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CONCEPTUALISING MORAL RESILIENCE FOR NURSING PRACTICE

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ABSTRACT

The term 'moral resilience' has been gaining momentum in the nursing ethics literature. This may be due to it representing a potential response to moral problems such as moral distress. Moral resilience has been conceptualised as a factor that inhibits immoral actions, as a favourable outcome and as an ability to bounce back after a morally distressing situation. In this article, the philosophical analysis of moral resilience is developed by challenging these conceptualisations and highlighting the risks of such limiting perspectives. It is argued that moral resilience is best understood as a virtue with two associated vices; faintheartedness and rigidity. The intellectual virtue of practical wisdom is required to express resilience as a virtue. This understanding leads to recommendations for professional education, for practice and further research.

INTRODUCTION

Nursing practice presents ethical opportunities to promote the flourishing of patients, families and communities. Nursing practice also presents ethical challenges. (Epstein & Delgado, 2010; Lützén, Cronqvist, Magnusson, & Andersson, 2003; Schluter, Winch, Holzhauser, & Henderson, 2008). The challenges that nurses encounter include a range of moral problems as outlined by Johnstone (2009). By moral problems Johnstone (2009) refers to: "moral matter or issue that is difficult to deal with, solve or overcome" (p. 94). One of the most researched moral issues in recent years is that of 'moral distress'. This involves negative feelings resulting from situations where the moral agent feels unable to act according to her or his moral judgement (Corley, Elswick, Gorman, & Clor, 2001; Hamric, 2012; Hanna, 2004; Jameton, 1984). Moral distress has been further developed introducing the differentiation between initial and reactive moral distress (Jameton, 1993). Additionally, the factors which can rise to moral distress have been identified such as factors internal to the caregiver; factors external to the caregiver; and clinical situations (Hamric, 2012).

It has been suggested that in order to reduce or avoid moral distress, and its deleterious consequences, one should try to maintain his or her moral integrity. It has been argued that this includes finding a source of inhibition which prevents conduct evaluated by the moral agent as wrong. Musschenga (2001) defined moral integrity as the coherence between one's beliefs and values and actions and as coherence between all roles and domains of one's life. Hardingham (2004) described integrity as "wholeness in the relationship between our actions and our values and beliefs" (p. 129). However, integrity should not be understood as being static but rather as something continuously changing and thus as a process that finds its roots in personal self-knowledge and self-reflection (Cox, La Caze, & Levine, 2003). The ability to negotiate one's values is also pivotal in the case of conflicts with partners because it allows nurses to foster and determine their readiness and willingness to find compromises. Indeed, McFall (1987) stated that in order to maintain integrity, commitments have to be ranked for importance, and not all

commitments can be unconditional.

The source of inhibition which prevents wrong conduct has been defined in the literature as 'moral resilience'. Monteverde (2016) has defined moral resilience as a favourable outcome following an experience of moral distress. Rushton (2016) has defined it as the individual's ability to bounce back after an experience of moral distress.

What follows, in this article, is a critique of the current conceptualisations of moral resilience. This critique aims to demonstrate that the current conceptualisations are not sufficient for nursing. Nursing will be discussed as a moral practice, following MacIntyre's definition of practice, where virtues play a central part. This is followed by a discussion of the value of virtue ethics in relation to nursing. Finally we offer an interpretation of moral resilience as a virtue with its vices.

NURSING AS A MORAL PRACTICE

Nursing can be understood as a moral practice (Armstrong, 2007; Bishop & Scudder, 2001; Edwards, 2001; Gastmans, de Casterlé, & Schotsmans, 1998; Sellman, 2011). This is in accord with the definition offered by MacIntyre (2011).

MacIntyre (2011) asserts that practice is carried out in a socially established way, which implies that the person who enters the practice is invited to embrace its standards and the mean time to partially renounce at personal taste, preferences and attitudes (MacIntyre, 2011).

In order to better understand the practice of nursing we would like to briefly discuss the definition of a practice offered by MacIntyre. MacIntyre (2011) defines a practice as follows:

"By a 'practice' I am going to mean any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended" (p. 218).

We focus on four elements of MacIntyre's definition which are relevant to nursing. First, we have to consider that practice must be carried out within a community, which guarantees collaboration and coherence. Second, the community must have a shared knowledge of the practice. Third, practices have internal and external goods - by internal goods are meant virtues, which are exercised for their own sake and with the aim of achieving standards of excellence. External goods are not necessary for practice, but only as a contingency that is not specific to a determinate practice; such as fame and money. The result of exercising virtues is the acquisition of knowledge and skills specific to that practice. The choice of the virtues and their meaning is inspired by *phronēsis*, which is guided by *logos* and the ultimate goal of engaging in a practice is represented by *eudaimonia*, that is to say to live a flourishing or happy life. Finally, internal goods can only be appreciated and judged by individuals who engage in the practice.

Applying this understanding of practice to nursing involves reflection on virtue ethics. Aristotle divided

virtues into two types: ethical (or moral) and intellectual virtues where ethical virtues refer to morality and to the individual's behaviour whereas intellectual virtues refer to the intellect and reason, which determine the exercise of ethical virtues (Ross & Brown, 2009). Aristotle asserted that humans have the potential for developing virtues but they need to be exercised continuously in order to become a habit and a custom: "neither by nature, then, nor contrary to nature do the virtues arise in us; rather we are adapted by nature to receive them [*virtues*] and are made perfect by habit" (Ross & Brown, 2009, p. 23). In fact the Greek word *ethos* means habit, use, custom, way of being (Rocci, 2010). Aristotle argued that a singular virtuous action is not enough to be virtuous as virtues need to be exercised continuously. He asserts that: "For one swallow does not make a summer, nor does one day; and so too one day, or a short time, does not make a man blessed and happy" (Ross and Brown, 2009, p.12). According to Aristotle, it is not so important that someone knows exactly what a determinate virtue is, but it is more important that someone acts according to that virtue (Ross & Brown 2009). The exercise and the amount of the requested virtue vary from situation-to-situation depending on the details and its characteristics (Ross & Brown 2009). This is to say that virtue is not the median point between two vices but rather the mean between two vices, which depends on the characteristics of the singular situation. Aristotle asserted: "Thus a master of any art avoids excess and defect, but seeks the intermediate and chooses this – the intermediate not in the object but relatively to us." (Ross & Brown, 2009, p. 30).

But how can a person recognise the intermediate point and which virtues need to be exercised in a given situation? This choice is made possible by the intellectual virtue of *phronēsis*. In order to live a practical life, which is not contemplative, the most important intellectual virtue is represented by practical wisdom (*phronēsis*). *Phronēsis* refers to the particular wisdom, which helps the individual to choose the right ethical virtue to exercise in a given situation in order to achieve the *telos* (Ross & Brown 2009). On *phronēsis* Aristotle asserted: "The remaining alternative, then, is that it is a true and reasoned state of capacity to act with regard to the things that are good or bad for man." (Ross & Brown, 2009, p. 106).

In recent years virtue ethics has gained much attention among nurses and ethicists (Armstrong, 2006, 2007; Banks & Gallagher, 2009; Hooft, 1999; Sellman, 2011).

In keeping with MacIntyre's (2011) arguments, Edwards (2001) asserted that the technical activities of nursing, interpretations, and morality are crucial for nursing practice and represent its internal goods. These involve virtues such as empathy, honesty, integrity, courage, justice and care (Edwards, 2001). These virtues find their expression in the practice of nursing and are necessary in order to achieve the ultimate goals of the vocation. Bishop and Scudder (2001) believed these virtues to be necessary in order to be a good nurse, which is defined as one that is concerned for their patients. This concern is central to efficient, effective and attentive care that fosters patient wellbeing.

Sellman (2011) defined nursing as a practice in the MacIntyrean sense as well: "The good that nursing seeks is the wellbeing of individual patients, which characterises nursing as a moral enterprise with associated moral obligation on the part of individual nurses to provide excellent care. Nursing is thus a caring practice that aims at the good of those who find themselves in receipt of nursing" (p. 101).

Sellman (2011) identified the virtues of honesty, justice and courage as being at the core of nursing

practice, and trustworthiness and open-mindedness as indispensable attitudes. Armstrong (2007) dedicated a book chapter to the notion of nursing practice based on MacIntyre's work and partially on Sellman's work. Armstrong (2007) agreed with Sellman's conception of nursing as a practice, in accordance with MacIntyre's perspective, but claimed that Sellman lacks clarity in addressing the internal goods of nursing. Armstrong (2007) suggested that internal goods are only achievable through the exercise of virtues, because internal goods are represented by the feelings and emotional responses that arise in nurses when they act, think and feel in a morally virtuous way. Armstrong (2007) stated that standards of excellence can only be reached through the exercise of kindness, patience, courage, compassion, justice and respectfulness. He did not give a clear definition of 'standards of excellence' in nursing but asserted that they relate to the particular ends of nursing. However, according to some authors, the ultimate goals of nursing are to alleviate pain and suffering, maintain patients' dignity, promote recovery, enhance quality of life and offer comfort (Armstrong, 2007; Benner, 1997; Edwards, 2001; Gastmans et al., 1998; Sellman, 2011). These goals were defined by Sellman (2011) as "goods of excellence" (p.80).

In real life, the goods of excellence sometimes clash with the goods of effectiveness usually pursued by organisations. This clash inevitably leads nurses into areas of tension and fields of conflict, especially with institutions, which fail to value the goods of excellence expected by nurses (Sellman, 2011).

MORAL DISTRESS IN NURSING

The literature on moral sources of stress among nurses is substantial. Lütznén and Kvist (2012) differentiated between moral stress and moral distress: the former serves as a reminder of moral obligation and represents a sign of moral sensitivity; the latter refers to the set of negative outcomes following unsuccessful acting in a situation of moral stress. As suggested by Lütznén and Kvist (2012) literature in nursing is much more focussed on moral distress than on moral stress. This is due to the negative and devastating consequences of moral distress such as burnout and leaving practice. Hamric (2012) offers a comprehensive classification of sources of moral distress among nurses. She differentiates between: factors internal to the caregiver (perceived powerlessness, lack of knowledge of alternatives or of the full situation); factors external to the caregiver (institutional constraints such as inadequate staffing, lack of administrative support, incompetent caregivers); and clinical situations (unnecessary/futile treatment, aggressive treatment not in the patient's best interest, inadequate informed consent, lack of truth-telling, such as giving false hope).

Oh and Gastmans (2015) carried out a quantitative literature review on moral distress experienced by nurses. Their findings indicate that the main sources of moral distress are: working with incompetent staff; giving futile care; the nursing shortage; and uncooperative challenging behaviour by patients or family members.

The term 'moral distress' was first used by Jameton in 1984 who stated that: "Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right

course of action.” (p. 6). Hanna (2004) offers a much more complete and complex definition of moral distress, asserting that it involves a perceived violation of the person, whether this is articulated or not, and it produces a disconnection from one’s self and others and it represents a harm of one’s living purpose.

In later writing, Jameton (1993) distinguishes between initial distress which is felt as soon as a decision is felt as wrong and reactive distress which is the set of feelings resulting from failing to avoid the pursuit of the right course of action. Webster and Baylis (2000) refer to moral distress as an incoherence between one’s beliefs and actions and to moral residue as negative feelings resulting from losing one’s own moral integrity as a result of failing to pursue what is thought to be the right course of action (Webster & Baylis, 2000). Epstein and Hamric (2009) enlarge the discourse on moral residue, asserting that it has a cumulative effect: each time one experiences a morally distressing situation he or she will never go back to the condition before the episode. The next time he or she will experience a morally distressing situation she/he will start from an already higher level of distress due to the residue of the previous experience.

Even though some authors have amended the concept of moral distress, there is general agreement in the literature that moral distress arises from some kind of constraint which prevents nurses from exercising their moral agency; that moral distress is connoted by two phases (initial and reactive); and that the experience of moral distress can intensify over time. (McCarthy & Gastmans, 2015) According to McCarthy and Gastmans (2015) consensus is reached in describing moral distress in psychological-emotional-physiological terms. Moral distress has not only negative consequences on nurses, but also on quality of care.

Some studies have investigated how nurses react to moral distress (De Villers & Devon, 2013; Deady & McCarthy, 2010; Gutierrez, 2005; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). The results from all these studies demonstrated mainly negative reactions that directly affected the quality of care. One of the reactions that emerge from the literature is avoidance (De Villers & Devon, 2013; Deady & McCarthy, 2010; Gutierrez, 2005; Varcoe et al., 2012) which is defined as the withdrawal of information or suppressing arguments in order to prevent conflicts or protecting self-identity (Wang, Fink, & Cai, 2012).

Recently the attention of researchers has moved from investigating the frequency and intensity of moral distress to finding solutions to the problem.

MORAL RESILIENCE AS A RESPONSE TO MORAL DISTRESS?

Webster and Baylis (2000) argued that moral distress can lead to an erosion of moral integrity. Thus, doing something to maintain one’s moral integrity could potentially represent a way to avoid these negative consequences. The literature suggests that in order to maintain moral integrity one should find a resource to inhibit oneself in doing wrong while strengthening one’s moral agency (Burston & Tuckett, 2013; Grace, Robinson, Jurchak, Zollfrank, & Lee, 2014; Monteverde, 2014; Monteverde, 2016; Musto, Rodney, & Vanderheide, 2015).

According to Titus (2006) and Oser and Reichenbach (2005) moral resilience represents the source of

inhibition for immoral actions and is necessary in order to resist negative external and internal pressures when taking a moral decision.

Titus (2006) asserts that moral resilience is only possible if the moral agent exercises the virtue of fortitude. Titus (2006) follows a Christian theological discourse where the final goal is represented as salvation of the soul.

Oser and Reichenbach (2005) approach the discourse of moral resilience from a slightly different perspective. They assert that moral resilience is, on one hand, the source of inhibition for immoral actions and, on the other hand, it can potentially represent a source of unhappiness. In a later writing Oser, Schmid, and Hattersley (2006) declare that this is often due to the fact that morality and success represent a difficult binomial where the two things are frequently in contrast with each other. Oser et al. (2006) reach this conclusion through a series of studies, which demonstrated that maintaining a high degree of coherence with one's beliefs often leads to unhappiness due to failure to receive external rewards. What emerges from the perspectives offered by Titus (2006), Oser and Reichenbach (2005) and Oser et al. (2006) is that they are all more concerned with the behaviour of the individual, who needs to take a decision which mainly affects him or herself, rather than with individuals who practice collaboratively. Titus (2006) asserts that fortitude and moral resilience represent the key for salvation in a religious discourse and Oser and Reichenbach (2005) assert that the personal reward, which the individual receives when he displays moral resilience, is often frustrating due to the lack of external rewards.

Recently the term moral resilience has entered the field of nursing as a possible response to moral distress. Monteverde (2016) defined moral resilience: 'as an outcome based on as a change in PMD [Perceived Moral Distress through the administration of moral distress thermometer] in a given axis of time' (p.107). Thus it could be suggested that Monteverde (2016) clearly defines moral resilience as a favourable and desirable outcome after an episode of moral distress. Monteverde (2016) measured the success of ethics education based on lectures introducing the typology of moral stressors. Before and after the lecture, students were presented with vignettes depicting morally stressful situations. In his findings, Monteverde (2016) reported a statistically relevant reduction in measured levels of perceived moral distress after the lectures. Monteverde (2016) argues that moral resilience is a favourable and desirable outcome. This would mean that providing students - and more generally healthcare workers - with a sound knowledge of ethics could potentially prevent them from developing moral distress, or at least from developing its negative consequences by supporting their moral agency. However, defining moral resilience as an outcome that can be influenced by improving nurses' moral agency through education also presents some challenges. It could be suggested that Monteverde (2016), Titus (2006), Oser and Reichenbach (2005) and Oser et al. (2006) are all more concerned with the behaviour of the individual who needs to take decisions that mainly affect him or herself, rather than with the behaviour of individuals who operate in collaboration with others. The risk in applying this understanding of moral resilience is that of 'moral complacency', defined as the refusal to accept the possibility that one's own moral judgment or conviction is wrong, or to the even more dangerous problems of 'moral fanaticism',

which stem from a blind adherence to principles, regardless of the situation and of the people affected by the consequences (Johnstone, 2009).

So, is moral resilience a desirable outcome that is helpful for nurses?

Rushton (2016) offers a definition of moral resilience that draws from the general definition of resilience in psychology. In psychology resilience has been defined as the ability of bouncing back and coping successfully in spite of significant stress or adversities (Connor & Davidson, 2003; Jackson, Firtko, & Edenborough, 2007; Tusaie & Dyer, 2004). Rushton (2016) defines moral resilience as: "Moral resilience is defined as the capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, or setbacks" (p. 112). From this definition emerges clearly a very strong individualistic aspect of moral resilience. The individualistic focus has been challenged by Traynor (2017). His discourse addresses psychological resilience but one could argue that his arguments against psychological resilience apply to the definition of moral resilience offered by Rushton (2016). His point is that the risk of applying an individualistic perspective to resilience charges the individual with too much responsibility even in situations where the suffering is provoked by others (Traynor, 2017). Traynor (2017) writes: "When a situation is intolerable, coping and resilience is not a good answer" (p.27) and "I think it is preferable to make sure you stop getting hit rather than learn how to be able to last longer before you finally collapse" (p. 28). Traynor (2017) does not deny the need for resilience among nurses, but he argues that resilience must involve the ability of critique, which in turn includes the deep understanding of a situation which causes suffering. The critique should aim at differentiating between suffering proper of the profession such as for example assisting suffering patients and suffering caused by the system, such as for example under-resourcing or poor management (Traynor, 2017). Traynor (2017) suggests that in order to face suffering caused by the system, nurses should rather resist than acquiesce with the aim of challenge and ameliorate the system. It could be argued that in the individualistic definition of resilience offered by Rushton (2016) these external variables are not taken into account. Thus far, the definitions of moral resilience display some limitations. These limitations are illuminated by the discussion of the unique nature of nursing defined as a practice.

A NEW PERSPECTIVE ON MORAL RESILIENCE IN NURSING

We believe that moral resilience can potentially represent an answer to moral distress, but its understanding needs to be contextualised within and adapted to the nursing practice, where moral decision-making relates to and involves patients who have to be considered as vulnerable.

Since this paper supports the view that nursing is a practice (Armstrong, 2007; Bishop & Scudder, 2001; Edwards, 2001; Gastmans et al., 1998; Sellman, 2011) and that personal reward and individual endeavour cannot be the sole criterion when facing morally loaded situations, it is argued that there is the need for a different conception of moral resilience.

The ultimate goals and thus standard of excellence in nursing practice are to alleviate pain and suffering, maintain the patients' dignity, promote recovery, enhance quality of life and offer comfort (Armstrong,

2007; Benner, 1997; Edwards, 2001; Gastmans et al., 1998; Sellman, 2011), therefore we challenge the idea of moral resilience as the avoidance of doing immoral actions, because this definition does only consider the perspective of the moral agent. When nurses agree with patients' needs and wishes, it can be argued that there is no need for moral resilience. As discussed previously, one source of ethical challenge is when a nurse's opinion differs from that of patients. Applying moral resilience in the way Titus (2006), Oser and Reichenbach (2005), Oser et al. (2006) do can have the consequence of harming the patient even if we succeed in keeping our morally integrity intact. This would not be in keeping with the aim of moral nursing practice.

It is suggested therefore that within nursing practice the virtue of moral resilience is the character trait, which allow nurses to remain open for compromises with themselves and with the given situation without compromising their own moral integrity.

What follows is the rationale for the suggestion that moral resilience could be understood as a virtue in the Aristotelian understanding.

According to Aristotle's conception of virtues, they should be understood as a character trait where its excess and the deficiency are represented by vices (Ross & Brown 2009). Further on in order to be considered good and achieve success a person must choose the right virtue according to the demands of the situation and its right mean according to the circumstances (Ross & Brown 2009).

The position this paper argues is that moral resilience is a virtue according to these characteristics

Moral Resilience as a virtue

Resilience has been described as a set of personal characteristics and as a process. In this paper the focus is on resilience as a set of personal characteristics. The term 'resilience' has been described in the psychological literature as a set of character traits which allow the individual to bounce back and thrive in the face of adversities (Connor & Davidson, 2003). Even if virtues refer to character traits, not all character traits are virtues. In order to be defined as a virtue, a character trait must be regarded as morally good or excellent (Banks & Gallagher, 2009).

We suggest that moral resilience should be considered as a character trait that allows people to remain open to compromises without compromising themselves. This means that people should contemplate compromises with themselves and according to the demands of a given situation. However, this should happen without compromising one's own moral integrity. This understanding includes the ability to bounce back in case people decide to make a concession in their ethical decision and to carry out an action they do not completely share but which does not compromise their moral integrity. Thus, on one hand moral resilience allows people to maintain an openness to compromise and on the other hand it helps people not succumb under unacceptable concessions.

Vices and moral resilience

Both excess and deficiency lead to the loss of virtue when making moral decisions. This paper suggests that the excess in relation to the virtue or moral resilience is represented by the vice of rigidity or inflexibility, that is to say a lack of readiness for any kind of compromise. Rigidity implies that when

someone is absolutely deeply convinced they know the right thing to do, he or she will carry out his or her decision without considering others' opinions and wishes. If this is explored in depth, this meaning of rigidity we reflect a sort of pride, which brings the individual to the firm belief in knowing better than others what is the right thing to do. Moreover it could be said that this vice leads to two of the moral problems identified by Johnstone (2009): moral fanaticism and moral complacency. Both problems can lead to deleterious consequences for patients.

The lack of moral resilience is represented by the vice of faintheartedness. Faintheartedness leads the individual to the desire of doing nothing probably as a consequence of a sort of moral laziness or weakness. Faintheartedness is not to be confused with blindness which occurs whenever the moral agent does not recognise the moral dimension of a given situation or with unpreparedness where the moral agent has a clear lack of knowledge in respect to moral issues (Johnstone, 2009). Moral faintheartedness partially refers to a further moral problem identified by Johnstone (2009), which is moral indifference, where the moral agent is not concerned or interested in the moral dimension of a given situation. It refers only partially to that problem because faintheartedness goes even further, with the moral agent recognising the moral dimension but deciding not to intervene in order not to get involved.

Not all ethical decisions require the exercise of moral resilience. When for example all the involved persons agree, there is no need for moral resilience. Moral resilience is required, for example, in those cases where a patient, a colleague or the institution makes an explicit request that is partially against nurses' beliefs. Johnstone (2009) identifies this situation as 'partial radical moral disagreement', defining it as the situation in which dissenting parties might agree on some relevant criteria but not all. However as asserted by Aristotle, ethics is not a precise science, and the choice of the right virtue and its right amount is determined by *phronesis* (Ross & Brown 2009). The continuous exercise of a virtue, followed by reflection, allows the individual to find the right mean. However as pointed out by Foot (2002) *phronēsis* implies two main things: "the wise man knows the means to certain good ends; and secondly he knows how much particular ends are worth" (p.5). Foot asserts that *phronēsis* is a virtue and thus as pointed out by Aristotle: "we are adapted by nature to receive them [virtues], and are made perfect by habit" (Ross & Brown, 2009, p. 23). Somehow there must be the will of receiving, recognising, choosing and exercising *phronēsis* in order to make a habit out of it. This paper suggests that *phronēsis* can only be learned and not taught. However, recognising moral resilience as a virtue while considering its vices and while aiming at achieving nursing goods, that is, to alleviate patient's pain and suffering, to maintain patients' dignity, to promote recovery, to enhance quality of life and offer comfort (Armstrong, 2007; Benner, 1997; Edwards, 2001; Gastmans et al., 1998; Sellman, 2011), means nurses are brought to the exercise of *phronēsis* in a natural way. Finally, *phronēsis* can indicate to nurses the limit beyond which they risk to lose their moral integrity, harming themselves.

CONCLUSIONS

In this paper we argue that understanding moral resilience as a virtue can represent an innovative and, more importantly, a guide for nurses during their daily moral practice. We suggested that within nursing

practice the virtue of moral resilience is the character trait, which allows them to remain open for compromises with themselves and with the given situation without compromising their moral integrity. Excesses and defects of virtues are represented by vices, and in case of moral resilience its excess is represented by rigidity and its defect by faintheartedness. The mean between these two vices is chosen according to *phronēsis*. Indeed *phronēsis* indicates, on the one hand, the mean in order to achieve the good ends of nursing and on the other hand it prevents nurses from harming themselves accepting compromises, which can potentially compromise their moral integrity. What follows from this in terms of professional education and research is that educators should invite nurses to foster their self-knowledge about their own moral values and moral limits while reflecting on their practice experience. Research should focus on finding new and innovative ethics interventions for supporting nurses in doing so while considering the cultural context of nurse's practice.

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