Relationships Among Moral Distress, Level of Practice Independence and Intent to Leave of Emergency Department Nurse Practitioners

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Abstract

Purpose: This study investigated relationships among moral distress, level of practice independence and intention to leave of emergency department nurse practitioners (ED NPs).

Methods: This quantitative, cross-sectional, correlational study used a survey methodology. A convenience sample of 236 ED NPs was recruited through a mailed survey of ED NPs in an international nursing specialty association. The participants completed instruments regarding moral distress using the Moral Distress Scale-Revised (MDS-R), level of practice independence using the Dempster Practice Behavior Scale (DPBS) and intent to leave the clinical position through self-report.

Findings: The MDS-R was a significant predictor of intention to leave in ED NPs. The DPBS did not yield significance for intention to leave and was noted to have a slight negative but non-significant relationship with the MDS-R in that when the MDS-R scores were higher, the DPBS scores were lower. Both male and female MDS-R scores were higher if the respondent revealed they were considering leaving or left their position than when they were not considering leaving. Respondents found poor patient care due to poor staff communication and working with incompetent coworkers as the most morally distressing situations in their practice.

Discussion: Findings support the MDS-R is a valid and reliable instrument in measuring moral distress. This study further validates that moral distress is a significant indicator of one's intent to leave their position. Examining the root causes of moral distress in ED NPs and developing interventions to alleviate moral distress may be effective in keeping highly trained ED NPs in their clinical position.

UNIVERSITY OF VIRGINIA
SCHOOL OF NURSING

Doctoral Program

DISSERTATION APPROVAL SHEET

Formal approval is hereby given to this submitted dissertation by

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CHAPTER ONE

Introduction, Theoretical Framework, and Specific Aims

Introduction

About 82 million Americans have no health insurance or have inadequate health insurance and do not receive preventative health care or services for their medical conditions and therefore often have more difficult and serious health outcomes (Kaiser Family Foundation, 2010). Nurse practitioners (NPs) are experiencing the demand for more access to healthcare and have identified it as an ethical issue (Laabs, 2005). Therefore with the increasing demands on nurse practitioners to uphold the access to primary care for both insured and uninsured patients, the potential for moral distress and the intention to leave the practice become more worrisome. To begin, the theoretical framework, Ajzen and Fishbein's theory of reasoned action, precedes as the foundation of the dissertation, followed by the specific aims. In the study for this dissertation, emergency department nurse practitioners (ED NPs) were specifically targeted, as ED NPs are members of the 'first line' in the field of healthcare, and often treat patients in the ED with primary care complaints as well as more emergent conditions. In this dissertation, a research proposal posits a study investigating nurse practitioners working in emergency departments and their moral distress, level of practice independence and intention to leave their position. Three articles containing knowledge gained from this proposal and subsequent study are presented in the following chapters. In chapter two, the first article reviews the literature pertaining to nurse practitioners and moral distress, with an in depth analysis of the themes found within the studies identified in the assessment. The second article, in chapter three,

examines the ethical issue of prescribing medications to patients seen in the ED for prescription refills of their chronic disease medications and the dilemma that faces ED NPs in their moral obligation in treating patients for primary care concerns in the ED. The third article, presented in chapter four, presents detailed findings of the large national survey conducted of ED NPs and their views of moral distress, level of practice independence and intention to leave their position. Lastly, a conclusive summation chapter aggregates the work of the dissertation, reviews the changes from the proposal to the study, and offers implications for further research.

Theory of Reasoned Action (TRA)

Fishbein and Ajzen's theory of reasoned action (TRA) is the theoretical and conceptual framework used to guide my research and study (Fishbein & Azjen, 2010). The TRA is a popular framework in social science and healthcare research, and is used in predicting, explaining, and changing human social behavior (Fishbein & Ajzen, 2010; Ajzen, 2012). The TRA has been used in research regarding risk behaviors including tobacco use, illicit drug use, and sexual behaviors (Noonan, Kulbok, & Yan, 2011; Jemmott, 2012; Garcia-Retamero & Cokely, 2011). Researchers have also integrated the TRA into their studies examining the intended and actual behaviors of nurses and physicians, as well as other health care professionals (Sable, Schwartz, Kelly, Lisbon, & Hall, 2006; Liou, 2009; Natan, Beyil, & Neta, 2009). In this dissertation, the operational definitions will be described utilizing the key concepts from my research interests, and the strengths and weaknesses of the TRA as it applies to the study.

The first key tenet of this theory is the *attitude toward behavior* and it is framed as personal and professional beliefs and values of the ED NP for this study. Fishbein and

Ajzen define attitude as a tendency to respond with some degree of favorableness or unfavorableness to a psychological object (2010). In other words, attitude is determined by the individual's beliefs and moral values about the behavior. The framework evaluates the individual's attitude toward a particular behavior. In this study, the ED NP's personal and professional environments shape their attitude behaviors. For example, if the ED NP has positive feelings or feels empowered towards the organization's goals and values, wants to maintain membership within the organization, and senses support in practice, then the ED NP's attitude towards stressors, specifically moral distress in this study, will be different than if the ED NP feels little support or empowerment within the organization. Attitude is operationalized by the ED NP's beliefs and values in this proposed study.

The next tenet, *perceived norm* and *perceived behavioral control* are the social contexts that influence individuals' behaviors (Fishbein & Azjen, 2010; Ajzen, 2012). In research regarding risk behaviors, perceived norms are often in the context of social pressures (Noonan, Kulbok, & Yan, 2011; Curtis, 2012; Jemmott, 2012). Health professionals also cite social or professional pressures in their actions and medical decisions (Sable, Schwartz, Kelly, Lisbon, & Hall, 2006; Liou, 2009; Natan, Beyil, & Neta, 2009). For this study, the ED NP has many perceived norms influencing their reaction to moral distress, including healthcare access, confidentiality concerns, treatment constraints, and policy limitations to name a few. If these norms are perceived to have more control than others, these perceived behavioral controls lead the ED NP to have moral distress when the control over their intended or actual behavior or action is not their own (Fishbein & Azjen, 2010). Thus, the operational

definitions of perceived norms and behavioral control are the social pressures and constraints found within the ED NP's practice and the moral distress caused by the loss of control over the social pressures on practice, respectively.

The last tenet for the proposed study is *behavior intention*. Fishbein and Ajzen define behavior intention as the outcome of the individual's attitudes and perceived norms and control (Fishbein & Azjen, 2010). The stronger the belief or attitude and the positive or negative social norms predict the individual's intent to do an action (Fishbein & Azjen, 2010). The TRA describes behavior intentions preceding actual behaviors, which predict whether a person actual performs the behavior. Stated another way, if a person has identified an intention to do a behavior, there will be characteristics in the person predicting whether the person will actually perform the behavior or not. Researchers of risk behaviors use the TRA to examine the intended behaviors by assessing if the attitudes and behaviors of study participants are determinants of the behavior (Fishbein, 2008).

For this study, moral distress and level of practice independence are examined to determine if these constructs (predicting behaviors) predict ED NPs intent to leave their current job or practice (behavioral intention). These decisions were studied using the instruments, Moral Distress Scale-Revised (MDS-R) and Dempster Practice Behaviors Scale (DPBS). The measures were utilized to determine if level of practice independence and moral distress have a relationship to a nurse practitioner's decision to leave their position.

The TRA has several strengths as a theoretical framework in research. First, the TRA is accepted across several sciences, and while the model was constructed for

psychology research, it has been extensively used in nursing, medicine, and sociology studies (Ajzen, 2012). The framework has been facilitative in research focusing on relationships between beliefs and behaviors (Noonan, 2010; Natan, Beyil, & Neta, 2009). Knowing the predictors for a behavior is helpful when developing interventions to change behavior. The framework contributes in understanding individual's beliefs in behaviors and allows investigators to visualize the motivation of the individual's behavior (Ajzen, 2012; Fishbein, 2008). Using regression analysis, researchers obtain important information about the predicted norms and their relationships to the intended behavior. However, while the framework allows focus on determinates that predict behaviors, it is that narrow lens that can limit this conceptual model for researchers without robust samples.

Furthermore, there are some limitations to the TRA. One such limitation the creators of the theory acknowledge is the difficulty in isolating a limited number of determinates to predict behaviors (Ajzen, 2012; Fishbein, 2008). Another limitation of the framework is analyzing data using hierarchical regression, unreliable variances in the steps could occur related to the isolation of a few determinants. Standard multiple regression was calculated in this study, not hierarchical regression to avoid this concern. In the proposed study, the TRA is a strong framework for the purpose of determining if moral distress and level of practice independence have a relationship in the ED NP's intent to leave their position.

Specific Aims

The purpose of this quantitative research study is to investigate moral distress among emergency department nurse practitioners (ED NPs), and to examine

relationships between moral distress and level of practice independence on the intent to leave their position or profession. Evidentiary support will be offered to the relevance of these issues to current health care and advanced nursing practice. The specific aims of the study are as follows:

Aim 1: To examine the relationships between moral distress and level of practice independence of ED NPs

Aim 2: To examine the relationships between moral distress and level of practice independence on the intent to leave of ED NPs.

CHAPTER TWO

PHS 398 – Moral Distress of Emergency Department Nurse Practitioners

Project Summary:

Purpose and Specific Aims: The aims of this research study are to investigate moral distress among emergency department nurse practitioners (ED NPs), and to examine relationships between moral distress and level of practice independence on the intent to leave their position or profession. Background: ED NPs are increasingly practicing in a safety-net role, providing primary care for patients who lack insurance or access to a primary care provider. Providing primary care in an ED setting does not allow for adequate follow up and may, in fact, be dangerous, as many patients leave the ED with only a short-term solution for chronic problems. The NPs' lack of practice independence or control in changing the system to provide premium care may create moral distress. Level of practice independence has been found to have a relationship with a NPs' intention to leave. Methods: A correlational design using a quantitative survey method will be used. The study will examine moral distress using the Moral Distress Scale-Revised (MDS-R), level of practice independence using Dempster's Practice Behavior Scale (DPBS) and intent to leave through self-report. A convenience sample of ED NPs, identified from the mailing lists of national nursing specialty organizations, the Emergency Nurses Association (ENA) and the American Academy of Nurse Practitioners (AANP) will be used. Correlational and regression analysis of data will be done to characterize moral distress among ED NPs as well as the relationships between moral distress, level of practice independence, and intent to leave. Implications: This study will act as a pilot study for a program of research investigating

relationships among moral distress, level of practice independence, and intention to leave in NPs working in EDs. Further studies will be developed to explore the findings from this research and formulate interventions to alleviate moral distress, level of practice independence, and intention to leave.

Relevance:

As ED NPs work in an increasingly more critical environment within our healthcare system, it is important to discover the elements causing so many to leave the profession. Thus, it is important to investigate reasons of dissatisfaction and address concerns of ethically disturbing behaviors felt by NPs in these settings and their subsequent affect on the intention to leave the position or profession.

Resources:

The University of Virginia offers students an environment rich in opportunities for research and professional development. Some of these opportunities are described below.

UVA School of Nursing

Established in 1901, the School of Nursing is one of 11 schools within the University (the newest being the interdisciplinary Frank Batten School of Leadership and Public Policy dedicated in 2007), and is part of the University's Health System that includes the Medical Center, School of Medicine, and Claude Moore Health Sciences Library. McLeod Hall has housed the nursing school since 1973 and is now accompanied by the new Claude Moore Nursing Education Building, dedicated in fall 2008. The buildings are across from one another and adjacent to the Medical Center and medical school, facilitating interdisciplinary synergy. The Medical Center is uniquely situated to serve diverse populations from both the urban setting of Charlottesville and from rural areas throughout the state, especially Central Virginia. School of Nursing facilities include high-tech clinical simulation laboratories, computer labs, research space, offices and conference areas (including teleconferencing and videoconferencing technology), an auditorium and classrooms/lecture halls. The addition of the new building has expanded our research capacity with additional meeting/consultation space and more state-of-the-art technology infrastructure.

U.S. News & World Report (2012 edition), ranked the UVA School of Nursing among the nation's top 2% of nursing schools, 15th place overall. Two graduate programs were ranked in the Top Ten of America's best graduate schools, Psychiatric/Mental Health at #8 and Clinical Nurse Specialist-Adult/Medical-Surgical at #6. The UVA School of Nursing Pediatric Nurse Practitioner program ranks #13, while the Family Nurse Practitioner program ranks #16. The School of Nursing was ranked #22 in National Institutes of Health nursing research funding and #1 in the U.S. for doctoral student-authored NRSA fellowships in 2006.

The new **Claude Moore Nursing Education Building**, designed by Bowie Gridley Architects of Washington, DC, has been constructed across the street from McLeod Hall's entrance. Now outgrown and inadequate to meet the need of new programs, increased enrollment, and cutting-edge research, McLeod Hall is undergoing renovation. The renovation plans are inseparable from the construction of new space as the school's academic programs are efficiently organized between two buildings. In these buildings our dedicated faculty, staff, and students will continue improving on the specialized training that mirrors the changing and challenging role of nurses in 21st century health care. The integrated buildings (one new, one renovated) provide:

- Lecture halls and classrooms of various sizes and flexible design, with the latest in instructional technologies
- Increased space for research teams in close proximity to classrooms and the hospital, given that evidence-based practice and education relies on the creation of new knowledge and proven outcomes
- Meeting rooms and common space to promote interaction among students, faculty, and staff
- A Student Life Center where student organizations have a home and where leadership development can be fostered
- 32,000 gross square feet of new space and 54,000 gross square feet of renovated space

The design of the new building reflects the values of the nursing profession, including wellness promotion, community outreach, and self-care. In this spirit, the building includes an open stairwell spanning all four floors – to promote fitness and interaction to which large windows bring in natural light. A commons area and adjacent café give students, faculty, and staff a place to meet and enjoy healthy meals and snacks throughout the day. Given the proximity of the nursing education buildings to the medical education buildings, harmonies created through landscaping complement the values inherent in the health care professions and reinforce the vital links between them. The construction of the new building has enabled reconfiguring for improved space in McLeod Hall. Included in the renovation for McLeod Hall is an expanded home and exhibit space for the Center for Nursing Historical Inquiry and its valuable collections, increased space for the Office for Nursing Research, improved conference facilities, and a state-of-the-art Clinical Simulation Learning Center.

The School of Nursing's **Office for Nursing Research (ONR)** provides support to faculty and graduate students in all aspects of grant proposal preparation, including budget formulation, biosketches, resources and environment information, preparation and copying appendix material, assurance of proposal compliance with sponsor requirements, and routing of proposals through the institutional approval process. To further support the research enterprise of faculty and students, the School of Nursing and the ONR began the "Virginia Nursing Research Enhancement Initiative". This initiative involves several components to increase research and scholarly activities in the School of Nursing. The SON has contracted with nursing researchers with distinguished research careers, to work closely with faculty and graduate students to help them develop research trajectory plans with yearly goals and evaluations.

The ONR also presents regular Research Forums, attended by faculty and students, to showcase ongoing research at the School of Nursing. Forums and workshops held in the last year have included the following:

Forums:

- **Caregiver Occupational Stress in Navy Medical Personnel**
  Richard Westphal, PhD, RN, PMHCNS-BC
- **University of Virginia Center for Survey: Understanding the Services for Faculty and Students**
  Thomas Guterbock, PhD
- **Writing for Publication**
  Vicki Conn, PhD, RN, FAAN
  Editor, Western Journal of Nursing Research
- **Electronic Dissertation and Thesis Submissions**
  Anne Houston
  Jennifer Roper
  Madelyn Wessel
- **Preventing Fetal Alcohol Spectrum Disorders: a program of research on reducing alcohol exposed pregnancy**
  Karen Ingersoll, PhD
  Associate Professor, Psychiatry and Neurobehavioral Sciences
- **Randomized Behavioral Clinical Trials: Points of Consideration from the NIH Summer Research Institute**
  Joel Anderson, PhD
  Assistant Professor of Nursing, Roberts Scholar
- **Robert Wood Johnson Foundation Nurse Faculty Scholar Program**
  Jackie Campbell, PhD, RN, FAAN
- **Federal Funding for Nursing Programs in the Current Fiscal Environment: Trends, Challenges, and Opportunities**
  Erica Froyd
  Julie Jolly, Lewis-Burke Associates
- **Facilitating Health Care Decision Making: Patient Education is Not Enough**
  Donna Berry, PhD, RN, AOCN, FAAN
  Associate Professor of Medicine
  Director, Phyllis F. Cantor Center for Research in Nursing and Patient Care Services, Dana Farber Cancer Institute

- **Mobile Health Interventions for and with Underserved Youth: Design, Implementation, and Outcomes**
  Kathy Kim, PhD
- **IRB Process**
  Bronwyn Blackwood, Director IRB for Social & Behavioral Sciences (SBS)
  Susie Hoffman, Director IRB for Health Sciences Research (HSR)
- **Visiting Scholar in Hospice and Palliative Care: Lessons Learned and Gifts for the Journey**
  Patina Krongyuth, pre-doctoral visiting scholar from Mahidol University in Thailand

Workshops/Conferences:

- **Multilevel Models for Longitudinal Data / Multilevel Models for Clustered Data**
  Lesa Hoffman, PhD
  Associate Professor and Cognitive Program Director
  Department of Psychology, University of Nebraska-Lincoln
- **ONR Webinar - Qualtrics: A Tool used for survey research, experimental research, assessments, evaluations, test & quizzes, accreditation's, event registrations, and a direct download of raw data into SPSS**
  Jennifer Brinkerhoff
  Academic liaison for the Qualtrics Group

The ONR also supports doctoral nursing education and doctoral student research. PhD students and at least one faculty usually make an annual visit to NINR, sponsored by the ONR and the UVA School of Nursing. This trip provides an opportunity to attend a symposium sponsored by NINR and/or a meeting of the National Advisory Council for Nursing Research to observe the review process firsthand. These experiences generate classroom discussion about research methodology, reinforcing the content of a research methodology course. Additionally, through the ONR, numerous intramural scholarships are available for both undergraduate and graduate students to be paired with faculty members to conduct clinical research.

A Doctoral Retreat is held annually at the beginning of the fall semester at an off-campus location. Students at varying levels in the doctoral program meet to informally discuss expectations about the program as well as possible contacts related to their research interests. Faculty later joins the students to introduce their areas of research and expertise as potential research experiences for students to pursue. The serene surroundings promote the growth of interpersonal communication among students and faculty.

"Writing for Publication," a full-day seminar sponsored by the ONR, has been presented several times by noted author and editor, Elizabeth Tornquist. This seminar provides participants with suggestions and strategies for successful scientific writing. Although the focus of the conference is on grant-writing, manuscript development for comprehensive literature reviews and practice reviews is also discussed. In addition, private consultations are available by appointment, providing individualized feedback about current projects. Dr. Tornquist continuously reviews papers and grant proposals for both faculty and graduate students.

Students and faculty from the UVA School of Nursing attend the annual Southern Nursing Research Society (SNRS) Meeting. This conference offers an opportunity to learn about ongoing nursing research and to network with doctoral students and faculty from other universities.

SON Computer Support

The School of Nursing provides dedicated computing systems management and support to its faculty, staff, researchers, and students under the University's federated technology support model. The School employs a full-time Director of Information Systems who manages a team of engineers, a Web developer/user experience specialist, a systems developer/integrator, and technical support staff. The School also employs a facilities management/audio visual technician, and the Information Systems department manages the related collateral job duties of several Local Support Associates, administrative support staff who work directly with faculty and researchers to provide basic technical support needs and to provide access and referral to more advanced support resources as appropriate.

The School's professional technical staff provides technical consulting, support, systems administration, and development/integration services to its various constituencies. The technical staff maintains extensive experience:

- developing and implementing .NET client-server and Web-server applications
- developing and implementing relational database management systems
- architecting and administering directory services, storage systems, Microsoft Windows and Enterprise Linux application servers, and data security appliances
- supporting Windows and Macintosh clients
- providing information security and records management services, consulting, and monitoring.

Staff also provides technical training to users, consults with users in regards to technology acquisition and implementation, and designs and implements Web sites and online survey systems.

The Director of Information Systems and the Systems and Network Administrator are both Global Information Assurance (GIAC)-certified security professionals, responsible for ensuring the application of defense in-depth security measures and information security best practices. The Director of Information Systems also provides strategic planning and management expertise to the organization.

Each full-time faculty and staff member of the School is provided with a dedicated PC or laptop for their exclusive use. Part-time faculty and staff are provided either a dedicated PC or a shared PC based upon their individual requirements. An on-site Help Desk staffed by the School's technical staff, in concert with the Local Support Associates and a 24x7 University Help Desk, fully supports the hardware and software configuration needs of all School faculty, staff, and researchers.

The School's computing infrastructure consists primarily of a Windows infrastructure, with predominantly Windows 7 Enterprise at the desktop; additionally, approximately 60% of students and some faculty and staff utilize Mac laptops. Enterprise computing systems in which the School of Nursing has invested include Windows Server 2008 R2 physical and virtual servers, MS-SQL2012 database servers, Windows Terminal Servers, Windows 2003 and Server 2008 Web servers, RedHat Enterprise Linux application and file servers, Windows 2008 application servers, System Configuration Servers, Content Management Systems, Document Imaging Systems, Disk-Attached Storage systems, and Storage Area Networks.

A new (2011) secure data center providing redundant power and cooling hosts mission-critical and core computing infrastructure hardware. A remote, off-site Hierarchical Storage Manager tape library supplements a contract with a national records management and information management provider to provide redundant, secure storage facilities for data backups, alongside locally hosted backups.

Peripheral computing equipment owned by the School includes color LaserJet printers, color landscape printers, multifunction enterprise-class copiers/scanners/printers/FAX machines, high-speed duplexing LaserJet printers, digital cameras, digital visual presenters, digital video recorders, portable and fixed video projection systems, multipoint videoconferencing and lecture capture systems, clinical simulation systems, and technology-enhanced classrooms and conference rooms.

A total of 12 classrooms, six conference rooms, eight videoconferencing rooms, two specialty procedure/observation rooms, and a clinical simulation learning center are provided by the School. The largest videoconferencing room provides 30 seats for multipoint conferencing and live video streaming, with the largest classroom providing videoconferencing and distance learning services seating 125. A 475-seat auditorium also offers remote broadcasting and recording capabilities for lectures and other events.

The School's Local Area Network connects directly into the campus 10-gigabit Ethernet aggregate core Wide Area Network (WAN) via fiber uplinks. Desktop systems are linked onto a switched Ethernet backbone via 100Mbps connections, with 1000Mbps full-duplex connections available as required. A WPA2 Enterprise wireless infrastructure also is provided, utilizing EAP-TLS authentication with AES encryption; wireless authentication via digital certificates serves a dual purpose of authentication and verification that any connected wireless access point is an official and secure access point. AES encryption also ensures that every data packet is transmitted over the airwaves with a unique security key. Remote clients have access to the University network via encrypted Virtual Private Networking (VPN) solutions and remote desktop services.

The School manages a three-tiered network infrastructure that compartmentalizes clients, server and appliance resources, and data streams. Each tier, or Level, represents an increasing level of security and compartmentalization.

The Level 1 (lowest) network tier offers standard security protection measures, such as an Intrusion Detection System, and affords network access to public devices and student-owned computing devices.

Level 2 and Level 3 network tiers provide enhanced security for networked computing devices utilized by faculty, staff, and researchers. The Level 2 network provides a more secure network architecture with redundant firewalls, stateful network connectivity, Intrusion Detection System, and a Virtual Private Network (VPN) concentrator positioned between the Internet and internal systems. Most faculty and staff client PCs are placed on the Level 2 network, as are most server systems containing non-restricted data.

The School addresses the storage of sensitive and regulated data (such as data that falls under the security provisions of the Health Insurance Privacy and Portability Act [HIPAA]) with the deployment of a Level 3 network. This highest level of the network infrastructure hierarchal pyramid hosts hardened Windows 2008 and Linux application servers, as well as enterprise disk storage hosted in a separate, secure facility behind a highly secure private network segment. Access to this network segment from any client PC, including on-campus, requires a secure VPN tunnel with dual-factor authentication to the network segment, and an additional (third) level of authentication to the servers and applications hosted on this segment. Additional firewalls and monitoring, coupled with stringent compartmentalized access, provide additional protection to this network tier.

Information security constitutes a major focus of the University and School. The School completes a comprehensive Risk Assessment and Mission Continuity planning document every three years; additionally, the School develops and maintains annual Continuity of Operations plans. The School performs Disaster Recovery exercises annually. A catalogue of sensitive data, its retention schedule, and location is maintained. The Library of Virginia's Records Management guidelines, in concert with federal and state regulations, and individual funding agency requirements, drive the management and retention of records and data. The Director of Information Systems serves as the School's Records Management Official.

H.263/.264 videoconferencing is available for small to large-size meetings, and live virtual classroom technology is provided for classroom and some conference room uses. Both technologies offer fast-frame video transmission across TCP/IP network connections, multi-point Voice over IP (VOIP), and desktop application sharing. Tandberg® and LifeSize® infrastructures build out multi-point videoconferencing capabilities within the School, including clinical simulation and one distance learning modality. The University also licenses the Blackboard Collaborate® online collaboration software, available in many classrooms and conference rooms, as well as usable on individual-use devices (such as office PCs and laptops), for additional distance learning and conferencing needs.

An Information Technology Strategic Plan and a technology steering committee comprised of the School's Associate Deans and Information Systems Director guide the overall information technology strategies of the School. The information technology steering committee meets three times a year to vet technology strategies and policies, to prioritize and review projects, and to discuss other information technology matters requiring senior management direction.

The University stands prominently as a founding partner in the National Lambda Rail (NLR) initiative. NLR brings onto the campus the next generation of large-scale digital communication beyond the commodity Internet and Internet2 backbones (the University was a charter member of Internet2).

The University has connected to Internet2's Abilene network (that connects Internet2 universities to regional network aggregation points through an advanced network) since 1998. The Abilene network advances the work of computational researchers by enabling them to carry out computational analysis and collaboration via the Internet. Access to the NLR provides additional network capacity for collaborative research projects involving large datasets, and for transportation of specialized applications, such as video, across a TCP/IP network.

The University now participates on the Internet2 NET+ initiative's steering committee. The NET+ intiative seeks a unified, integrated portfolio of commercial and institutional cloud and InCommon trust solutions. Participation in this initiative with Internet2 and other premier institutions affords the University the opportunity to acquire, test, and implement leading cloud-based technologies that meet the unique requirements of a national research institution.

In 2011, the University, along with 28 other universities and communities nationwide, launched Gig.U: The University Community Next Generation Innovation Project. Gig.U accelerates the deployment of ultra-high-speed networks to leading U.S. universities and their surrounding communities. The University has worked with the local community over the project period to extended services already available on-campus, such as high-end video conferencing, telemedicine, and data-enabled collaboration, into local communities.

Also in 2011, the University entered into a partnership with 16 other institutions to benefit from a $121M National Science Foundation project called the Extreme Science and Engineering Discovery Environment (XSEDE). Utilizing the XSEDE infrastructure, University researchers have access to some of the most important research sites and databases in the world, including national centers in California, Illinois, and Texas. In addition, the XSEDE infrastructure affords University researchers a platform for secure collaboration with both local and remote researchers. It also includes other specialized digital resources and services, including common authentication and security mechanisms, global access to files, remote job submission and monitoring, and file transfer services. Available resources continue to expand throughout the enduring life of the project.

The University Libraries' Research Data Services initiative assists the School and other University departments with developing data management plans. The University recently led the creation of two consortium-based preservation systems: 1.) APTrust (Academic Preservation Trust), a shared preservation-oriented repository that takes advantage of the economies of scale that come with building shared, large storage and digital preservation services; and, 2.) a national Digital Preservation Network (DPN). The goal of DPN is to create a preservation backbone to ensure that digital objects subject to preservation are replicated across diverse software architectures, organizational structures, and geographic locations. APTrust and DPN provide a foundation for developing data workflows (data storage, deposit, retrieval, and access) and research management plans to respond to emerging requirements from funding agencies, as well as a foundation for humanities faculty to create new and sustainable digital scholarship.

The University's Research Computing Support Center assists University researchers in solving and demonstrating problems, testing programs, and provides training for research assistants. Center staff members provide educational outreach programs and doctoral-level technical assistance, with expertise in such areas as statistical computing, visualization, mathematical computing, and data access and archiving. Staff of the Research Computing Support Center acquire and manage the University's high-end computational platforms (including a 92-node research computing cluster), and coordinate the distribution of nearly 30 site-licensed scientific and statistical applications, with new or updated software packages added annually.

Software packages licensed through the Research Computing Support Center (or otherwise) by the School of Nursing for researchers include, among others, AMOS, the ESRI ArcGIS Suite, nQuery, NVivo, SAS, SPSS, and Stata. Microsoft productivity software and most client access licenses (CALs) are site-licensed under a Campus Agreement contract, and the University procures the Adobe suite of products under a cost-effective CLP (Cumulative Licensing Program) agreement.

Biosketch of Principal Investigator

Jennifer Trautmann — Principal Investigator, PhD student

Kent State University	Kent, OH	May 1995	BSN
University of Utah	Salt Lake City, UT	May 2001	MSN, FNP
University of Virginia	Charlottesville, VA		PhD student

A. Personal Statement

The goal of the proposed research is to examine relationships among moral distress, level of practice independence, and intention to leave of nurse practitioners in emergency departments. *Purpose and Specific Aims:* The aims of this research study

are to investigate moral distress of emergency department nurse practitioners (ED NPs), and to examine relationships among moral distress, level of practice independence, and intention to leave their position or profession. *Background*: Emergency department nurse practitioners are increasingly practicing in a safety-net role, providing primary care for patients who lack insurance or access to a primary care provider. Providing primary care in an ED setting does not allow for adequate follow up and may, in fact, be dangerous, as many patients leave the ED with only a short-term solution for chronic problems. The NPs lack of practice independence or control in changing the system to provide high-quality care may create moral distress. Level of practice independence has been found to have a relationship with a NPs' intention to leave. Moral distress may also play a significant role in staff nurses' intention to leave their practice, although this is currently unknown. *Implications:* This study will act as a pilot study for a program of research investigating relationships among moral distress, level of practice independence, and intention to leave in nurse practitioners working in emergency departments. Further studies will be developed to explore the findings from this research and formulate interventions to alleviate moral distress, level of practice independence, and intention to leave. *Relevant Experience*: I have 18 years of nursing experience, 12 years of nurse practitioner experience, and seven years of experience in emergency medicine. I have more than 40 hours of upper level coursework completed in ethics and research in healthcare.

B. Positions and Honors

2011-present	Family Nurse Practitioner, Inova Mount Vernon Emergency Department, Alexandria, VA
2010-2011	Family Nurse Practitioner, Dr. Saad Al-Hariri M.D., Pediatrics, Falls Church, VA
2009	Family Nurse Practitioner, ER Med, Baptist Health Hospitals, Montgomery, AL
2007-2009	Family Nurse Practitioner, 49 Medical Group, Holloman AFB, NM
2006-2007	Family Nurse Practitioner, ER Med, Baptist Health Hospitals, Montgomery, AL
2005-2007	Family Nurse Practitioner, Medical Outreach Clinic, Montgomery, AL
2004-2005	Family Nurse Practitioner, Family Practice Clinic, Naval Base Little Creek, Norfolk, VA
2003-2005	Family Nurse Practitioner, Cardiac Services, Sentara Hospitals, Norfolk, VA
2001-2003	Family Nurse Practitioner, Nowcare Urgent Care Clinic, Roy, UT
2010-present	Instructor, Graduate Teaching Assistant, Primary Care Nurse Practitioner Program, University of Virginia

2004-05	Nominated twice for employee of quarter, AspenMed Services
2000-2001	University Teaching Assistant, Pharmacology class, BSN program, University of Utah, SLC, UT
2000	Grant recipient, College of Nursing, University of Utah, Spanish for Medical Personnel seminar, Rios Associates, Phoenix, AZ
2000-2001	National Health Service Corps, Utah SEARCH program participant, University of Utah
1998	Juanita Redmond Award, USAF Nurse of the Year, nominee, Moody AFB, Valdosta, GA
1995	Distinguished Graduate, Air Force ROTC, Kent State University, OH

C. Selected Peer-reviewed Publications

2004	Poster Presentation, 'Nursing Care of Breast Cancer Patients in the 1950s', Southern Association for the History of Medicine and Science conference

D. Research Support and Research Related Coursework

2013	Recipient of the Barbara Brodie Doctoral Scholars Endowment University of Virginia
2013	Recipient of the Phyllis J. Verhonick Clinical Research Award, Beta Kappa Chapter of Sigma Theta Tau International Nursing Honor Society, University of Virginia, 2013
2011	Relationships among Moral Distress, Level of Practice Independence, and Intention to Leave of Nurse Practitioners in Emergency Departments, Emergency Nurses Association/ANIA CARE grant, (not funded).
2004-present	Coursework related to research, ethics, advanced practice nursing, statistics, and methodology

Statistical Methods in Health Care Research I	A-	2010	Qualitative Research Methods	A	2011
Statistical Methods in Health Care Research II	B+	2011	Research Practicum I & II	A B+	2011 2012
Statistical Methods in Health Care Research III	B+	2011	History of Health Care	B	2003

Philosophy of Nursing Knowledge	A-	2010	Scientific Progress of Nursing	A-	2003
Introduction to Clinical and Classroom Teaching and Practicum	A-	2010	Proposal Writing I	A-	2003
Quantitative Research Methods	B+	2011	Ethics & Law of Human Subject Research	B+	2011
Nursing Ethics for Advanced Practice	A-	2011	Health Promotion/Disease Prevention	A	2004
Foundations of Bioethics	B	2011	Proposal Writing II	B-	2004
Seminar on Public Health Ethics	A	2012	Health Survey Methods	B+	2012
Independent Study in Clinical Ethics	B+	2012			

Specific Aims

The focus of this research study is to investigate the relationships among moral distress, level of practice independence and the intention to leave the position or profession of emergency department nurse practitioners. To this end, the specific aims of the proposed study are: 1) To investigate the relationship between moral distress and level of practice independence in ED NPs and 2) to investigate their effects upon intent to leave of ED NPs.

Innovation

This study is the first study known to focus on moral distress of ED NPs. Also unique to this study is the use of the MDS-R instrument to determine root causes of moral distress among ED NPs. There is little empirical evidence of moral distress root causes for nurse practitioners in the literature and this study will be an important addition to the literature existing regarding moral distress.

Background and Significance

Nurse Practitioners in Emergency Departments

In 2009, approximately 140,000 nurse practitioners were in practice in the United States and approximately 6,700 NPs reported they worked in the ED (Goolsby, 2009). The role of ED NPs varies widely, from diagnosing and treating uncomplicated diseases such as upper respiratory infections and otitis media, to intubating and establishing a patent airway in a trauma patient (Cole & Ramirez, 2002). Increasingly, ED NPs are being utilized as primary care providers within the ED, treating patients with non-urgent diagnoses in order to alleviate overcrowding and decrease patient waiting times (Institute of Medicine, 2006; Patrick & Lazarus, 2010; Quattrini & Swan, 2011). For over 20 million uninsured Americans, the ED is their only access to primary healthcare and account for one-fifth of all ED visits in the United States in 2006 (Agency for Healthcare Research and Quality, 2009). Working in the ED setting is often a safety net venue for patients with limited or no access to primary care, thus associated with high stress levels and turnover related to overcrowding (Dominguez-Gomez & Rutledge, 2009; Felland, Hurley, & Kemper, 2008). These challenges combined with provider shortages, delivering quality healthcare and ensuring patient safety in the ED can be a challenge (Schneider et al., 2010).

Moral Distress

Moral distress is defined as occurring when one believes they know the ethically appropriate action to take, but are constrained from taking that action (Jameton, 1984; 1993). Moral distress affects the nurse or nurse practitioner psychologically, as well as challenges the provider's belief system (McCarthy & Deady, 2008). Moral distress has

been studied in nurses, particularly critical care nurses, but less in depth for NPs and physicians (Hamric, Borchers, & Epstein, 2011; Hamric & Blackhall, 2007; Elpern, Covert, & Kleinpell, 2005; Laabs, 2005; Corley, Elswick, Gorman, & Clor, 2001). Laabs (2005) stated primary care NPs feel constrained by insurance companies, clinic policies, and other factors in their ability to serve their patients. Also, Laabs (2007) reported primary care NPs described difficulty maintaining their professional integrity when faced with moral distress including frustration over external constraints. ED NPs possibly have these similar pressures, with the additional complexity of working in a critical care environment. For the reason that ED NPs also work as a primary care provider to many who come to the ED, it is important to understand if ED NPs have different root causes to moral distress than those NPs who work in primary care clinics. Further, no studies of moral distress have been done with ED NPs; therefore, it is important to study ED NPs as they provide both primary and critical care to patients.

Level of Practice Independence

Level of practice independence is one of the cornerstones of advanced practice nursing and NPs are increasingly becoming part of the solution of keeping health care accessible to Americans (Kleinpell, Hudspeth, Scordo, & Magdic, 2012). For NPs, level of practice independence includes collaborative practice and authority treating patients with a physician, using advanced practice skills and knowledge, and self-directing in medical judgments (Maylone, Ranieri, Griffin, McNulty, & Fitzpatrick, 2011; Cajulis & Fitzpatrick, 2007; Ulrich & Soeken, 2005; Dempster, 1990). Scope of practice is defined by the laws of the state of which the NP practices and therefore differs from level of practice independence. ED NPs are unique among NPs as they treat both primary care

and emergent problems in one setting. Several research studies analyze level of practice independence of NPs, often referred to as “autonomy” in the literature (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; Ulrich & Soeken, 2005; Dempster, 1990). A serious gap in current knowledge is the extent to which practice independence, moral distress, and intent to leave are associated. This study will address this knowledge gap for ED NPs.

Intention to Leave

Moral distress and Intention to Leave. Recently, the topic of intention to leave has received much attention as more healthcare workers leave or change their professions, often citing moral distress as one of the reasons (Hamric, Borchers, & Epstein, 2011; Hamric & Blackhall, 2007; Elpern, Covert, & Kleinpell, 2005). Researchers reported a correlation between a positive ethical environment and job satisfaction among nurses (Goldman & Tabak, 2010). Hamric and Blackhall reported forty-five percent of the nurses surveyed had left or had considered leaving a position related to moral distress (2007). Thus, in this era of needing more healthcare workers for our aging national population and retaining healthcare providers in areas of primary care, emergency medicine, and critical care, it is important to investigate reasons of dissatisfaction and address concerns of ethically disturbing behaviors felt by NPs in these settings and their subsequent affect on the intention to leave the position or profession.

Intention to Leave and Level of practice independence. NPs and other health professionals have discussed in recent years leaving their position or profession (Knifed, Goyal, & Bernstein, 2010; Laabs, 2005; 2007; Viens, 1995). Several of the

NPs described leaving their position in primary care in favor of having more control over their practice environment (Laabs, 2007). In another recent study, over forty percent of surveyed critical care nurses and NPs said they intended to leave their current position due to…. (Fitzpatrick, Campo, Graham, & Lavandero, 2010). De Milt, Fitzpatrick, and McNulty (2010) reported twenty-seven percent of the surveyed NPs from the American Academy of NPs national conference indicated intent to leave their current position and just over five percent intended to leave the nursing profession for practice independence concerns. Few studies have explored ED NPs' level of practice independence---speak to the variability of the role and how this is unique. As ED NPs work in increasingly more critical environments within our healthcare system, it is important to discover the elements that possibly cause ED NPs to consider leaving the profession or change in position. Currently, there is no literature that reports if or how many ED NPs consider leaving or leave their position. Themes for intention to leave noted in both nurse and nurse practitioner research was the feeling of powerlessness and lack of independence in relation to their occupation satisfaction (De Milt et al., 2010; Fitzpatrick et al., 2010; Goldman & Tabak, 2010; Laabs, 2005; 2007).

Impact of Study on Nursing Research. The findings of this study will improve our current understanding of moral distress and level of practice independence among ED NPs. Neither concept is fully understood among NPs. ED NPs are unique in that they diagnose and treat both non-urgent and emergent cases in one setting. Impact of this study will bring new information on ED NPs regarding their moral distress and its possible relationship to level of practice independence and intention to leave. Knowledge gained from this study will possibly influence patient outcome measures if

ED NPs are feel they have power within their practice, have fewer instances of moral distress and therefore, remain in their clinical position. Having a more stable provider staff will lead to continuity of care. If ethical dilemmas unique to NPs are identified in the ED setting in relation to their level of practice independence and intention to leave, education and interventions could be developed. These interventions could lead to more satisfying experiences for the NP; therefore, keeping the providers in the ED, decreasing the cost of provider turnover, and maintaining continuity in both the department and healthcare system.

Theoretical and Conceptual Framework

The theoretical framework guiding the proposed study is the theory of reasoned action (TRA) (Fishbein & Ajzen, 2010). The TRA describes behavior intentions preceding actual behaviors, which predict whether a person actual performs the behavior. The key tenets of this theory are attitude toward the behavior, perceived norm, perceived behavioral control, and intention (Fishbein & Ajzen, 2010). These tenets summarily depict personality traits and correlate them to behaviors (Fishbein & Ajzen, 2010). The TRA is a popular framework in social science and healthcare research, and is used in predicting, explaining, and changing human social behavior (Ajzen, 2012; Fishbein & Ajzen, 2010). In this study, the behavioral intention is the intent to leave and the predicting behaviors include level of practice independence and moral distress. These actions will be studied using the instruments, the Moral Distress Scale-Revised (MDS-R) and the Dempster Practice Behaviors Scale (DPBS). The proposed study will use the instruments and the theoretical framework to explain the predicting behaviors moral

distress and level of practice independence to describe whether or not a person will consider leaving the profession or position. A visual model is in Appendix D.

Methodology

Design

This study will be conducted using a cross-sectional correlational design to investigate possible relationships among moral distress, level of practice independence, and intention to leave of NPs in the ED environment.

Advantages

Survey research has been used successfully to interpret individual's opinions and behaviors for over 75 years (Dillman, Smyth, & Christian, 2009). Questionnaires, the term used in survey methodology to describe the instrument administered to the sample, can be distributed to a large number of individuals. This can be done fairly cost effectively with mailings, especially when comparing the cost of face-to-face interviews for the same number of respondents (Dillman et al., 2009; Groves et al., 2009). When using a self-administered questionnaire instead of face-to-face interviews, there is no bias responding to another individual (Groves et al., 2009). In other words, there is less worry about the respondent not giving an honest answer because they do not want the interviewer to know their response or they respond to visual or verbal cues of the interviewer (Groves et al., 2009). Therefore a self-administered questionnaire is an advantage in this study as moral distress is a personal issue and a confidential approach to gather information is essential.

Another advantage of survey research is the ability to ask many questions about a concept. If the researcher carefully constructs the questions within the instrument, the

resulting answers will yield information supporting the specific aims of the study (Dillman et al., 2009). The MDS-R and the DPBS instruments in this study have had rigorous testing and have been found valid in healthcare research (Cajulis & Fitzpatrick, 2007; De Milt, Fitzpatrick, & McNulty, 2011; Hamric, A. B., 2011; Ulrich & Soeken, 2005). An instrument can be constructed to have the questions build on one another to gather the most information on a subject and these instruments have been vetted with both psychometric testing and practical use (Dempster, 2011; Hamric, A. B., 2011; Hamric, Borchers, & Epstein, 2011; Dillman et al., 2009; Groves et al., 2009). When doing face-to-face interviews, even scripted questionnaires can vary and thus making the data collected difficult to analyze and relate the responses among the participants. As there are valid instruments developed to investigate moral distress and practice independence, a survey design is appropriate for this study.

Additionally, an advantage of survey design is the ability to readily analyze the data. In this study, using Likert scales quantifies attitudes and behavioral responses, and allows for comparisons and relationships to be derived from responses (Hulley, Cummings, Browner, Grady, & Newman, 2007). Likert scales with five to seven responses yields the most unambiguous responses and do not overwhelm the respondent (Dillman et al., 2009). It is also important to have both positive and negative sides represented equally by the scale (Dillman et al., 2009). These elements combine to make the ordinal responses statistically measureable by software and the results can be easily disseminated.

For the final advantage addressed in this essay, the cross-sectional data approach has several benefits. First, cross-sectional design is the study of a sample in

a moment in time (Hulley et al., 2007). Cross-sectional design is particularly strong in providing descriptive information about prevalence of a subject or describes relationships among subjects as it is used in this study's proposal (Hulley et al., 2007; Polit & Beck, 2008). Cross-sectional design is economical and there is no worry of dropout respondents or retaining subjects over a long period of time (Hulley et al., 2007; Polit & Beck, 2008). For examining the phenomenon of moral distress and practice independence and their relationship to intention to leave, the cross-sectional design is a reputable method.

Disadvantages

Conversely, using cross-sectional design does have its weaknesses. Cross-sectional research studies cannot predict outcomes or incidence from observational data in a one-time measurement design (Hulley et al., 2007). Sequencing of events cannot be inferred from this type of research design (Hulley et al., 2007). As in survey methodology, a large sample size is needed to yield generalizable results about a target population (Groves et al., 2009; Polit & Beck, 2008). If a researcher wanted to study a rarely occurring phenomenon or disease, a cross-sectional study design would be impractical (Hulley et al., 2007).

Sample and setting. ED NPs will be identified using convenience sampling from the ENA master mailing list by credential and position description (Glenn Lortie, ENA research office, personal communication, June 8, 2011). This list categorizes 34,000 members, including about 300 NPs (Penne Morgan, ENA listserve customer service representative, personal communication, August 25, 2011). If necessary, the PI will sample an additional 200 NPs in the AANP mailing database as approximately 6,700

NPs surveyed by the AANP stated they worked in an ED or urgent care (Goolsby, 2009). Inclusion criteria are: 1) NP working in an ED setting or 2) working in a civilian ED within the United States or a military installation ED. Exclusion criteria includes: 1) NPs not working in an ED, and 2) ED NPs working outside the United States unless at a military installation.

A target sample size of 200 completed packets is expected. Controlling for non-respondents and incomplete packets, 300 questionnaires will be mailed to ED NPs identified from the ENA list. Additional questionnaires will be mailed to AANP NPs if it is necessary to obtain sample size (Cummings, Savitz, & Konrad, 2001; Goolsby, 2009). The lists will be scanned for duplicate memberships between the organizations.

Study power. The power for the proposed study was calculated with nQuery. MDS-R calculations were based on the means and standard deviations from a recent study (Hamric et al., 2011; Virginia Rovnyak, personal communication, July18, 2011). A sample size of 171 will have greater than 99% power at an α of .05 significance level in the mean MDS-R score between those currently considering leaving versus not leaving their job. For the intention to leave power calculations, estimations were gleaned from results of a study using the standard deviations and means between the NP groups intending to leave their positions versus those not intending to leave their positions (De Milt et al., 2010). A study with 171 subjects will have 80% power to detect a difference at an α of .05 significance. For analysis of the intention to leave variable and a sample size of 171, only two predictor variables to be calculated in the study (Harrell, 2001).

Procedures. Prior to data collection, approval from the University of Virginia Investigational Review Board will be obtained. Study packets will include measures, a

postage-paid return envelope, and introductory letter with a small financial incentive and mailed to at least 500 ED NPs identified from the ENA and ENA nurse manager if needed mailing lists. Reminder postcards will be sent 2, 4, and 6 weeks after the first mailing. Data from returned surveys will be entered into a statistical software package for analysis.

Measurements. *Moral Distress Scale-Revised (MDS-R).* The MDS-R has been successfully tested with nurses and physicians (Hamric et al., 2011). This 21-item Likert scale survey assesses both the frequency (0=never, 4=very frequently) and level of disturbance (0=not disturbing, 4=very disturbing) of common morally distressing events. Multiplying the frequency and disturbance scores for each item, with possible scoring range from 0 to 336 for the survey. When tested among nurses and physicians in adult and pediatric intensive care settings, the MDS-R was found to have a Cronbach α of 0.89 for nurses, 0.67 for physicians, and 0.88 overall (Hamric & Blackhall, 2007). Please see Appendix A for an example of the MDS-R.

Intent to leave. The MDS-R includes one three part question and one dichotomous question asking respondents about their current and past intent to leave their position due to moral distress. Patrician reports single-item questions contribute reliable results and have administration ease and little respondent burden (2004).

Dempster Practice Behavior Scale (DPBS). The DPBS is a scale to determine the participant's level of practice independence behavior and has been used successfully in previous survey research (Bahadori & Fitzpatrick, 2009; Cajulis & Fitzpatrick, 2007; De Milt et al., 2010; Dempster, 1990; 2011). The DPBS has 30 items, using a 5 point Likert rating scale measuring four different aspects of level of practice

independence of NPs: readiness, empowerment, actualization and valuation. The response ranges from 1 (not at all true) to 5 (extremely true) and the scores may range from 30 to 150. A higher score on the scale reflects a higher level of practice independence. Dempster reported content validity of the instrument to be 1.0 and the construct validity using factor analysis and a multitrait-multidimensional analysis (1990). A Cronbach alpha of 0.95 was reported for the psychometric testing of the DPBS with a population of 569 practicing nurses (Dempster, 1990). The inter-rater item reliability was .39 (Dempster, 2011). Please see the appendix for an example of the DPBS.

Potential Limitations and Strategies to Overcome. Several limitations must be addressed. First, obtaining an adequate sample size may be challenging. Strategies to overcome this limitation include using two national mailing lists and sending reminder postcards to eligible participants. Second, a potential for nonresponse error is present, as those returning surveys may be significantly more morally distressed and thus motivated to complete the surveys than those who are less morally distressed. This is an internal hazard of the study design and an explanation of this potential selection bias will be included in the study findings (Dillman, Smyth, & Christian, 2009). Lastly, a sampling error is considered as surveyed NPs who belong to a national specialty organization may have different views than NPs who do not register for a national professional organization (Groves et al., 2009).

Data Analysis

For studying correlation between moral distress and level of practice independence, using Fisher's z test for the Pearson correlation coefficient $p<0.001$, the correlation will have 82% power to detect a p of only 0.22 when the sample size is 171,

and greater than 99% power to detect a *p* of 0.40. Harrell (2001) concludes no more than 8 to 17 predictor variables for linear regressions of the quantitative variables moral distress and level of practice independence. For the intention to leave variable and a sample size of 171, Harrell (2001) recommends only two predictor variables to be calculated in the analysis of the findings.

Analysis plan for Aim 1: Descriptive statistics of the study variables will be conducted. Means standard deviations of the participants will be calculated using SPSS. The scores for the MDS-R and DPBS will be calculated. Factor analysis will be used to determine areas describing moral distress among the ED NP participants. Pearson's *r* correlation analysis will be calculated to determine a possible relationship between MDS-R and DPBS scores, specifically observing for a negative correlation of high MDS-R scores with lower DPBS scores.

Analysis plan for Aim 2: Calculations of T-tests for intent to leave versus not considering leaving and DPBS scores and MDS-R scores will be worked. Linear regression will be computed using the score from the MDS-R as the dependent variable and level of practice independence scores with demographic variables as independent variables to further explore these relationships. The MDS-R includes the questions for the variable intention to leave. There are continuous covariates within the study including age of the advanced practice nurse, years as an advanced practice nurse and years in the ED setting. The sample is not large enough to look at all the covariates within one test, but after checking for assumptions, one variable may be studied to investigate differences of moral distress and level of practice independence within the group. Logistical regression will be used if multicollinearity assumptions are met to

measure effects of moral distress and level of practice independence on the intention to leave are significant within the group controlling for age or years of practice as a nurse practitioner or in an emergency setting. The alpha (α) will be established at the .05 level of significance for the statistical tests and all tests will be two-sided. A Cronbach alpha coefficient will be computed and compared with the psychometric data in the literature related to the MDS-R and DPBS. The data analysis will be ongoing throughout the data collection phase of the study.

Human Subject Ethical Issues and Inclusion of Women and Minorities

For this proposed study, several ethical issues will be addressed. Research conducted with human subjects must satisfy certain conditions including gaining valuable knowledge, favorable balance of risks and benefits, and protection of privacy and confidentiality, to name a few (Beauchamp & Childress, 2009). First, Institutional Review Board approval will be obtained from the University of Virginia before data collection. Additionally, it will be important to assure participants their personal information will be handled with care and the data will be collected de-identified for confidentiality and privacy concerns. Further reassurance will be explained in the study packet that any personal information related to the study will be secured. Informed consent for the study will be presumed when a completed questionnaire is returned. Potential harms associated with the study would include the experience of emotional distress the questionnaire could invoke upon the participant. A note included with the questionnaire will encourage troubled participants to seek medical attention should this occur. These ethical issues will be addressed in the conduct of the proposed study.

The proposed study will include both men and women who are ED NPs. In a recent survey by the American Academy of Nurse Practitioners, over ninety percent of nurse practitioners surveyed are women and less than four percent of the respondents surveyed stated are a member of a minority race (AANP, 2011). Every attempt will be made to recruit similar demographics for this study.

Practical, Methodological, Ethical Challenges; Justifications

To close, there are several practical, methodological, and ethical challenges ahead with this proposed study. First, accessing a database or list of ED NPs is not straightforward, thus choosing an emergency nursing organization mailing list was determined a viable way to access this NP specialty. Conducting a survey using validated instruments is a proven design to gather descriptive and correlational data. Privacy of data and confidentiality is paramount in survey research and gaining trust of participants (Hulley et al., 2007). A letter will accompany each mailed questionnaire packet stating the participant's address and other identifiers will not be relatable with the instrument responses. If the individual returns the completed questionnaire, informed consent will be assumed and institutional review board approval will be obtained prior to starting research. Accordingly, this study proposal has addressed the justifications, advantages and disadvantages, practical, methodological and ethical challenges foreseen with the proposed research design.

Policy Issues and Innovation

The proposed research study will contribute to health policy issues facing ED NPs. In 2009, the number of uninsured people in the United States reached 50 million (Kaiser Family Foundation, 2010). The ED is the only access for uninsured and

underinsured Americans to primary healthcare accounted for one-fifth of all ED visits in the United States in 2006 (Agency for Healthcare Research and Quality, 2009). NPs were able to offset medical costs per patient in the ED setting, when paired with an attending physician and a resident (Sucov, Sidman, & Valente, 2009). NPs save healthcare costs in primary care by achieving similar quality care outcomes with lower labor costs (Roblin, Howard, Becker, Kathleen Adams, & Roberts, 2004). ED NPs are answering this call to action by alleviating overcrowding and patient flow through the ED by treating non-emergent patients (Patrick & Lazarus, 2010; Quattrini & Swan, 2011). ED NPs have been included in studies comparing NPs with ED physicians and the findings of the study reported NPs performed similarly in treating patients with similar diagnostic accuracy and efficiency of emergency physicians (Sakr et al., 1999; van der Linden, Reijnen, & de Vos, 2010). As more NPs work in the ED setting, meeting the demands of increasing responsibility for patient care in the ED could cause increased stress to the ED NP. In a hospital-based study, NPs were associated with lowering patients' length of stay and consequently lowering the hospital cost by over $1,500 per visit (Cowan et al., 2006). Orienting nurses for critical care positions can cost over $10,000 and it has been reported a turnover of a nurse can cost up to 75% of the nurse's annual salary (Reiter, Young, & Adamson, 2007). With the Affordable Care Act of 2010 forecasted to increase health care to all Americans, nurse practitioners will be taking a greater role in providing medical services (DHHS, 2012). Nurse practitioners are integral in the rebuild of the primary care workforce and expanding health care to uninsured and vulnerable populations (DHHS, 2012). Keeping providers in their

positions and reducing turnover is a major cost-saving measure for hospitals and provider groups (Sucov et al., 2009).

CHAPTER THREE

ARTICLE 1:

Advanced Practice Nurses and Moral Distress: Integrated Literature Review

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Abstract

Introduction: Moral distress in the healthcare setting, a situation in which one believes he/she knows the appropriate ethical action to take but is unable to take that action, has received substantial attention in the past decade. Moral distress has been linked to work environment dissatisfaction and staff turnover including critical care nurses, primary care nurse practitioners and physicians. *Methodology:* After reviewing twenty-seven study abstracts from four search engines, ten studies met the criteria for this review. The selected studies included advanced practice nurses as subjects and the investigators measured moral distress or ethical issues.

Purpose: The aim of this integrated review is to examine studies of moral distress among advanced practice nurses including nurse practitioners.

Data Sources: Using electronic databases, studies pertaining to nurse practitioners, advanced practice nursing and moral distress were examined for this review. PUBMED, Google Scholar, CINAHL, and Proquest MEDLINE were utilized by searching for English articles between the years of 1994 and 2013.

Conclusions: NPs are unique among healthcare providers in one particular respect; NPs have worked in healthcare settings prior to their advanced practice education, and then quickly become independent providers making autonomous decisions about patients and their well-being. Related to this unique quality, two themes emerge from this literature review: 1) Difficulty discerning psychological stress from moral distress; 2) Root causes of moral distress in NPs. Alleviating moral distress will keep healthcare workers in their positions, thereby saving dollars lost to workforce attrition and opening communication to mitigate conflict in the clinical setting.

Implications for practice: There is a pathway of research needed to clarify the very important health policy and ethical dilemma concerns including moral distress facing NPs and the healthcare system in general.

Keywords: Nurse Practitioners, Advanced Practice Nurses, Moral Distress, Level of Practice Independence, Primary Care Nurse Practitioners.

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Introduction

Moral distress in the healthcare setting, a situation in which one believes he/she knows the appropriate ethical action to take but is unable to take that action, has received substantial attention in the past decade. This phenomenon is increasingly recognized as a serious problem among nurses, physicians, and other healthcare providers because of its apparent link to burnout and intention to leave (Metzler & Huckabay, 2004; Hamric & Blackhall, 2007). Some institutions are now devising intervention strategies such as education programs and committees to address moral distress with their personnel (Rogers, Babgi & Gomez, 2008). However, advanced practice nurses, specifically nurses in the nurse practitioner (NP) role, experience of moral distress are understudied in comparison to staff nurses and physicians, and this lack of understanding of moral distress among NPs may impact the effectiveness of hospital-wide strategies to reduce moral distress (Elpern, Covert & Kleinpell, 2005; Knifed, Goyal & Bernstein, 2010; Caveliere, Daly, Dowling, & Montgomery, 2010). The aim of this integrated review was to examine the literature investigating research studies measuring moral distress of advanced practice nurses including NPs.

Background

Nurse Practitioners and Healthcare Impact

Currently, there are 157,000 NPs in the United States (AANP, 2013a) and nearly 90% are trained in primary care. Over 75% of all NPs are actively practicing in the primary care setting (AANP, 2013a). Because NPs are a highly effective and a necessary entity within the healthcare system, their contribution is expected to grow with the implementation of the Patient Protection and Affordable Care Act (PPACA)

(Kaiser Family Foundation, 2010) for several reasons. NPs save healthcare costs in primary care by achieving comparable quality care to their physician counterparts with lower labor costs (Roblin, Howard, Becker, Adams, & Roberts, 2004). Furthermore, NP-directed care was associated with shorter hospital stays, lowering hospital costs by over $1,500 per visit (Cowan et al., 2006). Their contribution is expected to grow with the implementation of the PPACA because there is strong evidence that the use of NPs saves costs without diminishing healthcare quality (Bauer, 2010; Sucov, Sidman, & Valente, 2009).

Moral Distress

Ethical dilemmas are encountered in all aspects of healthcare. An ethical or moral dilemma is a situation in which there are at least two morally justifiable solutions to the problem, and none of these solutions are wholly adequate (Beauchamp & Childress, 2009). Moral distress is different from ethical dilemmas in an important way, because it involves a situation in which there appears to be a clear, ethically justifiable solution, but resolution happens to be impossible to implement (Jameton, 1984; 1993).

Moral distress has been studied in nurses, particularly critical care nurses, but less in depth for nurse practitioners and physicians (MDs) (Corley, Minick, Elswick, & Jacobs, 2005; Elpern, Covert, & Kleinpell, 2005; Hamric & Blackhall, 2007; Laabs, 2005; 2007; Wiggleton, Petrusa, Loomis, Tarpley, et al., 2010; Hamric, Borchers, & Epstein, 2011).

Several studies of moral distress centered on nurses and physicians 'at the bedside' experiences, particularly intensive care settings (Corley, Minick, Elswick, & Jacobs, 2005; Hamric & Blackhall, 2007; Wiggleton, Petrusa, Loomis, Tarpley, et al.,

2010; Hamric, Borchers, & Epstein, 2011). Consistently, moral distress scores are higher among nurses than physicians when questioned using a moral distress scale (Hamric & Blackhall, 2007; Knifed, Goyal & Bernstein, 2010; Hamric, Borchers, & Epstein, 2011). Some root causes reported by Hamric & Blackhall of moral distress in nurses include: following family wishes to continue life support even if not in the patient's best interest, initiating life saving measures prolonging death, continuing to participate in care when no decision can be made to terminate life sustainment, following orders for aggressive treatment for terminally ill patients, to name a few (2007). Physicians (MDs) have some similar root causes of moral distress as nurses but find working with MDs/nurses who are not as competent as care requires more distressing than nurses as well as placing a device in severely ill patient who is a 'no code' (Hamric & Blackhall, 2007). Conversely, MDs think ordering aggressive treatments that are unnecessary for terminally ill patients was less morally distressing than nurses (Hamric & Blackhall, 2007). Other moral distress root causes for both nurses and MDs include witnessing diminished patient care quality due to poor team communication, witnessing patient care suffering due to lack of provider continuity, and providing care that doesn't relieve suffering because the provider is afraid increasing pain medication may cause death (Hamric & Blackhall, 2007; Wiggleton, et al., 2010; Hamric, Borchers, & Epstein, 2012; Fernandez-Parsons, Rodriguez & Goyal, 2013).

NPs are a unique healthcare provider, as they possess qualities of both nursing and medical practice. There is evidence suggesting the longer a nurse stays in clinical practice, the higher the level of moral distress, suggesting a relationship with the phenomenon of burnout (Meltzer & Huckabay, 2004; Elpern, Covert & Kleinpell, 2005).

Conversely, physician residents exhibit higher moral distress levels early in their careers, then they experience lessening moral distress levels with time in medical practice (Knifed, Goyal & Bernstein, 2010). Very little is known about NPs and their levels of moral distress over time because of their unique blend of nursing and medical diagnostic expertise.

Methods

A systematic search for articles targeting NPs and moral distress was done using PUBMED, Google Scholar, CINAHL, and Proquest MEDLINE databases. Search words included moral distress, advanced practice nursing, nurse practitioners. Articles published in English between the years of 1994 and 2013 were included for review. The criteria for inclusion were articles describing empirical research studies of either qualitative or quantitative methodologies including NPs or advanced practice nurses as a specific group as the target population. The study also needed to be published in a peer-reviewed medical journal. See Table 1 for a summary of details pertaining to each study.

Table 1. Summary of Studies Meeting Inclusion Criteria.

Author, year	**Study Population /Purpose of Study**	**Method of Research & # of Participants**	**Study Summary & Results**	**Strength/Weakness of Study**
Godfrey & Smith, 2002	Nurse Practitioners/ Discuss five categories of ethical issues in practice: 1) Access to care, 2) tension r/t standard & quality, 3) NP risk & responsibility, 4) wrestling with 'greater good,' 5)	Qualitative; open-ended group interview or one-to-one interview; 5 subjects	Descriptive study discussing root causes of moral distress in both veteran and neophyte NPs	*Strengths*: Descriptive and detailed experiences of moral distress specific to NPs *Weaknesses*: Small sample

	working within system			
Ulrich et al., 2003	Nurse Practitioners in the state of Maryland/ To determine perceptions toward ethical conflict in managed care practice by NPs	Descriptive, cross-sectional, correlational survey of a stratified random sample of 700 NPs	NPs in HMOs had less ethical concerns than NPs in other practices	*Strengths*: Large sample; strong methodology *Weaknesses*: No report of focused questions pertaining to moral distress, gleaned moral distress data from results of ethical stress survey
Ulrich et al., 2005	Nurse Practitioners in the state of Maryland; test a causal model of ethical conflict in practice and autonomy of NPs working in primary care in Maryland, USA	Quantitative; survey design asking about ethical climate; 254 respondents; this study part of the 2003 survey study by the same author	Perception of ethical environment was a significant predictor of ethical conflict and in ethical concern in NP practice in managed care	*Strengths*: Large sample; stepwise regression used to determine predictors of ethical conflict: strong quantitative methodology *Weaknesses*: Focus in one geographical area; 8-page booklet questionnaire focusing on ethical stress, no specific focus on moral distress
Ulrich et al., 2006	Nurse Practitioners and Physician Assistants (PAs); identify ethical concerns and conflicts NPs and PAs encounter r/t managed care in delivery of primary care to patients and factors influencing ethical conflict	Quantitative; survey design asking about ethical conflict in managed care; 833 NP respondents	72% of respondents reported insurance constraints interfered with their practice and led to ethical conflict including moral distress	*Strengths*: Focus on primary care NPs and PAs *Weaknesses:* Authors adjusted response rate possibly causing a response bias to the data results. Study not focused on moral distress
Laabs, 2005	Nurse Practitioners; identify the ethical issues NPs encounter in primary care, examine the types of moral problems that arise related to those issues, and determine the	Quantitative; convenience sample of NPs surveyed from a local organization; 71 participants	Descriptive survey investigating ethical issues encountered by NPs; Greatest ethical issue to NPs in study was patient refusal of appropriate treatment; NPs felt powerless and frustrated when faced with ethical	*Strengths:* NP specific ethical concerns identified *Weaknesses:* Small sample, lengthy questionnaire

	level of distress NPs experience		dilemmas and changed jobs or contemplated leaving practice	
Laabs, 2007	Nurse practitioners; describe the process NPs use to manage the moral problems commonly encountered in primary care	Qualitative study; 23 participants	Grounded theory used to examine moral integrity in face of moral conflict: descriptions of individual cases encountered in practice: NPs experienced self-doubt, regret, outrage and frustration to external constraints to moral problems in primary care; NPs tried to resolve issues by avoiding, convincing themselves, and compensating for the integrity disturbance	*Strengths*: Rich information from interviews using hypothetical cases to generate morality discourse in participants *Weaknesses:* Small sample; did not ask specific questions regarding moral distress
Radzvin, 2011	Certified Registered Nurse Anesthetists (CRNAs); determine if CRNAs experience moral distress in their nursing practice	Quantitative study; Survey study using the Ethics Stress Scale; 293 participants	CRNAs experience moderate moral distress; psychological stressors reported	*Strengths*: Large sample *Weaknesses*: Instrument does not specifically addresses moral distress: used demographic data from participants with incomplete responses
Laabs, 2012	Master's prepared advanced practice nursing graduates (APNs); purpose of this study was to deter- mine APNs' ethics knowledge and perceived level of confidence in their ability to manage ethical problems in advanced practice.	Self-report questionnaire with 3 instruments; 363 participants	APNs reported limited ethics knowledge, but reported fairly high level of confidence in decision-making in an ethical dilemma including moral distress	*Strengths*: Large sample *Weaknesses*: One program of graduate APNs surveyed; modified survey instrument

Viens, 1995	Nurse practitioners in various settings in major Western US city; purpose of study: 1) What are the Moral dilemmas experienced by NPs in their clinical practice, 2) What is the moral reasoning used to resolve these moral dilemmas?	Descriptive phenomenological study of NPs in practice; 13 NPs interviewed in 14 sessions; 10 interviews used for actual study analysis.	Described various case scenarios causing the NPs interviewed moral distress	*Strengths:* Rich descriptions of morally challenging dilemmas encountered in NP practice. *Weaknesses:* Small sample
Butz, A. M., Redman, B. K., Fry, S. T., & Kolodner, K. (1998).	Identify types of ethical conflicts and their resolutions reported by a groups of certified pediatric nurse practitioners in their ambulatory practice and to examine demographic, educational & practice setting factors associated with these ethical conflicts	Regional survey of pediatric national association members; 118 completed survey using a demographic form and Moral Conflict Questionnaire.	34% stated had parent/child/provider conflict; 31% reported moral dilemma conflict stating there were 2 or more moral principles in question but not a clear answer could be determined. 22% of ethical conflicts remained unresolved per the participants.	*Strengths:* Large sample, interpretation of results done by experts *Weaknesses:* Open ended questionnaire no examples given;

Results

Ten articles met the criteria for review, including three qualitative and seven quantitative studies. Nurse practitioners and nurse anesthetists were included in the studies and they worked in various clinical practices. Noted throughout the studies were common themes including giving standard care and treatment to patients without insurance, pressure to see more patients than felt comfortable taking in a shift; and practicing within the laws governing licensure (Godfrey & Smith, 2002; Laabs 2005; 2007; 2012; Ulrich, et al., 2003; 2005; 2006). Other studies demonstrated concerns

regarding stressors related to intimidation by other colleagues, patient adherence concerns, provider conflict with patients or parents, or making clinical decisions regarding patient safety (Viens, 1995; Butz, et al., 1998; Radzvin, 2011). Two themes emerged from the studies findings: 1) does increased responsibility and independence of advanced practice nursing stressors cause emotional reactions and become blurred into a definition for moral distress, and 2) does patient compliance issues, colleague concerns, patient insurance status stressors, and other organization level issues 'pass the litmus test' as root causes of moral distress?

Theme: Blurred boundaries: increased responsibility and independence of the advanced practice role: Is it moral distress?

The small, descriptive, qualitative studies noted specific NP practice concerns unique to the role of the primary care NP that differed from the concerns of registered nurses (Godfrey & Smith, 2002; Laabs, 2007). These authors noted how the increase in independent practice led to more ethical and moral challenges among their participants, including moral distress (Godfrey & Smith, 2002; Laabs, 2007). Specifically, respondents noted that increased risk and responsibility, tension between standard care and quality care, and wrestling with the 'greater good' are particular stressors (Godfrey & Smith, 2002). Additionally, NPs describe work environment constraints and the increased responsibility of advanced nursing practice, which the authors contended were all root causes for moral distress (Godfrey & Smith, 2002).

In one grounded theory qualitative study with NPs, clinical scenarios with ethical dilemmas were described to participating NPs and the participants were asked to comment on the situation presented (Laabs, 2007). The author described influencing

factors including work environment, knowledge and experience in maintaining moral integrity within moral conflict (Laabs, 2007). The author found NPs sensed their moral conflict using a four-phase process: encountering conflict, drawing a line, finding a way to avoid crossing the line, and evaluating the action (2007). Time constraints, productivity quotas, and constraints of the healthcare system were also factors that threatened NP practice and NPs stated they felt morally challenged (Laabs, 2007). The author concluded that many external factors caused NPs to feel morally conflicted, but often NPs would attempt resolving the issue to preserve their integrity and often experience moral distress from the situation. In this study, the moral conflict, moral challenge, moral distress, and moral outrage were difficult to distinguish from one another and all types caused the NPs in the study to sense their moral integrity as well as their professional integrity were being challenged (Laabs, 2007).

Psychological reactions versus moral stressors were found in the following studies. In a study of 293 CRNAs, Radzvin found that psychological reactions were common in situations participants described in their increased responsibility as CRNAs described as morally distressing. Certified nurse anesthetists (CRNAs) reported crying, fear, and feelings of low self-worth associated with high levels of moral distress. In particular, participants described their increased responsibility as well as their sense of powerlessness as morally distressing (Radzvin, 2011). Radzvin used the Ethics Stress Scale to measure moral distress but this instrument was not constructed to directly measure moral distress (Hamric, 2012). Further, nurse practitioners also report self-doubt and regret for not maintaining moral integrity regarding care of a patient as moral distress predictors (Laabs, 2007).

Theme: Root causes of moral distress in NPs: constraints to practice by colleague issues, patient issues, and organization level issues

Another theme identified NPs and other advanced practice nurses experienced root causes of moral distress in conjunction with a lack of insurance, colleague conflict, or patient or parent treatment compliance or adherence (Viens, 1995; Butz, et al., 1998; Godfrey & Smith, 2002; Ulrich et al., 2003, 2005, 2006; Radzvin, 2011). For example, studies found NPs felt constrained by managed care guidelines and had difficulty making decisions planning a patient's care within the organization (Ulrich, et al., 2003; 2006). These studies were not specifically asking about moral distress, but about ethical environments. Though the authors labeled some responses as examples of moral distress, these responses may broaden the definition of moral distress to encompass this ethical problem among NPs surveyed (Epstein & Hamric, 2009). In another study of NPs working in HMOs, NPs experienced less ethical conflict in practice than NPs in other practice settings (Ulrich, et al., 2003; 2005). This may be due to the patients having a 'medical home' and basic health care covered within the HMO. However, a subsequent study found a higher incidence of ethical conflict in managed care settings, which are similar to HMO settings (Ulrich, et al., 2006). While these studies were methodologically sound, the findings suggest more research is necessary to determine the nuances of ethical conflict in health care organizations as well as separately measure moral distress in NPs. However, many of these situations could also be reported as disappointment or frustration and not as moral distress. It is important to avoid blurring of a truly ethical dilemma with morally distressing components with clinical challenges (Epstein & Hamric, 2009).

In other studies, participants have higher moral distress when working with less competent colleagues, patients or parents do not adhere to medical regimens, are intimidated by colleagues, or have patient safety concerns (Viens, 1995; Butz; et al., 1998; Laabs, 2005; Radzvin, 2011). Certified nurse anesthetists reported to have moral distress issues when pressured into clinical decisions by other colleagues and were unable to share their frustrations with other anesthetists (Radzvin, 2011). Two authors reported NPs reported moral distress when patients refused appropriate treatment in studies measuring ethical dilemmas in clinical practice (Viens, 1995; Laabs, 2005). Pediatric nurse practitioners reported feeling moral distress when faced with situations regarding a child's safety or when communicating with a child's parent (Butz, et al., 1998). However, many of these feelings could be interpreted as disappointment, emotional or ethical stress, or patients' making their own decisions, and not truly a situation or fit into the definition of moral distress.

Limitations of the Studies

Limitations of several of the studies included homogenous samples or small sample sizes (Godfrey & Smith, 2002; Laabs, 2005; 2007). In studies with more respondents, the limiting factors included regional sampling (Butz, et al., 1998; Ulrich, 2003; 2005; 2006; Radzvin, 2011). In the qualitative studies conducted, little information was provided on the questioning procedures (Godfrey & Smith, 2002; Laabs 2005; 2007). Several studies did not directly ask respondents about moral distress, but noted situations describing characteristics of moral distress using other instruments not constructed to measure moral distress (Laabs, 2005; Ulrich, 2006; Radzvin, 2011). In the quantitative studies, few reported their methods for handling missing data and the

studies used various instruments to measure ethical conflict or moral distress. Radzvin did report dropping surveys if not all items were completed (2011). In Laab's 2005 survey analysis, 'no answer' or 'no response' was placed if the respondent did not answer an item. The results of all of the quantitative studies are difficult to generalize to other advanced practice nursing populations, as the studies were either narrowed by specialty or by the state in which the advanced practice nurse was licensed. Limitations of this review include the exclusion of unpublished studies, dissertations, and studies published in a language other than English.

Discussion and Research Implications

There are several studies regarding moral dilemmas and distress in NPs, but more research needs to be done with a special emphasis on moral distress. Though the research on moral distress in registered nurses find prolonging life of patients due to pressures of family, and continuing care after knowing the quality of life of the patient will be diminished are strong root causes for moral distress, the findings in NP studies are very different (Hamric & Blackhall, 2007; Hamric, Borchers, & Epstein, 2011). NPs find external constraints such as patient adherence issues, colleague support issues, and lack of insurance coverage to be their sources of moral distress (Viens, 1995; Ulrich, et al., 2005; Laabs, 2007; Radzvin, 2011). On one hand, NP moral distress issues are similar to physician moral distress issues regarding insurance constraints, and on the other hand, NPs moral distress issues are different from nursing moral distress issues regarding patient end of life issues (Hamric & Blackhall, 2007; Hamric, Borchers, & Epstein, 2011).

As the demand for greater access to healthcare continues to increase, NPs are experiencing an increase of work-related stress and moral distress when faced with an ethical issue (Viens, 1995; Laabs, 2005; 2007). These emotional components are also similar to those found in studies of nurses reporting moral distress (Wilkinson, 1988; Corley, 1995; Elpern, Covert, & Kleinpell, 2005). It is important to carefully separate root causes of moral distress from psychological stressors encountered in daily practice so appropriate action can be taken to resolve the conflict (Epstein & Hamric, 2009). Although nurse practitioners report they have received ethics knowledge training, they still report lack of confidence in making ethical decisions in practice (Laabs, 2012). Perhaps review and possible revision of ethical training in advanced practice nurses will increase NPs' confidence in the advanced practice role and allow NPs to confront moral conflict with more tools to prevent moral distress. Because NPs have an ever-growing role in providing healthcare today, it is very important to educate NPs about ethical conflict and identify the differences separating psychological stress and moral distress.

Moral distress has many sources in the healthcare arena. For advanced practice nurses, issues around managed care and practicing more independently are thought to be major sources of moral distress. The evidence is clear that moral distress affects NPs; however, moral distress manifests differently from registered nurses and more research is needed to establish root causes unique to NPs and their role in the healthcare industry. Several areas come to light for future research implications.

Further systematic study of moral distress in NPs using a validated and reliable instrument is necessary. A favorable and often used instrument in recent literature is the Moral Distress Scale – Revised (MDS-R). This instrument has been shortened and

revised from the Moral Distress Scale (Corley, Elswick, Gorman, & Clor, 2001). The MDS-R has been found to be reliable instrument for measurement of moral distress in several populations (Hamric, Borchers, & Epstein, 2011; Fernandez-Parsons, Rodriguez & Goyal, D., 2013; Leggett, Wasson, Sinacore, & Gamelli, 2013; Sirilla, 2013). The MDS-R has not been used to measure moral distress in NPs, but has demonstrated reliability in a study including physicians (Hamric, Borchers, & Epstein, 2011). MDS-R provides an opportunity for participants to identify root causes not asked by the 21-item instrument. As NPs report root causes similar to physicians and nurses, the MDS-R may assist researchers in identifying a specific panel of root causes of moral distress for NPs.

Further research is necessary to tease out more sources of moral distress among nurse practitioners. As other studies in the literature have examined various specialty nurses, targeting studies to unique NP specialties including emergency department NPs, acute care NPs, pediatric and family nurse practitioners could add more substance to the literature in causes of moral distress in NPs. For example, little evidence is available on ED NPs in regards to moral distress and ethical issues affecting their practice. Distinctively, ED NPs are primary care and critical care providers, faced with unique challenges in their practice (Cole & Ramirez, 2005). NPs in the ED will often care for critically ill patients during the same shift they are refilling medications for patients with limited access to healthcare. With the issues of moral distress, overcrowding of the ED, and lack of access to primary care, there is a pathway of research needed to clarify the moral distress concerns facing ED NPs and the healthcare system in general. Additionally, identifying and solidifying root causes for

NPs, comparing and contrasting similarities and differences in moral distress in different NP settings would be an important addition to the literature.

Conclusion

Many healthcare providers experience moral distress; however, NPs have seldom been included in studies of moral distress even though this literature review demonstrates NPs struggle with moral distress, often feeling constrained by system policies or insurance limitations. It remains important to correctly identify moral distress, and teasing it apart from other terms and stressors confused with moral distress. More emphasis is needed in delineating policy and political challenges in future research to effectively develop interventions and alleviate moral distress. Furthermore, research is needed to explore the dynamics of moral distress in NPs and to investigate solutions to eliminate or control the sources of the moral distress. Alleviating moral distress will keep healthcare workers in their positions; thereby saving dollars lost to workforce attrition and improve the patient health care provided by NPs.

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CHAPTER FOUR

ARTICLE 2:

Ethical Issue Analysis: Bridge to Nowhere: Addressing the Treatment Gap between the Emergency Department and Primary Care

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Abstract

The emergency department (ED) is intended for diagnosis and treatment of urgent and emergent medical problems; however, often the ED is a venue for patients with limited or no access to primary or follow-up care and account for nearly 20% of all ED visits in the US annually (Agency for Healthcare Research and Quality, 2009; Dominguez-Gomez & Rutledge, 2009; Felland, Hurley, & Kemper, 2008). This is a problem for ED providers, as their clinical skills should be directed toward emergent treatment situations. ED NPs are increasingly utilized for their clinical acumen and procedure skills often encountered during an ED visit. This paper examines the case of an uninsured patient visiting the ED for a blood pressure medication refill, and explores ethical issues ED NPs contend with resulting from an obligation to create an opportunity enabling medication refill and outpatient follow up; a level of care unavailable to the patient. Principles explored include respect of autonomy, beneficence, nonmaleficence, and justice.

Key Words: ethics, nursing, advanced practice nursing, nurse practitioners, emergency departments, uninsured emergency department visits

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Introduction

The emergency department (ED) is often a venue for patients with limited or no access to primary or follow-up care (Dominguez-Gomez & Rutledge, 2009; Felland, Hurley, & Kemper, 2008). Persons without insurance and therefore, no primary care access, account for approximately 20% of all ED visits in the US annually (Agency for Healthcare Research and Quality, 2009; Cunningham, 2011). While it is hoped that the Patient Protection and Affordable Care Act (PPACA) and a resultant increase in patients with medical coverage will reduce the numbers of people seeking primary care in EDs, the actual effect remains to be seen. At this time, the ED continues to be the only healthcare access point for many uninsured persons with non-urgent but serious health care problems.

In many EDs, emergency department nurse practitioners (ED NPs) are hired to assist with patient management flow within the ED often incorporating ED NPs in managing non-urgent cases while ED physicians manage the more emergent cases. This methodology may be effective at addressing patient volume; however, it is not necessarily the most effective at providing overall care for patients lacking access to primary care, and often has unintended effects on both the patient and the NP. Primarily, what risks do patients incur, and what stressors and risks do NPs incur while providing care in emergent settings for patients with non-emergent, chronic healthcare issues knowing that the patient does not have access to follow-up care? The purpose of this article is to present an ethical analysis using an ED case report and analyzing the risks, benefits and other ethical aspects of the providing primary care in an ED setting, using a principles framework.

Background

Nurse Practitioners in the Emergency Departments

NPs play a vital role in the ED because they practice with independence, use a caring approach to disease prevention, and adapt to working in a variety of ED clinical settings (Lin, Hooker, Lens, & Hopkins, 2002). The impact of ED NPs on healthcare outcomes and costs has been demonstrated in several studies (Cooper, Lindsay, Kinn, & Swann, 2002; McGee & Kaplan, 2007; Quattrini & Swan, 2011). In one study, ED NPs were shown to alleviate waiting times of lower acuity patients, improve overcrowding situations, and reduce the patient's length of stay in the ED when working in the ED 'fast track,' an area within the ED designated for non-urgent ED visits (Quattrini & Swan, 2011). Additionally, NPs in EDs often provide primary care for underserved populations, as the ED is often a venue for patients with limited or no access to primary or follow-up care (Dominguez-Gomez & Rutledge, 2009; McGee & Kaplan, 2007; Felland, Hurley, & Kemper, 2008; Agency for Healthcare Research and Quality, 2009). In a national survey of emergency visits in 2008, 10 to 50 percent were considered non-urgent ED visits (Cunningham, 2011). Therefore, until there are primary care venues accessible to Americans without insurance, the ED will continue to be a place where patients with no, or poor insurance, will seek health care, and NPs will continue to be an important part of the healthcare team in the ED, assisting in treating the millions of patients that seek care.

The Bioethical Principles at Stake: Respect for Autonomy, Beneficence, Nonmaleficence, and Justice

The four principles of bioethics: respect for autonomy, nonmaleficence, beneficence, and justice, are a classic framework for analyzing ethically challenging problems in healthcare (Beauchamp & Childress, 2009). Respect for autonomy addresses the individual's ability to decide what is best for his or her own good and the healthcare providers' obligations to both advance the individual's desires and remove barriers so that an individual may act autonomously (Beauchamp & Childress, 2009; Christman, 2011). Beneficence is the ethical act of 'doing good,' and is best described as an act any decent human being would do under similar circumstances unto another in need (Beauchamp & Childress, 2009). Nonmaleficence, the principle that requires healthcare providers to 'do no harm,' is different from beneficence in that it is considered a higher moral obligation than beneficence (Beauchamp & Childress, 2009). Nonmaleficence requires the individual to intentionally refrain from harming others, while beneficence requires one to 'help' or take action by doing good, removing harm, or preventing harm (Beauchamp & Childress, 2009, pg 151). Justice is the most complex of the principles, and describes the different ways in which resources can be distributed fairly (Beauchamp & Childress, 2009). In the case that follows, the beneficence, nonmaleficence, and justice principles are at highest risk of being violated, in regards to providing short-term prescription medications for a chronic problem.

Case: J. R.

J.R. is a 43-year-old African-American female with hypertension. She often has systolic blood pressure readings over 200 mmHg and diastolic readings over 110 mmHg. She works part-time as a bus driver but does not have health insurance. She does receive primary care intermittently from a free clinic, when she can get

transportation, or from the ED. The clinic provided her blood pressure medications monthly. She takes the anti-hypertension medications sporadically as the medications make her feel fatigued and limits her ability to perform her bus-driving job.

She presents to the ED with feelings of weakness and a headache. Although her other vital signs are stable, her blood pressure is 230/110 mmHg. She explains that she has been unable to get a ride to the clinic recently and therefore has run out of medication. She is also up for 'renewal' in the clinic, meaning that she must provide several documents showing she is not earning more than 200% over the national poverty level, and provide proof she lives in a domicile within the county. Until she provides this proof, she is not eligible for care in the free clinic.

While examining the patient, the ED treatment team determines she has visited the ED several other times for similar symptoms in the past year. The ED treatment team, including an ED NP, performs a CT scan without contrast of the brain, chest x-ray, EKG, and laboratory tests to rule out other life-threatening illnesses, and gives her oral and intravenous medications to lower her blood pressure. Lastly, the ED treatment team decides to give J.R. a two-week prescription of her anti-hypertensive medications, and tells her to follow up with an outpatient primary care clinic. A provider's name that is 'on call' for the ED is provided to J.R., but when J.R. calls to make an appointment, the provider states she needs to pay $70 before she can be treated in the clinic. J.R. does not have the funds to pay for this appointment. The ethical questions presented in this case analysis are: Should J.R. be given short-term medication prescriptions for hypertension when she comes to the ED for acute manifestations of her chronic illness when we know her access to primary care is sporadic at best, non-existent at worst?

Do ED NPs have a moral obligation to assure that J.R. is able to obtain her medications and continue her treatment outside the ED?

The Principle Approach

Each of the four principles plays an important role in this case. Respect for autonomy addresses J.R.'s needs and obligations to care for her own condition, including planning transportation and clinic visits and obtaining anti-hypertensive medications, as well as healthcare providers' obligation to help her achieve her goals. Beneficence and nonmaleficence come into play as the ED NP weighs and balances risks and benefits of various options, wanting to 'do good' and also 'do no harm.' Lastly, the principle of justice is at stake in this case because J.R. has barriers to a standard of healthcare; therefore, her socio-economic status and lack of health care coverage does not allow her the 'decent minimum' as someone who has health insurance. These principles will be explored separately in the following analysis.

Respect for autonomy. Respect for autonomy is defined as the obligation of a healthcare provider to assist patients achieve the goals and to respect their perspective and decisions. This self-determination comes from the person's beliefs and morals he or she values to make a decision. Making an autonomous decision requires the person to act with intention, to understand the pros and cons of their options (agency), and to be without controlling influences that may influence the decision (liberty) (Beauchamp & Childress, 2009, pg. 101). Applied to this case, J.R. has the capacity of self-governance, defined by Beauchamp and Childress as the ability to make his or her own decisions (2009). After the ED visit, J.R. will need to exercise self-determination by buying the anti-hypertensive medications, taking them as prescribed, and attending

follow up appointments for her chronic disease. For J.R., a controlling influence that should be considered is her lack of access to adequate primary care or follow up care, because she does not qualify for insurance. However, J.R. does display agency in this case, as she chose to visit the ED to address her health concerns, but only because her choices were limited.

Nonmaleficence. This argument is centered on the principle of nonmaleficence. Beauchamp and Childress argue that 'do no harm' entails thwarting, defeating, or setting back interests in providing standards of due care (2009, 153). We could argue the ED NP has an obligation to 'do no harm,' or in other words, to not inflict harm to the patient. Of particular interest in this case is the potential to do harm when prescribing anti-hypertensive medications without the availability of an outpatient follow up appointment versus the potential of doing harm by not controlling her hypertension. In considering with regard to the standard of due care, ED NPs cannot monitor the patient after discharge from the ED and therefore and cannot monitor for side effects or effectiveness to the medications. While it is within the scope of ED NP practice to provider urgent care to lower J.R.'s blood pressure, it is stretching toward the outer limits of NP practice to prescribe medications knowing that the follow up of the regimen is questionable at best, unobtainable at worst. In an outpatient setting, often primary care NPs contact the patient after an office visit to verify there are no detrimental side effects or questions resulting from the medications. This is a difficult course of action for an ED NP, as they do not have "follow up" appointments, and the principle of nonmaleficence is at risk of being violated in this case. Alternatively, providing J.R. a short-term prescription of anti-hypertensive medications and arranging a follow up

outpatient visit honors the principle of nonmaleficence by preventing further damage to her body from hypertension, and expressing a desire and intention to promote long-term health and thereby avoiding harm.

Furthermore, in the ANA code of ethics, provision three states the nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient (ANA, 2008). This provision supports the ED NP's decision that it is not safe to merely prescribe medications for J.R.'s blood pressure, but more importantly ensuring she has a legitimate ability to obtain follow up care for her condition. Therefore, it would be in J.R.'s and the ED NP's best interest to give her medication during her visit in the ED and scheduling a follow up appointment for the next morning to execute a plan of care for J.R.

Beneficence. Frankena wrote of four levels of beneficence: one ought not to inflict evil or harm (what is bad), one ought to prevent evil or harm, one ought to remove evil, one ought to do or promote good (1973). Providing a prescription for blood pressure medication to bridge the gap between the ED visit and arranging an outpatient visit prevents "harm" and promotes "good." Moreover, the ED NP has a duty to protect the patients in his or her care, prevent harm from taking place, and remove conditions that could cause harm. For example, the ED NP prescribes medication to control hypertension and teaches lifestyle modification to prevent organ damage from hypertension. Considering the principle of beneficence, one of the first questions providers must ask when deciding on a course of treatment in the ED is "what does the patient need to be discharged from the ED?" The second question is "how far does our obligation reach after the patient is treated in the ED?" Answering the first question is

often straight forward. However, when NPs provide primary care to those who come to the ED for medications or non-emergent treatment for their chronic diseases, knowing that follow-on care is critical to a standard of care, but access to that care is unlikely, plays to the heart of the beneficence question. In this scenario, at what point does, or does not the NP transition from preventing harm to inflicting harm? The ED NP discussed the importance of taking medications for her hypertension, and briefly discussed other lifestyle changes in an attempt to promote good by treating the patient's chronic medical condition to control symptoms and decrease organ damage. Nonetheless, a potential exists that the short-term and sporadic treatment received in the ED may actually lead to a worsening of the chronic illness, and therefore could be interpreted as a violation of beneficence (Frieden & Berwick, 2011).

William Frankena stated the act of beneficence is very different from the act of nonmaleficence (1973). Furthermore, he stated the act of not harming others is held to a higher moral standard than 'doing good' for others (Beauchamp & Childress, 2009, p.150). In his example, a bruise resulting from an injection is worth the benefit of the injection itself. In this more complicated case, the benefits of prescribing medication to reduce the effects of hypertension outweigh the potential for harm (i.e. stroke or heart attack) were something to occur from J.R.'s inability to access primary care after discharge from the ED. If the NP weighs the benefits/risks ratio and decides to provide a blood pressure prescription, the obligation of both doing good and preventing harm are fulfilled.

In the ANA Code of ethics, Provision Two states: "The nurse's primary commitment is to the patient, whether an individual, family, group, or community" (ANA,

2008). The provision details the NP's collaboration is not only cooperation but also concerted efforts of all parties to attain a goal (ANA, Code of Ethics, 2011). In this case, the ED NP maintains fidelity to the patient with providing assistance in accessing care, and by giving them medication for their chronic disease. This act of 'doing good,' or applying beneficence, solidifies the case for the ED NP to prescribe patients short – term medications for their chronic disease in the ED until they are able to see their primary care provider—if they have such a provider.

Lastly, beneficence is also at risk in this case, as the ED NP tries to 'bridge the gap' between the ED and primary care. However, if ED NPs continue to treat patients in the ED and facilitate their outpatient visits, patients may use the ED as an alternative source for primary care, thus propagating and, in fact, facilitating the problem of patients using the ED as their primary care clinic. It is important to note that the obligation to provide access to emergency services is a federal mandate; but does this obligation carry through to a follow up primary care visit (Hermer, 2006)? For example, if J.R. enters the ED with hypertension symptoms of headache, change in vision, or noted her 'pressure was up,' and she is unable to obtain her blood pressure medications because she doesn't have access to primary care, then this scenario is likely a warning sign her disease is not controlled. Eventually, this could lead to her having a sentinel event such as a stroke or heart attack. Meanwhile, if J.R. never seeks, nor has the opportunity to establish a primary care provider, she will never achieve management status of her hypertension, thus causing herself harm. Because the above scenario limits the promotion of J.R.'s medical welfare, the beneficence principle is violated.

Justice. The justice principle is represented in this case through the disparity of race, gender and socioeconomic status of J.R. In the state this case took place, there was a high number of uninsured persons and low number of primary care providers who provided care to uninsured patients (Kaiser Family Foundation, 2010). Gaining access to primary care was difficult for J.R. as she had constraints of family duties and available transportation, work obligations and limited access related to her lack of insurance. In the spirit of the justice principle, the ED NP should coordinate a follow-up primary care visit for J.R., and provide enough medication to bridge the gap between the ED visit and the outpatient visit thus beginning her hypertension management. However, this would take coordination of community resources and hospital resources to create either a transitional care plan between the ED and a private practice or, taking it a step further, creating a follow up clinic within the ED. These options would be possible courses of action to address the problem of the unjust distribution of resources, and offering all patients seen in the ED access to follow up treatment. Additionally, a clinic that specialized in following patients after they are discharged from the ED would possibly relieve other clinics in the community of the problem of caring for patients in need of primary care in a timely manner. Working in an ED, seeing this injustice on a daily basis, and locating providers to treat patients without insurance is a silent crisis in the United States' health system.

Both humanitarian view of justice and utilitarian theory of justice are useful in analyzing this case through the justice principle lens. Utilitarian theory of justice can be defined as acting in such a way as to obtain the greatest good for the greatest number (Beauchamp & Childress, 2009; Danis, Clancy, & Churchill, 2002). The humanitarian

view of justice is defined as improving the welfare of others. The practice of prescribing medications in the ED for chronic diseases, in this case, J.R., the ED NP invokes the humanitarian view of justice (according to need). The ED NP is giving treatment in the ED and prescribing medications for J.R.'s hypertension because she requires the medication to maintain her health and continue to work. At the same time, as the ED NP treats primary care problems in the ED, which is an over-utilization of the ED, this practice reduces resources available for others. This violates utilitarianism because the greatest good (giving emergency services to patients with emergent problems) cannot be provided to the greatest number. While ED NPs are often faced with treating chronic disease in the EDs by simply providing medications, the overall benefit or value of the ED is not to provide primary care. Providing this level of care might immediately benefit an individual, but inhibits the ED from realizing its greater intended benefit to society of treating emergently ill patients and ultimately compromising the intended distribution of resources. To conclude, this case demonstrates the complexities of the ethical dilemma ED NPs face daily, how does one manage uninsured patients with chronic medical problems without primary care or follow up care outpatient management?

Potential Solutions

In this case, the ED NP initiates treatment for J.R.'s hypertension as a stop-gap measure allowing J.R. the time to access primary care after discharge from the ED. But, how far does the ED NP's obligation to care for the patient's non-emergent illness extend? There are several potential solutions to this case.

J.R. is a productive citizen of the community and to continue work, she needs to remain healthy. This it would benefit society if access to anti-hypertension medication

was an obligation of the healthcare system. J.R. may or may not be able to make or keep her follow up appointment. Her ability and access to clinic follow up will influence whether or not she can continue to be a productive citizen, or if not, she will have complications. If J.R. continues to have her hypertension managed inconsistently, the risk of stroke, heart attack, or other severe complication could occur. Therefore, there is a joint effort on both J.R.'s and the health care system to achieve a mutually sustainable goal of maximum health is needed, such as a follow up clinic or safety net system that captures patients with socio-economic limitations. A few solutions are offered for this case.

First, one potential option that could be utilized in this case would be instructing J.R. have her blood pressure checked at a local retail pharmacy. The ED NP could educate her on what a normal blood pressure reading is, what values are worrisome indicating a necessity to return to the ED for evaluation. Yet another option would be to instruct J.R. about which pharmacies provide $4 dollar prescriptions and prescribe anti-hypertension medications on the $4 lists. Also, there are accounts in the literature of hospitals and communities instituting follow up clinics for the ED, but this solution is not nation-wide and was not an option in this case (Felland, Hurley & Kemper, 2008). Perhaps an alternative to an ED follow-up clinic could have a nurse call patients that visit the ED for chronic illnesses to coordinate with the hospital pharmacy to fill prescriptions and connect case management resources to assist with primary care provider placement.

From an ethics perspective, it could be argued the hospital has an obligation to assist J.R. in obtaining follow up care by providing case management or other social

services within the ED. This concept would need to consider 'priority setting' for the institution. However, there are recommended frameworks to address resource allocation and prioritization. Martin and Singer (2003) recommend establishing a framework to assist an institution in deciding where to allocate their resources. Improved continuity in the care of the ED patient would reduce the burden of repeat ED visits. This concept would also allow the primary care provider earlier access to the patient and enhance their ability to monitor the patient's medications. This streamlined access to primary care from the ED would be a great contribution to resolving this ethical issue at the institutional level.

Additionally, the local community could assist in this ethical dilemma by increasing the access of primary care providers to patients with no insurance or other barriers to achieving primary care. In one community, the local churches in the area created a consortium to provide a free health clinic for adults without insurance (www.momclinic.org). While this clinic could not serve the entire community, it was a step in the right direction with the community taking action to fill a need. Of note however, this service blurs the ethical distinction between justice and charity; in other words, is the clinic a charitable act of the community to citizens that have no insurance, or is the clinic an act of justice, an attempt of providing equal access to all citizens of the community. Either way, it addresses a significant shortfall in access to health care. Furthermore, the clinic was a strategic step towards fulfilling the utilitarian view of justice of maximizing social welfare (Beauchamp & Childress, 2009). This intervention by the local community would jumpstart the awareness of the necessity to have healthcare accessible to all members of their population; thus, bridging community need by fulfilling

a moral obligation of health care versus having health care be a moral elective decided by the community.

All US states are struggling to fund their Medicaid insurance programs and now are having initiation pains with starting the PPACA, thus delaying the ability for patient without insurance to sign up for health care (Kaiser Family Foundation, 2011; Weisman & Pear, 2013). Oberlander and Brown (2003) discuss the question: should the decent minimum include fewer people and more services, or more people and fewer services? Oberlander and Brown conclude that the United States operates on the premise that healthcare is not a right but a good that is supplied as privately as possible and provided publicly when private care is no longer an option (pg. 186). Beauchamp and Childress define the decent minimum as requiring equal access only to fundamental health care and health-related resources (2009). However, universal access to health care is fundamental to this approach. With twelve percent of the population of the United States uninsured, this ethical issue stares the dilemma of a decent minimum in the eye (Kaiser Family Foundation, 2011). If the state could offer primary care services to all people and charge people for non-emergent use for the emergency department, then this could shift care for chronic diseases from the ED to the primary care setting. The Affordable Care Act of 2010 is a step towards this bridge in having affordable preventative health care for all Americans (Health and Human Services, 2013).

Conclusion

In this case, it was clear that there were several barriers to providing J.R. the standard of care for hypertension. J.R.'s lack of health insurance limits the ED NP in what they can do for her in this ED visit. Additionally, the ED NP is burdened with the

difficult task of deciding what level of care to provide a patient who is productive in society and has a family to support, but does not have resources to maintain that productivity. The healthcare system currently has many shortfalls for uninsured medical care including providing resources for follow up visits from the ED.

The issues in this case surrounding the ethical principles of respect of autonomy, beneficence, nonmaleficence and justice are multifaceted and there are no easy answers. Ultimately, an NP's desire would be to provide medications for the short term to J.R for her blood pressure, improve her quality of life, assist in controlling her illness, and potentially lessen the drain on her financial resources while striving to provide equitable care for all underserved patients within the ED. None of the courses of action available to the ED NP were without potential risk to her long-term health, especially considering her ability to follow-up with a primary care provider. However, considering the circumstances, it is believed the benefit of providing medication to J.R. outweighed the overall risk. Lastly, addressing underserved patient populations and underinsured persons by either legislating access to care, using community support activities such as making a follow up clinic for discharged ED patients, or case management within the ED has the potential to diminish the dilemma ED NPs face.

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CHAPTER FIVE

ARTICLE 3

Relationships Among Moral Distress, Level of Practice Independence, and Intent to Leave of Nurse Practitioners in Emergency Departments: Results from a National Survey

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Abstract: **Purpose and Specific Aims:** The aims of this research study were to investigate moral distress among emergency department nurse practitioners (ED NPs), and examine relationships between moral distress and level of practice independence as well as intent to leave a position. **Background:** Moral distress has been studied in registered nurses (RNs) and physicians (MDs) but less so in nurse practitioners (NPs). It is important to study moral distress in NPs as they tread a unique path between nursing and physician roles. This study used the Moral Distress Scale – Revised (MDS-R), arguably the most rigorously tested instrument for moral distress in the current literature. Moral distress may also play a significant role in staff nurses' intention to leave their practice. Level of practice independence has also been found to have a relationship with a NPs' intention to leave in the literature. The Dempster Practice Behavior Scale (DPBS) measures level of practice independence. Intention to leave is measured within the MDS-R and has been notably connected to both moral distress and practice independence (Hamric, Borchers, & Epstein, 2011; De Milt, Fitzpatrick, and McNulty, 2011; Hamric & Blackhall, 2007). **Methods**: A correlational design using a quantitative survey method was conducted. The study examined moral distress using the Moral Distress Scale-Revised (MDS-R), level of practice independence using Dempster's Practice Behavior Scale (DPBS) and intent to leave through self-report. A convenience sample of ED NPs were identified from the mailing list of a national nursing specialty organization, the Emergency Nurses Association (ENA). Correlational and regression analyses of data were conducted to characterize moral distress among ED NPs as well as the relationships between moral distress, level of practice independence, and intent to leave. **Results**: The survey packets were mailed to 788 potential participants with 246 returns. A total of 236 cases were analyzed for relationships between the two instruments. ED NPs experience mild to moderate moral distress and they find poor patient care due to poor staff communication and working with incompetent coworkers as the most morally distressing situations in their practice. A slight negative relationship was found between the MDS-R and the DPBS scores; when the MDS-R score was higher, implicating high levels of moral distress, the DPBS scores were lower, implicating the level of practice independence was lower. The MDS-R was a significant predictor of a respondent's intention to leave, when age, facility type, gender, NP type, DPBS score, years of NP practice, and years of ED practice were taken into account. **Implications**: This study is the first of its kind to explore moral distress in ED NPs. Clear root causes of moral distress were found affecting ED NPs and leading to their consideration of leaving their position. Further studies will be developed to explore the findings from this research and formulate interventions to alleviate moral distress in ED NPs.

Key Words: moral distress, ethics, nursing, advanced practice nursing, nurse practitioners, emergency departments, quantitative study, and moral distress scale revised.

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Introduction

Moral distress in the healthcare setting, a situation in which one believes he/she knows the appropriate ethical action to take but is unable to take that action (reference), has received substantial attention in the past decade. This phenomenon is increasingly recognized as a serious problem among nurses, physicians, and other healthcare providers because of its apparent link to burnout and intention to leave (Hamric & Blackhall, 2007). Some institutions are now devising education programs and committees for addressing moral distress with their personnel (Rogers, Babgi & Gomez, 2008). However, the experiences of moral distress among advanced practice nurses, specifically nurse practitioners (NP), are understudied in comparison to staff nurses and physicians. NPs are distinctive as they have previous experience as registered nurses with additional education to diagnose and treat patients. Without an understanding of moral distress among advanced practice nurses including NPs, healthcare organizations' efforts to address this phenomenon may not be as effective as hoped. The purpose of this study was to measure moral distress among a population of NPs, specifically those in the emergency department (ED), and to examine relationships between moral distress and intention to leave as well as level of practice independence.

Review of the Literature

Moral Distress

Ethical dilemmas are encountered in all aspects of healthcare. An ethical or moral dilemma is a situation in which there are at least two morally justifiable solutions to the problem, and none of these solutions are wholly adequate (Beauchamp & Childress, 2009). Moral distress is different from ethical dilemmas in an important way

because it involves a situation in which there appears to be a clear, ethically justifiable solution, but resolution happens to be impossible to implement (Jameton, 1984; 1993).

Moral distress has been studied in nurses, particularly critical care nurses, but fewer studies describe this phenomenon among NPs and physicians. Moral distress scores are consistently higher among nurses than physicians (Hamric & Blackhall, 2007; Knifed, Goyal & Bernstein, 2010; Hamric, Borchers, & Epstein, 2011), but NP moral distress level are not known. Additionally, some studies suggest that nurses' moral distress levels rise with increasing years in a current position (Elpern, Covert, & Kleinpell, 2005; Hamric, Borchers, & Epstein, 2011). However, this crescendo effect has not been seen among physicians (Knifed, Goyal & Bernstein, 2010). Interestingly, the root causes of moral distress among critical care physicians and nurses appear to be similar (Hamric, Borchers, & Epstein, 2011).

NPs are unique in their healthcare role. They possess qualities of both nursing and medical practice in that they have experience as registered nurses and education to diagnose and treat patients. NP moral distress has been characterized through qualitative studies (Viens, 1995; Godfrey & Smith, 2002; Laabs, 2007) or through the use of instruments designed to measure ethics stress, (Ulrich, Soeken, & Miller, 2003; Ulrich & Soeken, 2005; Ulrich, Danis, Ratcliffe, et al., 2006) ethical dilemmas, or ethical knowledge (Laabs, 2005, 2007, & 2012). Ulrich and her colleagues used an ethical conflict instrument to examine ethical dilemmas and Laabs, used both qualitative methods as well as developed her own instrument to discover information regarding ethical stressors and knowledge of the NPs she researched. These studies suggest that NPs experience moral distress when they are constrained by insurance companies,

clinic policies, lack of patient compliance or by pressure to see more patients, (Viens, 1995; Godfrey & Smith, 2002; Laabs, 2005; 2007). This is the first study to report moral distress among NPs using one of the most rigorously tested instruments, the Moral Distress Scale-Revised (Hamric, Borchers, & Epstein, 2011).

Level of Practice Independence

Level of practice independence is a cornerstone of advanced practice nursing and NPs are increasingly becoming part of the solution of keeping health care accessible to Americans (Kleinpell, Hudspeth, Scordo, & Magdic, 2012). For NPs, level of practice independence includes collaborative practice and authority treating patients with a physician, using advanced practice skills and knowledge, and self-directing in medical judgments (Dempster, 1990; Ulrich & Soeken, 2005; Cajulis & Fitzpatrick, 2007; Maylone, Ranieri, Griffin, McNulty, & Fitzpatrick, 2011). Several research studies analyze level of practice independence of NPs, often referred to as “autonomy” in the literature (Dempster, 1990; Ulrich & Soeken, 2005; Cajulis & Fitzpatrick, 2007; Bahadori & Fitzpatrick, 2009). Practice independence is different from scope of practice as it can be a personal perspective of one’s clinical practice, while scope of practice is dictated by the state’s nurse practice act (AACN, 2013).

ED NPs are a unique group within advanced practice nursing as ED NPs practice both primary care medicine and take care of critically ill patients. A serious gap in current knowledge is the extent to which practice independence, moral distress, and intent to leave are associated. This study addresses this knowledge gap for ED NPs.

Intent to Leave

Turnover of medical staff is a problem experienced by health care systems all over the world (Aiken, Sermeus, Van den Heede, Sloane, et al., 2012). Both moral distress and level of practice independence have been cited as reason nurses and nurse practitioners leave their positions or even the profession (Hamric, Borchers, & Epstein, 2011; De Milt, Fitzpatrick, and McNulty, 2011). Fitzpatrick, Campo, Graham, & Lavandero found forty-one percent of critical care nurses and NPs surveyed stated they intended to leave their current position due to lack of empowerment (2010). De Milt, Fitzpatrick, and McNulty (2010) reported 27% of NPs surveyed at a national conference indicated their intent to leave their current position and 5% intended to leave the nursing profession for practice independence concerns. Common threads for intention to leave found in both nurse and nurse practitioner research was feelings of powerlessness, lack of independence and moral distress in relation to their occupation satisfaction (Laabs, 2005; 2007; De Milt et al., 2010; Fitzpatrick et al., 2010; Goldman & Tabak, 2010). Thus, in this era of needing more healthcare workers for our aging national population and retaining healthcare providers in areas of primary care, emergency medicine, and critical care, it is important to investigate reasons of dissatisfaction, and address concerns of moral distress and level of practice independence experienced by NPs their subsequent affect on the intention to leave the position or profession.

Specific Aims

The aims of this research study are to investigate moral distress among ED NPs, and to examine relationships between moral distress and level of practice independence as well as intent to leave their position.

Methodology

Design. This study was conducted using a cross-sectional correlational design to investigate possible relationships among moral distress, level of practice independence, and intention to leave of ED NPs.

Sample and setting. ED NPs were identified using convenience sampling from the Emergency Nurses Association (ENA) master mailing list by credential and position description (Altair Daleo, ENA research department, personal communication, February, 2013). Of the 34,000 members, nearly 800 are NPs (Shar Russell, Infocus Marketing representative, February, 2013). Inclusion criteria were: 1) NP working or have worked in an ED setting or 2) working in a civilian ED within the United States or a military installation ED. Exclusion criteria included: 1) NPs not working in an ED or never worked in an ED, and 2) ED NPs working outside the United States unless at a military installation.

Study power. Using the statistical software, nQuery, it was determined, a sample size of at least 171 was expected to have greater than 99% power at an α of .05 significance level in using the mean MDS-R score in relation to respondents reporting intent or no intent to leave. Power calculations for the MDS-R were based on results from a recent study regarding moral distress in ICU register nurses and physicians (Hamric, Borchers, & Epstein, 2011). Because little is known about moral distress in ED NPs, power calculations were done from both types of provider of the study. The calculations including the means and standard deviations, assumed that 21% of the 171 will be considering leaving and 79% will not be considering leaving (Hamric, Borchers, & Epstein, 2011). In the final analyses for this study, the sample size was 207.

Procedures. We obtained approval from the University of Virginia Investigational Review Board and the Institute of Emergency Nursing Research within the ENA prior to data collection. Study packets including measures, a postage-paid return envelope, and an introductory letter were mailed to 788 ED NPs identified from the ENA mailing list. Reminder postcards were sent at two and three weeks after the first mailing. Data from returned surveys were entered into the statistical software package IBM SPSS 21.0 for analysis.

Measurements. *Moral Distress Scale-Revised (MDS-R).* The MDS-R has been successfully tested with nurses and physicians (Hamric, Borchers, & Epstein, 2011). This 21-item Likert scale survey assesses both the frequency (0=never, 4=very frequently) and level of disturbance (0=not disturbing, 4=very disturbing) of common morally distressing events. Total MDS-R scores were obtained by multiplying the frequency and disturbance scores for each item (range 0 -336). Higher scores indicate higher levels of moral distress. When tested among nurses and physicians in adult and pediatric intensive care settings, the MDS-R was found to have a Cronbach alpha of 0.89 for nurses, 0.67 for physicians, and 0.88 overall (Hamric, Borchers, & Epstein, 2011).

Intent to leave. The MDS-R includes two categorical items asking respondents about their current and past intent to leave their position due to moral distress. These type of yes and no questions are reliable for general perspective questions (Patrician, 2004).

Dempster Practice Behavior Scale (DPBS). The DPBS is a scale to determine the participant's level of practice independence behavior (Cajulis & Fitzpatrick, 2007;

Bahadori & Fitzpatrick, 2009; De Milt et al., 2010; Dempster, 1990; 2011). The DPBS has 30 items and uses a 5-point Likert scale measuring four different aspects of level of practice independence of NPs: readiness, empowerment, actualization and valuation. The response ranges from 1 (not at all true) to 5 (extremely true) and the scores may range from 30 to 150. A higher score on the scale reflects a higher level of practice independence. A Cronbach alpha of 0.95 was reported for the psychometric testing of the DPBS with a population of 569 practicing registered nurses (Dempster, 1990).

Results

Settings and Sample. A total of 246 questionnaires were received (31% response rate). Ten respondents were removed from the sample as they did not complete the questionnaire for various reasons. Another 29 cases were removed due to missing responses. More than 10% missing data from the MDS-R was missing by 26 subjects, and another three subjects had more than three missing responses from the DPSB, leaving a final sample of 207. The descriptive statistics as well as the inferential statistics were performed using the final sample. As shown in Table 1, the sample consisted of mainly women and most respondents were white and over 45 years old and had less than 10 years of ED NP experience.

Further analyses were calculated of the 29 removed cases (12%). The gender distribution was similar to the final sample as was the ethnicity (female 80%, male, 19%; non-Hispanic 97%, Hispanic, 2.5%). An independent t-test statistic revealed that the removed cases were different significantly from the final sample in years of NP practice (p = .02). A Chi-Square test for independence indicated a significant association between no score for either MDS-R or DPBS and intent to leave, χ^2 (n = 29) p = .007.

No other significant findings were determined from the removed cases group in regards to age, race, NP type, facility type or years in ED.

Moral Distress. MDS-R scores were calculated using the guidelines provided by the instrument author (personal communication with Ann Hamric, PhD, March, 2011). Questionnaires with more than 10% missing data were omitted from analysis as stated above. Those respondents with less than 10% missing data were scored by adjusting each score by adding the total number of items completed and then summed for a total adjusted score. A Cronbach alpha was 0.85. MDS-R scores ranged from 0-224, and the mean was 74.4 (SD 39.6). Items from the MDS-R are ranked in descending order to identify the most common causes of moral distress among ED NPs (see Table 2).

Level of Practice Independence. We calculated the DPBS scores by adding the item responses together and using the guidelines given by the instrument author (personal communication with Judith Dempster, DNSc, March 2011). For the instrument DPBS, subjects with more than 3 missing questions were dropped from the final analysis and a final score was obtained using the same method for an adjusted score as the MDS-R. A total of 233 DPBS scores remained for analysis. A Cronbach alpha was 0.84. The five negative statement questions within the DPBS were reverse coded when entered into SPSS. DPBS scores ranged from 81 to 149 (mean 127.6, SD12.1). There was no significant difference in the means for the DPBS score between female and male respondents. The items with the highest level of perceived practice independence are listed in Table 3.

MDS-R and DPSB relationship: A Pearson correlation coefficient was used to test the strength of the relationship between the MDS-R and DPBS instruments. Assumptions

of normality, linearity and homoscedasticity were tested and met. For the research question, is there a relationship between level of moral distress and level of practice independence among ED NPs, there was a non-significant correlation between the two variables, r = -.071, n = 207, p < .312. A multiple regression was used to assess the ability of the measure DPBS to predict scores on the MDS-R after controlled for age, gender, facility type, NP type, years of NP practice, and years of ED practice. Preliminary analyses were conducted to view if violations of the assumptions of normality, linearity, multicollinearity and homoscedasticity. The total variance of the explained by the model was 8.9% (Adjusted R square = .05, p = .028). Only two control measures neared statistical significance, which were gender (p = .065) and years of NP practice (p = .08). The DPBS measure was not a significant predictor of MDS-R scores.

Intent to Leave. Two questions at the end of the MDS-R instrument asked respondents if: 1) have they have ever considered leaving their current position, and 2) are they considering leaving their position now due to moral distress. Nearly half (47%) of the respondents affirmed they have not considered leaving, while 27% stated they had considered leaving, and 25% stated they did leave a position (Table 4). Further investigation noted 43% of female respondents acknowledged they have not considered leaving a position compared to 63% of male respondents. Significant differences were found between women and men with the item asking respondents had they left, considered leaving, or not considered leaving a position (Table 4). Comparing MDS-R means with answers to the intent to leave revealed those with high MDS-R scores were more likely to consider leaving their position or left their position and those with lower MDS-R scores had not considered leaving their position (p < .001, Welch test of equality

of means). Male and female respondents were analyzed separately, using one-way ANOVA, Kruskal Wallis, Pearson *r* correlation, and Spearman rho statistics (Table 4). When females and males were compared answering the question were they or were they not leaving, there were no significant differences between MDS-R means for this item (Table 4).

To identify significant factors on ED NPs' intent to leave, a logistic regression was performed with ten predictor variables to determine if other factors besides moral distress had an impact on intent to leave their position (Table 5). After determining that the model passed assumption tests, the model included ten independent variables including age, gender, years of NP practice, years of ED practice, MDS-R score, DPBS score, type of NP specialty (FNP, ACNP) and facility size (small, medium, large). The full model was statistically significant, $\chi 2$ (10, $p < .001$, indicating the model was able to distinguish between the ED NPs who reported they intended to leave and those who did not intend to leave. As a whole, the model explained between 24.7% (Cox and Snell R square) and 32.9% (Nagelkerke R square) of the variance in the intention to leave, and correctly identified 69.8% of the cases. However, only one of the independent variables made a unique statistically significant contribution to the model (MDS-R). The odds ratio for the MDS-R was 1.034 and was the strongest predictor of reporting an intention to leave. This indicated that an ED NP with a higher MDS-R score were 1.034 times more likely to leave than those who had lower MDS-R scores when controlling for all other factors in the model.

Conclusions and Discussion

In the literature, it has been reported that RNs experience fairly high levels of moral distress (Corley, Elswick, Gorman & Clor, 2001; Elpern, Covert & Kleinpell, 2005). In more recent studies, physicians surveyed reported having moral distress, but to a lesser extent than RNs (Hamric & Blackhall, 2007; Hamric, Borchers, & Epstein, 2011). In this study, ED NPs experienced lower moral distress than RNs but experienced slightly higher moral distress than MDs reported in a study by Hamric, Borchers & Epstein (2011). ED NPs find witnessing poor patient care related to poor staff communication the most morally distressing situation offered in the MDS-R, followed closely by working with nurses and colleagues not as competent. These findings are different from the study by Hamric, Borchers, and Epstein where RNs reported following family wishes to continue futile life support and initiating extensive lifesaving actions that prolong death (2011). In other studies exploring moral distress in NPs, psychological stress such as insurance constraints, seeing more patients, and patient treatment compliance were often confused with moral distress, muddying the concept of moral distress.

In regards to level of practice independence, ED NPs reported high levels of practice independence. This is likely because NP practice acts across the nation are allowing NPs to practice on own or have looser ties to collaborative physicians. This possibly explains the lack of relationship between level of practice independence and moral distress in this study, as most ED NPs have independence in their practice and therefore lack of practice independence is not likely a contributor to their moral dilemmas encountered in practice.

Exploring relationships between level of practice independence and moral distress in ED NPs, it was found that these respondents experience moral distress. However, although the literature suggests that practice independence might be a source of moral distress, we did not find a correlation between the two concepts. There are a few reasons this may be the case. The level of practice independence has progressed in most states for NPs. Because most NPs are practicing more independently from physicians, and they are utilized in virtually every facet of medicine, the experience of having little power to make independent clinical decisions may be less frequently experienced. Another possible reason is that the stresses from practicing as an NP are psychological stresses and not moral distress. While the literature discusses NPs experience of moral distress in practice, there may be a blurring of the definition between moral distress and psychological stress (Laabs, 2005; 2007, Ulrich, et al., 2006). In this study, ED NPs reported they feel empowered in their practice by scoring high on the DPBS (mean = 127.6), and they have mild to moderate moral distress by scoring somewhat moderate scores (mean = 74.4).

ED NPs do consider leaving practice or leave practice if they experience a higher level of moral distress. Other studies have found this relationship to be true (Hamric & Blackhall, 2007; Hamric, Borchers, & Epstein, 2011). Now that this phenomenon is established, more emphasis is needed to address moral distress in EDs. Because ED NPs reported somewhat different morally distressing items than other studies, unit specific analysis may be most helpful in determining sources of moral distress to develop programs to address concerns and therefore retain ED NPs within their positions.

Limitations. There were several limitations within this study. The study participants are members of an international emergency nursing organization and therefore may not be representative of all ED NPs and their feelings of moral distress and level of practice independence. While the response to the mailed survey was quite good for this study, this method is limited to the large attrition rates related to lengthy questionnaires, and the time it takes to return the response. No incentive was offered and therefore this may have discouraged some respondents to return the questionnaires. The MDS-R instrument, while very accurate in determining and scoring moral distress, is very difficult to administer. Twenty-six cases were lost to greater than 10% missing data and often it was noted the respondent did not answer the second half of the question regarding frequency and the entire case would be dropped. More work on making this instrument friendlier to administer needs to be considered. Perhaps transfer to a web-based format that requires completing both components of the question before advancing would decrease missing data. Also, the sample was quite homogenous, as the majority of the respondents were white, women, and over the age of forty. Lastly, cross-sectional, correlational studies cannot determine causal relationships between variables.

Implications for Future Research

The findings from this study lend support to further research in identifying causes of moral distress and the intention to leave in ED NPs. The relationship between moral distress and intent to leave the position warrants further investigation for interventions addressing this relationship and other relationships causing moral distress and intention to leave. With further development of the MDS-R, this instrument shows promise as an

indicator of moral distress of health care providers. Further research should attempt to recruit a more diverse group, as well as develop more complex studies to explore the complex relationships among moral distress and intention to leave in ED NPs. Moral distress is a difficult and very real challenge to ED NPs and other healthcare providers in today's healthcare arena.

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Tables

Table 1. Demographic data.

Variable		N (%)	Mean (SD)
Gender	Female	167(81)	
	Male	40(19)	
Age			49.8 (9.7)
	25-35	18 (9)	
	36-45	45 (22)	
	46-55	76 (37)	
	56-70	68 (33)	
Ethnicity	Hispanic or Latino	5 (3)	
	Non-Hispanic	195(97)	
Race	American Indian or Alaskan Native	1 (.5)	
	Asian	4 (2)	
	Native Hawaiian or Pacific Islander	2 (1)	
	Black or African American	3(1.5)	
	White	195 (95)	
Advanced Practice Nurse type			
	FNP	143 (69)	
	ACNP	34 (16)	
	CNS	6 (3)	
	Other	24 (12)	
Years as an NP or CNS			9.5 (6.5)
	0-10 yrs	113 (56)	
	10.1-20 yrs	82 (41)	
	20.1-30 yrs	7 (4)	
Years in ED			7.8 (6.3)
	0-10 yrs	137 (67)	
	10.1-20 yrs	62 (30)	
	20.1-30 yrs	5 (3)	
Facility type	Large	58 (29)	
	Medium	105 (52)	
	Small	33(16)	
	Military	5 (3)	

Table 2. Top 5 reported MDS-R items.

Item	**Mean (S.D.)**
Witness diminished patient care quality due to poor communication	6.6 (4.5)
Work with nurses or other healthcare providers not as competent	6.3 (4.4)
Work with levels of nurse or other healthcare provider staffing that I consider unsafe	6.1 (4.8)
Watch patient care suffer because of a lack of provider continuity	5.8 (4.8)
Initiate extensive life-saving actions when I think they only prolong death.	5.0 (4.3)

Table 3. Top 5 DPBS reported items.

Item	**Mean (S.D)**
Take responsibility and am accountable for my actions.	4.92 (.27)
Accept the consequences for the choices I make.	4.80 (.46)
Have a sense of professionalism.	4.77 (.49)
Provide quality services through my actions.	4.75 (.47)
Base my actions on the full scope of my knowledge and ability.	2.27 (1.19)

Table 4. Intention to Leave with mean MDS-R scores.

Females (n= 167)				Males (n=40)		
Variable	n(%)	Mean MDS-R (SD)	*p* value	n(%)	Mean MDS-R (SD)	*p* value
No, not considered	71(43)	58.41(32.98)	<.001[1]	25(63)	47.87(20.94)	.02[2]
Considered leaving	47(29)	97.57(44.20)		9(23)	84.67(43.06)	
Yes, left	46(28)	89.06(36.08)		6(15)	68.50(19.83)	
Not leaving now	129(79)	75.51(41.83)	.13[3]	33(85)	60.30(30.93)	.82[4]
Yes leaving now	34(21)	87.47(38.18)		6(15)	63.33(22.89)	

Legend: [1] One way ANOVA; [2] Kruskal Wallis; [3] Pearson r correlation; [4] Spearman rho

Table 5. Logistic Regression Predicting Likelihood of Intention to Leave of ED NPs.

Predictor Variable	B	S. E.	Wald	df	p	Odds Ratio Exp(B)
Age	-.021	.022	.959	1	.327	.979
DPBS	-.003	.015	.034	1	.854	.997
MDS-R	.033	.006	30.768	1	*.000	1.034
Gender	.297	.421	.498	1	.480	1.346
Large vs. Med Facility	.227	.405	.313	1	.576	1.254
Small vs. Medium Facility	-.648	.459	1.987	1	.159	.523
FNP	-.440	.539	.667	1	.414	.644
ACNP	-.997	.698	2.045	1	.153	.369
Years of Practice	.015	.045	.114	1	.736	1.015
Years ED Practice	-.006	.042	.021	1	.886	.994
Constant	-.683	2.303	.088	1	.767	.505

Legend: *B: Estimated coefficient of the independent variable in the linear predictor ; S. E.: standard error; df: degrees of freedom; p: level of significance; Wald: value of statistic for each predictor; Odds Ratio: change in the odds of case being in one of the categories if value of a predictor increases by one (Pallant, 2010).*

CHAPTER SIX

Conclusive Summary

During the course of this dissertation, this study originated as an intimate examination moral distress of ED NPs. However, the study evolved into a large-scale venture for a few reasons. One, the accessible sample size was much larger than anticipated when designing the study. In the beginning of study development, the Emergency Nurses Association (ENA) reviewed its mailing list for research, and gleaned about 300 possible participants. When institutional review board approval was received several months later and the ENA was contacted again for mailing list access, the list of possible participants was nearly 800! Suddenly, the study became a possible key piece of research of moral distress, particularly as NPs have little quantitative work in the moral distress literature.

Development of the data set for this study continues to flux, as more investigation of the raw data reveals more depth of information from the respondents. Many participants wrote 'free text' comments within both the MDS-R and DPSB. Comments ranged from specific stories of ethical dilemmas or morally distressing acts met in practice, as well as narratives describing their roles in the ED or their reasons for considering leaving or leaving practice. More analysis is necessary to examine these important vignettes of the sample. For future trials, other variables within the data set collected with this research would be further developed. More analysis utilizing facility type, what area of the United States the respondent practiced as an NP, and the unforeseen number of respondents with more than one NP certification is needed to further explore the nuances of the sample.

One data analysis aim was determined to be incongruent to the rest of the study findings. Factor analysis of the MDS-R was briefly examined, but because it is a data reduction technique and not a test designed to test hypotheses or determine differences between groups, a decision was made to calculate and review this analysis in a future study (Pallant, 2010). Factor analysis is often used in the development and evaluation of instruments and this study was determining relationships between concepts. The statistician engaged in the analysis of this study, as well as the creator of the MDS-R and the dissertation advisor, was contacted and approved of this decision. Factor analysis of the MDS-R within this study will be a helpful finding for both the researcher and the creator of the instrument, but clearly belongs in a separate investigation in the future.

In the bioethics research realm, more analysis of moral distress, and development of interventions and approach to resolving ethical conflicts for NPs are areas for future research. Outside of research, more involvement in policy including political and system-level involvement is necessary to foster change in access to healthcare for the uninsured and underinsured. In this arena, healthcare is changing faster than the news sources can report it and healthcare professionals at every level will need to metaphorically grab hold of the reins and collectively, determinedly, guide the way of caring for patients into the next segment of delivering healthcare to Americans.

When searching the literature, this study is the first of its kind for ED NPs. The findings from this study can be used to further distinguish NP moral distress nuances from registered nurses and physicians. Furthermore, using the knowledge gained from

the study's findings of the high incidence of ED NPs intent to leave their position, more steps may be taken to intervene and keep ED NPs in their clinical position. Because the intent to leave questions were asked in conjunction with the MDS-R instrument and a relationship was found between higher MDS-R scores and an intent to leave, there may be other reasons besides moral distress that compel ED NPs to consider leaving or leave their position and therefore, needs further exploration.

Past research regarding NPs and their moral distress has been largely derived from musings found in qualitative studies or quantitative studies measuring other concepts such as ethical climate. The MDS-R is becoming a highly effective instrument in measuring moral distress in healthcare professionals. Further research is required to confirm moral distress root causes in ED NPs and identify other root causes in other specialties of NPs. This dissertation study affirms moral distress affects ED NPs and their decision to remain in their clinical position.

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Appendix A

Moral Distress Scale – Revised

Relationships Among Moral Distress, Level of Practice Independence, and Intention to Leave of Nurse Practitioners in Emergency Departments - Survey
Moral Distress Scale - Revised
MDS-R Nurse Questionnaire (ADULT)

Moral distress occurs when professionals cannot carry out what they believe to be ethically appropriate actions because of internal or external constraints. The following situations occur in clinical practice. If you have experienced these situations they may or may not have been morally distressing to you. Please indicate how frequently you experience each item described and how disturbing the experience is for you. If you have never experienced a particular situation, select "0" (never) for frequency. Even if you have not experienced a situation, please indicate how disturbed you would be if it occurred in your practice. Note that you will respond to each item by checking the appropriate column for two dimensions: *Frequency* and *Level of Disturbance*.

	Frequency					Level of Disturbance				
	Never			Very		None			Great	
	frequently					extent				
	0	1	2	3	4	0	1	2	3	4
1. Provide less than optimal care due to pressures from administrators or insurers to reduce costs.										
2. Witness healthcare providers giving "false hope" to a patient or family.										
3. Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient.										
4. Initiate extensive life-saving actions when I think they only prolong death.										
5. Follow the family's request not to discuss death with a dying patient who asks about dying.										
6. Carry out the physician's orders for what I consider to be unnecessary tests and treatments.										
7. Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support.										
8. Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.										
9. Assist a physician who, in my opinion, is providing incompetent care.										
10. Be required to care for patients I don't feel qualified to care for.										
11. Witness medical students perform painful procedures on patients solely to increase their skill.										

	Frequency Never Very frequently					Level of Disturbance None Great extent				
	0	1	2	3	4	0	1	2	3	4
12. Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.										
13. Follow the physician's request not to discuss the patient's prognosis with the patient or family.										
14. Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.										
15. Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.										
16. Follow the family's wishes for the patient's care when I do not agree with them, but do so because of fears of a lawsuit.										
17. Work with nurses or other healthcare providers who are not as competent as the patient care requires.										
18. Witness diminished patient care quality due to poor team communication.										
19. Ignore situations in which patients have not been given adequate information to insure informed consent.										
20. Watch patient care suffer because of a lack of provider continuity.										
21. Work with levels of nurse or other care provider staffing that I consider unsafe.										
If there are other situations in which you have felt moral distress, please write them and score them here:										

Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?

No, I've never considered quitting or left a position _____
Yes, I considered quitting but did not leave _____
Yes, I left a position _____

Are you considering leaving your position now? Yes No

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Appendix B

Participant Information Form

Relationships Among Moral Distress, Level of Practice Independence, and Intention to Leave of Nurse Practitioners in Emergency Departments Survey

Principal Investigator: Jennifer Trautmann, MSN, RN, FNP-BC

Participant Information Form

ID# for participant:_____

1. Birth year:_____
2. Gender: Female ____ Male_____
3. Race or Ethnicity:
   a. Caucasian_____
   b. Black_____
   c. Latino_____
   d. Other_____
4. Type of Advanced Practice Nurse
   a. Family Nurse Practitioner
   b. Acute Care NP
   c. Clinical Nurse Specialist
   d. Other _____
5. State/Country practicing _____
6. Currently working in an ED? Yes____ No_____
7. Years working as an NP? _____years
8. Years working as an NP in an ED? _____years
9. Years working as an NP in current position? _____years
10. Type of facility working:
    Large ED; Level 1 Trauma Center: _____
    Medium ED; Level 2 or 3 Trauma Center_____
    Small ED; Level 4 or lower Trauma Center_____
    Military installation ED_____

Appendix C

Dempster Practice Behaviors Scale

Relationships Among Moral Distress, Level of Practice Independence, and Intention to Leave of Nurse Practitioners in Emergency Departments Survey

Jennifer Trautmann, MSN, RN, FNP-BC

Dempster Practice Behaviors Scale (DPBS)

Please CAREFULLY read and think about EACH statement below. Then, for each statement, mark the response that BEST indicates how TRUE that statement is for you in YOUR PRACTICE. (1 – Not at all true, 2 – Slightly true, 3 – Moderately true, 4 – Very true, 5 – Extremely true)

In my practice I…	Response				
	Not True				Extremely True
	1	2	3	4	5
1. take responsibility and am accountable for my actions.					
2. have developed the image of myself as an independent professional.					
3. base my actions on the full scope of my knowledge and ability.					
4. self-determine my role and activities.					
5. derive satisfaction from what I do.					
6. take control over my environment and situations I confront.					
7. am valued for my independent actions.					
8. am constrained by bureaucratic limitations.					
9. provide quality services through my actions.					
10. am confident in my abilities to perform my role independently.					
11. have been professionally socialized to take independent action.					

In my practice I…	Response				
	Not True				Extremely True
	1	2	3	4	5
12. function with the authority to do what I know should be done.					
13. have too many routine tasks to exercise independent action.					
14. have a sense of professionalism.					
15. have the rights and privileges I deserve.					
16. have the professional experience needed for independent action.					
17. am restrained in what I can do because I am powerless.					
18. collaborate with others outside my field when I feel there is a need.					
19. derive feelings of self-respect and esteem from what I do.					
20. make my own decisions related to what I do.					
21. possess ownership of my practice; that is, my role belongs to me.					
22. have the power the influence decisions and actions of others.					
23. have a sense of self-achievement.					
24. am provided with a legal basis for independent functioning					

In my practice I…	Response	
	Not True	Extremely True

	1	2	3	4	5
25. demonstrate mastery of skills essential for freedom of action.					
26. have my activities and actions programmed by others.					
27. have the respect of those in other disciplines.					
28. cannot optimally function because I do not have legal status.					
29. establish the parameters and limits of my practice activities.					
30. Accept the consequences for the choices I make.					

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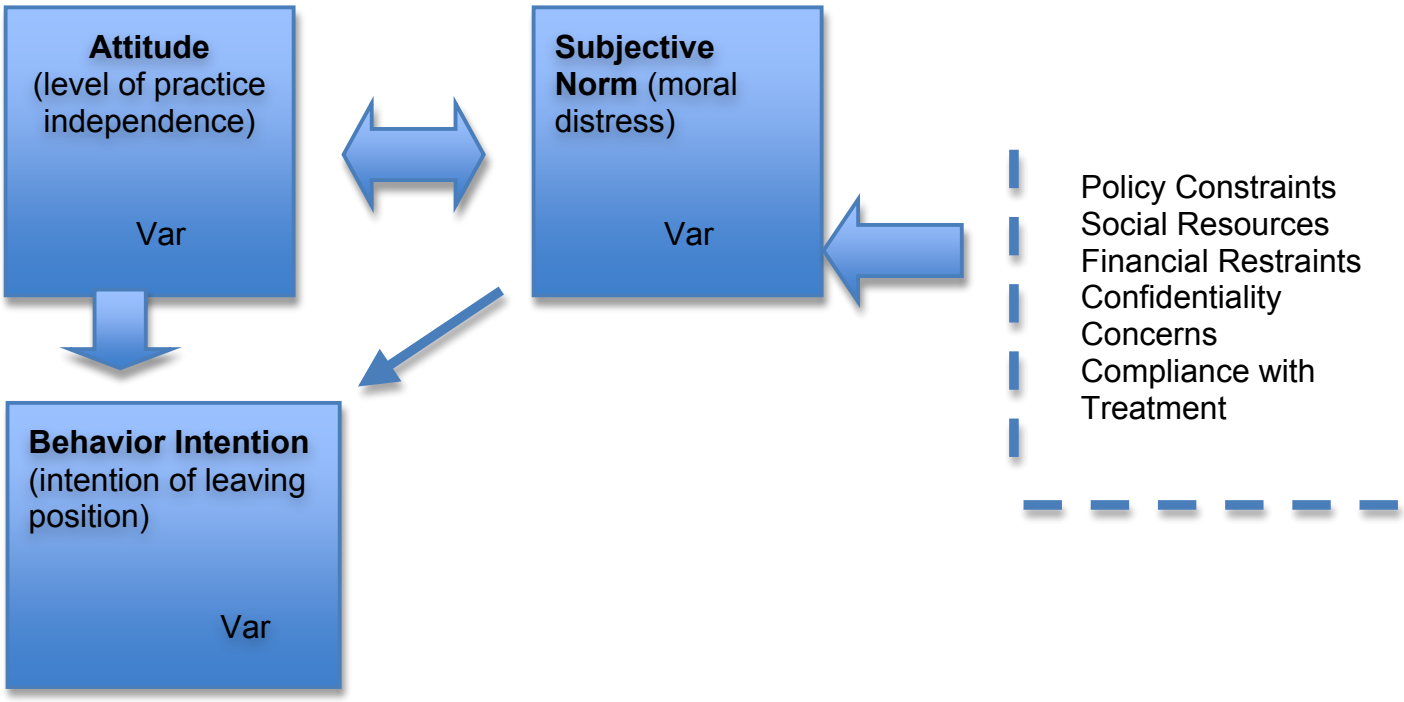
Appendix D

Conceptual Framework for Study

Research Conceptual Framework Integrating Theory of Reasoned Action (adapted from Fishbein & Ajzen, 1975; 2009).



Legend: Var: variable

Appendix E

Guidelines for Journals Selected for Submission for Articles Included in Dissertation

Article 1: Advanced Practice Nurses and Moral Distress: Integrated Literature Review

Journal selected: Journal of the American Academy of Nurse Practitioners

Author Guidelines: (http://www.aanp.org/publications/jaanp/author-resources)

JAANP Guidelines For Authors (GFA) Page 2 (version 111020)

Section 1: Overview and General Information 1.1 - Aims and Scope

The Journal of the American Academy of Nurse Practitioners (JAANP) is a monthly scholarly, peer-reviewed journal for Advanced Practice Registered Nurses (APRNs) and is the official journal for all members of the American Academy of Nurse Practitioners (AANP; see www.aanp.org for more information). Formed in 1985, the AANP is the largest and only full-service professional membership organization in the United States for NPs of all specialties. The JAANP supports the mission of AANP to:

- ▪ Promote excellence in NP practice, education and research;
- ▪ Shape the future of healthcare through advancing health policy;
- ▪ Be the source of information for NPs, the healthcare community and consumers;
- ▪ Build a positive image of the NP as a leader in the national and global healthcare

  community.

  The mission of the JAANP is to help serve the information needs of nurse practitioners (NPs) and others with an interest in advanced practice nursing and primary health care. The readers of the JAANP are mostly primary care NPs and other advanced practice registered nurses (APRNs), who practice in domestic and international settings where they serve clients of all ages, manage a broad spectrum of acute and chronic conditions, prescribe a variety of medications and treatments, and function to the full scope of advanced practice nursing in their respective states and countries. We have experienced a growing membership of acute care NPs and a steady increase in NPs who have completed DNP programs; therefore, there is a need for information related to system issues such as quality improvement, translational research, and conditions more commonly encountered in acute care settings.

The JAANP encourages submission of articles addressing evidence-based clinical practice, integrative/comprehensive reviews, research, novel case studies, NP education, legislation, health policy, practice improvement, and other advanced practice nursing issues. International submissions that address advanced practice nursing issues throughout the world are also encouraged. Manuscripts must be original, unpublished works submitted for the exclusive use of the JAANP in accordance with these guidelines. The review process is double-blinded.

1.2 - Correspondence

All editorial queries and commentary should be sent by email to: jaanp.eic@gmail.com

It is not necessary to send a pre-submission query. We recommend instead that authors visit the online journal website (http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1745-7599/earlyview) and check the table of contents and abstracts for the previous 12-24 issues to view the scope of topics covered in JAANP.

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JAANP Guidelines For Authors (GFA) Page 3 (version 111020)

1.3 – Review and Response

All reviews are completed on-line via the ScholarOne Manuscripts™ program and the results of reviews are sent to the authors at the email address entered into the system by the submitting author. We try to provide a first response within 60 days, however, this depends on the timeliness of the reviewers' responses. Careful consideration is given to all submissions and decisions are rarely changed. If the author believes that misconduct on the part of the reviewers may have occurred (a conflict of interest for example), the author should contact the editor-in-chief and request a review of the decision. A decision of Reject is not sufficient reason to request a review, nor is the fact that the reviewers did not understand what the author meant to say. Poorly written material, flawed research, or a focus that is not appropriate for the journal's audience are valid reasons for rejection.

Section 2: Manuscript Submission Criteria

Manuscripts must be submitted via the ScholarOne ManuscriptsTM JAANP online submission site at http://mc.manuscriptcentral.com/jaanp. The steps must be followed exactly to assure your submission is complete. If you do not receive an automated e-mail response, your manuscript has not been successfully entered into the system.

2.1 - Publication Ethics

The JAANP adheres to the principles stated in the Uniform Requirements for Manuscripts Submitted to Biomedical Journals. (http://www.icmje.org/urm_main.html) All authors should meet the criteria for authorship as stated in the ICMJE Uniform Requirements. The required Cover Letter must include the statement “All authors meet the criteria for authorship as stated by the ICMJE in the Uniform Requirements for Manuscripts Submitted to Biomedical Journals.”

All authors should have made substantial contribution to the manuscript submitted and be prepared to defend any content included therein. To fully understand the issues of Authorship and Conflicts of Interest, authors are encouraged to read the full text of the Uniform Requirements for Manuscripts Submitted to Biomedical Journals at (http://www.icmje.org/urm_full.pdf). If changes are made to authorship following a revised submission, all authors must agree to the change by completing the Change of Authorship Form, available from the editor on request.

The JAANP is a member of the Committee on Publication Ethics (COPE) and adheres to the ethical publication practices. The JAANP adheres to the Good Publications Practice Guidelines, version 2, available online at http://www.gpp-guidelines.org/ for all sponsored material.

A separate statement regarding conflicts of interest is also required and is covered in great detail in the section titled Acknowledgements (3.4).

Revised October 20, 2011

JAANP Guidelines For Authors (GFA) Page 4 (version 111020)

All manuscripts are submitted to iThenticate, a plagiarism detection program, prior to peer review. Manuscripts that appear to be duplicate submissions will not be reviewed and all authors will be notified of the iThenticate report. Significant issues of apparent ethical misconduct will be addressed according to the COPE guidelines (available at http://publicationethics.org), which may include notification of Deans, supervisors, and/or funding agencies of ethical breaches.

2.2 - Manuscript Files and Format

This section provides general guidelines for format and length of manuscripts and some specific guidelines for selected types of manuscripts. It is important that the submitter review the submission to assure that files are uploaded properly and that any author identifying information is removed to assure a fair and blinded review process.

Manuscript text should not include page numbers, running heads, headers/footers, or hard returns at the end of each sentence (use the word wrapping feature of the word processor). Tables and figures should not be included in the body of the Main Document file. They should be in separate Table and Figure files and labeled appropriately (e.g., Table 1).

Prior to submission you will need to do a word count (available on the MS Word Tools menu) of the Main Document file, excluding the abstract and references. This word count is to be entered in a specified data field during the submission process.

2.3 - Categories of Articles

Research: The general format for research articles is Introduction, Methods, Results, and Discussion (IMRaD). For quality improvement research, the SQUIRE Guidelines should be followed. For quality or practice improvement projects, the research format is not appropriate and more specific guidelines can be found in a subsequent section.

All research reports must contain a statement in the methods section about the protection of human subjects and approval by the appropriate review committee. Checking the appropriate box on the Manuscript Details form in the submission process is also required.

Research references are limited to no more than 50 and should be the most current references available. Classic articles related to methods or instruments are acceptable. Additional references may be included in a table for on-line supporting information.

For randomized control trials (RCTs), the CONSORT (Consolidated Standards of Reporting Trials) Statement should be used as a guide. Authors should refer to the website (http://www.consort-statement.org/) for the most current guidelines. For reporting of company sponsored research, authors should also refer to the Good Publication Practices Guidelines, version 2 (also known as GPP2) for guidance on transparency of the process, which is available at http://www.gpp-guidelines.org/

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For qualitative research, the type of analysis and control for rigor and credibility must be clearly stated. Any identifying information in responses from subjects must be removed.

Reviews: Systematic reviews are encouraged either with or without meta-analysis. A systematic approach to finding relevant studies, for example the PRISMA Statement (http://www.prisma-statement.org), the Joanna Briggs Institute (http://www.joannabriggs.edu.au/about/home.php) or the Cochrane Collaboration (http://www.cochrane.org/reviews/clibintro.htm), should be used as a guideline for reporting reviews. Authors should clearly describe the system they used to assure they have produced an unbiased review.

Sponsored Reviews, developed by authors in collaboration with medical communications companies or independent medical writers and funded by pharmaceutical or device companies, cannot be considered at this time unless the sponsoring company is willing to pay for the supplement pages required to print the

article. If sponsorship includes paying for supplementary pages to the journal, sponsored articles will be considered as long as they are unbiased and focus on entire drug/device classes or diseases, not just a single product. Off-label use of drugs in any drug review must be clearly identified. Conflict of Interest declarations must be completed by anyone submitting reviews of drug or devices. Sponsored material will be peer reviewed and must be relevant to NP practice. Contact Kurt Polesky (kpolesky@wiley.com) for further information on sponsored material. We adhere to the principles stated in Good Publication Practices Guidelines, version 2, which is available at http://www.gpp-guidelines.org

Practice Improvement/Quality Improvement/Decision analysis projects: The synthesis and application of research to questions of clinical relevance for NPs is a focus of many DNP programs. Manuscripts reporting such projects do not usually conform to the standard research reporting guidelines. The importance of these projects is the local application of research; thus, the focus should be on local context, lessons learned, and process. We suggest authors consider using the recommended guidelines for Quality Improvement Reports (QIR) published in Quality in Health Care (Moss & Thompson, 1999, vol 8, p. 76). These projects may be exempt from human subjects review; however, a clear statement of any ethical review process, including exemption, must be made. For further guidance, see sample article (freely available without subscription) Cox, S., Wilcock, P., & Young, J. (1999) Improving the repeat prescribing process in a busy general practice. A study using continuous quality improvement methodology. Quality in Health Care, 8: 119-125.

Case Study: All identifying material must be changed, and a statement to that effect made in the manuscript, so that the patient cannot be easily identified. Any photos or diagnostic studies of the patient must also be anonymized. In cases where complete anonymity might not be possible, an informed consent by the patient is necessary.

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Clinical Articles: Manuscripts reporting new or novel clinical insights will be considered for publication. Information already available in textbooks or considered general knowledge is not considered new or novel and will not be reviewed.

Brief Reports. Pilot studies or clinical reports with limited focus will only be considered for Brief Report formats. These manuscripts are no longer than 3000 words and limited to 30 references.

CE Articles: Articles with potential for continuing education (CE) are selected by the editor and the editorial board based on content and the needs of the members. Authors who think their manuscript might be suitable for CE credit may indicate this in the cover letter but there are no additional specific requirements for objectives or questions on

submission. Authors who wish to contribute CE materials to the AANP should visit the CE Center on the AANP website for more information.

Supplements: Supplements must have sponsorship and all proposals for supplements are first reviewed by the Wiley-Blackwell Development Team (kpolesky@wiley.com) and referred to the Editor. All material submitted for supplements must follow all these guidelines and go through the peer-review process. The JAANP adheres to the GPP-2 Guidelines available online at http://www.gpp-guidelines.org/ for all sponsored material.

2.4 - Size / Length / Fonts

The title should be no longer than 30 words and should reflect the content of the paper.

The body text of a typical manuscript, excluding abstract, references, tables, figures or graphics, should not exceed 4,000 words. Longer articles may be considered at the editor's discretion. Text should be double-spaced, with approximately one inch margins.

Standard Fonts such as "Times New Roman" or "Times" are preferred. For maximum clarity, use sans serif fonts "Arial" or "Helvetica" for labeling figures, and "Symbol font" for Greek letters and the MS Word symbol menu for other unusual characters. Unusual fonts may not be supported on all systems and may be lost on conversion of your documents at the time of online submission.

If you have used the Track Changes feature in the process of writing and editing your manuscript, please save a final version that accepts all the changes you intend to include before you upload your file.

2.5 - Style and References

The Publication Manual of the American Psychological Association 6th edition (APA) is the style manual used by the JAANP to format citations, references, headings, and other matters. The use of electronic bibliographic citation managers (such as EndNoteTM) is both acceptable and desired. There are special provisions for submission

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within the ScholarOne ManuscriptsTM system that may make submission easier for those who use EndNoteTM.

DOI numbers are acceptable in citations and are the preferred method for "on-line ahead of print" or "early-view" manuscripts. References for manuscripts in-press are acceptable but they must be updated before the manuscript is published. There is

extensive information about the use of DOIs in the APA 6th edition if you have questions.

References are limited to 50 for most articles except Brief Reports which are limited to 30. Pay particular attention to the APA requirements for citation of on-line material. This has changed significantly in the latest edition.

References should be listed alphabetically in a separate section at the end of the body of the manuscript Main Document file, double-spaced under a heading titled References. Do not put them in a separate file.. References should be current and journal titles should not be abbreviated. For most manuscripts, citations older than five years, other than classic works, are rarely required. It is the author's responsibility to assure that all references are complete and accurate. Manuscripts that do not conform to referencing guidelines will not be reviewed.

Reference works not cited in the main text should be deleted from the manuscript. In some cases it may be useful to create a table titled Useful Resources or Useful Websites for inclusion as on-line supporting information. There is also helpful information about references for systematic reviews included in the latest edition of the APA.

2.6 - Footnotes

Do not use footnotes in the abstract or the main body of the manuscript. Footnotes to tables or figures should clearly spell out all abbreviations used. Statistical significance may also be indicated with footnotes.

Section 3: Additional Guidelines

The following section details specific elements of the submission that are required at the time of submission.

3.1 - Title Page

The information on Title Page contains more than just the title and will be used at production time to properly identify the authorship of the manuscript.
The title of 30 words or less should be descriptive, unambiguous, and entice the audience to read your work.

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Following the title should be a list of, all authors in the order in which they will appear in published form, along with institutional roles and affiliations, must be listed. The contact author must be clearly identified (this does not have to be the first author) along with

complete contact information. Alternative email addresses and phone numbers are helpful in case we encounter difficulty contacting you.

Any disclaimers required by Federal law (e.g., military) should be included on the title page.

3.2 - Cover Letter

The cover letter must contain the title of the manuscript, a statement about authorship as described previously (see section 2.1 Publication Ethics), and attestation that the manuscript is submitted in accordance with the current GFA (see version number top left of this page) for the sole consideration of the JAANP and the material has not been published in any form previously. If the material has been presented at a conference or is part of a larger study (e.g., a subgroup analysis), that should also be stated.

If the paper reports findings from a clinical trial that has been registered, include the registration information. If the paper requires special consideration related to the NIH Public Access Mandate, please alert us with a statement in the cover letter.

3.3 - Abstract

The JAANP Abstract follows a structured style. It must be formatted with the following four specific headings -- each separated by a blank line: Purpose; Data Sources; Conclusions; and Implications for Practice. (You can see examples while you are online going through the previous 12-24 issues of the JAANP). Do not use references in the abstract. The abstract (the first item in the main document) must be copied into a designated abstract field during the submission process. Reviewers receive the abstract from this field when they are asked to perform a review – so it is the first impression you make on a reviewer. . NOTE: There is a firm 200 word limit for the abstract.

3.4 - Acknowledgements

Acknowledgements fall into two categories - Personal and Expository.

Personal acknowledgements are used to acknowledge such things as competitive grant funding and unpaid editorial assistance from mentors and colleagues. To avoid compromising the author’s anonymity, these acknowledgements are to be uploaded in a separate file during submission designated as a “Supplementary file not for review”.

Expository acknowledgements are used to divulge those items pertaining to conflicts of interest (COI) and funding for the development or editing of any article that mentions

specific drugs, devices, or other proprietary content. This includes any editorial or writing assistance provided by pharmaceutical, manufacturing, or medical communications companies, which must be clearly acknowledged including the name of the editor/writer and the source of funding. These acknowledgements are to be uploaded in a separate file during submission and designated as a “Supplementary file for review.” Details of this support must also be copied into the corresponding fields of the online Manuscript Details form. This file will be included in the information accessible by reviewers, so it's important to use author initials or author 1, 2, etc, when disclosing any funding to maintain anonymity.

NOTE: If the submitter checks “no” to the “Do you have any conflict of interest?” statement, you are declaring that: No relationship exists between any of the authors and any commercial entity or product mentioned in this article that might represent a conflict of interest. There was no solicitation of the author(s) by any commercial entity to submit the manuscript for publication.

If you have no COI to declare, checking the box on the Manuscript Details page in your submission is sufficient. If a failure to disclose a relevant COI is discovered after final publication of the manuscript, the editor may decide to retract the article, or at least publish an erratum or statement of concern, and may preclude the authors from future submissions.

To review the scope of COI go to the link on the ICMJE home page (http://www.icmje.org/ethical_4conflicts.html) that explains in detail what are considered relevant COI. Whenever there is a possibility of a COI regarding commercial interests and the content of a manuscript, all authors are required to complete the ICMJE COI Disclosure form disclosing this potential or actual conflict-of-interest. (See editorial related to use of the uniform disclosure form at (http://www.icmje.org/format.pdf). This form is available in the public domain for authors to complete and upload with their submission at http://www.icmje.org/coi_disclosure.pdf

3.5 - Electronic File Formats

The Main Document file of the submission must be in a .DOC, .DOCX (not DOCM or .WKS), .RTF or other Microsoft Office compatible file format. Further information on file formats can be found under the Get Help Now tab of ScholarOne ManuscriptsTM manuscript central website.

3.6 - Tables, Figures and Graphics

Tables, Figures, and Graphics must not simply duplicate what has been said in the body of the manuscript. If they do not enhance the text, they may be eliminated for space considerations. Tables, figures, and graphics must be cited in the text in the appropriate location (e.g., see Table 1). Footnotes to tables or figures should clearly spell out all abbreviations used. Statistical significance may also be indicated with footnotes. Online

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JAANP Guidelines For Authors (GFA) Page 10 (version 111020) only supporting materials (such as data tables, maps, a review matrix, and interview forms) may be considered at the time of publication at the editor's discretion.

Tables should be numbered with Arabic numbers in the order in which they are mentioned in the text. Each table should be double-spaced and include an appropriate caption. Every column must have a description or heading. Demographic tables must clearly indicate the total N either as a footnote or in a column heading. Use a table function to create your table – do not use tabs or the spacebar to create columns (this will result in columns that do not align properly when your submission is converted to HTML or PDF).

Figures and Graphics for the print edition should be grayscale. (Color graphics may be considered for paid insertion or as online supporting materials). Figures and graphics should use one of the file formats recommended by the publisher at: http://authorservices.wiley.com/bauthor/illustration.asp All figures must have captions, which can be included as a separate file labeled "Figure Captions" if it is not possible to include the caption on the figure itself.

Tables and figures should be uploaded as separate files during the submission process.

3.7 - Permissions

All authors must obtain any necessary permissions to reproduce previously copyrighted materials. Permissions to reprint Tables, Figures, Graphics, Instruments, or any other previously copyrighted information should accompany the manuscript at the time of submission. The copyright holder may be a publisher, an author, an agency, or any combination thereof. Be sure you have requested permission from the actual copyright holder.

If a payment for permission to reprint is required, it will be the author's responsibility to pay all fees prior to publication and submit evidence of such payment to the editor. NOTE: Do not pay fees until the manuscript has been accepted and scheduled for publication. Permissions should be scanned or copied into a file and uploaded as a "Supplementary file not for review." Permissions must include both print and electronic publication. Permissions granted to students for materials included in a dissertation or project do not cover publication in commercial journals; therefore, a separate permit is required.

3.8 - Copyright Transfer Agreement (CTA)

NOTE!!! Manuscripts cannot be reviewed until a signed CTA Contributor's Signature Page for each author has been attached to your submission.

The CTA, a legal document required by the JAANP publisher on all submitted manuscripts, serves to transfer copyright for publication and, more importantly, outlines the contributor's (author's) representations (see Section G) of the CTA form.

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JAANP Guidelines For Authors (GFA) Page 11 (version 111020) forms are available online at http://www.aanp.org/ under publications>journal>author information.

The CTA further outlines your retained rights and permitted uses and allows for the posting of NIH grant-funded work to PubMed Central upon acceptance of the final manuscript. There are also special provisions for work produced by employees of the U.S. Federal Government (which includes all military services), as well as other government employees, so that your work will reside in the public domain.

Only one copy of the first page of the CTA needs to be completed by the submitting author; additional pages for signatures of all authors should be appended to the first page of a single CTA. The completed CTA must be uploaded at the time of submission as a "Supplementary File not for review" (pdf, tif or jpg files are all OK).

To avoid an administrative processing delay you should attach the complete CTA file to your original submission. If you are unable to do this, the CTA pages may be faxed to the number on the on the bottom of the CTA form and a JAANP Administrator will combine them and attach them to your submission. If the CTA pages will be faxed please note this in your Cover Letter.

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Section 4: Guidelines for the online submission process

The JAANP uses the ScholarOne Manuscripts (S1M) online submission processing system.

Submission site URL: http://mc.manuscriptcentral.com/jaanp

To make a submission you must login to your S1M JAANP account. If you do not have such an account you must create one. (NOTE: most S1M JAANP MC Accounts are dual role Author/Reviewer accounts so if you are an active JAANP reviewer you should already have an account.)

A submission by an author's agent is acceptable. If you are a submitting agent for the manuscript (i.e., a project manager or administrative assistant), you should enter all the required submitter information under your own name and check the appropriate box so that you will not be listed as an author.

4.1- PRIOR TO LOGIN

Before you log in to create/update your account and start a submission we suggest that you print out this file, read it, and then use it as a reference.

Have an email address for all authors and have a permanent backup webmail address (e.g., hotmail, yahoo, Gmail) for yourself and any second author.
Decide how you wish you and your co-author(s) to be addressed:
Dr. Miss Mr. Mrs. Ms or Prof

(NOTE: If your manuscript is accepted for publication you will be able to update your credentials, address, affiliation, etc. at proof reading time.)
Make sure that there are no page numbers in your main document. (Nothing should be in the header or footer.)

Determine the approximate number of words in your main document.
Select keywords for both your account and submission. (See Key word Tips below)
Limit your Title to 30 words.
Limit your Running Head to 50 characters (letters, punctuation, and spaces.
Limit your Abstract to 200 words and ensure it is structured according to the JAANP Author Guidelines.
Create a cover letter document that includes the required information described above. You may enter or copy and paste your cover letter text into a "Cover Letter" box OR you can attach a file containing your cover letter following the onscreen instructions.

NOTE: All submissions must include a CTA signed by all authors and a Cover Letter that includes an ICMJE statement. Submissions that don't comply with the GFA will incur delays or may be rejected immediately.

4.2 - Be prepared to:

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Confirm that the manuscript has been submitted solely to this journal and is not published, in press, or submitted elsewhere.
Confirm that all the research, citations, and authorship statements meet appropriate ethical guidelines, including adherence to the legal requirements of the study country. By confirming this statement you are declaring that you have read and understood the ethical guidelines published by the International Committee of Medical Journal Editors (ICMJE) available online at http://www.icmje.org/

Confirm that you have prepared a complete text minus the title page, acknowledgments, and running head with no author names, to allow blinded review.
State if you have any conflicts of interest.

4.3 - AFTER YOU HAVE LOGGED IN

NOTE: If necessary, you may interrupt the submission process and logout. When you are ready to resume, just login, go to the author dashboard and click the "Continue submission" button.

TIP: Pressing the letter U five times on the “Country” field lands you on "United States"

In the "Degree" field please enter only your highest academic degrees.

4.4 - KEYWORD TIPS

You will be required to select four keywords for the creation of your account and each submission. The JAANP keyword selection list found in S1M is fixed. It contains almost 800 broad-based nursing science keywords that should be suitable for most submissions. Your account keywords should reflect your areas of professional expertise and interest. The keywords selected for your submission should reflect the content of your manuscript. You may provide a list of additional keywords in the TitlePage.doc if you do not find suitable ones in the S1M list but you will need to select 4 keywords from the list in order to proceed.

TIP: When selecting keywords from the list, enter three or four letters AND an asterisk (wild card symbol) to filter the list.

Upload your submission files in the upload-order specified below.

NOTE: The JAANP conducts a blinded peer-review. When uploading your manuscript you must upload a Main Document file with no author identifying information in it (designated as the Main Document) and a separate title page (designated as the Title Page) with all author identifying details including an email address for all authors. This is the author information you would like the readers to see in a published article. The next section details file type and naming conventions.

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4.5 - Manuscript File Naming for Submission

The S1M system will demand that you designate your files as one of the following types:

Title Page is required. It should include the title of the submission and complete author contact and work affiliation information. Authors should be listed in proper order of contributorship and the corresponding author must be clearly identified.

NOTE: This page is not included in the reviewer files when the manuscript is sent out for review.

Main Document is required. It includes the body of the text and references with all author identifying information removed, no page numbers, no running head (which is entered in S1M in a separate data field), and no embedded tables or figures. If you have been using Track Changes to make final editorial corrections to your document, be sure to accept all changes and save the corrected file with Track Changes turned off. (Track changes leaves contributors' names visible in the document unless this step is completed.)

Tables and Figures should be separated into individual files and uploaded with appropriate labels applied as requested during the submission process.

Supplementary Files Not for Review may be uploaded to provide specific information such as permission to reprint material, a completed and signed ICMJE conflict of interest disclosure if required, or a copy of the letter of approval to conduct research from the appropriate review board. If possible a scanned copy of your signed CTA form(s) should be uploaded here as well -- otherwise fax it to 512-442-6469 and state in the Cover Letter that the CTA has been faxed to AANP

Suggested upload-file name conventions:
(Contact Author Last name and _Initial followed by file type).

NOTE: The S1M system uses the following user selectable file designations Title Page, Main Document, Figure, Table, or Supplemental (may or may not be designated for review) This is the specified upload-order.

Smith_A TitlePage.doc Smith_A MainDoc.doc Smith_A Figure-1.tif Smith_A Table-1.doc Smith_A SupFile-CTA.doc Smith_A SupFile-Permit.doc

In all cases the Main Document file should have the Contact Author's name prepended to it. eg. Smith_A Adolescent Obesity article MainDoc.doc

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During the upload process your files will be converted into both HTML and PDF format for use by the reviewers. Sometimes the conversion process takes a while or fails. If it seems to be taking too long, close the conversion-in-progress window and check to see if a file conversion actually occurred. If the file conversion appears stalled or failed, follow any instructions that appear on the screen. Otherwise delete any corrupted files and start the process over.

Please be aware that S1M services millions of users and sometimes you may experience a glitch in file conversion processing (e.g. "Unable to convert file Author_N1 CL.doc (PDF)" it did make an HTML) and you may have to delete a botched job and restart the process.

Once your submission is complete you will receive an automatic email from the S1M system verifying your submission and providing you with your Manuscript ID Number. You will be able to track the progress of your submission from your Author Center in the S1M system.

It is not possible for authors to change or add anything once the submission is complete. If you fail to follow the guidelines or you need to add or change something to your submission, we will have to “unsubmit” your manuscript for you to resubmit your corrected files. This can cause major aggravation and delays!

NOTE: Email inquiries regarding your submitted manuscripts should be directed to the ADM through your Author Center or to jaanp.eic@gmail.com Be sure to include your Manuscript ID so we can easily find your file in the S1M system.

4.6 After your submission is complete

All authors will receive an automated confirmatory email that the submission has been accomplished. Any further communication regarding the review, revisions, decisions, or production details are only sent to the contact author (or submitting agent). It is the contact author's (or agent's) responsibility to maintain communication with all other authors throughout the process. Failure to do so may result in production delays.

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Section 5: MANUACRIPT SUBMISSION CHECKLIST JAANP

This is a summary checklist of the essential elements for your submission. Please be sure that everything is included as directed in your submission to avoid administrative delays.

Title Page (See Section 3.1)	Contains title of manuscript in 30 words or less, complete author list in correct order with contact and work information, contact author clearly identified with active email address
Abstract (See Section 3.3)	Formatted with required elements: Purpose, Data Sources, Conclusions, Implications for Practice
Cover Letter	Contains the title, statement of authorship and exclusive submission to JAANP, states the work conforms to

(See Section 3.2)	Guidelines for Authors version 110106
Main Document (See Section 2)	All identifying author information removed, no page numbers or running head included, any drugs named as follows: generic (Trade - optional)
Tables, Figures, Graphics (See Section 3.6)	Captions are complete, footnotes added where necessary, each table, figure or graphic is cited in the text in the appropriate location
Acknowledgements (See Section 3.4)	Expository information does not identify authors by name, funding sources and writing/editing support is explicitly acknowledged by name
Permits (See Section 3.7)	Required for previously copyrighted material and must be uploaded with the submission
Copyright Transfer Agreement (CTA) (See Section 3.8)	Signed by all authors, scanned and uploaded with submission

Article 2. Ethical Issue Analysis: Bridge to Nowhere: Addressing the Treatment Gap between the Emergency Department and Primary Care

Journal selected: Nursing Ethics

Author Guidelines:

Nursing Ethics is an international peer reviewed journal that welcomes submissions on the morality, ethics and law of the caring professions. (http://www.uk.sagepub.com)

1. Peer review policy

Nursing Ethics adheres to a rigorous double-blind reviewing policy in which the identity of reviewers and authors are concealed from both parties. Each manuscript is reviewed by at least two referees. Suitable manuscripts are reviewed as rapidly as possible, e.g. within 4-6 weeks of submission. Reviewers are directed to the COPE Ethical Guidelines for Peer Reviewers.

2. Article types

Nursing Ethics features commissioned and non-commissioned research articles, case studies, opinion pieces, reports, book reviews, correspondence and notices of meetings, events and conferences.

Length: Articles should be between 2500 and 6000 words long (including abstract, text and references; excluding tables). Review articles may be up to 8000 words (including tables). Book reviews should be about 500 words. Case studies are normally 500 words

(see guidance below). Letters are welcome.

Abstract: Please supply an article abstract of 100-150 words. Please supply up to six key words. See more detailed guidance below.

Authors whose first language is not English are requested to have their manuscripts checked carefully for linguistic correctness before submission.

3. Authorship

Papers should only be submitted for consideration once the authorization of all contributing authors has been gathered. Those submitting papers should carefully check that all those whose work contributed to the paper are acknowledged as contributing authors.

The list of authors should include all those who can legitimately claim authorship. This is all those who:

1. have made a substantial contribution to the concept and design, acquisition of data or analysis and interpretation of data
2. drafted the article or revised it critically for important intellectual content
3. approved the version to be published.

Authors should meet the conditions of all of the points above. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content. When a large, multicentre group has conducted the work, the group should identify the individuals who accept direct responsibility for the manuscript. These individuals should fully meet the criteria for authorship.

Acquisition of funding, collection of data, or general supervision of the research group alone does not constitute authorship, although all contributors who do not meet the criteria for authorship should be listed in the Acknowledgments section. Please refer to the ICMJE Authorship guidelines at http://www.icmje.org/ethical_1author.html.

4. How to submit your manuscript

Before submitting your manuscript, please ensure you carefully read and adhere to all the guidelines and instructions to authors provided below. Manuscripts not conforming to these guidelines may be returned.

Nursing Ethics is hosted on SAGETRACK: a web based online submission and peer review system powered by ScholarOne™ Manuscripts. Please read the Manuscript Submission guidelines below, and then simply visit http://mc.manuscriptcentral.com/ne to login and submit your article online.

IMPORTANT: Please check whether you already have an account in the system before trying to create a new one. If you have reviewed or authored for the journal in the past year it is likely that you will have had an account created. For further guidance on submitting your manuscript online please visit ScholarOne Online Help.

All papers must be submitted via the online system. If you would like to discuss your paper prior to submission, please refer to the contact details below.

5. Journal contributor's publishing agreement

Before publication SAGE requires the author as the rights holder to sign a Journal Contributor's Publishing Agreement. SAGE's Journal Contributor's Publishing Agreement is an exclusive license agreement which means that the author retains copyright in the work but grants SAGE the sole and exclusive right and license to publish for the full legal term of copyright. Exceptions may exist where an assignment of copyright is required or preferred by a proprietor other than SAGE. In this case copyright in the work will be assigned from the author to the society. For more information please visit our Frequently Asked Questions on the SAGE Journal Author Gateway.

Nursing Ethics and SAGE take issues of copyright infringement, plagiarism or other breaches of best practice in publication very seriously. We seek to protect the rights of our authors and we always investigate claims of plagiarism or misuse of articles published in the Journal. Equally, we seek to protect the reputation of the Journal against malpractice. Submitted articles may be checked with duplication-checking software. Where an article is found to have plagiarised other work or included third-party copyright material without permission or with insufficient acknowledgement, or where the authorship of the article is contested, we reserve the right to take action including, but not limited to: publishing an erratum or corrigendum (correction); retracting the article (removing it from the journal); taking up the matter with the head of department or dean of the author's institution and/or relevant academic bodies or societies; banning the author from publication in the journal or all SAGE journals, or appropriate legal action.

5.1 SAGE Choice and Open Access

If you or your funder wish your article to be freely available online to non subscribers immediately upon publication (gold open access), you can opt for it to be included in SAGE Choice, subject to payment of a publication fee. The manuscript submission and peer review procedure is unchanged. On acceptance of your article, you will be asked to let SAGE know directly if you are choosing SAGE Choice. To check journal eligibility and the publication fee, please visit SAGE Choice. For more information on open access options and compliance at SAGE, including self author archiving deposits (green open access) visit SAGE Publishing Policies on our Journal Author Gateway.

6. Statements and conventions

6.1. Acknowledgements

Any acknowledgements should appear first at the end of your article prior to your Declaration of Conflicting Interests (if applicable), any notes and your References.

All contributors who do not meet the criteria for authorship should be listed in an

'Acknowledgements' section. Examples of those who might be acknowledged include a person who provided purely technical help, writing assistance, or a department chair who provided only general support. Authors should disclose whether they had any writing assistance and identify the entity that paid for this assistance.

6.2 Declaration of conflicting interests

Within your Journal Contributor's Publishing Agreement you will be required to make a certification with respect to a declaration of conflicting interests. It is the policy of Nursing Ethics to require a declaration of conflicting interests from all authors enabling a statement to be carried within the paginated pages of all published articles.

Please include any declaration at the end of your manuscript after any acknowledgements and prior to the references, under a heading 'Declaration of Conflicting Interests'. If no declaration is made the following will be printed under this heading in your article: 'None Declared'. Alternatively, you may wish to state that 'The Author(s) declare(s) that there is no conflict of interest'.

When making a declaration the disclosure information must be specific and include any financial relationship that all authors of the article has with any sponsoring organization and the for-profit interests the organization represents, and with any for-profit product discussed or implied in the text of the article.

Any commercial or financial involvements that might represent an appearance of a conflict of interest need to be additionally disclosed in the covering letter accompanying your article to assist the Editor in evaluating whether sufficient disclosure has been made within the Declaration of Conflicting Interests provided in the article.

For more information please visit the SAGE Journal Author Gateway.

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Article 3: Relationships Among Moral Distress, Level of Practice Independence, and Intention to Leave of Nurse Practitioners in Emergency Departments: Results from a National Survey

Journal selected: Advanced Emergency Nursing Journal

Author guidelines: (http://journals.lww.com/aenjournal)

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