SAMPLE PAPER TITLE: Moral Distress: Analysis of a Concept

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Moral Distress: Analysis of a Concept

The concept of moral distress has been in existence for over twenty years, yet the term itself and the majority of associated research have been predominantly in nursing. This comes as no surprise because the discipline of nursing is founded upon principles of ethical practice. The ANA Code of Ethics sets high standards for nursing practice and serves as a guide for ethical behavior. In everyday practice, nurses act as moral agents, making choices to further the well-being of their patients.

According to Webster's Dictionary, moral refers to that which is concerned with the principles of right conduct or the distinction between right and wrong. Webster's defines distress as to afflict with pain, anxiety, sorrow, trouble, or worry.

Philosopher Andrew Jameton first defined moral distress, as it pertains to nursing, in 1984. In his nursing ethics book he defines the concept as that which occurs when one is aware of the appropriate ethical actions to take but is unable to do so because of institutional obstacles such as time constraints, lack of supervisory support, imbalance of power between physicians and nurses, institutional policy, or legal limitations. In 1993, Jameton further elaborated on the issue, differentiating between initial and reactive moral distress. Initial moral distress is experienced when nurses feel
frustration, anger, and anxiety when confronted with institutional obstacles and one’s own interpersonal value conflicts. Reactive distress occurs when one does not act on their initial distress and negative feelings ensue (as cited in Corley, Minick, Elswick, and Jacobs, 2005).

Wilkinson further describes 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 (as cited in Lutzen, Cronqvist, Magnusson, and Andersson, 2003).

Moral distress is philosophic in nature and is used to denote a situation in which one is constrained from acting on a moral choice (Austin, Rankel, Kagan, Bergum, and Lerner, 2005). It is a term that may be applied to various health care disciplines including, medicine, psychology, pharmacy, and social work, yet it is not limited to the health care setting.

Lieutenant General Dallaire, a former Canadian soldier, wrote a book in which he details the moral distress he experienced while in charge of a United Nations peacekeeping force in Rwanda in the early 1990’s. He was unable to get the necessary permission and support to use his troops to prevent the massacre of hundreds of thousands of Rwandans and the injury of millions of others (as cited in Austin et al.). General
Dallaire subsequently suffered from posttraumatic stress disorder, and was medically discharged from the armed forces. From a nursing perspective, moral distress is a growing problem that remains greatly under recognized within the profession itself, and by the larger health care community. What is this phenomenon and why is so little known about it?

Nurses face numerous obstacles in their attempts to provide compassionate, competent care. Advances in technology, constraints placed by managed care, and the nursing shortage all set the tone for ethical dilemmas in practice and prompt nurses to question whether being an effective patient advocate is truly possible in light of these challenges. It is when nurses cannot effectively advocate for their patients that strong negative feelings arise; yet when asked to define moral distress, many nurses are unable to do so. I have experienced moral distress in everyday clinical practice, never having recognized it as such. This issue needs to be openly acknowledged by the nursing profession as well as the larger medical community, and further explored through nursing research.

From a historical perspective, early nursing leaders placed emphasis on etiquette and the virtuous character of the nurse, each essential to maintaining high standards. Nurses were discouraged from questioning those in a position of authority or becoming involved in patient care decisions. According to
Jameton, nursing has carried a traditional deference... obedience to supervisors and physicians remained a central focus of nursing ethics teaching until the rebirth of feminism in the 1970's (as cited in Mathes, Michele, 2004, p.430). Physicians were viewed as father figures, and as such, were thought to have known what was best for their patients. These stereotypical gender differences promoted an imbalance of power that is still in existence today.

It is this sense of powerlessness that is repeatedly seen in the literature as playing a pivotal role in triggering moral distress. Nurses are frustrated with the inability to improve patient care or make changes in their work environment. A failure by those in power to address these concerns may result in a violation of professional autonomy and low self-esteem.

They become dissatisfied with their jobs and may resort to avoiding patients. Numerous studies, have found that moral distress is a powerful factor in nurses' decisions about remaining in practice (Hamric, 2000).

With fewer nurses and higher patient acuity, it becomes even more difficult to fulfill one's ethical responsibilities. Inadequate patient-staff ratios can lead to shortcuts and increased errors, resulting in compromised patient care. Nurses can no longer take the time to know their patients. There is less time for communication and collaboration with other health
care disciplines. A higher turnover rate often results in the employment of new nurses with limited knowledge or clinical expertise (Hamric, 2000). Nurses experience increasing fatigue and stress, having little time for breaks. Mandatory overtime results in less time off. Nurses often work harder and longer with no reprieve in sight. They perceive management to be unsupportive, and with fewer peers available to offer support, nurses feel greater isolation in difficult situations. A vicious cycle ensues, with moral distress leading to an increased nursing shortage, and in turn, the shortage promoting additional moral distress (Krlen, Judith, 2004).

I recall an incident as a new nurse that I now recognize as an example of moral distress. I was working the night shift on a surgical/oncology unit. I had eight patients in my care, one of whom was actively dying of terminal cancer. Three others had had surgery within the previous 24 hours and required a high level of care. I recall feeling ambivalence regarding my priority order. On one hand I had postoperative patients requiring close monitoring, and on the other, a terminal patient who might not last the night. I remember voicing my concerns to a coworker, "If this patient dies tonight, I’m afraid they are going to die alone." I spent the entire night attempting to frequently monitor this patient, while carrying out all of the care required with my other patients. Having little clinical
experience, I felt that I would be viewed as incompetent if I spoke up, possibly losing my job if I didn’t do what was expected of me. This incident occurred nearly 10 years ago and to this day, I can easily recall the turmoil I felt at that time. Episodes such as this are all too common for nurses and often are vividly remembered years after the experience. The issues and experiences may vary, but the resulting negative feelings make a lasting impression.

End of life care has the potential to be a “hot zone” for moral distress. Pursuing aggressive treatments for an obviously terminal patient often leads to side effects that can rival the disease itself, and strip the patient of any remaining quality of life. When there is consensus among the patient, family members, and health care professionals regarding plan of care, which may be palliative in nature, nurses are able to preserve a patient’s comfort and dignity while avoiding ethical conflicts, which can fuel moral distress.

Though the detrimental effects are numerous, might there also be some benefits to experiencing moral distress? Researchers have identified the concept as playing a positive role as well. Harding states that telling stories of moral suffering is important because they contain the most highly valued notions of good patient care. According to Benner, learning from past failures can leave us open to future
experiences, armed with additional built in emotional responses and a resolve to avoid such a painful episode again. In addition, Rushton noted the benefit of moral distress in that it contributed to both personal and professional growth, and thus more skill in compassionate care (as cited in Corley, 2002, p.641).

There are numerous concepts related to the experience of moral distress. According to Worthley, moral integrity refers to adherence to moral values that affect one’s sense of dignity and self-respect. Kelly notes that moral distress occurs as a result of the effort to preserve one’s moral integrity when acting against their moral convictions. Webster and Baylis refer to moral residue as that which we carry with us when we experience moral distress in a situation where we have compromised ourselves or allowed ourselves to be compromised. Lutzen et al describe moral sensitivity as the ability to recognize a moral conflict, show a contextual and intuitive understanding of the patient’s situation, and possess insight into the ethical consequences of the decision on behalf of the patient (as cited in Corley, 2002).

Researchers have designed some tools that can be used to measure moral distress. Corley developed the Moral Distress Scale, which measured moral distress among nurses primarily in hospital settings. From Hanna’s empirical study of the concept
came the Moral Distress Assessment Questionnaire. This measures the type, intensity, frequency, and duration of the experience of moral distress. The instrument can be used across disciplines, but is yet to be tested. Sporrong et al. designed and tested an instrument that measures everyday moral distress in various health care settings. It consists of two factors: level of moral distress and openness toward moral dilemmas. Further testing of the instrument needs to be done, but currently its strengths include a focus on everyday ethical dilemmas and the ability to be applied across health care disciplines (Sporrong, Hoglund, and Arnetz, 2006).

Although continued exploration of the concept is occurring, research on moral distress remains limited. Existing studies have focused on identification of moral problems, the relationship between moral distress and job satisfaction, and the development of instruments to measure moral distress. Future research efforts might be directed toward further exploration of the long-term effects of this phenomenon on the nurse, the impact on the patient, and the development of interventions to reduce moral distress for nurses.

The recognition of moral distress as a significant problem, and the development of strategies to deal with its sources may lessen the deleterious effects but not solve the problem.
References

Austin, W., Rankel, M., Kagan, L., Bergum, V., & Lemeremey, G. (2005). To stay or to go, to speak or stay silent, to act or not to act: Moral distress as experienced by psychologists. Ethics and Behavior, 15(3), 197-212.


