IRJIF: 5.012

North Asian International Research Journal of Pharmaceutical & Medical Sciences

ISSN: 2456-8287 Vol. 5, Issue-1 January -2021

Index Copernicus Value: 55.07 DOI NUMBER: 10.5859/2456-8287.2020.00007.5 Fulfill MCI Criteria Citation Index

A Peer Reviewed Refereed Journal

LIMITING IMPACT OF MORAL DISTRESS IN NURSING

NUSRAT FATIMA, GAZALA & SAIMA AKHTER

Introduction

Moral distress is the state of psychological discomfort and distress that arises when an individual recognises that they have moral responsibility in a given situation, make a moral judgement regarding the best course of action but for a range of reasons are unable to carry out what they perceive to be the correct course of action. In reference to nursing, it specifically refers to the psychological conflict that occurs when a nurse has to take actions that conflict with what they believe is right, for example, due to restrictions in practice policies within institutions (Fitzpatrick and Wallace, 2011). Studies in this area usually use the original definition by Jameton in 1993 "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" (Jameton, 1984). Â Further work by Wilkinson in 1987, who published an account of moral distress (Wilkinson, 1989) refined this definition to relate it directly to "psychological disequilibrium and negative feeling" (Wilkinson, 1987). Â Common causes cited by nurses for not being able to fulfil their moral responsibility include a lack of confidence in the ability of colleagues, negative attitudes of colleagues towards patients and a team decision on care that does not follow the patients expressed wishes, or fear of reprisal resulting from the course of action they feel is best for the patient (Wojtowicz et al., 2014).

For example, a nurse working in post-operative ward might experience a patient dying as the result of refusing a blood transfusion following surgery due to religious beliefs. The nurse's personal judgement may be that the patient should receive the blood transfusion to give them the best chance of surviving the surgery. However, because the patient did not consent, the nurse could not carry out the action they perceived to be correct.Â When the patient died, the nurse may have experienced emotional and psychological distress in the form of guilt and anger that they had not saved a life that may have been possible to save, as well as feelings of helplessness that they could not overrule the patient's wishes (Stanley and Matchett, 2014).

What situations are more likely to cause moral distress?

In 2015, Whitehead et al carried out a large scale questionnaire based study in the USA on moral distress amongst nurses and other healthcare professionals (592 participants, 395 of which were registered nurses). The most common causes of moral distress in nurses included frustration at a lack of patient care due to inadequate continuity (rated 6.4 by nurses on a Likert scale of 0-16), poor communication (5.8) or inadequate staffing levels (5.7). Additionally, nurses reported that giving life supportive therapy when not in a patient's best interest (6.0), or resuscitation only to prolong the process of death (5.8) were also rated highly. This study also showed that physicians and other healthcare professionals also rated these factors highly, but overall their scores were less than

those of nurses. The authors concluded that nurses are more likely to experience moral distress than other healthcare professionals, possibly due to a discrepancy between levels of responsibility for patient welfare and the required autonomy to make the decisions they believe should be made, as well as feelings of accepting treatment protocols from physicians which they feel are incorrect but unable to challenge or overrule.Â Poor team leadership and poor communication was also cited by nurses as a cause of moral distress (Whitehead et al., 2015).Â

Moral distress appears to be more likely amongst nursing staff who are involved in patient care protocols that are considered to be aggressive and futile e.g. prolonged end of life care, or care protocols that the nurse does not consider to be in the patient's best interest. For these reasons, moral distress is thought to be particularly prevalent amongst nurses treating patients in palliative care (Matzo and Sherman, 2009), paediatrics, intensive care (Whitehead et al., 2015; Wilson et al., 2013; Ulrich et al., 2010) and neonatal environments (Wilkinson, 1989). Additionally moral distress is also prevalent amongst psychiatric nurses due to increased feelings of responsibility for vulnerable patients, particularly as these patients are at risk of suffering from ethical mistreatments, e.g. misinformation about drug side effects (Wojtowicz et al., 2014).Â Other studies have also identified that issues with the institution itself can cause moral distress, such as inadequate staffing, depersonalisation of staff, inadequate supply of resources and overloading of work (Dalmolin et al., 2014).

How does it affect nursing staff?

Moral distress can have psychological consequences that affect the nurse's performance and wellbeing.Â For example, it is thought that nurses experiencing moral distress may self-blame or criticise themselves for an unsatisfactory outcome, and may experience emotions of anger, guilt, sadness or powerlessness (Fitzpatrick and Wallace, 2011; Borhani et al., 2014). They may shift blame onto others or exhibit avoidance behaviours such as taking time off for illness. Â Physical manifestations may also include headaches, diarrhoea, sleep disturbance and palpitations, which may well be interpreted as illness and require time off work, further contributing to low staffing levels, which perpetuates a cycle of understaffing = moral distress / illness = time off = understaffing (Fitzpatrick and Wallace, 2011).Â Moral distress is associated with "burnout" (or emotional exhaustion and extreme stress) and with a reduced sense of professional fulfilment (Dalmolin et al., 2014)

Moral distress and staff retention

Because experiencing moral distress has been linked to harm and stress to nurses, as well as a reduction in the quality of patient care, many studies have cited it as a reason for nurses to leave the profession, resulting in a reduction in staffing levels and self-perpetuating cycle of staff shortages (Fitzpatrick and Wallace, 2011; Borhani et al., 2014). Indeed, one study of 102 intensive care nurses in the USA found that as many as 40% had left or had considered leaving a job as the direct result of moral distress (Morgan and Tarbi, 2015),

Together, these issues can significantly compromise the quality of patient care and result in "burnout" of nursing staff, causing more to leave the profession to avoid the feelings of guilt that moral distress can cause, particularly in those specialisms typically associated with moral distress such as oncology or paediatrics.Â Moral distress also contributes to job dissatisfaction, typically as the result of a discrepancy between the experience the nurse is expecting to have at an institution, and the actual experience (Borhani et al., 2014) This is particularly true of student nurses, who are more likely to have higher expectations of the profession they have worked hard to join, and will be more familiar with the policies and values by which organisations "should" be run rather than the

reality, where it is likely that some practices will be sub-optimal or archaic (Wojtowicz et al., 2014; Stanley and Matchett, 2014).

Managing and limiting the impact of moral distress

As previously discussed, moral distress is thought to primarily result from either institutional disorganisation (which can be prevented), or distressing ethical situations such as providing futile life prolonging treatment which are unfortunately inevitable (Whitehead et al., 2015). However, there are ways in which nurses and their management can prepare themselves to deal with these situations effectively, thus reducing the impact of the moral distress (Deady and McCarthy, 2010).Â Â Although it is important for nursing staff to be supported by their management, ultimately the nurse should be responsible for themselves and their own psychological wellbeing in order to prevent burnout from moral distress (Severinsson, 2003).

Several studies have suggested that the best way to reduce the risk of burnout as a result of moral distress is for nurses to share their feelings and seek support from their peers, ideally in an environment where nurses can share their experiences and discuss ethical implications of specific situations. It is also important that nurses understand what moral distress is, and can identify the source of negative feelings. A Psychologically it is thought to be important that nurses acknowledge and identify these feelings so that they may be processed in a less damaging manner (Matzo and Sherman, 2009; Deady and McCarthy, 2010; Em Pijlâ€?Zieber et al., 2008).Â Nurses should also be encouraged to challenge treatment protocols they feel are inappropriate without fear of reprisal (Deady and McCarthy, 2010).Â Some researchers have advocated approaches such as nurses emotionally distancing themselves from distressing situations, or actively striving to desensitise themselves.Â However it is controversial whether or not this actually reduces moral distress, and of course raises questions about patient welfare with some suggesting that it is important that the nurse feels ethically responsible (Whitehead et al., 2015; Severinsson, 2003) and has a degree of emotional involvement in the situation in order to provide best possible care (Bryon et al., 2012; Linnard-Palmer and Kools, 2005; Severinsson, 2003).

The majority of studies in this area recommend that moral distress should be included in the curriculum studied by student nurses, along with practical recommendations regarding measures that can be taken to deal with it as and when it occurs (Wojtowicz et al., 2014; Borhani et al., 2014; Matzo and Sherman, 2009; Stanley and Matchett, 2014; Whitehead et al., 2015), for example in the form of ethical philosophical discussion to facilitate students to explore their individual moral value systems and emotional responses, as well as be more informed regarding the underlying psychological processes involved. Â Therefore nurses may better understand the thought processes involved, and be better equipped to identify unhelpful thinking patterns that may result from moral distress, thus limiting stress and avoiding the development of “burnout” (Stanley and Matchett, 2014; Severinsson, 2003).Â

It has been shown by several studies that moral distress occurs less in institutions and teams where there is a healthy and positive attitude towards ethics and the discussion of the application of ethics (Whitehead et al., 2015).Â Therefore, it is important that institutions encourage the development of an ethically healthy environment at all levels of management (Deady and McCarthy, 2010).Â Â Additionally, many studies highlight that incompetence in colleagues and subsequent errors in patient care is a primary source of moral distress in nursing staff, and as such institutions should ensure that an adequate quality of care monitoring system is in place,

preferably where staff are able to raise concerns without fear of reprisal (Whitehead et al., 2015; Stanley and Matchett, 2014).Â Â Institutions should also strive to reduce factors such as institutional disorganisation, inadequate resource levels and understaffing (Dalmolin et al., 2014). Anonymous reviews have also identified extreme examples of patient mistreatment and poor care, and a lack of empowerment of student nurses in particular to report or challenge unacceptable behaviour in colleagues.Â Universities and institutions should therefore encourage an environment where this is possible (Rees et al., 2015).Â Feelings of powerlessness to contest clinical decisions can also be reduced by encouragingÂ collaborative decision making within teams (Karanikola et al., 2014; Em Pijlâ€?Zieber et al., 2008).

Healthcare institutions should also recognise their responsibilities in reducing moral distress amongst nursing staff in order to support them correctly and also to retain staff and limit absence due to staff sickness.Â For example, an institution could appoint a designated ethics consultant who can offer guidance to nurses, and ensure that staff have access to counselling if required to address any psychological distress.Â The institution could also support the setting up of an ethics discussion forum where staff could discuss troubling situations (Matzo and Sherman, 2009), for example using an online forum which would also provide anonymity to facilitate open discussion.Â It has been recommended that such groups be cross-disciplinary, as this would allow for potentially valuable differing viewpoints to facilitate discussion and potentially offer different solutions or approaches to those traditionally used by a team (Matzo and Sherman, 2009)

Nursing management staff are thought to experience less moral distress than nurses themselves, presumably as the result of the “distance” perceived between themselves and the questionable moral decision (Ganz et al., 2015).Â As a result it may also be beneficial for management staff to receive specific training about moral distress so that they can understand the situation better and provide more effective support to their teams.

Conclusion

Moral distress is a significant factor for nurses leaving the profession. Â Combatting moral distress is important, not only for the welfare of nursing staff but also the patients themselves. Â Healthcare institutions have a responsibility to minimise moral distress as much as possible by improving administrative issues such as staffing levels, team organisation and job satisfaction.Â However nurses still have a responsibility to themselves and their patients to reduce moral distress and thus negate its impact on patient care (as well as their own health and wellbeing) by actively partaking in activities such as ethical discussion groups and peer support networks. Together nurses, healthcare institutions and universities can reduce the impact of moral distress by cultivating an environment where nursing staff can participate in controversial care plan discussions.

References

1. Borhani, F., Abbaszadeh, A., Nakhaee, N. and Roshanzadeh, M. (2014). The relationship between moral distress, professional stress, and intent to stay in the nursing profession. Journal of Medical Ethics and History of Medicine, 7, p.3. [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/25512824 [Accessed: 25 June 2015]
2. Bryon, E., Dierckx de CasterlÃ©, B. and Gastmans, C. (2012). ‘Because we see them naked’ – nurses’ experiences in caring for hospitalized patients with dementia: considering artificial nutrition or hydration

(ANH). Bioethics, 26 (6), p.285â€“295. [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/21320145 [Accessed: 25 June 2015]

3. Dalmolin, G. de L., Lunardi, V. L., Lunardi, G. L., Barlem, E. L. D. and Silveira, R. S. da. (2014). Moral distress and Burnout syndrome: are there relationships between these phenomena in nursing workers? Revista Latino-Americana de Enfermagem, 22 (1), p.35â€“42. [Online]. Available at: http://www.scielo.br/scielo.php [Accessed: 26 June 2015].
4. Deady, R. and McCarthy, J. (2010). A Study of the Situations, Features, and Coping Mechanisms Experienced by Irish Psychiatric Nurses Experiencing Moral Distress: A Study of the Situations, Features, and Coping Mechanisms Experienced by Irish Psychiatric Nurses Experiencing Moral Distress. Perspectives in Psychiatric Care, 46 (3), p.209â€“220. [Online]. Available at: http://doi.wiley.com/10.1111/j.1744-6163.2010.00260.xÂ [Accessed: 26 June 2015].
5. Em Pijlâ€?Zieber, Brad Hagen, Chris Armstrongâ€?Esther, Barry Hall, Lindsay Akins and Michael Stingl. (2008). Moral distress: an emerging problem for nurses in longâ€?term care? Quality in Ageing and Older Adults, 9 (2), p.39â€“48. [Online]. Available at: http://www.emeraldinsight.com/doi/abs/10.1108/14717794200800013Â [Accessed: 26 June 2015].
6. Fitzpatrick, J. J. and Wallace, M. (2011). Encyclopedia of Nursing Research, Third Edition. Springer Publishing Company. [Online]. Available at: https://books.google.co.uk/books?id=jAE_s82NjtAC&dq=nursing+moral+distress&hl=en&sa=X&ei=WMiLVfSZE8Ke7gaO4IGIBg&ved=0CD8Q6AEwBQ [Accessed: 25 June 2015].
7. Ganz, F. D., Wagner, N. and Toren, O. (2015). Nurse middle manager ethical dilemmas and moral distress. Nursing Ethics, 22 (1), p.43â€“51. [Online]. Available at: http://nej.sagepub.com/cgi/doi/10.1177/0969733013515490 [Accessed: 25 June 2015].
8. Jameton, A. (1984). Nursing practice: The ethical issues. 1st ed. Englewood Cliffs. [Accessed: 25 June 2015].