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Orignal Article

A survey of moral distress in certified registered nurse anesthetists: A theoretical perspective for change in ethics education for advance practice nurses

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ABSTRACT

Objective: The aim of this study was to examine the relationship between moral distress that may affect patient safety, and the clinical practice model, assessing ethical decision-making skills of certified registered nurse anesthetists (CRNAs).
Methods: A survey using the Ethical Stress Scale (ESS) and the Ethical Assessment Skills Survey (EASS) was conducted with 134 CRNAs.
Results: Results indicated no significant effect of practice model on level of moral distress or perceived ethical assessment skill knowledge [Wilks's lambda = 0.952, F (6, 256) = 1.068, $P = 0.382$, $n^2 = 0.02$]. A statistically significant positive correlation existed between importance and skill ($r = 0.275$, $P = 0.001$). CRNAs felt skilled to manage the actions or activities they deemed important.
Conclusion: CRNAs who perceived a higher skill level in addressing ethical issues experienced lower levels of moral distress. Findings indicate content-specific curricula for the CRNAs need to be evaluated for ethical decision-making skill assessment content.
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1. Introduction

Certified Registered Nurse Anesthetists (CRNAs) are advanced practice nurses (APNs) in the United States who have received specialized education and training in the field of anesthesiology. CRNAs independently provide more than half of the anesthesia services provided in rural areas [1]. Demographically and economically, many nurse anesthetists are the sole provider of anesthesia services [2], adding value to the role in filling the gap in anesthesia delivery in rural areas in the United States. The most cost-effective delivery of anesthesia services influences the cost of health care and access to health care [1,3]. For these reasons, protecting CRNAs and all APNs from moral distress is important to patient care and the health care economy.

The advocacy role of the APN often results in moral distress from ethical dilemmas stemming from circumstances such as scarce resources, or the challenges posed by conflicts with families and other health care professionals [4–8]. Moral distress is the tension caused by the discrepancy, which may cause feelings of fear, anger, anxiety, and powerlessness [5,8].

One large challenge, to increase production, decrease time, and adhere to strict utilization of resources may cause undue moral distress in the APN who feels these new obligations impinge on the adequacy of patient: practitioner interactions. Production pressure can become overbearing within the practice of nurse anesthesia, potentially jeopardizing patient safety.

Wilkinson [9] contends that any threat to patient care, such as moral distress, deserves further study. Ample research indicates current ethics education in nursing is not sufficient to meet the demands of ethical decision-making of APNs, including, CRNAs [10–15].

Jameton described moral distress as feelings that arise when it becomes difficult or impossible for a nurse to make decisions he or she feels to be the right choice concerning a patient [5]. Moral distress causes feelings of fatigue, frustration, job burnout, anger, and a fear of job loss and might lead to changes in patient care affecting the safety of the patient [8,16–19]. Moral distress and its effects on nurses have been well described in the literature [5,18,20–23]. The limitation of research on moral distress is that it contains minimal exploration into the experience for the APN, or more specifically, CRNAs.

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Radzvin [7,8] described the experience of moral distress in CRNAs but did not explore the perceived ethical assessment skills of CRNAs. Variations exist in the different practice models used in anesthesiology in the U.S. that might affect the experience of moral distress and change the direction of focus for future CRNA education. One variation is the level of supervision or collaboration with an anesthesiologist. Another variation is the autonomy of the role of CRNAs. In managed care or supervisory environments, CRNAs work closely with other anesthesia professionals, but in an independent practice model, a CRNA might be the sole anesthesia provider. To build on prior research, the purpose of this quantitative correlation study was to measure the relationship between perceived ethical assessment skill knowledge and moral distress and how this varies across the three CRNA practice models.

2. Study design and methods

2.1. Ethics statement

This study was submitted for Institutional Review Board approval. Participation in this study was voluntary with participant informed consent. The study involved minimal risk and the participants could withdraw by contacting the researcher.

2.2. Study design

This quantitative correlational study was a random sample using two survey instruments to measure the relationship between moral distress and perceived ethical skill assessment knowledge in the sample of CRNAs across three practice models including medically directed, supervision, and independent practice.

2.3. Setting and participants

The target population was the 44,000 CRNAs in practice in America [24]. Eligible participants were those CRNAs who were active certified members of the AANA. Retired members, nonpracticing members, and students did not meet eligibility requirements for the study. The minimum required sample size was calculated based on a multiple regression with five predictor variables. This statistical test had the largest required sample size of any of the statistical tests used for the study. With a power of 0.80, alpha level of 0.05, medium effect size [13], and five predictor variables, the minimum required sample size was 92. Participants were selected and recruited from a random sample provided by the AANA. Of the CRNAs who met the criteria of active membership who are in practice, a random sample of 920 CRNAs was selected.

2.4. Data collection

A representative from the AANA organization provided permission to recruit subjects, use the name of the organization, and use data from the organization. Participants were recruited from a random sample provided by the AANA via a mailed packet of surveys through the U.S. Postal Service. The AANA selected a random sample of eligible participants for the study, as described in the AANA research sample mailing list policy. The AANA organization provided mailing labels for the randomly selected individuals. From the 920 survey packets mailed, 145 participants returned surveys and 134 CRNAs' survey data were analyzed, yielding a 15% response rate.

2.5. Questionnaires

Radzvin [7,8] addressed the issue of moral distress in CRNAs using the Ethical Stress Scale (ESS) developed by Raines and Tymchuk [25]. Raines (1994) established a content validity index of 0.89, $P < 0.05$, of the ESS "using a 4-option Content Validity Index rating scale by a group of advanced practice nurse clinicians who were exposed to ethical dilemmas in their practice several times a week" [7]. According to Radzvin [8], "While the original ESS included 56 questions, Raines [30] did not address the method used to calculate the total score for the ESS". Radzvin [7] calculated the response to the first 52 questions to reach a total ESS score. The lower 10% indicates a high level of moral distress and the median score indicates a moderate level of moral distress. Radzvin tested the first 52 questions for face validity with four nurse educators and tested for internal consistency reliability using Cronbach's alpha of 0.87 for the research. Raines [30] tested for stability reliability using test–retest methods resulting in a reliability coefficient of $r = 0.82$, $P \leq 0.005$. This study included the same measurement scales as developed by Radzvin [8].

The study also included the Ethical Assessment Skills Survey (EASS) developed by Cassells and Gaul [26]to assess the self-perceived skill level of ethical decision-making. Cassells and Gaul expanded the EASS tool in 1998 to 12 ethical actions skills from the initial 11-step framework. "Content and expert validity tests were undertaken during the development and revisions of the instrument" and "they have been tested in a number of national and international studies [11]." "Reliability for the EASS was established by the test-retest method, with a coefficient alpha of 0.87 [11]". The focus of the study was to build on Radzvin's [7] descriptive study of the effects of moral distress on CRNAs.

2.6. Data analysis

Data analysis was performed using Statistical Analysis System (SAS), a statistical software program. A correlation analysis was then performed between the total ESS and the two dimensions of the perceived ethical assessment skill knowledge-measuring perceived importance and perceived ethical skill using Pearson's correlation coefficient.

Multiple linear regressions were used in answering the first research question to determine if a correlation existed between perceived ethical assessment skill knowledge (perceived importance and skill) and the level of moral distress.

To answer research question 2, the relationship of the practice models was tested using multivariate analysis of variance (MANOVA). The MANOVA provides an analysis to examine intercorrelations of the dependent variables such as in the current study of moral distress and the two dimensions of perceived ethical assessment skill knowledge.

3. Results

3.1. Moral distress and ethical assessment skill level

Descriptive statistics were a result of the data analysis seeking the demographics of the sample (Table 1). The total sum was first calculated for the ESS to better understand the relationship between the participants perceived ethical assessment skill knowledge and the dependent variable moral distress. By replicating the scoring pattern used by Radzvin [8], the total sum of the ESS for Questions 1–52 was used. The total sum for ESS Questions 1–52 ranged from 72 as the lowest to the highest score of 198. Replicating the scoring pattern, the lower 10% of the total was considered the range for a high level of moral distress, which included total scores of 134 and below. A total score of 158.5 (median) to scores of 135 indicated a moderate level of moral distress, and total scores above 158.5 indicated a low level of moral distress. To test whether a

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