

# Causes and effects of moral distress

Experience, Human Nature



Næss (2005) in his report, *Omsorgens vicar og de kommunale pleie-og omssorgtjeneste* use the term moral burden to describe employees' experience with management not taking them seriously when they claim they cannot take care of more dependent patients without extra staff, or when the care that they give is no longer acceptable or effective. When moral burden in caring as practice gets too heavy, the opportunity to show consideration for the recipient's characteristics disappear (Næss, 2005).

### 3. 2 The causes and effects of moral distress

There are a variety of clinical situations, external and internal causes identified in the literature (Table 2).

#### Clinical situations

Moral distress is most common when a nurse perceives care to be unnecessary specially in a life and death situation, end of life (EOL) situations, and when aggressive treatments are still undertaken despite knowing that these no longer benefit the patient (Gutierrez, 2005; Zuzelo, 2005; Elpern, Covert, Kleinpell, 2005; Rice, Mohamed, Rady, Verheijde, and Pedergast, 2005; Mobley, Verheijde, and Larson, 2007; Hamric and Blackhall, 2007; McClendon, 2007). Working with incompetent health team members is the most frequent encountered situation in the study of Corley (2005), Kälvemarm et al. (2003), Rice et al.(2007) and Zuzelo, (2007). Staffing levels perceived to be unsafe (Austin, 2003; Mrayyan, 2005; Zuzelo, 2007; Pauly, 2009; Corley, 2005; Rice, 2007) are also a common finding in the articles. The role of unsafe staffing is explained by Hamric (2000), Corley (2005) and Austin (2003) in their study. Family wishing to prolong life is one of the

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frequently encountered situations in McCledon et al. (2007) study. One article stated that a failure to advocate for patients can cause MD (Sundin-Huard, \_\_)

### Internal Causes

These are characteristics of a nurse that prevent them from doing the right thing as Wilkinson (1987), identified in his interview of 24 nurses working in the Intensive care unit (ICU). Statements like “ I was always taught to do as written” support the constraint of being socialized to follow orders. Nurses fear the possible consequences if they challenge health care members who are their superiors for it could mean losing their job, transfer, or physician anger. According to Zuzelo (2007), nurses perceive that they are inferior to physicians, making them powerless in clinical situations that they believe are unethical.

### External Causes

Many studies that investigated MD in nurses show that institutional constraints (Wilkinson, 1987), ethical work climate (Pauly, \_\_; Corley, 2005), hospital policies, laws, lawsuits ( ), lack of time and resources (Sporrong, \_\_, Kälve mark, \_\_)and lack of administrative support cause MD.

Table 2. Summary of causes and effects of moral distress

## **Clinical situations**

### **Internal**

### **External**

### **Effects**

\*Prolonging dying by continuing aggressive treatment

\*Nurses' belief system

\*Institutional constraints

Physical- headaches, diarrhea, heart palpitations, stomach troubles

\*Unnecessary treatment

\*Perceived powerlessness

\*Ethical work climate

Emotional-anger, guilt, frustration, sadness, irritability

\*Working with incompetent nurses and physicians

\*Increased moral sensitivity

\*Hospital policies, laws, and lawsuits

Psychological- depression, sleeplessness, nervousness, anguish and anxiety

\*Perceived unsafe staffing levels

\*Fear of losing job

\*Conflict of interest

Others- loss of self-worth, job dissatisfaction, withdrawal from patient, family, and co-workers, moral residue\*, reluctance to go to work, burnout, leaving the profession, interest in ethics

\*Family wishes for continuing life support

\*Being socialized to follow orders

\*Lack of time and resources

\*Unsuccessful advocacy

\*Lack of administrative support

Effects of moral distress

The effects of MD noted in the literature are manifested in the physical and mental health of nurses, job satisfaction, care delivery, and staff turnover. Common physical manifestations (Table 2) of MD in nurses are shown in the study of Wilkinson (1987), Hanna (2005), and Gutierrez (2005). Evidence suggests that nurses experiencing work related moral distress withdraw from family and friends (Gutierrez, 2005).

There is an assumption that MD affects the delivery of patient care; however, review findings showed otherwise. MD may not have any effect in the nurses' provision of care but if they ask to be reassigned to another patient, they withdraw from a morally challenging clinical situation (Gutierrez, 2005; Gunther, 2006; Austin, 2003). There are no data in MD literature on how

nurses experiencing MD are most definitely going to be affected in their provision of care and how they relate to patients.

### 3. 3 Coping with and management of moral distress

An important finding in the review is that nurses who experience MD cope in different ways. Nurses in Gutierrez's (\_\_\_) study find withdrawal a defense mechanism to cope with strong negative emotions. Others sought support from their fellow nurses when they encounter morally distressing situations (Zuzelo, \_\_\_; Corley, 2001). Crying, taking a long walk, being silent, resorting to narcotics are some coping mechanisms identified by (Hanna\_\_\_).

Kälvemark (\_\_\_) explained that individual coping mechanisms are not enough to reduce the effects of MD. Ethics rounds, ethics consultations, education and involvement in ethics committee, and improved communication and collaboration among health workers and families are some suggested management mechanisms to reduce MD in nurses (Elpern, \_\_\_, Gutierrez, \_\_\_; Hamric, \_\_\_; McCledon, \_\_\_; Kälvemark et al. \_\_\_). Only one study on targeted ethics round has been published (Sporrong, 2007).

### 3. 4 Models and Instruments for measuring moral distress

Researchers' attempts to understand moral distress call for a development of instruments to measure its frequency and intensity. Wilkinson (\_\_\_), proposed the first model of moral distress, based on his interviews with staff nurses. It is equated to a nurse encountering a moral situation and making a moral decision as to the right action, adding to the nurses perceiving inability to act on this moral judgment resulting in painful feelings and

psychological disequilibrium (Fig\_\_). Fry and these colleagues developed a model based on their interviews with military nurses. They suggest that moral distress has several contributory factors such as context, patient, and nurse (Fig\_\_). See appendix \_\_\_\_ (Preliminary process model of moral distress). The Moral Distress Scale (MDS) developed by Corley and co-authors attempted to improve nurses' understanding of moral distress and its consequences (Appendix\_\_). It is a 32-item questionnaire where respondents are asked to choose a response using a scale of 1, representing feelings/almost no moral distress, to 7, representing feelings of great moral distress (Corley et al., 2001). In 2006 Sporrang et al. constructed and validated an instrument that could be relevant for use in different health care settings. The questionnaire analyzes two factors: the level of moral distress and tolerance for openness to ethical issues in the workplace. They concluded that the questionnaire's strengths focus on everyday ethical dilemmas and could be used in different health care settings although the instruments need to be further developed and tested. Eizenberg et al. (2009), developed and tested the psychometric properties of a culture-sensitive moral distress questionnaire among nurses employed in a variety of work settings. It is a 15 item questionnaire where the respondents are asked to rate on a 6-point Likert type scale(1= not at all and up to 6= very large extent) the extent to which the described situation caused them to experience moral distress (Appendix\_\_). The questionnaire items describe specific situations nurses must deal with during everyday care of patients and their families. The authors concluded that this instrument exhibits acceptable reliability and validity in the Israeli cultural context which needs

further research to evaluate the measure in other cultural settings (Eizenberg et al, 2009).

Table 3. Instruments to measure MD

## **Author**

## **Name**

## **Description**

Eizenberg, Desivilya and Hirschfeld (2009)

The MD questionnaire for clinical nurses

A culture sensitive instrument, 15 item questionnaire

Corley, Elswick, Gorman and Clor (2001)

The MD scale

32 item questionnaire, based on Jameton's concept of MD

Sporrong, Höglund and Arnetz (2006)

Measures the level of MD and tolerance/openness to moral dilemmas

### 3. 5 Suggested management of moral distress in nursing

Most of the literature's suggested management of MD are focused on how to reduce situations that cause MD including improved and effective methods of communication between physicians and other health professionals, between nurses and families, and between families and patients (Zuzelo, ;



Rice, ; Mobley, ; McClendon, ; Gutierrez, ; Mobley, ); and enhancing a positive ethical work environment (Elpern et al. 2005; Corley et al., 2005; Pauly et al., 2009). Some believe that education workshops and programmes about nursing ethics and how to deal with MD can reduce the impact of MD (Mobley et al., 2007; McClendon, 2007)

IMPLICATIONS/RECOMMENDATIONS from REFERENCES (EXCERPT from articles)

Zuzelo- nurse managers must be adequately prepared to address nurses' concerns to specific ethical dilemmas., nurses should volunteer to participate on ethics committees and seek the education necessary for this role.

Educators should assess the ethical content in undergraduate and graduate nursing curricula to ensure that skills necessary for working within systems to improve ethics related outcomes. Institutions should consider implementing multidisciplinary discussions and round tables specific to ethical dilemmas, legalities and resource allocation, debriefing sessions with physicians, nurses, ethicists and clergy in a non judgmental atmosphere.

Future research is needed to determine the relative influence of moral distress to older and more experienced nurses as a reason to leave medical and surgical bedside nursing. Additional studies are required to identify if effective methods for communication and development of forums for patients and families to ask relevant questions about quality of life when making treatment of futile care in medical and surgical units.

Elpern- Analysis of moral agency in relation to organizational structures is required in order to enhance our understanding of MD in nursing practice

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and the possibilities of improving care. Given the current and future shortages of nursing, MD should be given attention and the development of positive ethical climates as a paramount importance to the evolution of quality work environment and quality patient outcomes.

Corley- administrators must evaluate strategies to enhance the ethical environment and provide possible approach to reducing moral distress so that nurses can provide quality patient care. Further research on how to skill levels compared with high level of expertise.

Rice- Further research is needed to determine the relative influence of moral distress for older and more experienced nurses leave medical and bedside nursing. Studies are required to identify if effective methods for communication and development of forums for patients and families to ask relevant questions about quality of life when making treatment or care decisions can minimize the encounter frequency of futile care in medical and surgical units. Open dialogue

Mobley- educational workshop's and programs on nursing ethics and responsibilities and how to deal with moral distress. Individual or group support for staff to provide alternative guidance for coping with such situations. Setting of realistic goals with individual's values and preferences to avoid situations of futile care.

Gutierrez- improve

McClendon- pts needs express their wishes for end of life with their family and then their families need to accept what they request. There needs to be

improved communications between pts., families, nurses and physicians. Third, nurses need to encourage each other to cope effectively. Implication for practice: support system for critical nurses, education program for new nurses, buddy system. Implication for future research: revising MDS to include some question that may not apply to the hospital interest, more number of participants (her no. of respondents were 9 ICU nurses), a study on relationship of MD to burnout and leaving the profession, a study about coping strategies.

Kalvemark- health care organization must provide better support resources and structure to decrease MD. Primarily need for further education in ethics and a forum for discussing ethically troubling situations experiences in the daily practice of care have been shown. Ethics rounds, with enter disciplinary participation was one suggested strategy that such strategies will hopefully help to identify ethical dilemmas earlier and increase the tolerance and respect for the moral perspectives of other, and thereby will reduce the level as stress experienced.

Mrayyan et al. - have recommendations for practice, research and education. Practices: reducing clinical errors or incidents should be a priority whether it is related to nursing shortage or not. Immediate mandate for clearly written institutional policies about clinical errors. For research: the nursing shortage is reported to cause of clinical errors, causing MD, thus it is important to study this concept or more depth. A qualitative study would help to explore different aspects of the nursing shortage as experienced by nurses themselves. For Education: emphasize the significance of complying

with the Nursing Code of Ethics and Patients Bills of Rights to students.

IMPLICATIONS. Nurses should be engage in changing the system. Clearly written institutional policies about clinical errors should be established and circulated for nurses using various methods. Encourage nurses advocacy for their patients.

Pualy et al. - multiple strategies are needed for enhancing ethical climates in healthy care. Such strategies could be related to improving relationships with peers, managers, hospitals, patient and physicians as part of recruitment and retention strategies there is a particular need to focus on the relationships among MD, ethical climate, recruitment and retention. Both qualitative and quantitative research is needed to understand these phenomena better and to generate evidence of the relationships between them and the decisions to leave nursing. Fruitful areas of future research include studying the relationships between MD, ethical climate and nursing workload.

## Chapter 4

### DISCUSSION

The aim of this systematic literature search is to find the meaning of moral distress, its causes and effects, how to measure its intensity and frequency, how nurses cope with the experience of moral distress and suggested management of moral distress in nursing practice.

Moral distress

The definition of MD in the past two decades has evolved from its traditional form to a more universal term. Jameton's traditional definition focuses moral distress on the nurse as moral agent to perform the act she knows right because of institutional constraints. This definition is supported and further developed by his follower, (Wilkinson). There appears to be several researches based on this definition. However, several authors have discredited this definition as incomplete and needs improvements (Nathaniel; 2006; Hanna2005; Corley; 2001; Jameston, 1993; Wilkinsons, 1987; Kalvemmark, 2004). Nathaniel argues that this concept of MD failed to explain its properties in her work grounded on the theory of moral reckoning in nursing. Nathaniel's theory of moral reckoning challenges nurses to tell their stories, examine conflicts, and participate as partners in moral decision making. She examined thoroughly nurses' struggles with morally troubling situations. It is very interesting to note that MD is not well known and understood, yet it is in nurse's daily practice of nursing. Attributing MD to nurse's experience makes it easy for nurses to cope with its detrimental effects by recognizing it as MD. Meanwhile, Kalvemmark et al (2004), argue that MD occurs due to situations that involve ethical dimensions.

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Nathaniel- her definition of MD conflicts with the definition in the literature where that the nurse must actually participate in moral wrong doing, violating his or her own moral values the stories told by her informants did not fit into the definition of moral distress. She argues that nurses undergo a process of moral reckoning when they face a particularly troubling patient

care situation. It is a three stage process where she deliberately explains each and its properties in her work of grounded theory of moral reckoning in nursing.

Kalvemark et al, (2003) concluded in their study of MD that it is not related to one specific category of health care professional as Jameton and his followers defined it to be. Furthermore, Kalvemark and associates asserted that the study of MD must focus more on the context of ethical dilemmas not on the health care provider and her / his subjective moral convictions as Jameton and his followers did in their study. The result of the study on living with conflict-ethical dilemmas and moral distress in the health care system by Karlvemark, Hoglund, Hansson, westerholm, and Arnetsin 200 leads them to revise the definition of moral distress as traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the health care provider feels she/he is not able to preserved all interest and value at stake.

Wilkinson (1987) Moral distress is defined as psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision.

Hanna (2005) Moral distress in universal terms as an act of aversion that occurs when some harm to an objective good is perceived.

Causes and effects

There are several situations that cause MD. The most frequent encountered situations are futile care, working with incompetent nurses and physicians, inadequate staffing level perceived to be unsafe, lack of resources, wishes of family to continue life saving actions to prolong life, and unsuccessful advocacy. Studies of MD were carried out in high acuity nursing situations such as adult and pediatric intensive care units, and psychiatric nursing. There seems to be lack or no studies on nurses working with the elderly and in nursing homes. These nurses are not excluded from experiencing MD. Although, Zuzelo's(2007) 22% respondents are from long term care, results cannot be generalized to include nurses in this area.

The results revealed that the experience of MD causes both physical and mental discomforts. These discomforts are consistent in the study of Wilkinson (1987-88) McClendon (\_\_\_\_), Elphern (\_\_\_\_), Corly (\_\_\_\_), Hanna (2005), and with this I support the concept of MD as an experience and effect according to Wilkinson. Hanna (2005) refers to this as internal aversion, a disgusting discomfort when there is a perceived harm to an objectively known good. The effects of MD can linger for many years. Nurses are unable to cope well with it will experience dissatisfaction and burnout. On the other hand, the experience of MD could be beneficial. It could facilitate personal and professional growth, and improve nurses' skill and compassionate care. According to Jameton (1984), telling stories of MD is important because they contain the most highly valued notions of good patient care. Giving meaning to nurses' experience of MD as what I understand makes nurses grow mature and with increased moral sensitivity as moral agents. Since MD could

not be eliminated, it should be recognized and resolved in the best possible way.

### Coping and management of moral distress

The literature further revealed that nurses cope differently with MD. Personal coping mechanisms include withdrawal from the situations, avoiding discussion of the topic, taking a long walk, and crying. These forms of coping do not resolve the negative effects of MD. Nurses may be too timid and underlying reasons differ from one individual to another. Thus, Kalvemarm's et al. (\_\_\_) personal coping mechanisms may not be enough. Nurses could prevent the negative consequences of MD by recognizing it, being vigilant to its signs and putting a name to their experiences. A number of suggestions for dealing with MD in literature need to be studied and put in practice. The most common are ethic round, consultation, and education. Kalvemarm and associates refer to this as ethical competence (EC), and their intervention study in Sweden concluded that EC is the key factor preventing or reducing moral distress. It is imperative their nurses must be able to cope effectively with their experience of MD and this can be attained when nurses are well educated and are encouraged to tell their stories.