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Moral distress: What can be done?

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Introduction

There is a persistent and growing need to educate and retain nurses who are prepared to competently address patient care needs within complex health care systems. Though recruitment efforts are strong, workforce attrition remains problematic. Approximately 17.5% of newly Registered Nurses (RN) leaves the profession within the first year of practice [1]. Moral distress, and its deleterious effects, contributes to workforce attrition [2,3]. Moral distress, or feeling constrained from acting upon one's ethical knowing, is associated with powerlessness, compassion fatigue, apathy, and burnout [4,5]. One may recover from adversity and attenuate moral distress, via personal, social and professional capabilities associated with resilience.

Resilience Protective Factors (RPFs) enable effective adaptation and coping amidst distress [6-9]. Per Monteverde, resilience is associated with the capacity to identify ethical issues, justify moral actions, and effectively cope with adversities inherent in health care practice [10]. Concerns about nurse workforce attrition and moral distress should motivate nurse leaders to develop and evaluate educational strategies that strengthen RPFs, preparing the future nursing workforce to thrive amidst ethical challenges. Through educational interventions, it may be possible to equip nurses with capabilities that reduce the deleterious consequences of moral distress.

In this review article, we will first explore literature that clarifies the prevalence of moral distress across healthcare settings and research on RPFs. Second, we synthesize Organizational Communication literature in order to establish why distress is a difficult organizational and professional issue. In reviewing literature across disciplines, we provide a rich understanding of moral distress as a difficult nursing issue and what organizational factors lend to a lack of empowerment. By understanding the factors that lend to distress, the review also establishes the exigencies that call for a new model that promotes a nurse's capacity to effectively navigate contextual ethical issues within complex health care workplace cultures. Thus, in the third and final portion of the manuscript, we propose and develop a new model, the Nelson-Marsh F.A.C.E heuristic model to enhance resilience and reduce moral distress. Each letter of the acronym represents a step in the process. We explicate each part of the model and offer the Nelson-Marsh Conflict-Risk Assessment Modes and communication strategies for each risk assessment scenario in order to provide nursing educators and post-licensure practicing nurses with effective communication and conflict management strategies. We argue that the Nelson-Marsh F.A.C.E. model and corresponding Nelson-Marsh Conflict-Risk Modes developed in this article will strengthen RPFs and empower one's ability to act on moral convictions during distressing situations.

Moral distress and resilience

A literature search of both nursing and allied health databases was conducted using the following key words: moral distress, nurse, retention, attrition, resilience, moral resilience and resilience education. The search returned empirical evidence that quantified and described moral distress and causative factors among student nurses and post-licensure nurses. This evidence base also included studies evaluating resilience education strategies and the effect of such education on resilience; however, these were less prevalent.

Moral distress, associated with nursing practice, often develops during pre-licensure nursing education. Two quantitative studies reported mild to moderate levels of moral distress among baccalaureate nursing students [11,12]. Several research studies reported clinical situations contributing to moral distress. Clinical situations included witnessing compromised best practices, patient confidentiality violations, disrespect toward patients and coworkers, and inadequate resources deemed necessary to alleviate human suffering [13-16]. The aforementioned morally distressing situations were ubiquitous across workplace settings, including primary care clinics, hospitals, community health centers, and home-health care. Researchers recommended nurse leaders implement educational strategies, which enhance nurses' abilities to proactively cope with adversities inherently associated with ethical issues, minimizing the effects of moral distress.

Resilience and Nurse Education

Resilience factors have been well identified [5,8,9,17]. Resilience protective factors include social support, experience, self-efficacy, cumulative successes, conflict management strategies, problem solving capacities, rehabilitating negative experiences into positive emotions, and empowerment [8,9,18,19]. While evidence exists about RPFs, limited investigations have been conducted. The studies that have been conducted approach resilience from two different positions. First, two studies focus upon the relationship between resilience and moral distress. Second, two additional studies focus upon interventions promoting resilience among student nurses and post-licensure nurses.

Research reporting relationships between resilience and moral distress are limited and only two studies were found. A pilot study of student nurses identified significant inverse relationships between social support and moral distress ($r = -.27$, $p < .05$), and between goal efficacy and moral distress ($r = -.37$, $p < .01$) [20]. The authors recommended prioritizing educational interventions that strengthen social-interpersonal protective factors such as peer support, faculty mentoring, teamwork, interpersonal communication, initiating conversations, and speaking up within hierarchies.

The second study examined resilience and distress among medical students. Studies using resilience workshops and cognitive behavioral interventions (problem solving, reflection, mindfulness, relaxation techniques, values clarification, self-awareness, and effective communication strategies) produced the strongest evidence for increasing medical student resilience. Specifically, studies utilizing the Pennsylvania Resilience Training program resulted in statistically

significant higher resilience scores ($P < .05$) [21,22]. Each study recommended strengthening communication strategies.

Two interventional studies measured the effect of resilience strategies on enhancing nurse resilience. The first study implemented simulation experiences designed to identify and build resilience through conflict resolution skills and psychological empowerment [18]. No significant post-intervention resilience changes were identified. The second study used social media messages to increase protective factors by encouraging reflection, discussion, and social support among nursing students. Initially, Stephens reported a post-intervention increase in resilience levels, but one month post-intervention, resilience levels returned to baseline [19].

A qualitative study evaluated the effect of resilience workshops among post-licensure nurses. McDonald et al., [23] implemented six resilience workshops that occurred over a six-month period. Topics included self-confidence, self-awareness, and self-care, assertive communication, establishing positive and nurturing relationships, developing a positive outlook, and exploring spirituality. Qualitative findings indicated participants experienced enhanced self-care, increased awareness of health maintenance strategies, social benefits associated with a supportive network, and they learned strategies for coping with workplace incivility.

Collectively, these aforementioned empirical studies suggest resilience may be enhanced via effective integration of communication strategies, building social support capacities and nurturing relationships within workplace settings. Specifically, pre- and post-licensure nurses may experience enhanced resilience by developing and implementing conflict resolution skills to help navigate ethical dilemmas and support collegial relationships in the workplace. Additionally, the literature indicates that resilience capacities develop over time. As such, pre- and post-licensure nurses should benefit from educational interventions that guide assessment of the contextual workplace dilemma, guide communication choices based on assessment, and facilitate evaluation of outcomes.

Moral distress and resilience education recommendations

Although rigorous empirical evidence is lacking, the literature suggests that resilience helps individuals mitigate moral distress and burnout [24]. Moreover, Rushton et al., [24] reported that enhanced resilience is associated with reduced stress, enhanced spiritual well-being, and personal accomplishment. Resilience education interventions may assist nurses to develop personal, social and professional attributes that promote effective adaptation and coping strategies. Such interventions may help nurses successfully navigate both existing moral distress and future adversity [5,8-10,25,26].

Per the literature, resilience-enhancing educational interventions include a combination of the following: a) mindfulness strategies, b) communication techniques, c) spiritual well-being and cultivating hope, d) knowledge of ethical decision-making frameworks, e) nurturing moral sensitivity, and f) opportunities to rehearse and experience cumulative successes managing challenging ethical situations [27,28]. Noteworthy here is the understanding that multiple education strategies are necessary to facilitate and enhance RPFs. For example, moral sensitivity is necessary, helping the nurse identify that an ethical dilemma exists. Concurrently, navigating contextual dilemmas embedded within complex health care environments requires effective communication techniques and integration of ethical decision-making frameworks.

In addition to explicit resilience education, the literature also recommends continuing education topics on ethics, leadership, and communication concepts to address reported workplace constraints inhibiting ethical action. For example, both students and post-licensure nurses reported the following: a) feeling subordinate within health care team hierarchies, b) lacking confidence in their ability to effectively communicate amidst power in health care environments, c) fearing retribution and reprimand if they speak up about questionable health care practices, and d) avoiding conflict so as to preserve relationships with co-workers and mentors [29]. These reported constraints highlight the contextual and cultural nuances of nursing practice and health care environments. Nurses have a professional responsibility to advocate for patients, safe work environments, and professional practice standards. This responsibility, at times, conflicts with organizational workplace structures and cultural norms, which influence who should speak, whose voice is powerful and justified, and who has ultimate decision-making authority. Additionally, structures and norms influence interpersonal communication patterns designed to preserve relationships.

Communication strategies - A mindfulness model

The studies on moral distress and resilience described above, while few in number, come to a common conclusion: there is a need to educate and train resilience capacities that aid nurses in initiating difficult conflict conversations. These studies also highlight that the relationship between moral distress and resilience involves individual, social, and organizational factors. In other words, resilient nurses will cognitively recognize the ethical problem, the patient needs, as well as the social and organizational environmental factors as part of the context. Resilient nurses will also have the capacity to speak up and advocate for the patient. Yet, nurses do not initiate conversation even when distressed because of the power and influence of social and organizational factors. The feelings of subordination and insecurity experienced by student nurses loom large as an ongoing and persistent issue in the health care industry [30]. The consequences for not speaking up when experiencing an ethical dilemma can have deadly outcomes. Thus, we propose that the research above makes clear that there is an urgent need for a model that promotes congruence between advocating for ethical patient care during distressing moments while also empowering nurses with strategies that preserve professional relationships with peers and superiors.

In order to understand how to cope with ethical dilemmas and mitigate moral distress, we draw upon research from the field of Organizational Communication. We focus on moral distress as it relates to fear of reprisal in a professional setting. Fear of reprisal can be broken down further into three dimensions: 1) fear of power and influence of another, 2) fear of potential relational harm after offending a superior, coworker, or subordinate, and 3) fear of engaging in conflict. In the remainder of this article, we unpack these three dimensions of fear and present an author-developed model to represent and guide communication practices that nurses may utilize as they mitigate substandard medical practices and preserve professional relationships.

Decoupling power and position

Fear of reprisal offers an important clue about moral distress because it points to the culture of an organization. Organizational systems and their cultures both promote and suppress ethical practices [31]. In other words, while an organization may formalize systematic protocol standards to promote ethical practices, an organizational culture may suppress the ability to ethically follow those standards. In order to understand how this is possible, we first differentiate between hierarchical authority and organizational culture power.

An organization develops a hierarchy in order to delineate the tasks and authority tied to different roles. Hierarchy is particularly important in organizations that deal with risk and crisis because it clarifies who has

the expertise and authority to make critical decisions and who supports and executes these decisions. From the military to an emergency room, establishing and maintaining a chain of command minimizes the need to negotiate that is responsible for certain tasks, who has the authority to make decisions, and who reports to whom. In the health care industry, the codification of authority and standard protocols enable care to be administered efficiently, effectively, and safely. In essence, the systematization of role arrangements in health care provides the context for understanding what to do in times of crises [32]. Power, however, is different than authority and not necessarily tied to position in the hierarchy.

When considered a cultural aspect of organization rather than a component of an organization's structure, power becomes the influence "A has over B to the extent that he [or she] can get B to do something that B would not otherwise do" (p. 202) [33]. One interpretation of this definition focuses upon the observable outcomes of power such as a directive. For example, a physician exhibits power as influence over a team of nurses when the physician asks the nursing team to withhold reporting an error and the nurses collectively comply, despite knowing the ethical obligation with document and report the error. The fear of potential retribution the nurses feel, in this specific scenario, is tied to the physician's capacity to use position and role to influence the nursing teams' behavior.

However, a second interpretation of Dahl's [33] definition of power highlights the cultural influence and political nature of power in organizations. For example, if a nursing peer asks a team of nurses to withhold reporting a medical error and the nursing team does not report, power is decoupled from authority and related only to the cultural power created and sustained by organizational members. In this second interpretation, cultural power involves the ability to influence others' actions to promote self-interest. While not a directive from a superior, subversive cultural power is in play when nurse colleagues fear speaking up and remain quiet, despite the ethical obligation to do otherwise,

Power, as a cultural phenomenon, is a means of preserving the self-interest and values of some at the expense of others, such as patients. By decoupling power from authority we can note that power is not a possession, nor is it tied to position. Cultural power is a subjective understanding of who has influence and is not related to protocol. Power then, is assigned and attributed to another while interacting with others in the moment. In other words, power is yielded to another. Thus, power doesn't exist with a person as an inherent possession. Nor is power inherently tied to a position, rather, "power is exercised through a dynamic process in which relationships of interdependence exist between actors in organizational settings" (p. 159) [34]. In this definition, nurses yield power to others while dynamically interacting during ethical dilemmas. However, yielding or attributing power is a choice. Nurses can choose not to yield or attribute power to another.

People choose to attribute power to another in dynamic interaction through communication. For example, when nurse A rolls their eyes at nurse B, this nonverbal act communicates disdain. When nurse B chooses to remain quiet, this communicates to nurse A, the acceptance of the disdain and the power to influence. In this micro-interaction, power is expressed and exercised between people. Communication, as we describe it, is more than information transfer, but is a transaction of cultural meanings inferred by different nonverbal and verbal cues. As stated by Javonovic and Wood [35], "communication action itself is an ethical (or unethical) doing, infused in an ethical (or unethical) culture" (p. 389). In other words, communication—as cultural transaction—is "complicit in the enabling and constraining of organizational ethics" (p. 154) [36].

While power tied to hierarchy and communicated as a directive is much more easily addressed, power covertly suggested is more difficult to recognize and alter. Covert influence, or horizontal violence, can emerge in several nonverbal communication acts such as eye movements and body posture [37]. Verbal messages that draw attention to what not to do can also be subtle. However, through professional enculturation, health care professionals learn the subversive cultural cues that discipline them into acting in the interests of the person assumed to be in power.

Due to the subtly of power influence, fear of reprisal, and the need for cultural understanding, we present the Nelson-Marsh F.A.C.E model (Figure 1) as a guide supporting effective communication and, thus, attenuating moral distress. This author-developed model visually represents interconnections between feelings associated with conflict, assessment of cultural power dynamics, integration of communication knowledge, and evaluation of the dynamic situation. The model serves as a guide, facilitating understanding of the situation and aiding decision-making. Real-world health care communication processes are too complex to fully comprehend, and yet, nurses may benefit from the F.A.C.E. model, which contains primary features of importance. The intent of the model is to guide communication processes, empowering nurses to communicate confidently amidst challenging situations while also ensuring quality patient outcomes and preserving professional decorum. Understanding the interplay between conflict, fear, self-preservation, and preserving collegial relationships provides necessary insights about the development of the Nelson-Marsh F.A.C.E. model.

Face, face work and fear

The fear of speaking up during distressing ethical dilemmas is documented. There are several reasons a nurse might have for not speaking up in ethically charged situations. We focus on two dominant reasons for remaining silent in the face of distress: 1) fear of preserving our own and others' reputation and 2) fear of conflict. We explore the theory behind these fears and follow this section with our proposed model.

We are not just organizational beings, but social beings. Restraining oneself from acting ethically is not indicative of the moral failure of a person. Rather, it highlights the power of relationships in an organization. As Erving Goffman [38] theorized, everyday interaction is always constrained by what he termed face. Face is a metaphor for the presentation of self that we desire others to see, value, and accept. Goffman argued that face is an unstable resource in interaction because it always has the potential to be threatened or esteemed. In other words, when a nurse interacts in a health care organization, they act not only rationally to administer care based on best-practice standards, but also socially to maintain the self-image they aim to preserve in the organization. This preservation of face relates to both a position in the organization and a position in the culture.

Face is a particularly important theoretical concept when considering conflict situations. Conflict situations bring the instability of face to the surface. Face thus, is a "vulnerable identity-based resource because it can be enhanced or threatened in any uncertain social situation" (p. 187) [39]. Fear of speaking up in the workplace emerges from the risk involved in the possibility of tarnishing one's face and reducing one's worth as a co-worker in the eyes of colleagues.

Furthermore, fear of challenging a co-worker also invokes face in that there is a fear of offending a co-worker's face. Offending a co-worker's face could result in a tense workplace environment and in-turn diminishes one's own face, which risks the desire to be liked and respected in the organization's culture [40]. Researchers argue that humans socially create expectations to protect and aid other's face and

note that "to fail to aid another in protecting and saving face is to bring harm to another's identity, the relationship, and to risk retribution" (p. 155) [36]. Within the context of ethically challenging health care situations, nurses feel constrained and conflicted by the desire to protect their own organizational and cultural face. Compounding the internal conflict is the expectation to protect their co-workers face identities within the organizational and cultural norms.

In a professional health care setting the work to preserve one's own or another's face, is referred to as "facework." Facework involves any communication behaviors that people enact to protect their own face. Facework also involves the communication actions that attempt to support, counter, or repair the effects of any face threatening actions that might challenge the social standing of the other person [38,39].

Facework communication strategies become incredibly important, but difficult to enact when in conflict situations because people often fear conflict. Most people assume they should avoid conflict with persons who have organizational authority or cultural power because such conflict threatens the face of the other and will erode workplace relationships. Thus, conflict is a particularly vulnerable moment for nurses because conflict involves protocol issues, cultural power issues, and face issues. Conflict is not a thing, however, it is a process that is defined as "the interaction of interdependent people who perceive opposition of goals, aims, and values, and who see the other party as potentially interfering with the realization of those goals" (p. 552) [41]. In this definition, conflict emerges in interaction with participants who rely on each other to complete a task and to support the public identity of the other. Face influences how a conflict unfolds because each participant in the conflict considers how to protect their own self-interest, engage the authority, andenact facework strategies that either honor or challenge the face of the other [39].

It is not uncommon for people to assume that in conflict, participants must choose whose interests and whose face will win. However, because conflict is a process nurses have the capability to choose from several communication approaches that can accommodate multiple interests and preserve the face of all parties involved. It is also important to note that in situations where one finds they have challenged the face identity of another, that facework offers the ability to counter, to mend, or to mitigate the effect of face threatening actions, and is often performed through linguistic adjustments [42-44]. In situations where one challenges the face of another, restorative or repair facework strategies may be enacted.

Restorative facework strategies include any actions that "repair damaged or lost face occurring in response to events that have already transpired. It reflects actions designed to re-establish or reassert one's capability and strength after one feels they have been damaged" (p. 281) [45]. Restorative facework strategies may be implemented in ways that repair face, offering an opportunity for nurses to mitigate face threats to their professional identities within the workplace culture. Restorative interactions are particularly important subsequent to assertive conflict communication situations that require such communication approaches to protect patient safety.

Understanding facework strategies as clusters of communication activities that support and restore professional and social standing accentuates the idea that conflict interaction is dynamic and offers opportunities to speak up to advocate for patients and preserve positive social and professional relationships in the workplace. How to engage in such conflict interaction is a choice.

Facework choices and conflict

When re-thinking how nurses might engage in facework communication within the context of encountering an ethical dilemma, it is important to note that conflict can be latent or manifest [46]. Latent conflict is the possibility for conflict and awareness that conflict is possible due to a perception of incompatible goals or values. Conversely, manifest conflict is visible and public. Finally, conflict is thought to be resolved when issues have been addressed to the satisfaction of the interdependent parties. Highlighting the difference between latent and manifest conflict aids in empowering nurses because it offers an opportunity to teach awareness of timing; i.e., when and how to engage facework communication strategies to mitigate substandard health care practices, promote moral action, and reduce moral distress.

Knowing that conflict can be latent aids nurses by heightening awareness about issues that need to be addressed. This awareness comes in the form of an emotional response to the actions of another [47]. This awareness of emotion acts as a cue, helping nurses identify when there is a need to speak up and advocate for a patient. Emotion emerges when expectations and feelings are challenged during an actual experience. In a conflict situation, the more intense the emotion, the more important the goal that is not being met or the more intense the face threat. In other words, when someone expects to achieve a particular outcome or expects another to have the same ethical values and these expectations are not met, not only will they experience conflict, but also some degree of emotion associated with that conflict [47]. The more intense the emotion associated with the challenging expectations, the more challenging the conflict is to resolve. The less intense the emotion, the easier the conflict is to resolve.

Becoming mindful of one's emotional response provides an in-the-moment cue that one has a choice to yield power or not, a choice to threaten one's personal face and support another, or the choice to challenge another's face. In other words, emotions offer an opportunity to engage in facework communication strategies and address the conflict. How one responds or orients to conflict is not an inherent trait, but instead is a habit that may be cultivated [48]. Understanding that there are several communication strategies for approaching conflict presents an opportunity to educate nurses on different conflict approaches to address conflict and navigate face issues.

Empowering nurses and attenuating moral distress requires tools that draw awareness to self-agency and ability to influence, even subtly, how a situation unfolds. Specifically, communication models, conflict scripts and self-awareness create opportunities for nurses to speak-up without fear of compromising professional ethical obligations, hindering position in the hierarchy, or creating tension with peers. Learning how to frame conflict and enact facework differs from situation to situation.

We propose the Nelson-Marsh F.A.C.E. heuristic model (Figure 1) that accounts for the variability of the ethical dilemmas nurses might encounter. This model also respects the cultural knowledge and power dynamics in health care workplaces. Thus, the model does not prescribe a specific instrument for approaching conflict, but describes how to become mindful of conflict interaction processes, aiding nurses to identify when and how to enact facework conflict strategies.

The Nelson-Marsh F.A.C.E. model is a process model and each letter in the acronym signifies a step in the process. While the first step, "F," focuses upon how to become mindful and identify the ethical dilemma, the remaining letters involve different actions for adapting and coping with the ethical dilemma using communication strategies. Therefore, in addition to the F.A.C.E. model, we offer and explain the Nelson-Marsh Conflict-Risk Assessment Modes model (Figure 2). This model extends the F.A.C.E. model and includes different approaches for conflict communication that recognize nursing practice situations when the crisis level of the ethical dilemma is high versus lower risk situations. Finally, we present conflict examples (Table

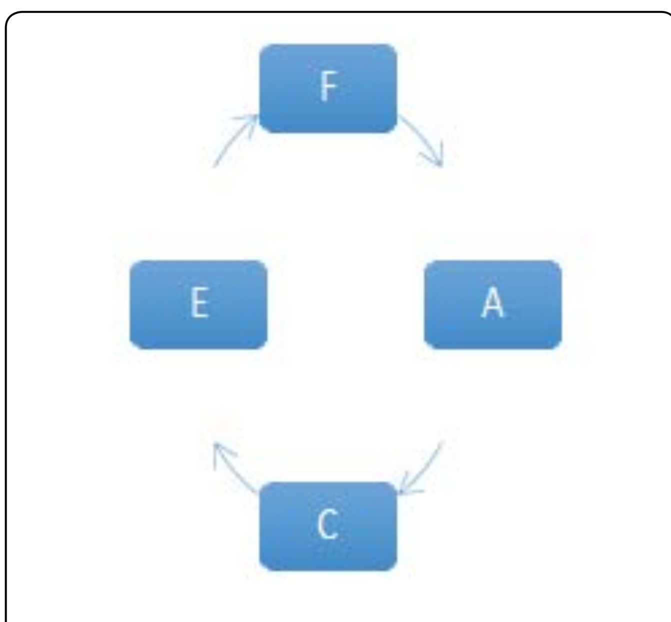

Figure 1: Nelson-Marsh F.A.C.E model. F represents identifying key feelings, A represents assessment of the situation, C represents communicate choices and E represents evaluation.

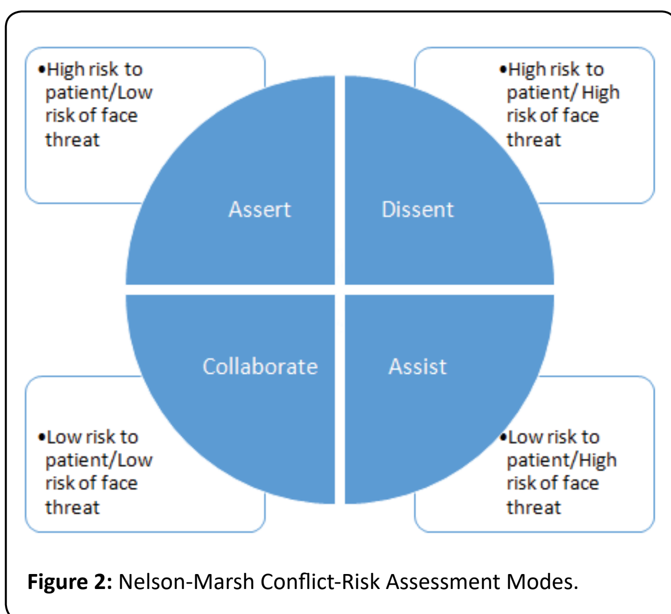

Figure 2: Nelson-Marsh Conflict-Risk Assessment Modes.

1), demonstrating application of both the F.A.C.E model and the Conflict-Risk Assessment Modes model. Table 1 offers restorative and repair facework strategies for situations that require the use of face-threatening conflict modes in situations when a nurse must confront conflict to protect patient health and well-being.

A heuristic model: Facework competence and moral agency

The Nelson-Marsh F.A.C.E. model presented in Figure 1 is a process model that was developed specifically with moral distress and health care cultures in mind. The model presents four essential areas to guide effective communication and ethical action during moments that are morally distressing. Each letter in the acronym of the model serves as a prompt for nurses. The model assists nurses to attenuate distress when experiencing both high-risk and lower-risk decisions. This process model considers how conflict unfolds and offers steps for becoming mindful while also acting during different phases of conflict develop.

The model provides guidance for conflict and facework communication for nurses encountering morally distressing situations within health care environments. The visual appearance purposefully guides nurses through a continuous and iterative cycle of mindful communication. The cycle begins with **F**eelings, progressing to **A**ssessment, then **C**ommunication and next, **E**valuation. The first cue that one is encountering a distressing situation is feelings. "F" prompts nurses to identify and name what they feel emotionally and physically as they encounter a conflict moment. This mindfulness strategy also aids in identifying the degree and severity of the distress. People physically experience emotions, particularly during conflict. For example, common physical manifestations include a flushed face or a shaky voice. Such physical cues prompt one to become mindful of feelings and to consider next best steps. This critical first step asks nurses to notice their feelings and develop conscious awareness of the moment. We suggest three brief questions to aid in identifying emotions nurses' experience: What am I feeling? How is this feeling manifesting physically? How intense is this feeling? This last question aids in considering how severe and high risk the situation might be.

The "A" in F.A.C.E. stands for assess. Assessment directs the nurse's gaze outward toward the environment and asks nurses to "read" the situation. Three guiding questions are helpful here: What is happening here? Who is involved? What cultural power and hierarchical authority do I assign to the people in the room?" During this phase, nurses develop a well-rounded picture of the scene, influencing subsequent choices about how to act and engage in conflict in order to advocate for the patient and mitigate distressing situations.

After identifying feelings and assessing the situation, nurses make choices about how to best communicate. We use "C" here because there is more than one person acting in a conflict situation and how one communicates during conflict situations is interpreted by another on two levels. Actions may be interpreted factually and provide information about how to do the job in the moment. But actions are also interpreted symbolically as nurses infer meanings about their relationships in the culture. For example, if a nurse decides to challenge questionable health care practices with a peer who has more power in the culture, this communicates both a change to protocol (factual information) and infers a challenge to the cultural power structure (symbolic meaning). Thus, "C" highlights that how one communicates in conflict is a choice. Below, we develop several suggestions for different conflict communication strategies that respond to the risk of the situation for the patient while also taking into account the authority and power hierarchies within the health care setting.

Finally, the "E" of the F.A.C.E. process model recognizes the need to evaluate. Conflict does not necessarily resolve at the end of an encounter. By assessing the situation nurses read the face needs of the various identities in the room by attending to the authority and power dynamics with those present in the room. In addition, consciously noting the intensity of one's feelings serves as an indicator for the level of risk to the patient and the risk to one's face and position in the organization. Becoming mindful of feelings and the environment then informs the decisions nurses make about how to communicate within the context of the specific situation. Yet, following the conflict encounter, nurses need to evaluate how the conflict unfolded and consider any follow-up communication that might be necessary. For example, if substandard practice presented a high risk for the patient and a high risk for challenging a colleague's face, the conflict communication in the moment might have been more assertive. Upon evaluation, a nurse may decide that repair facework

Table 1: Nelson-Marsh Conflict Mode Frames and Repair Facework Examples.

Risk Assessment	Communication Mode	Mode Frame Example	Evaluation	Repair Frame Example
High Risk to Patient Low Risk of Face Threat	**Assert**: Statements of fact with no hedging or mincing of words. Taking a position frames.	"The dosage is off; we need to re-do the math."	Competes for power and authority. Interpreted as forceful. Often requires repair.	Smoothing or accommodating Frames. Apologies, Humor, Self-Deprecation. Restores power dynamic and hierarchical order. Ex: "I'm sorry I was short with you back there. I was so stressed we would miss-dose her, thank you for hanging in with me while I stressed out."
Low Risk to Patient Low Risk of Face Threat	**Collaborate**: Inquiry and brainstorming frames.	"Would you mind taking a look at this with me?	The anticipated problem-solving frame takes time. This frame is interpreted as equality in power differential and integrates multiple perspectives to solve the problem.	Acknowledgement of expertise and appreciation Frames. Ex: "That took some time, but I learned a new method from you." Ex: "That was really helpful. Thanks."
High Risk to Patient High Risk for Face Threat	**Dissent:** Gracious and challenge Frame. Request Frame.	"I'm worried we are miss-dosing her. Would you re-calculate with me?	Interpreted as a challenge to face (either to another's authority/ power) Takes back some power and attributes some power.	Articulating understanding Frame. Recognition Frame. Ex: "You were really worried about her recovery." Ex: "That was a great method for calculating dosage."
Low Risk to Patient/ High Risk for Face Threat	**Assist:** Hedging Frames and Neutralizing Frames.	"I may be wrong, but I think the dosage is off. Would you check my math?" "I agree; this is a tough one. What do you think we should do?"	Interpreted as subordination. Can be interpreted as vulnerability and weakness. Softens the dissent and confrontation. Reinforces the power dynamic and hierarchical order.	Repair frames are embedded in the assist frames. Appreciation Frames when needed. Ex: "Thank you for taking the time to help me with my math."

communication strategies might be necessary to preserve the professional relationship.

The F.A.C.E. model presents a heuristic tool for nurse educators and post-licensure continuing education professionals to teach nurses how to interpret the variety of potential conflicts situations they encounter and communicate in ways that positively influence outcomes for patients while also preserving professional relationships. The Nelson-Marsh F.A.C.E. Model offers a process perspective at a meta-level in order to develop mindfulness and awareness of what is occurring in a situation. Each letter in the acronym offers a prompt to punctuate different moments in distressing situations and to guide a nurse through the process. Facework communication strategies, however, can be difficult to enact during distressing moments. Therefore, in order to clarify the "C" in the F.A.C.E. model, we recommend several different approaches and a variety of possible communication modes that may be utilized based upon the nurses' interpretation of possible risks associated with conflict situations.

Conflict communication modes

While understanding that power emerges in interaction and how to mindfully assess the situation supports the possibility of moral agency and advocacy, it does not alleviate the fear of actually speaking up. Indeed, most people avoid conflict with someone who has authority or power. However, conflict does not inherently mean destruction or erosion of a workplace relationship. In fact, conflict can be constructive. Conflict can be healthy, depending upon how the conflict communication occurs.

As previously discussed, conflict is not a thing, but an interactive process. How one chooses to interact influences how the conflict will unfold. There are several models that explore how to approach conflict [49-51]. The five most commonly discussed orientations for engaging in conflict communication include: avoiding, accommodating, competing, compromising, and collaborating. Each orientation could be appropriate based upon the context of the conflict situation and participant interpretation of the conflict. For example, collaboration is a conflict approach that requires more time to creatively negotiate task completion while also meeting the needs, values, and interests of all parties involved [52]. While the existing conflict models are a helpful start, we present the Nelson-Marsh Conflict-Risk Assessment Modes model (Figure 2).This author-developed model clarifies communication choices for nurses and accounts for the high-risk situations nurses navigate. The model

offers four conflict-risk assessment modes that nurses may use to guide and discern communication choices.

The model in Figure 2 comes into play when a nurse feels an emotional trigger, begins assessing the situation, and needs to make a **c**ommunication choice. The model visually illustrates the assessment of risk to the patient and the potential risk to the professional face of the other people present if the nurse speaks up and advocates for a change in healthcare procedures. The four boxes in each corner represent the degree of risk (high or low) for both patient and the degree of risk (high or low) of threatening the face of the colleague(s) present. These boxes sit visually recessed beneath the conflict communication mode choices (assert, dissent, collaborate and assist) because the assessment of risk motivates which mode may be implemented in the moment. Conflict communication mode definitions are presented in Table 1.

The assert conflict mode would be appropriate when a nurse **f**eels an intense emotion and **a**ssesses the situation as high risk to the patient while simultaneously assessing a low face-threatening risk. The dissent communication mode approach would be useful in a context where there is high risk to the patient and high face-threatening risk because dissent promotes both effective patient advocacy and preservation of professional reputation for involved persons. In situations that present low risk to the patient and low risk to face threats, a collaborative communication mode is appropriate. Finally, when the situation presents low risk for the patient, but a high face-threatening risk, an assist mode enables nurses to speak up and preserve the professional relationship. In all cases, the model aids nurses by providing a means for assessing the risk to patients and professional relationships as part of the morally distressing context. The communication modes may also be utilized in a manner that is medically, hierarchically, and culturally appropriate. The Nelson-Marsh Conflict-Risk Assessment Modes correspond to the "C" in F.A.C.E. and offers different modes a nurse may employ in order to navigate a morally distressing situation.

In Table 1, we have completed the heuristic model with possible communication frames that can be implemented during the "C" stage of the F.A.C.E. model; i.e, after becoming mindful of one's emotions and assessing the situation, inclusive of the Conflict-Risk Assessment modes. In addition to describing possible approaches for managing conflict, Table 1 offers evaluation descriptors (the "E" of the F.A.C.E. model) and repair facework narratives as needed based upon evaluation of the situation. Noteworthy here is the understanding that the repair facework examples are suggestions for conflict approaches, influenced by lived-experiences and anecdotal narratives with nurses. Conflict approaches will vary based upon context and dynamic conflict experiences. The intent was to present useful examples demonstrating purposeful integration of the F.A.C.E model with the Conflict-Risk Assessment Modes model, potential communication choices, and evaluation of the conflict approaches.

Recommendations for nurse educators include incorporating the F.A.C.E. model, the Conflict-Risk Assessment Modes model and the Conflict Approach Frames within the formal curriculum. For example, we recommend strategies that ensure opportunities to intentionally rehearse conflict handling during emotionally charged ethical dilemmas. A comprehensive curricular approach would intentionally incorporate cognitive, psychomotor, and affective domain teaching strategies [53]. Cognitive strategies include educating students about professional codes of ethics, ethical frameworks, facework, and mindful conflict management communication strategies. Affective domain strategies include reflection on practice, discourse which evokes values clarification, challenging automatic assumptions, and developing values congruent with the profession. Psychomotor strategies include rehearsal and refinement of skills, with specific attention to Conflict-Risk Assessment Modes and Conflict Approach Frames. High fidelity simulation also provides opportunities to integrate all domains of learning. Ethical dilemmas should be embedded in simulations, providing multiple opportunities for students to rehearse, refine, and inculcate communication strategies associated with effective conflict management.

Conclusion

Ethical dilemmas within health care environments are contextual and fraught with complexities. Thus, no single process or policy may effectively guide conflict communication approaches. Rather, the Nelson-Marsh F.A.C.E. heuristic privileges nurses' medical and cultural expertise. The corresponding Nelson-Marsh Conflict Assessment Modes and Conflict Approach Frames offer theoretically informed prompts that assist nurses in identifying ethically challenging moments. The models also cultivate knowledge, skills and attitudes that help nurses make informed communication choices, act on their moral convictions, and build resilience capacities. The communication modes and example frames are not an exhaustive list, instead there are several communication frames nurses might employ when they choose to assert dissent, collaborate, or assist. However, the samples of effective communication and conflict management strategies provided in this manuscript offer a starting place for those students and post-licensure nurses who are reticent to speak up. The Nelson-Marsh F.A.C.E. heuristic model ultimately animates congruence between knowing what one should do and acting in ways that make a difference for patients and for the culture of healthcare.

Pre-licensure education, workplace cultures, individual attributes, and assessment of risk in the moment of the ethical dilemmas all contribute to the complexity of distress. These complexities influence what a nurse is feeling, how they assess the situation, and the communication choices they make to address the ethical dilemma. Ultimately, nurses are accountable for promoting health, advocating for vulnerable persons, protecting patient rights and ensuring safety. Habitual integration of the F.A.C.E. model with strategic implementation of the Conflict-Risk Assessment Modes model and Conflict Approach Frames creates opportunities for nurses to attain congruence between ethical knowing and moral action. Such communication habits further strengthen capacities to preserve collegial relationships, strengthen face, while also promoting optimal patient care outcomes. Collectively, appropriate conflict communication strategies provide a pathway toward strengthening resilience and attenuating moral distress.

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