

Developing the Moral Distress Scale in the Population of Iranian Nurses

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Objective: To develop “moral distress questionnaire” and validate it in a sample of Iranian registered nurses.

Method: 26 registered nurses and 10 professionals attended focused group discussion (FGD) sessions and the acquired qualitative data was analyzed by Jameton scale analysis.

Results: Attitudes and definitions of nurses working in private and governmental hospitals of two medical universities in Tehran revealed moral distress in nurses, and also showed that moral distress influenced the sample population. Results of the present study were concordant with Jameton’s model although some background and conceptual differences were observed.

Conclusion: Design and conduction of some interventions to help nurses cope with the moral distress caused by their occupation seems necessary.

Key words

Clinical ethics, Nurses, Retrospective moral judgement, Validation studies

Moral distress was first described as “painful feelings or imbalance and lack of mental ease” by Andrew Jameton in 1984 (1). Moral distress is experienced in occasions where the nurse can not take action on what s/he knows to be the ethical or required activity due to the existing organizational complexities. A nurse can be under pressure in case of awareness concerning the required ethical response while s/he can not respond properly as a result of organizational obstacles such as shortage of time, lack of support from supervisor, etc.

During the 24 years past from the first definition by Jameton, moral distress has been recognized as a general and prevalent experience. Despite the very high prevalence of moral distress among medical staff, it is not widely discussed among health professionals. This issue has been studied in nursing community

recently and some studies have been conducted in this regard.

Jameton classifies moral distress into three main subgroups: moral hesitation, moral conviction, and moral distress (1). Some other related theories have been presented amongst which is “contradictory roles theory”, described by House and Rizzo (1). This distress is defined as the distress caused by the contradictory expectations of the organizational manager from the nursing staffs. In his study, Decker evaluated the factors affecting individual- role contradictions experienced by a group of nurses and depicted the influence of these contradictions on their job satisfaction and tendency to quit their jobs(2). He concluded that job satisfaction was mainly formed by environmental (hospital) factors while resignation happened mainly as a result of factors such as training and work experience. Based on these findings

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individual- role contradiction takes place whenever individual's beliefs, thought, and values are not compatible with her/his job definition and role in the system. It can also happen when the expectations of the individual are not fulfilled in her/ his role (3). Rocky's theory describes the "scale and system of value." the way individual value system motivates the behavior (4). If the instructions and organizational goal differ from nurse's values, contradictions happen and influence her/his motives negatively. As a result, the physician does not receive support from the nurse on one hand, and on the other, the patient is deprived of proper care. This contradiction is counted as one of the main sources of occupational tension(4). Jameton expanded the definition of moral distress in 1993 and classified it as either "primary" or "reactional". Where the individual faces the organizational obstacles and contradictory individual role values, a feeling of despair and hopelessness, anger, anxiety and restlessness happens which makes it difficult for him to be a part of the act(primary)(5). Reactional moral distress occurs when the individual feels clinically incompetence in fulfilling professional assignments (4). Davis recognizes three sources for crisis and moral distress: 1) clinical situations and conditions, 2) intrinsic factors influencing care- givers, and 3) extrinsic factors influencing care- givers (3)

Corely believes that nurses have a stronger sense of responsibility rather than decision making power when taking care of their patients. The duel between the sense of responsibility in the nurse, the power of the physician and hospital management causes an imbalance between "power" and "responsibility" and finally result in moral distress (4). In a study regarding moral problems among intensive care nurses in 1993, Holey recognized "desperation" of the nurses as one of the main factors. This mainly happened as they felt not having the power to help the patient (4). The results of the study depicted the fact that the sense of lack of power was formed in nurses as a result of organizational complexities which prohibit the nurse from performing their responsibilities. Fry et al. conducted a qualitative research to study the situation of American military nurses(6). The results showed that moral distress followed the same model of Jameton's in this group of nurses. Military nurses are at a special risk for moral distress. Because of military crises, these nurses experience unusual circumstances; sometimes they face contradictions while triaging the wounded: An individual with minor injuries is considered as a priority while others with deep and dangerous injuries remain unattended; especially when limitations of medical and pharmacological resources are faced. These kinds of unusual experiences can cause a more severe moral distress in military nurses. To sum up, the imbalance between nurse's real responsibilities, ethical codes in her/ his domain, and her/ his power results in moral distress. This adverse effect is one of the main complications that nurses face in patient care. This problem has been either neglected

or considered as a natural phenomenon in nursing community of Iran.

Materials and Method

This qualitative-quantitative study was conducted in 2007-8. Qualitative methods was used to develop the Moral Distress Scale (MDS) and validation was performed through quantitative approach. Jameton's MDS (4) with 30 phrases reflecting professional nursing tasks with ethical content was selected. This scale evaluates moral distress by Likert form responses ranging from 1(almost never) to 7 (very much). Those items never experienced by responder remain unanswered. Translation-back translation of the scale was conducted in order to prepare a valid Persian questionnaire, and through monitoring, the concepts and phrases of the scale were prepared for the qualitative part of the research. "Focus Group Discussions" and "Expert Panels" were selected as the proper methods to collect information. Focus Group Discussions were held in two hospitals- one in private and the second in governmental sector. Ethics approval was obtained from research committee of the Iran University of Medical Sciences (the supervising university) and steering committee of each hospital. Twenty six nurses and head nurses attended 3 FGDs. All participants consented that the data collected through FGDs was recorded through the session. The data was analyzed by thematic and conceptual analysis methods.

Expert panels

In this stage of development of validity and content of Moral distress scale, 10 professionals (all of which were academic staff members) from the fields of psychiatry, psychology, psychiatric nursing, health promotion, surgery, and emergency medicine attended expert panels. Through three expert panels the statements and meanings of the scale were discussed. Thematic analysis was used to analyze the data from expert panels and the results were comparison with the translated version provided. Preparation of a questionnaire with clear Persian phrases was assured. None of the items of the original questionnaire was omitted after the analysis, and no more phrases were added, either. Based on data driven from the panels demographic questions were modified. Final Moral distress Scale was provided in order to conduct a research to validate the scale on an Iranian sample of nurses.

Results

The results of the FGDs conducted in hospitals depict the fact that in a private hospital, the concepts of "hierarchy", "power imbalance", "rules and regulations", "instructions", and finally the "support systems" affect nursing care strongly. In the private hospital, participants recognized these factors as the main factors that create tensional atmosphere. All ranks of nurses regarded a high degree of tension caused by

emergency services such as CPR, and having to follow physicians' orders without any questions as a main source of distress. All of the participants agreed that physician's self, not being permitted to convey the right messages to the patient and his/ her family, frequent evaluation of their quality of work by physicians through questioning the patients, and being regarded as physician's man power as the main source of distress. One of the nurses working for 10 years in a private sector pointed out nurses' powerlessness in the caring system:

"Through CPR, it is the physician who makes the decision, and there is nothing a nurse can do".(N1, FGD2).

"When the doctor is doing her/ his job, the nurse has to be completely at her / his service".(N2, FGD2).

"For their own reasons, physicians do not tend to let the nurse provide the patient with information regarding her/ his own condition.". (P4, FGD2).

A nurse, forty two of age with 12 years of experience utilized how nursing is an invisible and uninstructed job which is extremely disappointing for her :

" When physicians get into the ward, all they can see is themselves and it seems they never see the nurse exist."

"There are no firm and practical instructions to run the ward."(P1, FGD2)

"The system does not support the nurses."(P7) "There are no code of conduct and regulations to define the interaction of the physician with the nurse."(P8)

One of the nurses in the session (P9) believed that the final decision makers in the private system were essentially individuals who benefited from the system so no change and reform could be brought up in the private sector practice.

Regarding patient care, three main issues were considered as the main sources of tension and distress by nurses: 1) Trying not to distress the patient, 2) Respecting the patient, and 3) Trying to provide a better care for the patient, and as a result, neglecting and distressing self. In FGD2, most of the participants shared the idea that a higher quality care could be provided if these conditions were solved. They noted that without direct order of the physicians, nurses were not even allowed to take action on instructions for which there existed no legal limitations. Lack of patient's cooperation with the nurse –somehow regarded as respect to the patient- was another source of harm to the working nurses and wasting their energy the issue the participants pointed out clearly. Majority of the nurses counted a good attitude of the physicians working closely with them as a facilitating factor.

Getting temporary contracts, lack of occupational security, difficulties in running day –to –day individual life, and the interaction between the physician and the nurse (superior- inferior) were regarded as the main individual factors affecting the nurses working in private sector. This means nurses face the threat of being fired in case they argue and question the system. All nurses are always bearing a high level of distress; yet they have to work under these conditions. Most of

the participants mentioned that their lives were somehow controlled by the system:

"Physicians need us, we do not get enough time. They do not agree with our rest, we can not go on leave. Somehow we are abused by the system." (,N7, N9, FGD2). Majority of the participants agreed that they dealt with the circumstances after some time, since they needed the job to lead their lives so accepted the difficulties: "Despite all the stress and tension, we have to go on working.", "We do not have job security."(P1,4, FGD2).

Effects: The effects of the tension- causing factors to which nurses are faced to make them resign and leave their job to find an alternative job either in a small surgical and medical unit or an insurance company. Some of them even prefer to work in pharmaceutical companies as visitors. Gastro-intestinal upset, stress, depression, and crying spells were mentioned as effects on individual health and behavior; yet men were reported to act differently from women: "Male nurses interject the problems while females either cry or talk to their peers. This way they ventilate their emotions."

In the governmental sector hospital the following were presented as the factors enhancing moral distress of the nurses : bureaucracy, frequent changes in management, changes in instructions of the ward, lack of human resources, expansion of assignments, wrong orders of residents, and lack of the possibility of communicating these mistakes as a part of doctor- nurse interaction.

Regarding patient care, majority of the nurses perceived the concept of "occupational morality" as the basic of both patient care and deterioration of moral distress. The "holy job" concept and high quality performance were mentioned as two important factors by this group although in some occasions, the unavoidable circumstances of the hospital shadowed this belief in care provided to the patients. Participants of this group counted factors such as respecting patient's values, getting nervous in interaction with the patient from time to time, keeping the patient unaware of the truth to keep her/ him calm, intervening in cases where they witness a colleagues misbehavior to a patient, stopping this misbehavior and trying to mediate as the main sources of moral distress.

The main individual factors influencing the nurse which rationalizes the covert moral crises in this group included: "disliking evening and holiday working shifts, feeling distressed while preparing the working shifts schedule of the month for nurses, lack of self confidence, losing motivations, the good feeling of seeing the patient recover, working passionately, tolerating psychological stressors, working based on personal beliefs, believing in the job, enjoying the job, working for patient's and colleagues' satisfaction, keeping on track as a result of being rewarded by colleagues, understanding colleagues' problems, calming oneself at night and counting down the left years of duty, the good feeling brought to the nurse while helping a patient, feeling happy at the time of returning home, having to continue working either

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because of financial circumstances of the family or fulfilling the years of service, learning gradually not to think of existing contradictions at work, feeling the loss of motives day by day, thanking god for having the opportunity to help people in pain, hiding the truth from the patient, not having the right to relay the true information to the patient especially in pediatric wards which are highly stressful, feeling at more ease at work and evening shifts as a single, intimacy of the colleagues, resolving each other's problem within the team, ...

Generally speaking, the adverse effects of moral distress in this group can be listed as: stress, restlessness, confusion, crying, leaving the job, introjecting the stress and transferring it home, aggression, psychological pressure, tolerating the pressure, depression, getting nervous in interactions with colleagues, acting contradictory to head nurse's orders, not motivating others to enter nursing colleges, losing working motivation, and feeling distressed as a result of insufficient introduction of the consent form to the patient.

Discussion

Considering the wordings of the nurses participating in this research who had experienced moral distress, it can be concluded that moral distress is a multi-dimensional problem in this population. The effects of the moral distress experienced by this group resemble the model first described by Jameton and practically determined by Wilkinson and Fry (6, 7). Our results magnified the reactional moral crisis which had not been observed in previous studies. This crisis was described by most of the participants as "tolerating", "coping", "silence", and "habituation". The finding of this study also show that background and facilitating factors as well as limited pre-determined instructions based on traditional models of hierarchy makes nurses vulnerable to crisis and moral and emotional distress .

Acknowledgements

This study was sponsored by Research Institute for Islamic and complimentary Medicine of Iran University Medical science. We appreciate the very cooperation of the staff of the institute. We express our thanks to the authorities of Iran, Shahid Beheshti and Tehran University of Medical Sciences and the managers as well as the nurses who sincerely participated in the research.

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