individual nurse, patient, and the organization. This can be done by collaborating to develop a structured agreement between the researcher and the organization's leadership. Creative collaborative partnerships that are determined up front and that honor the values and tenets of the researcher and the organization can allow for research to be conducted and also decrease the moral distress of the nurse leader who desires both to advance nursing knowledge and to avoid a potentially negative outcome for the organization.

Creating and Using Sacred Spaces

Another strategy to enhance the development of moral courage is that of creating sacred spaces. A sacred space is a defined physical space that invites contemplation, encourages an attitude of openness, and encourages story telling for the specific purpose of connection, support, and healing (Pijl-Zeiber, Hagen, Armstrong-Esther, Hall, Akins & Stingl, 2008). Sacred spaces can provide an environment in which nurses can 'pause' to consider the most appropriate response to a situation that is causing moral distress. Sacred spaces serve the diverse nursing community, regardless of role, position, or title. Yet it takes courage for nurse leaders to support the development of sacred spaces when space is already a scarce resource within the institution. Internal or external resources can be drawn upon to develop a sacred space. The author's previous organization supported and maintained a sacred space by finding the necessary philosophical and financial support to develop a Center for Nurse Excellence (CNE). The CNE is a dedicated space that provided a director skilled in mediation, reflective learning, support groups, and self-care programs. Inside the Center, the facility offers a reflective room for nurses, including nurse leaders, to use 24 hours a day.

Sacred spaces can be used to develop communities of nurse leaders who learn from one another through sharing, honest conversation, and skill development to better demonstrate integrity, courage, and authenticity. Communities of nurse leaders thrive primarily due to the

sameness of experiences. Nurse leaders can find synergy in these relationships within the context of sacred space. They can also find balance in their professional and personal lives enabling them to improve personal engagement and become better leaders. Strong communities connected in sacred spaces help nurse leaders find balance in their own lives and their practice in order to create and maintain healthy boundaries and act with moral courage (Palmer, 2010).

Recommendations

This section will make recommendations to enhance moral courage. Recommendations for both nursing practice and nursing research will be offered.

Recommendations for Practice

Nurse leaders are the creators, keepers, and recipients of the nursing culture of the organization in which they practice. Pauly, Varcoe, Storch, and Newton (2009) found that managers' support of direct-care nurses positively impacted nurses' ability to practice ethically and take action in situations that create moral distress. Helping nurse leaders to develop moral courage becomes circularly synergistic in that it also strengthens the moral courage of staff nurses, which in turn supports the nurse leader in practicing in a morally courageous manner. The following four practices, supported by both the literature and my personal experience, can be used to foster the development of moral courage throughout healthcare organizations.

1. Understand the current state of moral distress nurses are experiencing. Choose a valid and reliable survey tool, such as the Moral Distress Scale by Corley (2002) or the Professional Moral Courage Scale by Sekerka, Bagozzi, and Charnigo (2009) to assist in identifying opportunities to support moral courage for direct-care nurses and nurse leaders.
2. Create a professional culture that includes healthful practices in the areas where care is delivered so as to derive the greatest opportunity for moral courage to emerge. Support the culture through the creation of sacred space, mentoring, peer support programs, and a participative leadership model (Mohr and Horton-Deutsch, 2001; Pijl-Zieber et al., 2008; Repenshek, 2009).
3. Identify a model to increase moral courage (Fry, Harvey, Hurley, and Foley, 2002; Lachman, 2007; Rushton, 2008). Select a model that aligns with the strategic vision of the nursing department, promotes a healthy, professional-practice environment, and for which there are enough dedicated resources to implement, maintain, and evaluate the model outcomes.
4. Become knowledgeable regarding ethical theory and ethical decision-making practices (Grady et al., 2008; Kelly, 1998; Ketefian, 1980, 1981, 2001; Lang, 2008).

Recommendations for Research

Additional research in four areas specific to the nurse leader is needed to explore the experience of moral distress and to bolster moral courage in nurse leaders. These areas include (a) specific causes of moral distress, (b) the experience of moral distress, (c) characteristics of nurse leaders that increase moral courage, and (d) effectiveness of existing models for developing moral courage in nurse leaders.

Conclusion

Morally fit nurse leaders with the moral muscle to do what is right in the face of obstacles...are celebrated, respected, and followed. When we fail to recognize, respond, or communicate about moral issues in a professional manner we become morally silent. Bird (1996) has written that the greatest risk of moral silence is that we become blind and deaf to moral injustice. The act of transforming nursing, organizations, and healthcare systems requires nothing short of moral courage on the part of the nurse leader.

Morally fit nurse leaders with the moral muscle to do what is right in the face of obstacles, barriers, and limited power, and who do so despite great personal and professional risk, are celebrated, respected, and followed. Building such leaders in nursing with the courage to act and support acts of courage in today's complex healthcare environment while maintaining a moral foundation from which to act in politically and ethically charged situations, is one of our profession's greatest challenges. This article has offered strategies to help meet this challenge.

Letter to the Editor by Thompson
Reply by Author

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