Original Article

Moral Distress among Iranian Nurses

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Objective: The purpose of this study was to describe the moral distress among Iranian registered nurses.
Methods: This was a descriptive –analytic study, in which 264 out of 1000 nurses were randomly selected as a sample group and completed the questionnaire. The nurses' moral distress was assessed using Corley's 30-item Moral Distress Scale adapted for use in an Iranian population. The collected data were analyzed by SPSS version 19.
Results: In this study, no correlation was found between the level of moral distress and any of the demographic data. The mean moral distress score ranged from 3.56 to 5.83, indicating moderate to high levels of moral distress. The item with the highest mean score was "working with unsafe levels of nurse staffing". The item with the lowest mean score was "giving medication intravenously to a patient who has refused to take it". Nurses working in EMS and NICU units had the highest levels of moral distress.
C**onclusion**: A higher degree of moral distress is observed among nurses who work in health care systems. The results of this study highly recommend practical and research-oriented evaluation of moral distress in the medical society in Iran. Our findings suggest that Iranian version of MDS is a reliable instrument to measure moral distress in nurses.

Keywords: *Moral Distress Scale (MDS), Iranian Nurses, EMS, NICU*

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Moral distress is one of the greatest problems facing the nursing profession and involves nurses in all areas of healthcare; and it is greatest in settings that are understaffed or where staff are inadequately trained, and organizational policies and procedures put nurses in situations of difficulty or even make it impossible for them to meet and satisfy the needs of patients and theirfamilies1. Moral distress in nursing was first referred to by Jameton2 as a type of moral and ethical problem that 'arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action'. Today, moral distress is commonly experienced by nurses as an ethical conflict3.

Jameton believes that moral distress is one of the most important occupational problems in medical and paramedical occupations, especially among nurses, causing tension and negatively influencing health and medical cares. Given that moral distress as a common experience is increasing, physicians, authorities and even nurses themselves undermine this phenomenon. Meanwhile, this issue has recently attracted the attention of researchers 2.

Elpern and her colleagues8 found that moral distress was significantly correlated with years of nursing experience. They concluded that most likely with the increase in the number of years in the nursing profession, the cumulative weight of distressing experience also increases. Wilkinson,4 however, indicated that more experienced and knowledgeable nurses suffered less instances of moral distress.

Shorideh's study identified four themes and 20 subthemes of moral distress of Iranian ICU nurses. This article has provided an important understanding of the experience of moral distress among ICU nurses. In Iran, this qualitative research showed that ICU nurses experience moral distress from a wide range of causes 11.

Shorideh et al. reported four themes to describe the moral distress of nurses in the intensive care unit (ICU): (a) institutional barriers and constraints; (b) communication problems; (c) futile actions, malpractice and medical care errors; (d) inappropriate responsibilities, resources and competencies. Institutional barriers and constraints have a major role in producing moral distress 11.

In Iran, in a study by Merghati khoei et al., it was found that some factors including the administration governing private hospitals, lack of supervisory support of nurses and lack of written regulations and policies to support healthcare and ethical behavior increase tension, work environment stress and moral distress intensity 37.

Janvier et al. reported that moral distress among the nurses differed significantly between work environments. Nurses working in NICU and

obstetrics were more likely to overestimate cerebral pulsy (CP) prevalence (p<0.05) 12.
Meg Zomorodi reported increases in the numbers of patients dying in the ICU, and noted that it is important to understand the attitudes and behaviors of critical care nurses in providing this care as a basis for developing educational interventions and other resources to help the nurses to provide quality end-of-life care in the ICU 13.
Although the intensive care unit (ICU) is viewed typically as an intensive life saving area, 20% of all hospital deaths occur in this setting. The ICU is not an ideal place to die as patients are often isolated from their families in this highly technical and "sterile" environment.
In Iran,Vaziri et al. found higher levels of moral distress among nurses in EMS and NICU. In addition, they found that when the physician is less professional and functional and gives more unnecessary orders, or when there are conditions in which the patients' integrity is not respected or when the nurses work under unsafe situations, they experience more stress 14.
Hamric et al. (2007) reported that those registered nurses with higher moral distress scores had lower satisfaction with quality of care (p<o.oo1), lower perception of ethical environment (p<o.oo1) and lower perception of collaboration (p<o.oo1) 16.
Cavaliere et al. (2010) reported that among NICU RNs ,4 RN characteristics were significantly related to moral distress: the desire to leave their current position, lack of spirituality, altered approach to patient care and considering but not leaving a previous job because of moral distress 17.
Rice et al. (2008) reported that the intensity of moral distress was uniformly high in situations related to physician practice, nursing practice, institutional factors, futile care, deception and euthanasia. Encounter frequencies increased with years of nursing experience and caring for oncology and transplant patients 18.
Piers et al. (2011) reported the total MD score was significantly higher in nurses with intentional or actual job-leave. After adjusting for demographic factors, the following factors were independently associated with elevated MD: working in an acute geriatric care setting, lack of involvement in end-of-life decision, lack of ethical debate and specific measures of burnout 19.
Although substantial reforms have been made in Iran's health care system, ethical tension among care providers has been observed more and more frequently. Almost one third of nurses are somehow influenced during the period of their service. In the Iranian context, nurses only act based on the orders of the physicians or specialists, and lack of autonomy jeopardizes their morality in the workplace 14.

Material and Methods

This was a descriptive-analytic study investigating 264 nurses working in two medical educational hospitals and one private hospital in Tehran. The investigators made arrangements with the supervisors of each ward for data collection and were informed of number of nurses in all three shift works. The researcher went to the selected department at the beginning of each shift. These nurses were randomly selected and completed the questionnaires in their convenient time. First, the researcher provided a general explanation about moral distress and the main goals of the research. Then instructions were given to complete the forms.
The nurses signed the consent form.
Finally, the questionnaires were distributed among the nurses and were collected in the next working shift by the researcher.
The instrument used to measure moral distress was adapted for use in the Iranian health care setting by the first investigator through the Moral Distress Scale (MDS) developed by Corley15. Her MDS used Jameton's conceptualization of moral distress, Houses and Rizzo's16 conflict role theory and Rokeach's17 value thesis. The reliability was calculated as 90 in a sample of 214 nurses (Cronbach's alpha). Construct validity was based on expert evaluation. The investigators adapted the Corley's MDS for an Iranian population, and its reliability and validity have been established for the MDS in this study15. The Scale has responses ranging from 1 (little moral distress), to 7 (high moral distress) on intensity and frequency. Our instruments included Corley's 30-item Moral Distress Scale (MDS) questionnaire, demographic questions, and items on characteristics of the work conditions. The tool has been useful for documenting the presence and negative consequences of moral distress (MD) in nurses11, 15,18, 19.
Total scale scores could range from 30 to 210. Permission to conduct the research was obtained from the hospitals.
Data analysis was accomplished using version 19 of SPSS software for descriptive statistic methods, independent t-test, ANOVA and analysis of variance.
Ethical Considerations
Ethical approval was obtained from the Research Committee of the Shahid Beheshti University of Medical Sciences. Participants were asked to sign a consent form and were informed that they could withdraw from the study at any time.

Results

All the participants (N = 264) who participated in this study held BSc and MSc in nursing. The mean age of the participants was 33.61 ± 7.68. The majority of the participants (92.5%) were female and only 7.5% were male. Of the participants, 66.1% were married, 33.1% were divorced and 0.8% were widowed.

Table1 demonstrates the t-test results of the sample analysis such as, gender, type of hospitals and marital status.The questionnaire return rate was 77%; and the low return rate of questionnaires was mostly from emergency wards and neonatal intensive care units.

Our study is also indicative of either high or very high levels (65.5%) of family support for nurses, and only 22% of the nurses indicated either a high or a very high level of support from their supervisors and the management (Table 2).place The mean moral distress score ranged from 3.56 to 5.83, indicating moderate to high levels of moral distress. The item with the highest mean score was "working with unsafe levels of nurse staffing"

(M = 5.83, SD = 1.43). Table 4 displays items with the highest mean score moral distress.

The item with the lowest mean score was "giving medication intravenously to a patient who has refused to take it "(M = 3.56, SD = 1.90)

Table 5 displays items with the lowest mean score moral distress.

Discussion

In respect to nursing position, the higher levels of moral distress among nurses working in wards can be attributed to their more frequent encounters with problems and their obligation to follow physicians' orders.

Table 1: Results of T-Test

Characteristics		Mean	SD	P-value	Percent
Gender	Male	4.87	0.887	0.830	7.5
	Female	4.93	1.108		92.5
Type of	Government	4.98	1.082	0.107	90.5
Hospital	Private	4.54	1.041		9.5
	Married	4.87	1.025	0.278	66.1
Marital Status	Single	5.07	1.204		33.9

Table 2: Characteristics of Workplace

Rate of characteristic	Cooperation among nurses (%)	Management support (%)	Family support (%)
Very low	2.4	35.6	9.7
Low	18	42.4	24.8
High	49.6	17.5	38
Very high	30	4.5	27.5

Table: Results of F-Test (ANOVA) Between Hospital wards

Ward	Mean Score MDS	SD	P-value
CCU	5.06	0.179	
ICU	4.96	0.091	
Internal	3.95	1.516	
Surgery	5	0.097	0.192
NICU	4.5	0.280	
Operating room	5	0.169	
EMS	5.26	0.259	
ENT	5.08	0.416	
Ophthalmology	4.37	0.391	

Table4: Items with Highest Moral Distress

item	Mean score MD	SD
-Work with 'unsafe' levels of nurse staffing	5.83	1.43
-Work in a situation where the number of staff is so low that care is inadequate	5.69	1.66
- Ignore situations of suspected patient abuse by care givers	5.69	1.46
- Carry out a work assignment in which 1 do not feel professionally competent	5.65	1.65
-Avoid taking any action when I learn that a nurse colleague has made a medication error and does not report it	5.63	1.52
-Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay	5.57	1.71

Table 5: Items with Lowest Moral Distress

item	Mean Score MD	SD
- Give medication intravenously to a patient who has refused to take the medication orally	3.56	1.9
- Follow the physician's request not to discuss death with a dying patient who asks about dying	4.14	1.84
- Follow the family's request not to discuss death with a dying patient who asks about dying	4.27	1.86
- Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients	4.33	1.94
- Initiate extensive life-saving actions when I think it only prolongs death	4.40	1.91
-Follow the family's request not to discuss death with a dying patient who asks about dying	4.44	1.84

Moral distress was detected to be of higher intensity in the NICU, EMS and ICU units (Table 3). As a result of critical conditions of the patients in these wards and the urgency of the necessary diagnostic and therapeutic procedures, nurses in these wards become more susceptible to experiencing moral distress. The level of moral distress has been higher in the NICU ward, continuous crying of children in
NICU unit, their sensitivities and vulnerabilities to disease, their inability to communicate their pain and symptoms and continuous parental demands and questioning made nurses more vulnerable to experiencing moral distress; and this can be attributed to the high load of tasks in these wards (NICU, EMS and ICU). It must be noted that these load-heavy wards rank among those with the highest levels of moral distress.

Moral distress was of lower intensity in ENT, ophthalmology and surgery units. In these wards urgent diagnostic and therapeutic procedures are not frequent and nurses are less frequently prone to highly sensitive ethical situations (Table 3).

The level of moral distress was lower in wards with more than 30 beds handled by each nurse such as ENT, ophthalmology and internal medicine units. This might be resulted from the fact that urgent diagnostic and therapeutic procedures are less frequent in these wards. Nurses working in emergency wards and neonatal intensive care units (NICU) had the highest levels of moral distress. Because of the patients' conditions and urgency of medical interventions (either diagnostic or therapeutic), these nurses are prone to moral distress.

Taking the number of patients handled by each nurse into consideration, the test shows a significant difference ($p = 0.041$). This result shows that the level of moral distress correlates with the number of patients in the ward handled by each nurse as well as the type of the hospital.

In this study, the level of moral distress was higher in the public hospitals than in the private hospital (Table 3). Our finding is consistent with what was reported by Merghati7.

In our study, the participants had only been questioned about their intention to quit their job, and there have been no questions assessing one's resignation history and its correlation with moral distress. Thus, we cannot comment on whether the decision to resign directly correlates with moral distress. It is possible that resignation is rooted in many factors which have remained unquestioned in our study. The findings of this study are similar to those of Corley 15, Piere14 and Lazzarin 20 studies.

Our findings in this study, together with the results of other studies, demonstrate that family and colleagues' support have been effective in diminishing the level of moral distress while poor support by management has resulted in diminished job satisfaction and increased moral distress (Table 2). Austin et al. 21 concluded that health care organizations should provide a supportive environment for the staff who provide health care services and who experience difficult situations because of the nature of their occupation. Tai 22 has noted that increased support from family, friends and supervisors decreases the wish to change employment. He recommends supervisors to pay special attention to the need for support among staff members with high resignation potential.

Corley has concluded that nurses who have good relationships with their colleagues and comrades, patients, managers, executive management of the hospital and physicians experience lower levels of moral distress.18

In Corley's study, the three factors of responsibility (20 questions with Cronbach's alpha of 0.97), disinterest for patient care (7 questions with Cronbach's alpha of 0.82) and deception (3 questions with Cronbach's alpha of 0.84) have been considered. Considering the means and standard deviations, questions 14, 15, 16,17,18,19 and 20 in this study portray a high level of moral distress 15.

In our study, questions 17 and 19 were indicative of the highest levels of moral distress (Table 4); and questions 5, 6, 7 and 8 were indicative of the lowest levels of moral distress (Table 5). This is in disagreement with Corley's study, in which questions 5, 6, 7, 8, 9 and 10 were indicative of high levels of moral distress 15.

Apparently, a higher degree of moral distress is observed among nurses who work in health care systems with lack of clear policies, unsupportive atmosphere, lack of guidance in complicated ethical situations and ineffective resolution mechanisms for conflicts with physicians. Based on other studies conducted in this field, together with the results of this study, it is concluded that management teams should strengthen the supportive systems within the hospitals and the ministry of health should take necessary actions to promote staff-supporting systems in health centers 10.This fact signifies the high commitment and ethical standards of the nurses participating in this study. Corley et al. examined the relationship between moral distress intensity and frequency and the ethical work environments in a group of 106 nurses from two large medical centers; and they found that moral distress intensity and ethical work environments were correlated with moral distress frequency23. The ethical work environment predicted moral distress intensity. In another study, Elpern et al. 4 reported that moral distress was significantly correlated with years of nursing experience. Nurses reported that moral distress adversely affected job satisfaction, retention, psychological and physical well-being, self-image and spirituality. This finding supported our findings in Iran.

Conclusion

The results of this study highly recommend practical and research-oriented evaluation of moral distress in the medical society in Iran. The other point highlighted by this study and previous study by Vaziri et al.10 and

Shorideh et al.6 in Iran is the influence of the professional or practical competence of physicians on the moral distress of nurses. When the physician's competence is low, it results in higher rates of unnecessary laboratory tests and treatments, and therefore the nurse will suffer moral distress. Thus, promotion of academic expertise and provision of continuous educational opportunities for physicians, as well as participation in congresses and seminars are highly recommended.

The results of this study, as well as previous studies 10,18,20,24 , highlight the fact that strong support provided by family and colleagues are effective in decreasing moral distress levels. On the contrary, poor support from supervisors and the management results in decreased job satisfaction and increased moral distress. The results point to this fact that when the nurses are faced with specific and unsafe conditions in NICU, ICU and EMS, this will lead to an increase in the rate of moral distress among them. This study revealed that the intensity of moral distress was higher in EMS, NICU and ICU nurses than in ENT, ophthalmology and internal medicine units. Some nurses may become accustomed to moral distress as they gain experience, and some may suffer cumulative distress. Further research on this topic is required.

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Conflict of Interest

The author declares that there is no conflict of interest.

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