Draft: A Call to Action: Cultivating Moral Resilience and A Culture of Ethical Practice

Developed by the American Nurses Association Professional Issues Panel on Moral Resilience

Defining Moral Resilience

Moral resilience has been proposed as a promising direction for mitigating the moral suffering and distress experienced by nurses and other clinicians. Moral distress, "occurs when one recognizes one's moral responsibility in a situation; evaluates the various courses of action; and identifies, in accordance with one's beliefs, the morally correct decision—but is then prevented from following through. Through the diligent work of many researchers, the existence of moral distress is now recognized as a significant source of moral suffering among nurses and other clinicians. The sources and intensity of moral distress has been repeatedly documented (Epstein & Delgado, 2010; Houston et al., 2013; Allen et al., 2013; Whitehead, Herbertson, Hamric & Epstein, 2015; Mealer & Moss, 2016). In the 30 years since Andrew Jameton first coined the term, the field has not yet developed the skills and tools for nurses or other clinicians to successfully navigate its harmful effects. Given the complexity of the health care environment and the broader society, it is unrealistic to expect that moral distress can be eradicated. Rather, moral distress may be an important signal of individual clinician's conscientiousness in recognizing and addressing decisions, behaviors and actions that imperil their integrity. This recognition invites further exploration into the capacities and skills that are necessary to enable integrity, character and principled action in the midst of troubling and at times dissonant understandings of the moral and ethical terrain. This, coupled with focused attention on the

organizational and societal contributions and accountability for intentionally designing systems that support individuals to practice ethically.

The 2016 Symposium on Transforming Moral Distress into Moral Resiliency called for individuals, organizations, and professional organizations to engage in a variety of actions to address the gaps in our conceptual, theoretical and practical knowledge of the factors that contribute to moral suffering—particularly moral distress and to design strategies that mitigate the detrimental consequences (Rushton, Schoonover-Shoffner, & Kennedy, 2017).

Moral resilience is "the capacity of an individual to preserve or restore integrity in response to moral adversity" (adapted Rushton, 2016a). Moral resilience is a specific context in which the global concept of resilience can be understood. It focuses on the moral aspects of life with particular attention to integrity. Moral resilience, like other forms of resilience, is built in response to adversity. It is postulated that all clinicians have innate and learned abilities that can be leveraged toward and strengthened to address moral adversity. Intentionally strengthening those capacities, building new skills and abilities, and designing specific interventions offers hope and support for those at the front lines who are confronted daily with ethical challenges and complexity.

With respect, moral resilience recently has become a buzz word in academia, as evidenced by a multitude of articles in the literature from not only nursing but from philosophy, psychology, sociology, public health, medicine and even politics, with no real agreement on its meaning. Even a conceptual analysis of moral resilience in the March 2017 issue of *Nursing Outlook* by Young and Cynda Rushton, who seems to be taking the lead in the area of moral resilience and nursing, concluded that there is no unifying definition and that more work needs to be done at the conceptual level.

Similarly, the nature and meaning of moral distress continues to be debated and variously defined, some even calling it unsound at its theoretical foundation (Johnstone, MJ. 2013, Moral Distress - Time to abandon a flawed nursing construct, *Nursing Ethics;* Repenshek, M. 2009, Moral Distress: Inability to Act or Discomfort with Moral Subjectivity?*, Nursing Ethics*.)

Without meaningful understanding of terminology, it seems premature to venture forth on an aggressive large scale campaign to promote something that is not clearly understood.

The call to focus on the cultivation of moral resilience signifies an invitation for individuals, groups and organizations to work together to transform individual and team distress and the organizational culture to create the conditions where moral and ethical practice can thrive. Individual moral resilience alone will not shift the organizational decisions, structures and processes that contribute to imperiled integrity. Yet, because organizations are comprised of individuals, there is promise that reaching a critical threshold of morally resilient individuals within organizations will begin to produce results toward a broader goal of culture change.

So the desired outcome for the ANA is to *change the culture* by creating a critical mass of individuals who are morally resilient (whatever that means and looks like) such that "moral and ethical practice can thrive" (whatever that means and looks like). Again, before any of this can happen, don't we need to have an understanding and agreement on important terms and goals? What does the ANA mean by change the culture? What precisely is it about the culture that the ANA wants to change? Clarity is needed. What would be helpful is a statement that admonishes organizations to support nurses, who based on their integrity and role as patient advocates, challenge practices that endorse violations of ethical principles, such as beneficence and non-maleficence and justice. There needs to be a statement acknowledging that there are limits to demands based on patient autonomy and which violate these three principles.

Moral resilience is an important capacity for nurses to cultivate in response to the myriad ethical challenges faced in the inherently stressful and rapid paced environment of the profession. Nurses that demonstrate high levels of resilience in practice are less likely to develop stress disorders or leave the profession due to professional burnout (Turner, 2014; Mealer, 2012). Individual resilience attributes can be learned through different strategies, despite varying levels of individual capacity. Organizational support for cultivating these strategies contributes to the strength and benchmarks of an organization and its investment in and commitment to nurses, patients and to the health care system. This Call to Action will examine individual and organizational resilience independently, but some concepts overlap. These recommendations are aimed at building individual, team and organizational resilience.

Again, this is all very vague. One is left to wonder if the nurse, in the face of being unable to choose a response to an ethical conflict consistent with his/her moral values, is supposed to find a way to "live with" this violation of personal integrity. This is not dissimilar to the rationales of proponents of a position of neutrality by the American Medical Association toward physician-assisted suicide. Such a position rationalizes that professional opposition to physician-assisted suicide creates dissonance for the provider who wishes to engage in such a practice. Thus, rather than holding to an ethical standard an association should cave in to such violations to make providers comfortable in such violations, since they are legal in some states. This equates to the profession abdicating to the law ethical standards.

Moral resilience has gained attention over the last few years as the nursing and medical community, healthcare organizations and professional societies have learned about its potential role in the mitigation of symptoms related to moral distress, such as burnout syndrome, posttraumatic stress disorder, anxiety and depression (Moss et al., 2016). As a result, we have seen several small pilot studies and program evaluations in the literature investigating interventions that have the potential to improve moral resilience and mitigate the negative effects of moral adversity and moral distress. A number of interventions are being adopted to support clinicians, particularly nurses, which have not been disseminated outside of the local institution of implementation. This paper will describe a few of the most promising interventions that have been published thus far; however, it is important to understand that at this time, evidence to support the effectiveness of these interventions is lacking.

Individual Moral Resilience

It is well documented that today's nurse is exposed to situations that contribute to moral distress (Rushton, 2016a). Feelings of discomfort that arise as an individual is unable to take action and reconcile one's perceived moral responsibility in a situation, can lead to greater

turnover in health professionals (Rushton, 2016b). Recognizing moral distress is pervasive in nursing practice necessitates a discussion of moral resilience and strategies that can be used to

Do we have evidence of its pervasiveness of moral distress? If so, why is it so pervasive? Can the pervasiveness be attributed to lack of moral resilience? How do we know this if we can't even agree on the meaning of our terms? Why are so many nurses lacking in moral resilience? When did this phenomenon develop? Has it always been this way for nurses?

These are questions that need to be answered (clearly identify the problem) before a program to remedy the problem can be put into place. Without more clarity in the discussion, it is difficult to support the program. What appears to be happening from a number of landmark legal or union contract cases, be they the DeCarlo case in New York, the Tennessee case, or the Long Island and New Jersey cases, is that nurses are being told by employers that they must violate conscience because something is legal. [See: http://www.adfmedia.org/news/prdetail/2895; and http://www.newsday.com/long-island/politics/hospital-apologizes-to-nurses-over-abortion-decision-1.1884346; and http://www.ncregister.com/daily-news/new-jersey-nurses-face-job-loss-for-refusing-to-assist-abortions; and http://www.lifenews.com/2011/01/12/vanderbilt-abandons-policy-forcing-nursing-students-to-do-abortions/.]

foster this quality within individual healthcare professionals. To date, much of the conversation surrounding moral resilience has focused on the skill set and development of individual professionals to effectively recognize, respond to ethical challenges and to engage in integrity preserving action. **Cultivating moral resilience is necessary to respond to the aspects of the clinical environment that are not easily modifiable such as caring for patients with complex, often life limiting conditions, witnessing suffering, death, disability and social injustices.**

Okay, so is this the problem -

"aspects of the clinical environment that are not easily modifiable such as caring for patients with complex, often life limiting conditions, witnessing suffering, death, disability and social injustice"?

But this is what nursing has always been about! Nurses have always cared for persons who are sick, suffering in a multitude of ways, disabled, dying, homeless, in poverty, etc. This is and always has been the work of nursing.

That said, what is different about today's nurses and the work of nursing that leads nurses to experience distress of apparently historic proportions? Answers to that question are needed. What nurses are reporting is that they are being forced by employers to violate moral integrity in the name of patient autonomy. Those are the real challenges

While some attributes of the work environment can and must be modified, such as communication patterns or teambuilding; we must work at the individual, organizational and

societal level to address these concerns while finding ways to recharge compassion in practice and support professionals working in stressful environment without so much cost to themselves.

Patterns of communication and team building are process issues that can and should be addressed in any organization. But what work on the societal level is the ANA talking about? The ANA needs to be clear that it supports nurses, even those who challenge what is considered legal, but violates centuries of Hippocratic tradition..

Ethical Competence

In order to build capacity to develop moral resilience, individuals need to have a solid ground of ethics training and knowledge and understanding of what drives ethical practice including: (1) the ability to identify micro and macro-ethical issues inherent in complex healthcare environments, (2) assistance to be able to critically reflect and apply ethical theories in a dialectical decision-making process in which moral actions are justifiable, and (3) resources assisting individuals to develop resilience protective factors, including social skills, social support, goal efficacy, and problems solving. Research suggests that ethical competence, which includes coping development and learned leadership also contributes to building individual resilience (Turner, 2014). However, nurses may not always possess the competencies necessary to engage in ethical reflection, decision-making or ethical behavior (Cannaerts, Gastmans, Dierckx, 2014). Again, this is all very vague. There needs to be a challenge to agencies to provide ongoing in-service education in these domains, with sound agency policy to support nurses whose moral principles direct them to request a safe transfer of patient assignment.

Ethical competence is considered to be the foundation of moral efficacy, and supports moral resilience "by leveraging conscientious moral agency with the confidence in his or her capacity to recognize and respond to ethical challenges in an effective manner" (Holtz, Heinze & Rushton, 2017). It is the psychological skill to do one's job; the ability of a person, who confronts a moral problem, to think and act in a way that is not constrained by **moral fixations**

Moral fixations? What does this mean? Fixations ordinarily are defined as an obsession, preoccupation, making a firm and stable action. Did the author give examples of what he/she considered moral fixations and why the nurse should not be constrained by them?

Would the author consider a nurse's adherence to the prohibition against acting without the patient's informed consent such as forcing a treatment on a patient, taking photos of a patient with their cell phone, having sexual contact with a patient, or even killing a patient to be moral fixations that should not constrain the nurse from acting? People are sometimes constrained for good and proper reasons. Moral principles are deeply held convictions that some pejoratively, who disagree, will call fixations. This is clearly negative language about deeply held moral positions.

or automatic reactions (Sporrong, 2007). Gallagher (2006) describes ethical competence as the possession of ethical knowledge next to the ability to ‘‘see’’ what a situation presents (ethical perception); to reflect critically about what nurses know, are, and do (ethical reflection); to bring out the ethical practice (ethical behavior); and to ‘‘be’’ ethical. This is all very vague.

There are different ways to operationalize ethical competency into ethics education.

How does one operationalize something that is not clearly defined?

The development of teachable skills is necessary to build moral resilience by strengthening ethical competence. Nursing education programs should include educational programs that address applicable decision-making frameworks to navigate moral distress, including decision algorithms, with **strong grounding in ethical concepts and language**. Since ethics is a branch of philosophy, wouldn't a course in philosophy be helpful? Ethical decision-making theories include practice and change theory, conflict management theory, and Kohlberg’s Theory of Moral Development. **Educational programs designed to teach skills of mindfulness, spiritual well-being, self-regulation, self-reflection, and conflict management may also be implemented to contribute to building individual moral resilience**.

All of these programs and skills are directed toward self-care of the nurse/nursing student, which is fine. But what about programs and skills directed toward helping nurses to better understand what it means to be human, the human condition, human suffering and the proper nursing response to it? If, as is written above, "Cultivating moral resilience is necessary to respond to the aspects of the clinical environment that are not easily modifiable such as caring for patients with complex, often life limiting conditions, witnessing suffering, death, disability and social injustices" (aka, the work of nursing), nursing education should help students understand the nature of this work, and the proper nursing response to it. Fundamental questions of ethics should be asked, such as: What is

the good? How do we know? What is the proper use of my power? What is the proper relationship between means and ends? These are philosophical questions that fall within the purview of philosophy and the philosophy of nursing.

Ethics education should occur continuously in safe environments that are engaging, encourage understanding rather than judgment, and guide root cause understanding.

Self regulation and mindfulness

Self-regulation, is "the ability to use mindfulness skills, executive control processes, and metacognition to monitor, evaluate, reinforce or adapt one's responses to changing conditions or adversity" (Rushton, In press). Mindfulness is a key element of self –regulation in response to adversity. Mindfulness is a resilience strategy that has been studied and shown to have positive outcomes for patients and caregivers. Mindfulness is moment-to-moment awareness, which is cultivated by intentionally focusing attention, noticing and releasing sensations, emotions and thoughts that are distracting or depleting, promoting relaxation, and personal insight (Kabat-Zinn, 2005). Cultivating mindfulness and self regulatory skills can support nurses to practice with integrity in response to moral adversity. Again, what does this mean except to admonish nurses to accept a violation of their personal and professional integrity and move on?

Self Care

Provision 5 of the Code of Ethics for Nurses with Interpretive Statements holds that "the nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth" (ANA, 2015). Nurses must own his or her individual health in order to foster a healthy personal and professional balance. Self care is a commonly used term that relates to self-stewardship. However, the term self care may denote a negative association for some clinicians who perceive that focusing on one's own well-being indicates a selfish act.

To shift this pattern, a broader notion of self-stewardship is meant to convey "positive self respect and regard for one's own well-being in service of one's commitments to the caring for the wellbeing of others"(Rushton, in press). Intentionally fostering interventions aimed at supporting physical, emotional, spiritual and social well-being supports clinicians faced with moral adversity. When clinicians are imbalanced or depleted in any aspect of their being, they are more vulnerable to the negative effects of moral adversity or moral distress.

Recommendations to Foster Individual Resilience

The recommendations proposed below are to cultivate and support the moral resilience for individual nurses.

If you are an individual nurse:

1. Adopt ANA's Healthy Nurse Healthy Nation™ strategies to support your general well-being as a foundation for cultivating moral resilience.
2. Become skilled in recognizing, analyzing, and taking ethically grounded action in response to ethical complexity, disagreement or conflict. [See appendix]
3. Recognize and respond to your symptoms of moral suffering including moral distress.
4. Pursue educational opportunities to cultivate mindfulness, ethical competence and resilience.
5. Develop your personal plan to support well-being and build moral resilience.
6. Become involved in workplace efforts to address the root causes of moral distress and other forms of moral suffering.
7. Develop and practice skills in communication, mindfulness, conflict transformation, and interprofessional collaboration.
8. Identify and use personal resources within your organization or community, such as ethics committees, peer to peer support, debriefing sessions, counseling and employee assistance programs.
9. Develop courage to challenge mandates that violate personal and professional integrity.

The recommendations proposed below are for nurse managers and nurse leaders across practice settings to cultivate and support moral resilience.

If you are nurse leader:

1. Ensure that every individual has access to resources to mitigate moral distress and cultivate moral resilience.
2. Participate in institutional mechanisms to form and support ethical issues such as ethics committees or consultation services to bring the nursing perspective into the dialogue and decision making.
3. Develop strategies to support nurse's moral resilience based on evidence applied from other contexts of resilience.
4. Continue to systematically document and study the impact of individual interventions on nurses and other clinician's ability to address moral adversity such as moral distress.
5. Support your team in ANA's Healthy Nurse Healthy Nation™ strategies to foster clinician well-being as a foundation for cultivating moral resilience.
6. Become skilled in recognizing, analyzing, and taking ethically grounded action in response to ethical complexity, disagreement or conflict.
7. Nurse leaders should adopt a standardized screening and intervention tool to recognize and address moral distress and build moral resilience (i.e. SUPPORT model in Toolkit below).
8. Incorporate programs aimed at developing capacities and skills in moral resilience including mindfulness and self regulation, ethical competence, and self care into pre-licensure, graduate and doctoral programs, nurse residency programs, and continuing education.
9. Develop policies that support and allow for the safe transfer of care in situations in which nurses find their personal or professional moral values compromised by a particular assignment.

Organizational Resilience

Introduction

Recognizing that moral distress can negatively impact the retention of healthcare professionals in the field, organizations may consider implementing strategies that promote moral resilience among their workforce. **The environment of modern healthcare will continue to present situations that challenge the moral integrity of nurses and healthcare professionals**

Again, what precisely is it about the environment of modern health care that makes for situations that challenge the moral integrity of nurses and lead them to leave the workforce?

Identifying the reasons, the causes, especially if they are systemic and on an organizational level, would help in finding ways to prevent challenges to integrity. Yet, oddly this document is persistently silent on all that.

(Rushton, 2016b). Health systems seeking to recruit and retain a skilled and experienced nursing workforce will have to acknowledge this reality. Interventions are needed on the organizational

level to promote ethical practice environments where nursing staff can further develop the moral resilience needed to effectively respond to with the demands of today's practice settings. This is made challenging, however, by the lack of available evidence on efficacious interventions to achieve this goal.

Progress in ameliorating the root causes of moral adversity will be needed for individual strategies to be sustainable. While the original definition of moral distress focused on the organizational constraints to moral agency and action, solutions must align the dynamic interplay between individuals, teams, organizations and the broader society. Health care organizations are comprised of diverse people, disciplines, authority, and moral orientations. The context of health care is complex, uncertain and laden with conflict. Yet, in order to make sustainable progress, new paradigms for engaging individuals, leaders and organizations in designing solutions are needed. Lessons can be learned from safety and quality initiatives that engage solution finding at the local level, building infrastructure to monitor and respond to ethical challenges and moral adversity, co-creating mechanisms to address the root causes of threats to integrity and moral adversity.

Understanding the root causes of moral adversity, moral distress and other forms of moral suffering can be facilitated through developing incentives, regulations, and professional requirements that include attention to building integrity, ethical competence, self stewardship and self regulation and recognizing the signals of moral distress and other forms of moral suffering. This can be accomplished by engaging organizations such as the American Hospital Association, The Joint Commission, state Boards of Nursing, and, accreditation programs such as the Magnet Recognition Program to include key indicators that relate to an organization's infrastructure, policies, methods, and resources for recognizing the sources of moral adversity,

documenting them, and systematically addressing them using diverse, innovative strategies. Embedded in these are the needs for developing, communicating and using fair, respectful processes to respond to clinician claims of conscience in relation to actions they are asked to implement within their professional **roles**.

Is this what the ANA has been alluding to as the root cause of moral adversity and moral distress? People fearing, believing that they are being forced to violate their consciences in the practice of nursing? If so, this is a very serious matter and needs to be prevented at the public policy, professional and institutional levels Furthermore, confusion of the meaning of conscience could be a contributing factor. (See Laabs, C. A. (2009). Nurses and conundrums of conscience. *Forum on Public Policy: A Journal of the Oxford Round Table,* Spring 2009, 1-19.) Conscience is not subjective preference but a reasoned judgment formed in the knowledge of objective truth about right and wrong, good and bad.

Models such as those suggested by the American Thoracic Society collaborative offer a promising direction for organizations to adopt (Lewis-Newby et al., 2015). Beyond this, attention to the legal structure for protecting those who choose to "**blow the whistle**"

Whistle blowing on illegal activity certainly is a concern. But is this really a concern of day to day nursing that is causing the massive problem of moral distress across the nursing profession as indicated above? Is it not more of the day to day issues, as described in the article by the Am. Thoracic Society?

when egregious ethical violations occur will be an important component of successful organizational efforts.

Regulatory Considerations

Workforce safety has been identified as preconditional to patient safety. Workforce safety includes both the physical and emotional health of the workforce. When health care professionals are unable to work to their fullest potential, they are unable to flourish personally and professionally and find joy and meaning in their work. The health care workforce is experiencing growing rates of moral distress, burnout syndrome, posttraumatic stress disorder, depression, and suicide. Patient outcomes and employee engagement have been demonstrated to be improved in organizations that value the safety of both patients and the workforce. Leaders of healthcare delivery organizations must recognize the need for environments that are conducive to

moral acts, and characterized by safe, trusted, and non-punitive attributes. To effectively address issues of moral distress and build organizational resilience, the health care leaders must be foundationally committed to assessing their own work environments, and creating and sustaining initiatives that commit to moral resilience as a core value.

Workplace safety, to include emotional safety and wellbeing of healthcare personnel, was formally recognized by The Joint Commission (TJC) as a significant concern in 2012, and was examined in a monograph titled Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration, and Innovation (TJC, 2012). The article highlighted the need to provide evidence based psychological and emotional support to healthcare personnel after adverse clinical events, as well as creating positive work environments free from incivility, lateral violence, and other forms of emotional distress; all of which have been identified by the ANA as key areas of concern with regard to moral resilience in nursing. The Joint Commission article may serve as an example to other healthcare regulatory and accrediting agencies, and provide a starting point for building standards and regulations that address the need for healthcare organizations to adopt measures to improve moral resilience.

Interprofessional Collaboration

Efforts to build moral resilience and a culture of ethical practice will be enhanced through interprofessional collaboration among all health care professionals. Siloed efforts will have limited impact and risk undermining sustainability. Efforts such as the National Academy's Action Collaborative on Clinical Well-being and Resilience offer a mechanism for cross-disciplinary sharing and learning and the potential for innovations that engage the key stakeholders in designing solutions that benefit all. Recent efforts by critical care societies to

address moral distress as a factor contributing to burnout also offers a fruitful model for changing individual practices and organizational culture.

Recommendations to Foster Organizational Resilience

The recommendations proposed below are for organizations across practice settings to cultivate and support moral resilience.

If you are an organization:

1. Adopt and implement standards for a Healthy Work Environment (AACN, 2016).
2. Implement action steps outlined in AACN Position Statement on Moral Distress (AACN, 2008).
3. Incorporate programs aimed at developing capacities and skills in moral resilience, including mindfulness and self regulation, ethical competence, and self care into pre-licensure, graduate and doctoral programs, nurse residency programs, and continuing education.
4. Raise awareness of the sources and consequences of moral distress on individuals, organizations, patients and other stakeholders.
5. Develop strategies to support nurse's moral resilience based on evidence applied from other contexts of resilience.
6. Continue to systematically document and study the impact of individual interventions on nurses and other clinician's ability to address moral adversity such as moral distress.
7. Conduct intervention studies testing strategies to address the root causes of moral distress or other forms of moral adversity.
8. Fund, develop, and evaluate innovative individual and organizational models for cultivating moral resilience and a culture of ethical practice.
9. Collaborate with interprofessional ethics organizations, medical societies and to raise awareness, design and evaluate innovative trans-disciplinary programs, and contribute to the state of the science in addressing moral distress and building moral resilience.
10. Ensure core competencies in ethics for all levels of nursing students and professionals.
11. Ensure policies are developed, implemented and honored that respect deeply held moral convictions of nurses that allow for the safe transfer of patient care when such convictions are in jeopardy of being compromised.

The recommendations proposed below are for external stakeholders to cultivate and support moral resilience.

If you are an external stakeholder:

1. Healthcare accrediting and government regulatory agencies formally recognize the importance of moral resilience in the context of highly reliable healthcare organizations, and how moral distress may affect the ability of such organizations to provide safe care

with quality patient outcomes.

2. Petition the National Council of State Boards of Nursing to increase content focusing on ethical competence, recognition of moral distress, and skills in moral resilience.
3. Encourage state boards of nursing with continuing education licensure renewal requirements to mandate including of ethics competence, recognition of moral distress and skills in moral resilience.
4. Healthcare accrediting and government regulatory agencies facilitate awareness of and the implementation of evidence based programs and interventions to promote moral resilience, through consultative survey activities and other interactions with healthcare organizations.
5. Accrediting and government regulatory agencies evaluate the benefit of programs and evidence based interventions, and consider incorporating these into their standards and regulations.
6. Petition the Joint Commission to strengthen their regulatory requirement for health care institutions to have a robust method for responding to requests for conscientious refusal or objection by clinical staff.
7. Healthcare accrediting and government regulatory agencies include a mechanism for staff to report interpersonal or emotional safety issues that could negatively affect the quality of patient care and safety in addition to those conditions that affect patients directly, such as TJC Standard APR.09.02.01, Elements of Performance.
8. Healthcare accrediting and government regulatory agencies notify healthcare organizations and staff that this option is available for a defined set of issues related to emotional safety and moral distress.
9. Healthcare accrediting and government regulatory agencies include emotional safety, well-being, and moral resilience in the context of employee health monitoring, data collection, analysis, and improvement or interventional activities, such as TJC Standard LD.03.01.01, Maintaining a Culture of Safety and Quality.
10. Healthcare accrediting and government regulatory agencies educate surveyors to conduct consultative and educational activities with hospitals regarding moral resilience and employee health.

The recommendations proposed below are for nurse managers and nurse leaders across practice settings to cultivate and support moral resilience.

If you are nurse leader:

1. Ensure that every individual has access to resources to mitigate moral distress and cultivate moral resilience.
2. Participate in institutional mechanisms to form and support ethical issues such as ethics committees or consultation services to bring the nursing perspective into the dialogue and decision making.
3. Develop strategies to support nurse's moral resilience based on evidence applied from other contexts of resilience.

4. Continue to systematically document and study the impact of individual interventions on nurses and other clinician's ability to address moral adversity such as moral distress.
5. Support your team in ANA's Healthy Nurse Healthy Nation™ strategies to foster clinician well-being as a foundation for cultivating moral resilience.
6. Become skilled in recognizing, analyzing, and taking ethically grounded action in response to ethical complexity, disagreement or conflict.
7. Nurse leaders should adopt a standardized screening and intervention tool to recognize and address moral distress and build moral resilience (i.e. SUPPORT model in Toolkit below).
8. Incorporate programs aimed at developing capacities and skills in moral resilience including mindfulness and self regulation, ethical competence, and self care into pre-licensure, graduate and doctoral programs, nurse residency programs, and continuing education.
9. Ensure policies are developed, implemented and honored that respect deeply held moral convictions of nurses that allow for the safe transfer of patient care when such convictions are in jeopardy of being compromised.

Research in Resilience

The concept of moral resilience is in its **early stages of development.**

"The concept of moral resilience is in its early stages of development." Exactly! That is why this initiative is premature. Research should be done before designing and implementing program changes.

Further conceptual and empirical work is needed to refine the concept of moral resilience. However, evidence from biologic and psychological resilience studies and programs offer fruitful directions for developing moral resilience in individuals. Generally nurses use several types of resilience strengthening strategies such as coping focused behaviors, mindfulness, seeking support, and healthy self-care practices (Turner, 2014). There is likely overlap with general resilience measures and specific skills that foster moral resilience. Research related to moral resilience interventions is necessary to determine the efficacy in reducing symptoms of psychological distress, including moral distress and burnout syndrome.

Research on moral resilience will require a thoughtful and systematic approach. The priorities of this approach should include the development and validation of instruments to

measure individual and organizational moral resilience; large randomized controlled trials or mixed methods research designs to determine the effectiveness of both individual and organizational interventions; choosing the appropriate outcome variables to understand the impact of the intervention(s); and dissemination of successes and barriers encountered during local quality improvement and/or program evaluation efforts.

Determining the impact of moral resilience interventions may benefit both the individual nurse and healthcare organization as the profession aims to improve mental wellness and safety; and retain experienced nurses at the bedside. To date, there is a gap in the literature regarding moral resilience in nursing. There is also a paucity of evidence related to the broader concept of resilience as a modifiable capacity that nurses can acquire through individual and organizational resilience interventions.

No large randomized, controlled trials currently exist, that are adequately powered to determine the effectiveness of resilience interventions on mental health outcomes or more specifically, on health care professional outcomes such as staff retention and patient safety issues. Most of the published literature describes small pilot studies that have assessed resilience interventions in a variety of populations such as depression (Songprakun & McCann, 2012a; Songprakun & McCann, 2012b), breast cancer survivors (Loprinzi, 2011), PTSD (Kent, 2011), police officers (Arnetz, 2009), students (Kanekar, 2009; Bekki, 2013), and type 2 diabetes (Bradshaw, 2007). A number of interventions have been aimed at reducing stress in nursing. However, these studies did not assess effectiveness in increasing resilience or moral resilience.

Mindfulness

The most promising intervention identified in the literature for reducing stress in nurses is mindfulness. Mindfulness has been studied in a variety of contexts including… In nurses, studies

show that mindfulness reduced emotional exhaustion and burnout (Cohen-Katz, Wiley, Capuano, Baker, Kimmel et al., 2005), enhanced relaxation, reduced burnout (Mackenzie et al., 2006), and stress reduction (Pipe et al., 2009). Mindfulness strengthens the development of mental flexibility in moral conflict thereby reducing the intensity of an emotional response to situations of moral adversity (Rushton, 2016a). Nurses who develop mindfulness skills to take a positive mental and emotional approach are more effective in increasing individual and organizational resilience (Foureur, Besley, Burton, Yu, & Crisp, 2013).

What is "moral flexibility in moral conflict?" This would indicate that a nurse is to compromise principles in such situations. Forcing a violation of conscience under the guise of "flexibility" is in and of itself immoral.

Despite the promising findings related to mindfulness and MBSR, the intervention continues to be fraught with conceptual and methodological concerns. The concerns include small sample sizes; lack of comparison groups to control for group support, practice time and placebo effect; and the absence of research on the possible negative or harmful effects, which suggests that mindfulness may be beneficial for everyone (Irving, Dopkin & Park, 2009).

Resilience

Two small randomized, controlled trials studying resilience have been reported in nurses and physicians. West et al. (2014) conducted a randomized, controlled trial to investigate whether a protected time; biweekly-facilitated physician discussion group would promote well-being, job satisfaction and professionalism. This single-center trial included 74 practicing physicians in the Department of Medicine. Over 19 sessions, small group discussions covered elements of mindfulness, reflection, shared experience and small-group learning. The control group consisted of protected time only. Although resilience was not measured, self-reported

measures were collected to assess meaning in work, empowerment and engagement in work, burnout, symptoms of depression, quality of life and job satisfaction. Empowerment and engagement at work increased significantly in the intervention arm compared to the control arm, three months post-intervention (p=04), and was sustained at 12-months post intervention (p=.03). There were also significant improvements in the depersonalization subscale of burnout scores at 3 months (p=.004) and 12 months (p=.02) between groups (West et al., 2014).

The second study measuring resilience was a 12-week, randomized, controlled multimodal resilience training intervention conducted with ICU nurses (n=29) to determine whether the intervention would be feasible and acceptable (Mealer et al., 2014). The training intervention included a 2-day educational workshop, written exposure therapy, mindfulness practice, event-triggered cognitive-behavioral therapy and prescribed aerobic exercise. The control group did not receive any of the intervention components but did capture any exercise that they completed per week. The multimodal resilience training was reported to be both feasible and acceptable to the nurses. Although this study was not powered to determine its effectiveness related to building resilience and reducing symptoms of psychological distress, the results were promising and highlight the need for additional research on the topic. Baseline assessments indicated there was a significant reduction in symptoms of depression and posttraumatic stress disorder (PTSD) (p=. 03 and .01 respectively). There was also a significant improvement, over the 12 week program, on resilience scores (p=.05) (Mealer et al., 2014).

Both studies demonstrate the potential for impactful interventions to strengthen resilience and reduce symptoms of moral and psychological distress. Further development of research on moral resilience and interventions to support the process is important. More importantly, research that demonstrates increased workplace moral resiliency and the effect this has on

healthcare errors to help administrator's understand the financial benefits of building an individual's moral resilience. Evidence that identifies the importance of individual moral resilience has the opportunity to **encourage health systems to invest in moral resilience programs to cultivate a healthy work environment and improve the safety and quality of patient care**.

Is the ANA aware of the "Resiliency Program" that was implemented at the Ottawa Hospital in response to the decriminalization of euthanasia in Canada? It is described in a Letter to the Editor in the August 31, 2017 issue of *The New England Journal of Medicine*. The Letter describes a program designed to decrease the stress of involvement with euthanizing patients including a "4 hour boot camp before staff members participate in MAiD" otherwise known as Medical Assistance in Dying. Clearly, this is an application of the call to action that the ANA proposes here.

We have tried to give the ANA the benefit of the doubt in our comments to this document and hoped to only submit a warning that the ANA should not allow their efforts to be hijacked and used for nefarious purposes.

However, given the recently released revised Position Statement on Nutrition and Hydration in which the ANA supports voluntary stopping eating and drinking for the purpose of hastening death, a form of passive euthanasia, and given that the ANA has published articles in *AJN* in support of VSED to hasten death and even offered Continuing Education Credits for it (Schwarz, J.K. 2009. Stopping Eating and Drinking. AJN, 109 no. 9, 53-61), we are left with no other conclusion than that the ANA supports that patient autonomy is a sacrosanct principle to be supported by nurses even if patients choose to end their own lives. No health care profession can remain neutral toward public policies that allow for members of the healing professions to cooperate in ending persons' lives, even with patient consent. To support such decriminalization erodes the public trust in the profession. If this is the intent of the American Nurses Association its members and the public need to be made aware of such an intent. This document does nothing to assure that is not the intent of the Association.

Despite the vagueness in this call to action document, by taking a position in support of passive euthanasia as in the support of VSED as referenced above, the ANA is clear in its intention to go down a path that betrays the long-standing core values of the nursing profession and betrays the patients we have promised to serve. It represents a dramatic turning point in the history of nursing. It is stunningly unconscionable. We could not disagree more vehemently.

Recommendations for Program Evaluation and Research

If research funding is limited or clinical practice nurses are interested in adopting moral resilience projects at their institution or within their specialty unit, program evaluation is an attractive option that can still be evaluated, disseminated, and provide evidence to inform future projects. Program evaluation is a practical exercise that primarily determines if a program should be implemented as standard practice or whether it needs to be modified, provides evidence to support or oppose a program, and contributes to basic knowledge (Royse, Thyer &

Padgett , 2015). The CDC (1999) has identified a framework to guide program evaluation projects, which includes steps in the evaluation practice and the standards for effective evaluation. The steps in the evaluation include, engaging the appropriate stakeholders, describing the program, focusing the evaluation design, gathering credible evidence, justifying conclusions, and ensuring use and sharing lessons learned (Table 1). The standards for an effective evaluation of a program include utility, feasibility, propriety, and accuracy (Figure 1).

Steps	
Engaging Stakeholders	• Charge Nurse • Nurse Managers • Chief Nursing Officers • Hospital Administrators • Nurse colleagues • Team members • Patients
Describing the Program	• Why is moral resilience training needed? • What are the expectations of the moral resilience program? • What activities will the nurses be asked to participate in? • What tools will be used to evaluate the effectiveness of the program and its outcomes? • What resources are needed to implement the program?

Focus the Evaluation on Design	• What is the purpose of the moral resilience program? Improve nurse satisfaction? Increase moral resilience scores? Decreases symptoms of moral distress? Improve nurse retention? • Clearly define roles of those participating (users and evaluators) • Budget
Gather Credible Evidence	• What counts as evidence? • Moral resilience measure or general resilience measure • Symptoms of moral distress • Symptoms of burnout • Symptoms of other psychological issues such as PTSD, anxiety or depression • Turnover rate • Turnover cost
Justify the Conclusion	• Analysis of the evidence collected • Interpretation of the findings • Judgment of the findings based on predetermined standards • Recommendations regarding the adoption of the moral resilience program
Use and Lessons	• Provide feedback to your stakeholders • Disseminate lessons learned to your institution and other institutions • Prepare users for implementation if effective • Make modifications to the program based on what you learned.

577 Table 1. Centers for Disease Control (1999).

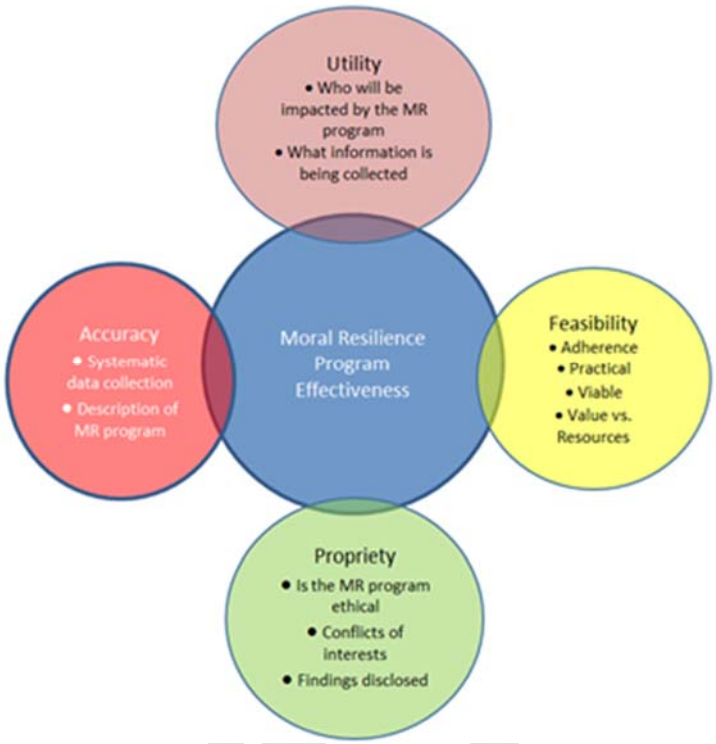

Figure 1. Centers for Disease Control (1999).

Resource Toolkit

Promising Practices to Optimize Individual and Organizational Resilience

The American Nurses Association Center for Ethics and Human Rights convened a Professional Issues Panel with an Advisory Board to explore promising solutions to build individual and organizational capacities for addressing the detrimental impact of moral distress and other forms of moral suffering. Promising practices **does imply endorsement,**

Should this read "does NOT imply endorsement"?

but rather acknowledges various current mediums of interventions that have not yet been studied or published in the literature. Individuals and Organizations are encouraged to do their own evaluation to determine appropriateness.

Media Type	Year	Title & Author(s)	Web Address	Description
Program **Website**	2012	University of Virginia School of Nursing *Compassionate Care Initiative (CCI)*	https://cci.nursing.virginia.edu	The purpose of the Compassionate Care Initiative (CCI) is to cultivate a compassionate workforce through educational programs. The vision is to have safe and high functioning healthcare environments with happy and healthy professionals caring for others – with heart and humanity. The program bolsters resilience in the process of teaching compassion, including a public radio documentary called Resilient Nurses. University of Virginia. (2017). School of Nursing Compassionate Care Initiative. Retrieved March 2017, from www.cci.nursing.virginia.edu
Program	2016	Johns Hopkins University School of Nursing & Johns Hopkins Hospital Mindful Ethical Practice and Resilience Academy (MEPRA)		This six-session program focuses on building moral resilience in nurses. The goals are to 1) Apply mindful practices to ethical issues in clinical practice, 2) Demonstrate ethical competence by applying tools and skills to ethical issues in clinical practice, 3) Cultivate resilience in response to ethical challenges and moral suffering including moral distress. Skills in mindfulness, moral discernment and analysis, self regulation, communication, and principled action are fostered through experiential, didactic and high fidelity simulation methods.
Program **Website**	2013	Lee Memorial Health *Journey to Empowerment*	http://www.nursinglibrary.org/vhl/bitstream/10755/602909/1/3_McNulty_D_p69934_1.pdf	Professional development seminar designed to focus on a health care provider's individual journey to empowerment, self-efficacy, emotional intelligence, spiritual intelligence, and moral courage. McNulty, D.M. (2015). Using the journey to empowerment professional development seminar to enhance nurses' sense of empowerment. Retrieved from http://www.nursinglibrary.org/vhl/bitstream/10755/602909/1/3_McNulty_D_p69934_1.pdf
Program	2014	Mercy Health Saint Mary's/Trinity Health *Tea for the Spirit*		With the support of our oncology social worker and chaplain, A safe environment established for nurses to process difficult and traumatic events through debriefing and verbalizing of feelings with others who understand the workplace environment. Tea for the Spirit is led by social work and chaplaincy as an open forum where use of reflection and self-care are methods are discussed for discussed for maintenance of nurses' emotional health and resiliency. Nurse's report improved sleep ability, less fatigue, and greater capacity for compassion. Antol, M. N. (1996). Healing Teas: Boost Your Health. New York: Avery. Cynda H. Rushton, C. G. (2004). The 4As to Rise Above Moral Distress Handbook. Retrieved October 30, 2014, from American Association of Critical Care Nurses: http://www.aacn.org/ Nancy Jo Bush, D. A. (2012). Self-Healing Through Reflection: A Workbook for Nurses. Pittsburg: Oncology Nursing Society.
Article	2016	Institute for Healthcare Improvement *Joy in Work*	http://www.ihi.org/Topics/Joy-In-Work/Pages/default.aspx	This article highlights innovation and resources around joy in work designed to reduce clinician burnout and encourage staff to feel both physically and psychologically safe. Feeley, D., Swensen, S. (2016). Restoring joy in work for the healthcare workforce. *Healthcare Executive, 31*(5), 70-71.
Website	2017	American Holistic Nurses Association *Holistic Stress Management Toolkit*	http://www.ahna.org/Home/Resources/Stress-Management	This toolkit designed for all nurses includes 14 steps to combat clinician burnout including self-reflection, intentional breathing, journaling, muscle relaxation and affirmations.
Mobile Application	2017	Tools for Peace *Stop, Breathe & Think*	https://www.stopbreathethink.com/	This app allows user to assess his or her emotional well-being by prompting users to input short mindful activities such as deep breathing, encouraging physical exercise, and healthy habits to promote emotional health.
Mobile Application	2015	National Center for Telehealth & Technology *Provider Resilience*	http://t2health.dcoe.mil/apps/provider-resilience	This app is designed to assist health care providers to combat clinician burnout and compassion fatigue when caring for members of the military and veterans. The app encourages self-assessments of quality of life including sleeping habits, fear, stress and personal outlook. The app provides the user with a resiliency score and methods to strengthen resilience.
Article	2016	William Martinez, MD, MS	https://my.van	The Moral Courage Scale for Physicians (MCSP) is a new

		Moral Courage Scale for Physicians	derbilt.edu/williammartinez/moral-courage-scale/	measure that has been designed to measure the moral courage for physicians. Moral courage is defined as the physician's predisposition to voluntarily act upon their ethical convictions, despite barriers. In a national survey that evaluated residents' and interns' speaking up about traditional and professionalism-related patient safety threats, a high level of moral courage has been positively associated with speaking up. Martinez, W., Bell, S. K., Etchegaray, J. M., & Lehmann, L. S. (2016). Measuring moral courage for interns and residents: scale development and initial psychometrics. *Academic Medicine*, *91*(10), 1431-1438.
Website **Article**	2017	The University of Texas at Austin *The Center for Mindful Self-compassion*	https://centerformsc.org/	This program is an 8-week long program designed to cultivate self-compassion in health care providers. Neff, K. (2011). Self-compassion: The Proven Power of Being Kind to Yourself. New York: William Morrow. doi:0061733520.
Program **Website**	2017	The Schwartz Center for Compassionate Healthcare *Schwartz Rounds™*	http://www.theschwartzcenter.org/supporting-caregivers/schwartz-center-rounds/	The Schwartz Rounds™ program allows health care providers an opportunity to discuss ethical or distressing issues drawn from actual patient cases allowing greater insight and self-reflection.
Website	2017	Duke Patient Safety Center *Three Good Things*	http://www.dukepatientsafetycenter.com/	The "Three Good Things" exercise, offered through the Duke Center for Patient Safety, provides participants with access to a two week online platform to identify three good things that happened each day. This exercise is based on the positive psychology work of Martin Seligman, and has been in use by Dr. Bryan Sexton. Sexton's work demonstrated that residents who participated in the exercise of identifying three good things at the end of each day statistically lower rates of burnout, depression, fewer delays, and improved work life balance. Seligman, M. E., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: empirical validation of interventions. *American psychologist*, *60*(5), 410.
Website	2016	National Academy of Medicine *Clinician Well-Being and Resilience*	https://nam.edu/perspectives-on-clinician-well-being-and-resilience/	This website contains resources aimed at building a collaborative platform for improving clinical well-being and resilience. NAM Perspectives is a group of informative papers relating to clinician resilience. A Culture of Series addresses stress and clinician burnout in health care professionals. The Stress and Wellness in Health Professionals Education Series describes a multifaceted systems approach to stress and wellness within health professional's education.
Article	2017	Johnson's Foundation Wingspread Center *A Gold Bond to Restore Joy to Nursing:* *A Collaborative Exchange of Ideas* *to Address Burnout*	https://ajnoffthecharts.com/wp-content/uploads/2017/04/NursesReport_Burnout_Final.pdf	This article is a collaborative report containing 35 proposed ideas to restore joy in nursing and reduce clinician burnout. The article highlights strategies for leadership in organizational and individual resilience.
Article	2016	The SUPPORT model	http://journals.lww.com/jonajournal/Abstract/2016/06000/SUPPORT__An_Evidence_Based_Model_for_Leaders.7.aspx	The SUPPORT model prepares nurse leaders to recognize individual, collective, and leadership actions to support nurse's moral agency in practice. Evaluation of the SUPPORT model has not been reported; yet it offers a practical and evidence based method to guide nurse leaders in their efforts to recognize, address, and remediate the causes of moral distress and other forms of moral suffering. Pavlish, C., Brown-Saltzman, K., So, L., & Wong, J. (2016). SUPPORT: An Evidence-Based Model for Leaders Addressing Moral Distress. *Journal of Nursing Administration, 46*(6), 313-320.
Program **Article**	2012	University of Virginia *Moral Distress Consult*		Moral Distress Consult Service (MDCS) was established to address institutional moral distress and ethical dilemmas. The MDCS is accessible via pager number and an ethics consultant, assists the caller in deciding

		Service		whether to trigger a consultation. Hamric, A. B., & Epstein, E. G. (2017, June). A Health System-wide Moral Distress Consultation Service: Development and Evaluation. In *HEC forum: an interdisciplinary journal on hospitals' ethical and legal issues 29*(2), 127-143.
Program **Website**	2017	Agency for Healthcare Research and Quality (AHRQ) Surveys on Patient Safety Culture™	https://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/index.html	Program allows organizations to assess staff perceptions of patient safety tools including patient safety culture environment and culture change over time. It provides a useful framework for establishing baseline performance and comparative analysis over time.
Website **Article**	2013	Institute for Healthcare Improvement *Through the Eyes of the Workforce: Creating Joy, Meaning, and safer Health Care*	http://www.npsf.org/?page=throughtheeyes	This is a report of the Lucian Leape Institute Roundtable on Joy and Meaning on Work and Workforce Safety. The report evaluates the state of health care as a workplace, and identifies vulnerabilities in health care organizations, including financial considerations and patient safety. Includes seven recommendations for action.
Policy	2015	Kaiser Permanente *Voice of Nursing*	http://kpnursing.org/nursingstrategy/toolkit/KP%20Nursing%20Professional%20Practice%20Introduction%20to%20the%20Voice%20of%20Nursing.pdf	This model standardizes professional nursing practice for all Kaiser nurses under a single vision, set of values, and nursing model aimed at transforming the organizational culture. In addition, Kaiser uses a Workplace Safety Index, in addition to composite scoring of other workplace safety measures. Their analysis of the Index and composite scores, which include measures related to ethics and speaking up, reveals that higher scores are related to fewer workforce injuries and improved patient outcomes.
Website **Program**	2017	Virginia Mason Institute *Patient Safety Alert System*	https://www.virginiamasoninstitute.org/2015/09/patient-safety-alert-system/	In 2002, Virginia Mason established a Patient Safety Alert Process (PSA) to encourage reporting by staff of any concerns, mobilizing teams to respond to and address each alert. The Institute/s "Respect for People Initiative" trains every employee on the core value of respect for all people in order to create and sustain cultures in which everyone feels safe speaking up. The percent of employees who report they feel comfortable speaking up freely has grown over the history of these initiatives.
Website **Article**	2017	Vanderbilt University *Vanderbilt Center for Patient and Professional Advocacy*	https://ww2.mc.vanderbilt.edu/cppa/	Professional accountability model that allows systematic monitoring of unprofessional conduct. The Co-Worker Observation Reporting System (CORS®) found that over a period of 3 years, this tool was effective in reducing staff concerns by 70%. Webb, L. E., Dmochowski, R. R., Moore, I. N., Pichert, J. W., Catron, T. F., Troyer, M., ... & Hickson, G. B. (2016). Using coworker observations to promote accountability for disrespectful and unsafe behaviors by physicians and advanced practice professionals. *The Joint Commission Journal on Quality and Patient Safety*, *42*(4), 149-AP3.
Program	2016	Children's Health/Children's Medical Center of Dallas *Research and Resilience, Integrated ethics, Staff Support, and Ethics Education (RISE)*		The RISE program will support the mission and values of Children's Hospital System of Texas by promoting integrated ethics through staff support, education, and research; enhancing the ethical climate, empowering staff and mitigating moral distress. RISE: Research and Resilience, Integrated Ethics, Staff Support and Ethics Education. The purpose of the RISE team is to: • Promote interdisciplinary research in ethics and moral distress. • Foster resilience in order to better prepare individuals to navigate moral complexities. • Integrate ethics into daily practice by creating a workplace environment that recognizes the impact of moral distress, supports moral resilience, and encourages discussion and collaboration.

				• Create readily available moral spaces in the midst of highly challenging situations. Knowledgeable team members will be available to facilitate identification of common goals, clarification of information, and discussion of ethically justifiable options in order to broaden perspectives, improve patient care and enhance team communication. • Explore opportunities to offer ethics education and to improve access to existing ethics education resources. "

Website
Program
Article
Mobile Application
Policy

References

American Association of Critical-Care. (2008). AACN Position Statement on Moral Distress. Retrieved from http://www .aacn.org/WD/Practice/Docs/Moral_Distress.pdf

American Association of Critical-Care Nurses. (2016). AACN healthy work environment assessment. American Association of Critical-Care Nurses Web site. Retrieved from http://www.aacn.org/wd/hwe/content/aboutassessment.content?menu=hwe&lastmenu=divheader_web_assessment_tool

American Nurses Association. (2015). *Code of Ethics for Nurses with Interpretive Statements*. Silver Spring, MD: Author. Retrieved from www.nursingworld.org/Code-of-Ethics

Allen, R., Judkins-Cohn, T., Forges, E., Lee, R., Clark, L., & Procunier, M. (2013). Moral distress among healthcare professionals at a health system. *JONA'S healthcare law, ethics and regulation*, *15*(3), 111-118.

Arnetz, B. B., Nevedal, D. C., Lumley, M. A., Backman, L., & Lublin, A. (2009). Trauma resilience training for police: Psychophysiological and performance effects. *Journal of Police and Criminal Psychology*, *24*(1), 1-9.

Bradshaw, B. G., Richardson, G. E., Kumpfer, K., Carlson, J., Stanchfield, J., Overall, J., ... & Kulkarni, K. (2007). Determining the efficacy of a resiliency training approach in adults with type 2 diabetes. *The Diabetes Educator*, *33*(4), 650-659.

Bekki, J. M., Smith, M. L., Bernstein, B. L., & Harrison, C. (2013). Effects of an online personal resilience training program for women in STEM doctoral programs. *Journal of Women and Minorities in Science and Engineering*, *19*(1).

Cannaerts, N., Gastmans, C., & Casterlé, B. D. D. (2014). Contribution of ethics education to the ethical competence of nursing students: educators' and students' perceptions. *Nursing ethics*, *21*(8), 861-878.

Centers for Disease Control and Prevention (1999). Framework for program evaluation in public health. *Morbidity and Mortality Weekly Report, 48*(RR-11), 1-41

Cohen-Katz, J., Wiley, S. D., Capuano, T., Baker, D. M., Kimmel, S., & Shapiro, S. L. (2005). The effects of mindfulness-based stress reduction on nurse stress and burnout. Part II: A quantitative and qualitative study. *Holistic Nursing Practice, 19*(1), 26–35.

Epstein, E.G., Delgado, S., (Sept 30, 2010) "Understanding and Addressing Moral Distress" *OJIN: The Online Journal of Issues in Nursing* Vol. 15, No. 3, Manuscript 1.

Foureur, M., Besley, K., Burton, G., Yu, N., & Crisp, J. (2013). Enhancing the resilience of nurses and midwives: Pilot of a mindfulness based program for increased health, sense of coherence and decreased depression, anxiety and stress. *Contemporary Nurse*, *45*(1), 114-125.

Gallagher, A. (2006). The teaching of nursing ethics: content and method. *Essentials of teaching and learning in nursing ethics: perspectives and methods. London, UK: Churchill Livingstone*, 223-239.

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

Holtz, H., Heinze, K., & Rushton, C. (2017). Inter-professionals' Definitions of Moral Resilience. *Journal of Clinical Nursing*. doi: 10.111/jocn.13989

Houston, S., Casanova, M. A., Leveille, M., Schmidt, K. L., Barnes, S. A., Trungale, K. R., & Fine, R. L. (2013). The intensity and frequency of moral distress among different healthcare disciplines. *The Journal of Clinical Ethics*, *24*(2), 98-112.

Irving, J. A., Dobkin, P. L., & Park, J. (2009). Cultivating mindfulness in health care professionals: A review of empirical studies of mindfulness-based stress reduction (MBSR). *Complementary Therapies in Clinical Practice*, *15*(2), 61-66.

Kabat-Zinn, J. (2005). Full catastrophe living: Using the wisdom of your body and mind to face stress, pain and illness. New York, NY: Delacourt Press.

Kanekar, A., Sharma, M., & Atri, A. (2010). Enhancing social support, hardiness, and acculturation to improve mental health among Asian Indian international students. *International Quarterly of Community Health Education*, *30*(1), 55-68.

Kent M, Davis MC, Stark SL, Stewart LA (2011). A resilience-oriented treatment for posttraumatic stress disorder: Results of a preliminary randomized clinical trial. *Journal of Traumatic Stress,* 24, 591-595.

Lewis-Newby, M., Wicclair, M., Pope, T., Rushton, C., Curlin, F., Diekema, D., ... & Langer, R. L. (2015). An official American Thoracic Society policy statement: managing conscientious objections in intensive care medicine. *American Journal of Respiratory and Critical Care Medicine*, *191*(2), 219-227.

Loprinzi, C. E., Prasad, K., Schroeder, D. R., & Sood, A. (2011). Stress Management and Resilience Training (SMART) program to decrease stress and enhance resilience among breast cancer survivors: a pilot randomized clinical trial. *Clinical Breast Cancer*, *11*(6), 364-368.

Mackenzie, S., Poulin, A., & Seidman-Carlson, R. (2006). A brief mindfulness-based stress reduction intervention for nurses and nurse aides. *Applied Nursing Research, 19*(2), 105–109.

Mealer, M., Jones, J., & Moss, M. (2012). A qualitative study of resilience and posttraumatic stress disorder in United States ICU nurses. *Intensive Care Medicine*, *38*(9), 1445-1451.

Mealer, M., & Moss, M. (2016). Moral distress in ICU nurses. *Intensive Care Medicine*, *42*(10), 1615-1617.

Mealer, M., Conrad, D., Evans, J., Jooste, K., Solyntjes, J., Rothbaum, B., & Moss, M. (2014). Feasibility and acceptability of a resilience training program for intensive care unit nurses. *American Journal of Critical Care*, *23*(6), e97-e105.

Moss, M., Good, V. S., Gozal, D., Kleinpell, R., & Sessler, C. N. (2016). A Critical Care Societies collaborative statement: burnout syndrome in critical care health-care

professionals. A call for action. *American journal of respiratory and critical care medicine*, *194*(1), 106-113.

Pipe, T. B., Bortz, J. J., Dueck, A., Pendergast, D., Buchda, V., & Summers, J. (2009). Nurse leader mindfulness meditation program for stress management. *The Journal of Nursing Administration, 39*(3), 130–137.

Royse D., Thyer B. & Padgett D. (2015). Program evaluation: An introduction to an evidence-based approach, 6th ed., Cengage Learning: Boston, MA.

Rushton, C. H. (2016a). Moral resilience: a capacity for navigating moral distress in critical care. *AACN advanced critical care*, *27*(1), 111-119.

Rushton, C. (2016b). Building moral resilience to neutralize moral distress. *American Nurse Today, 10*(11). Retrieved from https://www.americannursetoday.com/building-moral-resilience-neutralize-moral-distress/

Rushton, C. H., Schoonover-Shoffner, K., & Kennedy, M. S. (2017). A Collaborative State of the Science Initiative: Transforming Moral Distress into Moral Resilience in Nursing. *The American Journal of Nursing*, *117*(2), S2-S6.

Songprakun, W., & McCann, T. V. (2012a). Evaluation of a cognitive behavioural self-help manual for reducing depression: a randomized controlled trial. *Journal of Psychiatric and Mental Health Nursing*, *19*(7), 647-653.

Songprakun, W., & McCann, T. V. (2012b). Effectiveness of a self-help manual on the promotion of resilience in individuals with depression in Thailand: a randomised controlled trial. *BMC Psychiatry*, *12*(1), 12.

Kälvemark Sporrong, S. (2007). *Ethical competence and moral distress in the health care sector: a prospective evaluation of ethics rounds* (Doctoral dissertation, Acta Universitatis Upsaliensis).

The Joint Commission. (2012). Patient and Worker Safety: Opportunities for Synergy, Collaboration, and Innovation. Retrieved from http:thejointcommission.org

The Joint Commission. (2017). The Joint Commission's Electronic Accreditation and Certification Manuals. Retrieved from https:thejointcommission.org/standards_information/edition.aspx

Turner, S. B. (2014). The resilient nurse: an emerging concept. Nurse Leader, 12(6), 71-90.

West, C. P., Dyrbye, L. N., Rabatin, J. T., Call, T. G., Davidson, J. H., Multari, A., ... & Shanafelt, T. D. (2014). Intervention to promote physician well-being, job satisfaction, and professionalism: a randomized clinical trial. *JAMA Internal Medicine, 174*(4), 527-533.