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REVIEW ARTICLE

Moral Distress Part I: Critical Literature Review on Definition, Magnitude, Antecedents and Consequences

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Abstract

The articles are two-series paper. First one reviews the literature on moral distress focusing on definition, magnitude of problem, its antecedents and consequences. The issues on measurement will be covered on the second part. In 2002, Nathaniel defined moral distress as “the anguish in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing”. Moral distress is a serious problem in nursing. Studies show that 33-80% of nurses reported experiencing moral distress, and 15-26% of nurses who quitted the job reported they did so because of moral distress. Three sources of moral distress include clinical situations, factors internal to the caregiver, and factors external to the caregiver but inherent in the environment in which the moral distress occurs. Negative effects of moral distress on psychological and physical health, quality of patient care, moral integrity, burnout, job satisfaction, and turnover are also discussed.

Keywords: Moral Distress, Ethical Dilemma, Nursing ethics, Moral Psychology

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Introduction

The articles are two-series paper. First one reviews the literature on moral distress focusing on definition, magnitude of problem, its antecedents and consequences. The issues on measurement will be covered on the second part. Moral distress is a complex phenomenon of human experience affecting individuals and whole community. This concept has been investigated mainly in terms of nurses' occupational distress. This is because when nurses enter into a relationship with patients, and seek to foster their well-being, every aspect of nursing practice becomes morally defined. The nature of nursing relationships means nurses are constantly called upon to make choices in particular situations that bring about the good. However, it is important to acknowledge that moral distress is not unique to nurses.

Definition: Moral Distress

Though the human condition of moral distress certainly existed before Andrew Jameton put a name to it, his description of moral distress is the first instance of this concept appearing in the literature. Jameton, in his 1984 nursing ethics textbook, noted that what was often recognized as moral dilemma were more appropriately identified as moral distress (1). He delineated three different types of moral problems: moral uncertainty, moral dilemma, and moral distress (1). Moral uncertainty arises when one is unsure whether there is an ethical dilemma or not, or, if one assumes there is, one is unsure what principles or values apply in the ethical conflict. Moral dilemmas arise when two or more principles or values conflict or more than one principle applies and there are good reasons to support mutually inconsistent courses of action. Although it seems terrible to give up either value, a loss is inescapable. For Jameton, "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" (1). For example, in the over-treatment of a premature neonate with severe neurological results, the nurse who is required to continue with painful procedures to the infant when she believes that it is wrong to do so is experiencing moral distress.

Wilkinson, building on Jameton, defines moral distress as ''the 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'' (2). The failure to follow through the decision is due to institutional constraints. In accord with Jameton, Wilkinson assumes that moral distress could not occur in a state of uncertainty; on the contrary, the distress is a consequence of a severe moral dilemma, when the rightness or not of different courses of actions has been evaluated.

In 1993, Jameton brings in yet another distinction, namely between initial and reactive distress (3). Initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values. Reactive distress is the distress that people feel when they do not act upon their initial distress. Initial distress is caused by bureaucratic obstacles and/or

disagreeable colleagues. According to studies performed by Jameton and Wilkinson, nurses express a variety of strategies for coping with these situations, such as trying to influence the physician, call in the head nurse, submit an incident report or discuss the problem with the medical head of the unit (2,3). If these strategies are not successful, the reactive distress results. Depression, nightmares, headaches and feelings of worthlessness characterize this form of distress. Some studies have indicated that chronic reactive distress contributes to burnout and the decision to leave nursing (3,4).

Many researchers have tried to refine definitions or offer examples for clarification of the concept. However, nearly every subsequent source relies on either Jameton's or Wilkinson's definitions. For examples, Fenton writes, "Moral distress is the disturbing emotional response which arises when one is required to act in a manner which violates personal beliefs and values about right and wrong"(5). Others create definitions through example-sometimes substituting the terms dilemma or stress for moral distress. Davies et al. describe nurses' experiences with children dying of terminal illness as follows, ". . .they struggled with the dilemma [moral distress] between their obligation to follow physicians' orders and their duty to provide a comfortable death. Nurses' [moral] distress was compounded by following orders that were in conflict with their belief that children should be allowed to die peacefully without unnecessary pain. Nurses felt they had violated nurse/patient relationships when they were forced to continue to inflict suffering beyond the point of a possible cure"(6). Erlen and Sereika write, "Nurses do not know how to implement what they deem to be the right action to take" (7). Hamric extends Jameton's definition to include those who "believe they know" the ethically appropriate action, but are distressed because the information they have is insufficient. Once these clinicians gain additional information clarifying the moral picture (for example, from other providers, the patient, or family members), their distress goes away (8).

Nathaniel proposes an integrated definition from the literature: "Moral distress is the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing"(9). The authors support the use of this definition for future research for its comprehensiveness and not limiting the causes of moral distress to only institutional factors.

Magnitude of moral distress

Reports of the number of nurses who experience moral distress vary. Moreover, studies employed various measurement instruments and populations. As a result, we could not pool the data from each study. We decide to summarize the literature in narrative fashion. The first effort to measure moral distress used a one-item visual analogue scale. Over 80% of the nurses reported medium to high levels of moral distress (10). At least one-third of nurses (n=470) experienced moral distress (11). Nearly fifty percent of

nurses in another study (n=760) report that they had acted against their consciences in providing care to the terminally ill (12). Qualitative studies indicate that 45 percent to 50 percent (n=24) of nurses in their respective samples left their units or nursing altogether because of moral distress (2,13).

Corley developed the Moral Distress Scale (MDS) and administered it to ICU nurses (14,15). Not only did the ICU nurses involved experience moderately high levels of moral distress, but 15% said they had left a position in the past because of it. In a 1999 sample, 26% of the nurses had left positions in the past because of moral distress. Using an instrument that she had developed with a sample of critical care nurses, Corley found levels of moral distress of moderate intensity (14). A subsequent study of 214 nurses revealed moderate to moderately high levels of moral distress (15). In a group of 106 nurses from two large medical centers in US, mean moral distress intensity score of 3.64 out of a possible 6 reflects a moderate amount of moral distress (16).

Consequences of moral distress

Though all types of moral problems are difficult, situations involving moral distress may be the most difficult ones facing nurses. Moral distress may result in unfavorable outcomes for both nurses and patients. The article reviews the effects of moral distress on psychological and physical effects, quality of care and patients, moral integrity, burnout, job satisfaction, turnover, and also the beneficial effects of moral distress.

Psychological and physical effects

Some studies show that, as a result of moral distress, nurses experience physical and psychological problems, sometimes for many years (2,5,6,17-20). Distress manifests most often with symptoms such as frustration, anger, anxiety, guilt, loss of self-worth, depression, nightmares and concomitant physical reactions such as sweating, shaking, headaches, diarrhea and crying (2,3).

Quality of care and patients

There is anecdotal evidence that nurses' moral distress affects quality of patient care and subsequent health outcomes. Nurses who frequently experience moral distress are at risk for decreased coping, leading to decreased self-esteem, wholeness and ultimately, loss of the ability to give good patient care (2,13,21). Nurses may physically withdraw from the bedside, barely meeting the patient's basic physical needs, or may leave the profession altogether (2,11,13,14,17,22).

Nurses described situations in which they avoided patients or, on the other hand, were over-solicitous to them because they felt guilty about what was happening to them (23). Other effects on patients were increased pain, longer hospital stays, and inadequate and inappropriate care of patients (24). Some nurses used negative coping tactics to manage ethical distress, including distancing and escape–avoidance strategies towards patients (25).

Moral integrity

Moral distress has also been associated with loss of moral integrity in nurses (2), and is a powerful, overall impediment to ethical practice (8). The term moral integrity means soundness, reliability, wholeness, and integration of moral character over time. This signifies being faithful to coherent, integrated moral values and actively defending them when they are threatened. A person of moral integrity is not "disordered or disoriented by moral conflict and is faithful to the standards of the common morality as well as to personal moral ideals" (26). Deficiencies in moral integrity represent a break in the connections between moral convictions and actions. Moral distress may be a direct result of what nurses perceive as their participation in moral wrongdoing.

Burnout, job satisfaction, and turnover

These serious outcomes of moral distress require considerable fortitude on behalf of the nurses experiencing this phenomenon. Eventually, their resources may be overwhelmed, leading to reduced job satisfaction and "burnout" where the nurse leaves the setting or nursing altogether (2,5,13,15,27-30). Some relate burnout to nurses' experience of moral distress and suggest that many nurses leave the profession as a result (2,13,14). Loss of nurses from the workforce is an indirect but strong threat to patient care.

Beneficial effects of moral distress

Although researchers have outlined the detrimental aspects of moral distress, ironically, several have identified for it a more positive role. Telling stories of moral suffering is important because they contain the most highly valued notions of good patient care (31). "Being open to new experience implies learning from failure . . . This hard-won lesson lingers to color future experiences, adding built-in emotional responses along with a resolve to avoid this painful lesson again"(32). Because the nurse–patient relationship is so complex, "there is no way to get it right, without sometimes getting it wrong". Rushton saw a beneficial effect from nurse distress, in that it facilitated personal and professional growth and led to more skill in compassionate care (33). The interesting question is whether such benefits can be achieved in less stressful ways, through appropriate nurse education, and whether moral distress is indeed entirely unavoidable.

Factors affecting moral distress

Factors affecting moral distress identified in previous literature fall into three categories: clinical situations, factors internal to the caregiver, and factors external to the caregiver but inherent in the environment in which the moral distress occurs (34).

Clinical situations

Moral distress is most common when a caregiver perceives care to be unnecessary, unwarranted/futile or when a caregiver feels that continuing aggressive treatment is only prolonging or delaying dying, thus adding to the suffering of both patient and family. Inadequate informed consent can create moral distress when a nurse or physician believes that the requirements of informed consent, such as decisional capacity, voluntariness, and

disclosure of information have not been met. Most bio-ethicists consider informed consent more a "process" than an "event." But nurses and physicians-in-training are sometimes directed to "consent" a patient by physicians who interpret this as getting the patient's signature (an event) and little appreciate what obtaining consent (a process) should entail.

Despite recent emphasis on quality assurance and avoidance of medical errors, there are, and always will be, nurses and physicians who are not competent to treat patients. When clinicians observe substandard performance or incompetence in a colleague, they may become distressed at having to choose among professional integrity, loyalty to coworkers, and keeping a stable work environment.

Nurses are "caught between" in describing a nurse's position midway between patient and physician, with obligations to both. While the nurse's primary duty is to the patient, she has other professional commitments, such as to the attending physician, her employing institution, and the nursing profession itself. Nurses can feel trapped by competing obligations, with tension over prioritizing and balancing commitments becoming a potent source of moral distress. However, being "in the middle" can also represent opportunities (8), as when a team values collaboration and welcomes the nurse's contributions of patient information, with the result that the patient's care may improve.

Internal factors

Nurses' perception of their powerlessness is a dominant theme underlying their unwillingness or inability to resolve ethical problems. The power differential between nurses and doctors can be both a barrier to good care and a source of moral distress. A clinician's lack of knowledge can also be a source of moral distress, as when nurses who are not up to date on managing pain in terminally ill patients become morally distressed when caring for such patients; once they understand new approaches to treat pain and suffering, their distress usually diminishes or disappears. Increased moral sensitivity reduces moral distress, since sensitive providers should be more committed to patients and more morally competent (35). However, heightened moral sensitivity itself can be a source of moral distress. Nurses with keen moral sensitivity to the ethical dimensions of care will experience distress if they see the moral dimension of nursing being neither respected, discussed, nor managed. Thus, in a perverse way, moral sensitivity in clinicians can put them at risk for moral distress. In one study of patient advocacy among nurses, 40 percent of those who scored highest on advocacy had left the profession; one reason was moral distress (13).

External factors

The nursing literature focuses on institutional constraints as sources of moral distress. Inadequate staffing is the primary source of moral distress for ICU nurses (14). This constraint goes hand in hand with lack of time. Lack of administrative support is a similarly powerful source of distress, as clinicians may feel it a waste of time and energy to voice concerns to unsympathetic or unresponsive administrators. Even well-intentioned institutional policies and priorities may conflict with patient care and cause clinicians distress.

Conclusion

Previous studies clearly suggest that moral distress is a prevalent and serious problem in nursing. The majority of research has focused on nurses, with a few on physician or other professions. There is no research on moral distress in patients. The next report will focus on the measurement of the phenomena, proposed intervention and the critique of research methodology in this research inquiry

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บทความวิชาการ

ภาวะบีบคั้นทางจริยธรรม ตอนที่ 1: การทบทวนวรรณกรรมในเรื่องนิยาม ขนาดปัญหา ตัวแปรเหตุ และผลที่ตามมา

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บทคัดย่อ

บทความมีสองตอน ตอนแรกทบทวนวรรณกรรมเรื่องภาวะบีบคั้นเชิงจริยธรรมในประเด็นของนิยาม ขนาดปัญหา ตัวแปรเหตุ และผลที่ตามมา บทความตอนที่สองจะกล่าวถึงเรื่องการวัดตัวแปรดังนี้ ในปี 2002 นาธานเนียลนิยามภาวะบีบคั้นเชิงจริยธรรมว่าเป็น “ความปวดร้าวเมื่อบุคคลทราบว่าตนเองตกอยู่ในสถานการณ์ที่มีปัญหาทางจริยธรรม และเชื่อว่าตนต้องรับผิดชอบกับสถานการณ์นั้น พร้อมกับได้ตัดสินใจแล้วว่าการกระทำที่ถูกต้องควรเป็นอย่างไร แต่มีอุปสรรคทั้งที่เกิดขึ้นจริง หรืออุปสรรคในการรับรู้ของตนทำให้ต้องทำในสิ่งที่ตนเชื่อว่าเป็นสิ่งผิด” ภาวะบีบคั้นเชิงจริยธรรมเป็นปัญหาที่พบมากในวิชาชีพพยาบาล การศึกษาในอดีตพบว่าพยาบาลร้อยละ 33-80 กล่าวว่าตนเผชิญกับปัญหานี้ นอกจากนี้พยาบาลที่ลาออกจากงานร้อยละ 15-26 กล่าวว่าตนลาออกจากงานเนื่องจากปัญหานี้ ภาวะบีบคั้นเชิงจริยธรรมเกิดจากสามสาเหตุใหญ่คือ สถานการณ์ทางคลินิก ปัจจัยที่เกี่ยวกับตัวผู้ให้การพยาบาลเอง และปัจจัยแวดล้อมที่ ไม่เกี่ยวกับตัวผู้ให้การพยาบาล บทความยังกล่าวถึงผลกระทบเชิงลบของภาวะบีบคั้นเชิงจริยธรรมต่อสุขภาพกายและใจ คุณภาพการรักษาพยาบาล ความยึดมั่นในเรื่องจริยธรรม ความเหนื่อยหน่ายต่องาน ความพึงพอใจในงาน และการลาออกจากงาน

คำสำคัญ: ภาวะบีบคั้นเชิงจริยธรรม ปัญหาจริยธรรม จริยธรรมการพยาบาล จิตวิทยาจริยธรรม