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RESEARCH ARTICLE

Moral Distress Part II: Critical Review of Measurement

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Abstract

Objective: To review the psychometric properties of various measures of moral distress and to suggest how to improve them. **Methods:** Related literatures retrieved from several databases up to January 2007 were reviewed in terms of reliability, content validity, construct validity and sensitivity using a checklist based on the guideline of McDowell and Newell. **Results:** Review of previous research identified three groups of instruments with the total of nine scales. The first group is single item measures. The second group is the scales with limited psychometric information. The third group is the scale with more psychometric information (the scale by Decker, the Moral Distress Scale (MDS) 1995 version by Corley and its modified versions in 2001 and 2005, the Stress of Conscience Questionnaire by Glagberg et al., and the scale by Kälvemark-Sporrong et al. Overall, five scales with more psychometric information are reliable, but more information is needed on their construct validity, factorial validity, and responsiveness. The MDS has more psychometric information than the other scales. **Conclusion:** Scale development studies for moral distress are in the early stage. Overall, the development of new scales or improvement of the existing ones by theory-driven study is urgently needed. The conceptual framework of care ethics could inform the scale development and research in this area. New instrument should incorporate both general questions and situation-specific questions in the same scale.

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

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Introduction

This article is the second part of review papers on moral distress. The first article reviews the literature on definition of moral distress, magnitude of problem, its antecedents and consequences. 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” (1). The review shows that moral distress is a serious problem in nursing. About 33-80% of nurses reported experiencing moral distress, and 15-26% of nurses who quitted the job gave moral distress as a reason. Moral distress also shows negative effects on psychological and physical heath, quality of care and patient, moral integrity, burnout, job satisfaction, and turnover.

Valid and reliable measure is a prerequisite for conducting any empirical research. Nine measures of moral distress have been proposed (Table 1). However, these instruments vary in term of psychometric properties, stage of development, intended populations, ease of administration and popularity. There has been no comprehensive review of these instruments that can inform researchers on the selection of instrument. What is the best instrument for measuring moral distress? What are their strength and weakness? This review tries to answer these questions, and suggests how to improve the existing measures and points of concern for developing a new measure.

Methods

Article retrieval

Searches of several electronic databases (CINAHL, Philosopher’s index, Proquest, Academic Search Premier, ERIC, Pubmed, PsychInfo, International Pharmaceutical Abstract, Web of Sciences, Sciences Direct, and Sociological Abstracts) were conducted from their respective years of inception to January 2007. To locate the most pertinent literature, search fields were restricted to titles and abstracts containing terms ‘ethical or moral distress’ or ‘ethical or moral stress’ or ‘conscience’. The bibliography of the retrieved articles was examined to identify more studies on moral distress. General internet search engines such as Findarticles, Google scholar and Google were also used to retrieve the literature. We belief our search strategy could identify nearly all English literatures on the issue. The researchers reviewed all articles and identified instruments mentioned in the text and references. Quantitative studies using identified instruments and studies on scale development were critically evaluated.

Critical appraisal of the instruments

The critical appraisal exercise was guided by a checklist that drew on the work of McDowell and Newell (2). Specifically, the checklist elicited the following information on each instrument:

Reliability: Two types of reliability are commonly used in literature. Internal consistency reliability is a measure of the homogeneity of items in a scale. Test-retest reliability measures the stability of scores over time.

Content validity: This validity indicates how adequately the questions reflect the scale aims and definition. Theoretically, it is difficult, if not impossible, to evaluate how well the questions in the scale represent the total content of the construct. As a result, face validity is used instead by assessing the process of question generation and the review of questions by experts and people similar to target of measurement.

Construct validity: The test of theory-derived relationship between moral distress scores and some external variables. Relationships consistent to theoretical prediction provide evidence for construct validity.

Table 1. Measurement characteristics of reviewed instruments

Instrument	No. of items	Target	Content validity	Construct validity	Reliability	Sensitivity
Corley&Selig (3)	1	nurse	no	no	no	No
Single question by Kälvemark-Sporrong et al. (4)	1	general	no	no	no	No
The Moral Distress Assessment Questionnaire by Hanna (5)	NA[a]	General	yes	no	no	No
Scale for pharmacists by Kälvemark-Sporrong et al. (4)	14	pharmacist	yes	no	no	No
The Moral Professional Conflict by Decker (6)	3	nurse	yes	correlation, EFA	Alpha=0.74	No
The Moral Distress Scale by Corley et al.(7,8)	32 (2001 version)	critical care nurse	yes	correlation, EFA, known group validation	Alpha=0.82-0.98 among 3 subscales, Test-retest=0.86	No
	38 (2005 version)	critical care nurse	yes	correlation	Alpha>0.90	No
The scale by Kälvemark-Sporrong et al. (9)	9	General	yes	correlation	Alpha=0.78 and 0.62 for 2 subscales	No
The Stress of Conscience Questionnaire by Glasberg et al. (10)	9	General	yes	correlation, EFA	Alpha=0.76 and 0.75 for 2 subscales	No

EFA: Exploratory factor analysis

a: NA: not applicable because the instrument has not been published. Therefore, there is no information.

Factorial validity: This validity involves the use of exploratory factor analysis (EFA) to determine underlying factors of the scales. Factors are statistically identified clusters of items that measure one or more constructs.

Responsiveness (sensitivity): The ability to detect subtle but significant change, often as an outcome of an intervention.

Feasibility: Length of scale, burden on administration of instrument, and intended population.

The authors also looked for the information on criterion validity (the correlation between a measure and a gold standard of the same attribute). However, no study provides this information because there is no gold standard for measurement of moral distress, and no longitudinal studies on the change of moral distress levels.

Results

The literature review identified 9 instruments for moral distress: the one item visual analog scale by Corley&Selig (3), a global question by Kälvemark-Sporrong et al. (4), the Moral Distress Assessment Questionnaire by Hanna (5), the 14 item scale for pharmacists by Kälvemark-Sporrong et al. (4), the Moral Professional Conflict by Decker (6), the Moral Distress Scale by Corley (6) and Corley et al. (8), the scale by Kälvemark-Sporrong et al. (9) and the Stress of Conscience Questionnaire by Glasberg et al. (10). Table 1 summarizes psychometric information of all nine scales. Detail on each scale is described below.

Single item measures

The first effort to measure moral distress used a one-item visual analogue scale in US critical care nurses (3). Kävelmark et al. also measured moral distress in Swedish pharmacists using a global question (“I am sometimes forced to act against my conscience) (4). The advantage of single item measures is it is quick and easy to administer to large sample. However, the use of these measures is not recommended because single item measures tend to be less valid, and less reliable than multi-item measures. Nunnally and Bernstein recommended the use of multi-item measures instead of a single item for measuring psychological constructs (11). A single item has considerable random measurement error and is unreliable. “Measurement error averages out when individual scores are summed to obtain a total score” (11). Furthermore, a single item can only categorize people into a relatively small number of groups. It cannot discriminate among fine degrees of an attribute. For example, with a dichotomously scored item one can only distinguish between two levels of the attribute, i.e. they lack precision. The most compelling reason against the use of single item measures is it is very unlikely that a single item can fully capture a complex theoretical concept such as moral distress. The degree of validity and reliability of these single item measures for moral distress is not available.

The Moral Distress Assessment Questionnaire (MDAQ) by Hanna (5)

In her dissertation, Hanna conducted a phenomenological study to examine moral distress in

10 nurses who provided care during abortions (5). She criticized Jameton's definition of moral distress (12) as problematic and limited because it focused on an employer/employee conflict as the trigger event. Hanna defines moral distress as "an act of interior aversion which occurs with the perception of harm to an objective good" (5). The Moral Distress Assessment Questionnaire (MDAQ) was developed based on her findings, and its content validity has been tested. It measures type, intensity, frequency and duration of the experience of moral distress, and can be used across disciplines. The MDAQ exhibits good content validity because it was constructed using data from extensive interview and reviewed thoroughly by experts. However, there is no data available on its reliability, and construct validity.

The 14 item scale for pharmacists by Kälvemark-Sporrong et al. (4)

Kälvemark-Sporrong et al. derived 14 questions on situations involving ethical dilemmas in pharmacies from a focus group discussion of Swedish pharmacy staff (4). The sample questions are "3. The care of customers is deficient due to pressure of time" and "9. Customers that probably misuse medicines get their prescriptions dispensed nevertheless". The pharmacy staff was asked to rate the extent he/she experienced these situation as stressful on the 4 point scale. However, the authors did not report the check of face validity, Cronbach Alpha, or construct validity. It is also possible that the sample size was too low (n=59) to employ factor analytic technique.

The Moral Professional Conflict by Decker (6)

Decker's study is the only investigation that used moral stress as one of the independent variables to explain job satisfaction and propensity to leave the job (6). He used the term "moral professional conflict" instead of moral distress. His measure consists of three items on six point scale from completely agree to completely disagree: "I am required to do things on my job that are against my own professional nursing judgment", "I am required to do things on my job that I think do more harm than good to the patients" and "I usually do not have to do things on my job that go against my conscience".

The Decker scale is considered a general measure because the content of questions is not specific to any clinical situations such as ignorance of patient abuse, short of staff or deception in care. Decker developed the scale for nursing profession. However, it could be easily adapted to use in the other professionals. The comparison between professions is possible for this scale. However, the scale could not identify the clinical situations that nurses regard as most distressing because of its general content.

In fact, the content of this scale is similar to the single item measures. However, more information on psychometric properties is available. The scale is reliable with Cronbach alpha 0.74. Its correlations to job satisfaction (r=-.35), coworker relationship (r=-.29) and head nurse relationship (r=-.27) were consistent to theoretical prediction. The scale also shows factorial validity. In exploratory factor analysis, three items of the scale emerged as a clear factor different from many variables such as coworker relationship, head nurse

relationship, job satisfaction, and propensity to leave. The scale is short and easy for use in large sample. There is no information on responsiveness on the scale. The scale has not been used in any study except for Decker's. As a result, the experience with the scale is very limited.

The Moral Distress Scale by Corley (6) and Corley et al. (8,13,14)

The Moral Distress Scale (MDS) is the most well validated instrument and has more psychometric information than any other measures. However, it has been revised twice and is still in the process of refinement. Corley first developed the original 32-item MDS based on Jameton's concept of moral distress which is painful feelings that occur when the nurse cannot do what he or she perceives to be what is needed because of institutional constraints (6). Items in the questionnaire were generated from interview data and extensive literature review. Extensive expert review was also employed to ensure content validity. The first version of the MDS shows good reliability (test retest reliability coefficient = 0.86). Known-group validation was conducted in critical care nurses and occupational health nurses. Consistent to expectation, occupational health nurses reported no moral distress related to items on scale, whereas critical care nurses reported moderate to high levels of moral distress (6).

Corley et al. modified the MDS from 5 point scale to 7 point scale and administered it to 214 critical care nurses (14). Factor analysis suggested that the MDS had three dimensions; "individual responsibility" (20 items with Cronbach's alpha 0.98), "not in patient's best interest" (7 items with Cronbach's alpha=0.82) and "deception" (3 items with Cronbach's alpha=0.84). Sample question for "individual responsibility" is "Continue to participate in care for a hopelessly injured person who is being sustained on a respirator, when no one will make a decision, to `pull the plug'. Sample question for "not in patient's best interest" is "Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients". Sample question for "deception" is "Give medication intravenously to a patient who has refused to take the medication orally". Factor analytic result revealed cross-loading in many items, implying that those items measure more than one dimension of moral distress (14). This creates difficulty in computing composite scores. For example, the item "staff so low care is inadequate" measures both "individual responsibility" dimension and "not in patient's best interest" dimension. The problem is to which dimension this item belong in the calculation of score. The MDS is a situation specific measure i.e., having clinical content in questions. Each situation normally involves more than one dimensions of moral distress. This explains the unclear factor solution in the study.

The original version of the MDS did not include items about pain management, managed care or incompetent health care personnel, 6 items on these topics were added to the scale in the later studies (8,13). Three experts reviewed the revised MDS (38 items) to assess the extent to which each item could measure moral distress. The content validity index was 100%. Cronbach's alpha for the revised MDS intensity scale was 0.98 and 0.90 for the MDS frequency scale.

Factor analysis was not performed because of the small sample size (n=66). More study on underlying dimensions of the new version of the MDS is needed. The total MDS score was negatively correlated (r=-0.42, P<0.01) with The Ethical Environment Questionnaire which measures the degree to which a health care practice setting exhibits an ethical environment. The finding provides additional evidence for construct validity of the scale.

The MDS is long (38 items in the latest version), and is developed for use in critical care nurses. Modification is required for the use in the other types of work settings such as occupational health, primary care and neonatal nurses.

The Kälvemark-Sporrong et al. Scale (9)

Kälvemark-Sporrong et al. employed a broader definition of moral distress compared with Jameton's, 'traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the health care provider feels she or he is not able to preserve all interests and values at stake'(9). It means that the concept also includes stressful responses to ethical dilemmas also when a desired action has been pursued.

The researchers aimed to develop a questionnaire applicable to various health care settings. Items were generated using data from three semi-structured focus groups with Swedish health professionals including physicians, nurses, auxiliary nurses, medical secretaries, pharmacists, prescriptionists and pharmacy assistants. The final items were reviewed by three experienced pharmacists, psychologists, ethicists and philosophers.

Data from 200 staff members in clinical departments and 59 pharmacy staff were analyzed using exploratory factor analysis. Two factors of moral distress emerged; level of moral distress (6 items with Cronbach's alpha 0.78) and tolerance/openness (3 items with Cronbach's alpha 0.62). However, the researchers did not present enough information in the article for the reader to judge the clarity of factor solution. Sample question for "level of moral distress" is "It is difficult to adjust information to the needs of the patient/customer". Sample question for "tolerance/openness" is "At my place of work we talk about moral problems". Even though the study provided evidence for content validity, examination of question content casts doubt on its content validity. For instance, every question in "tolerance/openness" factor (see sample question) has nothing to do with the magnitude of moral distress, the phenomena which the scale tries to assess. Moreover, this scale consists of both situation-specific questions (such as "time pressure") and general questions (such as "act against conscience"). However, both of them are grouped into same factor, which is conceptually inappropriate.

For "level of moral distress" factor, its correlation with the Quality Work Competence (QWC) subscale was not significant, implying the "level of moral distress" scale measured moral stress, not the non-specific stress as measured by the QWC. However, the correlation of social climate subscale of the QWC and "tolerance/openness" factor was significant (r=-

0.39), suggesting that two scales may somewhat overlap.

This scale is still in the early stage of development and need further refinement. The major advantage of this scale is its brevity, and being applicable to any health professionals.

The Stress of Conscience Questionnaire (SCQ) by Glasberg et al. (10)

The development of the SCQ is based on the notions of conscience or 'voice' that guides people on how to be and act. Troubled conscience is a discrepancy among this 'voice', internal demands (e.g., desires and inclinations) and external demands. Stress of conscience refers to the stress generated by a troubled conscience. Even though the researchers argue that moral distress and stress of conscience are not synonymous, but do overlap somewhat, the examination of items' content and definition reveals that they are very similar concept. Items in the SCQ were generated from literature and were reviewed by several groups of expert including experienced researchers in nursing, medicine, psychology and theology, as well as nurse teachers and nurses. The SCQ contained nine items, each assessing frequency of stressful situation and intensity of troubled conscience in each situation. The original version of the SCQ is in Swedish. English, Norwegian and Danish versions are in the process of validation.

The scale was tested in 395 health care employees consisting of nurse aides, enrolled nurses, registered nurses and physicians. Factor analysis suggested two factor solution: "internal demands" (Cronbach alpha 0.76) and "external demands and restriction" (Cronbach alpha 0.75). However, four out of 9 items of the scale showed cross loading, implying that they measured both dimensions of moral distress. Glasberg et al. employed the SCQ to study the relationship between burnout and stress of conscience in 432 health care professionals, mostly nurse aides, enrolled nurses, registered nurses and physicians (15). The correlation of the SCQ with emotional exhaustion (r=0.67), depersonalization (r=0.38), support from superior (r=-0.25) and resilience (r=-0.27) was consistent to theoretical prediction. The SCG is applicable to many health professions, easy to administer and could be completed within 5-10 minutes. The missing data in each item were low (0.9%-2.5%) (10).

Critical review on moral distress measures

The authors do not support the use of single item measures and scales with limited psychometric information on reliability and validity. Even for the four scales with more information on psychometric properties (the MDS, the Kälvemark-Sporrong et al. scale in 2006, the SCQ and the Decker's scale), their studies are still in the early stage. More research is needed on their construct validity, factorial validity, and responsiveness. Overall, their reliability of these four scales is acceptable. There is no evidence on responsiveness in any scales. The MDS has more psychometric information than any other scales. However, its limitation is length (38 items), narrow target (for critical care nurses), and cross loading in many items. Among these four scales, the MDS and the Decker's scale are

available in English.

However, most problematic area is the subscales of the MDS, and the SCQ are not unidimensional, i.e., many items measure more than one dimension of moral distress as indicated by the presence of cross-loading in factor analytic results. This problem is less prominent in the MDS compared to the SCQ. It is surprising that the researchers did not delete the items with high cross-loading. Kälvemark-Sporrong et al. did not report factor analysis result in detail (9). As a result, we can not evaluate the extent of this problem in this scale.

The problem of cross-loading stems from two related issues; the inadequate use of factor analysis and atheoretical scale development study. First the application of factor analytic technique in the previous studies may not be adequate, e.g. the use of orthogonal rotation instead of oblique rotation. Orthogonal rotation assumes that factors are unrelated which is not realistic in the case of moral distress. Each dimension (or factor) of moral distress (such as external demand and internal demand) should be related. As a result, the output of factor analysis maybe misled. The second reason is scale development studies were mostly atheoretical and data-driven. The researchers directly generated items from qualitative studies without having clear organizing framework or theories in mind, and then went on using factor analysis to group the items into various factors. Theory is hardly used to group the items. The morally distressing situations solicited during qualitative research phase normally involve more than one dimension. Items should be selected in the way that they are unidimensional (or measures one dimension only) according to theory.

One way to improve the quality of the measures of moral distress is to distinguish between “situation-specific questions” and “general questions”. New scale should consist of subscales of general and specific questions. Subscale with general questions (such as ““I usually do not have to do things on my job that go against my conscience”) could be used across professions and facilitate the comparison across professions. Decker’s scale could be a good source of general questions. However, general question could not provide information on specific issues such as moral distress from euthanasia. The scale should also include questions specific to professions or settings of interest (critical care, pharmacies etc.) to provide a more complete picture of moral distress.

Conclusion and suggestions for further research

The review shows that moral distress is a serious problem in nursing. Moral distress also shows negative effects on psychological and physical heath, quality of care and patient, moral integrity, burnout, job satisfaction, and turnover. The majority of research has focused on nurses, with a few on physician, pharmacists and psychologists. There is no research on moral distress in patients. Nine instruments for moral distress are identified. However, the studies on these scale properties are in the early stage. More research is needed on their construct validity, factorial validity, and responsiveness. Improvement of existing measures by theory-driven study is urgently needed in this area of research.

This article encourages the researchers to use existing theoretical framework in developing new scale, improving the existing scale or advancing the research in this area. New terms or concepts should be avoided because the field is already flood with redundant, overlapping and confusing terms. Care ethics is a well developed theory that could be used to inform research in this area (16). Moral distress could be redefined as "failure to care" stemming from inability to give enough attention, responsibility over situations, perceived incompetence, and lack of feedback for care-receivers. These four dimensions should guide the generation of scale items, scale development and the selection of independent variables to explain moral distress.

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References

1) Nathaniel A. Moral distress among nurses [Online]. 2002 [cited 2007 Jan 2]. Available from: URL: www.nursingworld.org/ethics/update/vol1no3a.htm.
2) McDowell I, Newell C.. Measuring health: a guide to rating scales and questionnaires. Oxford: Oxford University Press; 1996.
3) Corley MC, Selig P. Prevalence of principled thinking by critical care nurses. Dimens Crit Care Nurs 1994;13:96–103.
4) Kälvemark-Sporrong S, Höglund AT, Hansson MG, Westerholm P, Arnetz B."We are white coats whirling round"–moral distress in Swedish pharmacies. Pharm World Sci 2005; 27:223-9.
5) Hanna DR. Moral distress redefined: the lived experience of moral distress of nurses who participated in legal, elective, surgically induced abortions [dissertation]. Boston: Boston College; 2002.
6) Decker F. Socialization and interpersonal environment in nurses' affective reactions to work. Soc Sci Med 1985;20:499-509.
7) Corley MC. Moral distress of critical care nurses. Am J Crit Care 1995;4:280-5.
8) Corley MC, Minick P, Elswick RK, Jacobs M. Nurse moral distress and ethical work environment. Nurs Ethics 2005;12:381-90.
9) Kälvemark-Sporrong S, Höglund AT, Arnetz B. Measuring moral distress in pharmacy and clinical practice. Nurs Ethics 2006;13:416-27.
10) Glasberg AL, Eriksson S, Dahlqvist V, Lindahl E, Strandberg G, Soderberg A, et al. Development and initial validation of the Stress of Conscience Questionnaire. Nurs Ethics 2006;13:633-48.
11) Nunnally J, Bernstein I. Psychometric Theory. New York: McGraw Hill; 1994.
12) Jameton A. Nursing Practice: The Ethical Issues. Englewood Cliffs, NJ: Prentice-Hall; 1984.
13) Corley M, Jacobs M, Minick P. Ethical work environment, nurse moral distress, and patient satisfaction with participation in treatment decision making [Abstract] . In: Proceedings of the

Association for Health Services Research Annual Meeting; 2000 Jun 26; Los Angeles, CA.

14) Corley MC, Elswick RK, Gorman M, Clor T. Development and evaluation of a moral distress scale. J Adv Nurs 2001;33:250-6.

15) Glasberg AL, Eriksson S, Norberg A. Burnout and 'stress of conscience' among healthcare personnel. J Adv Nurs 2007;57:392-403.

16) Gastmans C. The care perspective in health care ethics. In: Davis A, Tschudin V, De Raeve T, editors. Essentials of teaching and learning in nursing ethics. Edinburgh: Elsevier; 2006. p.135-48.

บทความวิจัย

ภาวะบีบคั้นทางจริยธรรม ตอนที่ 2: การทบทวนวรรณกรรมในเรื่องการวัด

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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