

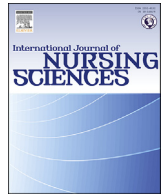
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The relationship between professional autonomy and moral distress among nurses working in children's units and pediatric intensive care wards



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ABSTRACT

Background: Nurses serve as the primary source of care for minor patients in intensive care units. Even though they support both patients and their relatives, these nurses may experience moral distress from their profession. While managing their daily relationships with their patients, nurses must also be able to control their actions to feel that they are from a social unit and feel their competence in association with others.

Objective: This study aimed to investigate the relationship between professional autonomy and moral distress among nurses working in children's units and pediatric intensive care wards.

Methods: This descriptive/comparative cross-sectional study was conducted in 2015 using 120 nurses as subjects. Subjects were selected using the census method. The research tools used to gain measurable data were the Pankratz nursing questionnaire (PNQ) and Corley's Moral distress scale (MDS). In order to analyze the collected data, descriptive statistic tests such as the relative frequency distribution, mean, standard deviation and the Pearson correlation test, T-test, ANOVA, and regression were used. The SPSSv.20 software was also used to analyze the data obtained.

Results: The relationship between professional autonomy and moral distress revealed that there was a significant positive relationship between professional autonomy and moral distress in the intensity ($r = 0.39$; $P < 0.001$) and the iteration ($r = 0.41$; $P < 0.001$). In addition, professional autonomy predicted 18% of changes in intensity of moral distress in total ($MR = 0.42$, $R^2 = 0.18$) and also professional autonomy predicted 25% of iteration in moral distress in total ($MR = 0.507$, $R^2 = 0.25$).

Conclusions: The results of this study revealed that there was a direct positive relationship between professional autonomy and moral distress.

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1. Introduction

Over the past three decades, moral distress amongst providers in the healthcare system has become both a growing concern and a focus of research [1–3]. Jameton (1993) defined the concept of moral distress as: the nurse knows the work they are doing is morally correct, but pressures from corporate leadership and other partners create disincentives to do the job [4]. Hence when a person makes a

moral decision, but it is followed by an action contrary to ethical behavior, they experience negative feelings and mental imbalance [1].

Researchers have shown that moral distress creates system-wide problems and negative consequences for health care providers, including nurses [3,5–8], and these negative consequences include physical conflicts and moral disorders. For nurses, moral distress also has negative consequences such as reduced external relations with other members of the health team, decreasing organizational support, fear of subsequent legal action, and adverse effects [9]. Moral distress in addition to having an impact on employees also significantly influences patients because it leads to interference in the safe care of patients [10]. All of these negative consequences ultimately lead to disappointment and job

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dissatisfaction by the nurses [11]. Professional autonomy is an important feature of the nursing profession [12], and it is essential for safe and high-quality care [13]. Independence allows professionals to make their own decisions and judgments about specific services provided with the least pressure from external sources, such as employees, servants, and legislators, and so on [13]. One of the most important factors related to nurses' job satisfaction and their ability to work independently is found within the scope of their duties [14]. The nurses who work with low levels of autonomy may have unpleasant feelings of personal and professional experience [15]. Lazzarini et al. (2012) believe that moral distress is a common problem in clinical nurses, especially in relation to young patients [16]. Given the close relationship of nurses with parents and children and the family-centered care approach of nurses, nurses play effective roles in reducing stress and unhappiness of patients and families while assuming a caregiver role at admission and during hospitalization of children [17]. Therefore paying attention to professional autonomy and moral distress of nurses working in pediatric units is especially important for children.

Given the importance of moral distress and professional autonomy and its impact on patients, nurses, and health care system and also given the limited number of studies in the field of professional autonomy and moral distress – especially in nurses serving in Iranian hospitals as well as with regard to the personal experiences of the researcher in the care of children – this study was conducted within pediatric wards and pediatric intensive care units.

2. Material and methods

2.1. Research design and setting

This descriptive cross-sectional comparative study was conducted in 2015 on 120 nurses working in the pediatric unit. The study population consisted of all nurses working in pediatric wards of hospitals in Kerman.

2.2. Sampling

The sampling was conducted using the census method to select a sample population from the entire staff of the hospital pediatric wards and pediatric intensive care units of Afzalipour hospital, Payambar Azam Hospital, the hospital Seyedalshohada (AS), Samen Alhojaj Hospital of Kerman. With a total of 131 nurses among them, ultimately 120 nurses working in pediatric wards were entered. The inclusion criteria of this research include: a willingness to participate in the study, employment in one part of the children or pediatric intensive care, having at least a Bachelor's degree in nursing, and a minimum of 6 months' experience in pediatric wards or intensive care of children.

2.3. Measurement tool

The applied tool was the Pankratz nursing questionnaire (PNQ) and Corley's Moral distress scale (MDS). Of course, in order to evaluate demographic characteristics, these demographic variables were examined at the beginning of the questionnaire. The Moral distress scale consists of 21 questions. The questionnaire is designed in such a way that each question weighs the severity and frequency of moral distress in nurses. The options were arranged on the severity from no (zero) to very high (five) and in the iteration from the never (zero) to repeatedly (five). The PNQ consisted of 47 items, which were formed from three categories: nursing autonomy and advocacy, patients' rights, and rejection of traditional role

limitations. The questionnaire surveys nurses' professional autonomy using a Likert scale of 5 points (from 1 = strongly disagree to 5 = strongly agree). The score range was from 47 to 235. Validity and reliability of Crowley's moral distress scale were confirmed in several studies [18–20]. Validity and reliability of PNQ in Iran was approved by Iranmanesh and colleagues in 2014, Cronbach's alpha 0.70 with Cronbach's alpha as 0.70 [21]. The questionnaires were given to 10 members of the Faculty of Nursing and Midwifery, Islamic Azad University, Isfahan to determine the validity, then the reviews and responses of the professors were applied. After that the questionnaires were given to the 20 nurses who already had inclusion criteria and Cronbach's alpha test was used to determine reliability. Cronbach's alpha of 0.85 was considered for professional autonomy while Cronbach's alpha of MDS was 0.80.

2.4. Data collection

In order to collect information, the researcher enlisted Kerman hospitals and their pediatric wards and then contacted the pediatric wards of hospitals in Kerman during different shifts and asked the nurses to complete the questionnaires. The completed questionnaires were collected.

2.5. Ethical consideration

In order to comply with ethical principles, Ethics Code was received from Isfahan University of Medical Sciences Ethics Committee with IR.MUI.REC.1394.4.86 Number. From the beginning, nurses were informed about the purpose and importance of the research, how to answer the questionnaire completely, and they were also ensured that their information would remain confidential. Additionally, it was noted that participation in the study was completely optional and their written consent for participating in the study was taken from.

2.6. Statistical analyses

In order to analyze the collected data, descriptive statistics, such as the relative frequency distribution, mean, standard deviation, Pearson correlation test, T-test, ANOVA, and regression were used. The SPSS 20 v.20 software was used.

3. Results

The female subjects had the highest frequency in terms of gender (95.8%). In terms of marital status, the majority of the nurses participating in the study were married (64%). In terms of the service location, the majority of the nurses participating in the study worked at the Afzalipour hospital (67.5%) with the smallest sample percentage coming from Samenolaemeh hospital (3.3%). Based on shifts, this study showed that 104 (86.7%) nurses were working rotational shifts. In terms of their position, most of the subjects (117) were working in nursing positions. Ninety-seven point five percent of the participants had a bachelor's degree in nursing. Sixty subjects (50%) worked in intensive pediatric units, 60 (50%) of them were working in the pediatric ward as well as in terms of work experience, and 77 (2.64%) subjects had work experience from 1 to 5 years.

The mean score of professional autonomy for the nurses in pediatric wards (113.57 ± 16.10) was at a low level. This was also seen in the pediatric intensive care units where nurses (113.92 ± 20.54) were at a low level. The mean score of nurses' moral distress in pediatric care both in intensity (58.13 ± 12.29) and in iteration (65.04 ± 21.57) were at an average level, and nurses of the pediatric intensive care sectors experience the intensity (56.28 ± 15.89) at a

low level and the iteration (16.04 ± 56.86) was at a moderate level.

In order to investigate the basic relationship between professional autonomy and two aspects of the severity and iteration of moral distress, the Pearson correlation coefficient was used and the results were reported as the correlation matrix. Accordingly, there was a positive and significant correlation between professional autonomy and moral distress in terms of intensity (r = 0.39) and frequency (r = 0.41) (Table 1).

In order to predict the intensity of moral distress using aspects of professional autonomy, spontaneous regression was used and the results were found as MR = 0.42, R2 = 0.18, which means that professional autonomy predicts a total of 18% of changes in the intensity of moral distress (see Table 1). Spontaneous regression was also used to predict the iteration aspect of moral distress using professional autonomy, and the results were found as MR = 0.507, R2 = 0.25, which means that professional autonomy predicts a total of 25% change in moral distress (Table 2).

Studying the impact of aspects of PNQ on the intensity of moral distress revealed that aspects of nursing autonomy and advocacy (β = 0.65) and aspects of the rejection of traditional role limitations (β = 0.108) predict the intensity of moral distress, but the findings were non-significant (P > 0.05). Additionally, the patients' rights aspect predicts moral distress to be direct (β = 0.33) and significant. By increasing the patients' rights, the intensity of moral distress also increases (P < 0.001) (see Table 3).

While evaluating the impact of the PNQ on iteration of moral distress, it became clear that levels of independence and nursing support (β = -0.096) predict the intensity of moral distress as

direct, but non-significant (P > 0.05). However, both patients' rights (β = 0.33) and rejection of traditional role limitations (β = 0.346) predict iteration of moral distress in a significant and direct way. By increasing the rights of patients and levels of rejection of the limitations of the traditional role of nurses, the moral distress increases (P < 0.001), (Table 4).

4. Discussion

The results of this study indicated low levels of professional autonomy among nurses working in pediatric wards and pediatric intensive care units. Papathanassoglou et al. (2012) reported the mean score of professional autonomy among European nurses as 84.26 (which is a low score) [22]. Both Iranmanesh et al. (2014) and Amini et al. (2013) found moderate levels of professional autonomy among the studied nurses [21,23]. Such differences in the results of available studies might be justified by differences in working conditions and hospital rules and regulations. Moreover, challenges in the field of professional autonomy among nurses might have also been responsible for such differences, e.g., vague definitions of nursing autonomy, inappropriate measurement tools [24], absence of a relevant theory [22], unsuitable training of students and teachers by placing an emphasis on conventional methods of education, failure in cooperation and teamwork [25], physicians' negative attitudes toward nurses [26], managers' lack of support [27], poor management structure [28], and nurses' capabilities and power [29].

The results of this report suggested the intensity of moral

Table 1
Correlation matrix of variables.

Scale	Professional autonomy	Moral distress Intensity	Moral distress frequency
Professional autonomy	1	–	–
Moral distress intensity	0.39*	1	–
Moral distress frequency	0.41*	0.76*	1

*P < 0.01.

Table 2
The relationship between dimension of professional autonomy and moral distress.

The correlation ratio	The coefficient of determination	Adjusted coefficient	The standard error of estimate	Scale
Moral distress intensity	13.09	0.161	0.18	0.42
Moral distress frequency	17.0831	0.237	0.25	0.507

Table 3
The relationship between dimension of professional autonomy and moral distress Intensity.

Model	Non-standard coefficients		Coefficients-standard	t	P
	B	Standard fault	β		
Constant factor	22.089	10.099		2.187	0.031
Nursing autonomy and advocacy	0.095	0.159	0.065	0.599	0.550
Patients' rights	0.535	0.149	0.339	3.604	0.001
Rejection of traditional role limitations	0.257	0.256	0.108	1.001	0.319

Table 4
The relationship between dimension of professional autonomy and moral distress frequency.

Model	Non-standard coefficients		Coefficients-standard	t	P
	B	Standard fault	β		
Constant factor	10.088	13.187	0.650	0.765	0.446
Nursing autonomy and advocacy	-0.192	0.208	-0.096	-0.926	0.356
Patients' rights	0.714	0.194	0.330	3.684	0.001
Rejection of traditional role limitations	1.126	0.334	0.346	3.367	0.001

distress in intensive care nurses is low, but the iteration of moral distress in pediatric nurses is moderate in terms of occurrence. Moral distress occurs when care providers fail to turn moral choices into moral practice. This may be the result of various factors including care providers' incompetence, poor patient care, extremely hard and intolerable work shifts, having to deal with patients' suffering, and laziness and lack of support from colleagues [30]. Since environmental conditions are known to be the main cause of moral distress [31], the religious commitment of the Iranian population might justify the low intensity and iteration of moral distress in the present study. Ravari et al. (2012) identified spirituality as an essential and indispensable element of nursing. In fact, an internal and intrinsic force can encourage nurses to provide purposeful and meaningful interventions and to establish more honest and effective relationships with patients [32]. Furthermore, nursing textbooks emphasize the necessity of respect for patients' religious beliefs and attitudes [33]. Dyo et al. (2016) believed that nurses' race and ethnicity played a major role in the intensity and iteration of moral distress among them [31].

Numerous studies have reported moderate to high intensity and iteration of moral distress in adult intensive care units [8,18,22,31,34,35]. The present research and studies conducted by Dyo et al. (2016) and Pavlish et al. (2015) showed lower levels of moral distress among nurses working in pediatric units than in those working in adult units [31–34].

Our findings highlighted a significant positive relationship between moral distress and professional autonomy. In fact, professional autonomy explained 18% of the variance in the intensity of moral distress with higher professional autonomy being associated with higher intensity of moral distress. In addition, professional autonomy predicted 25% of the variance in the iteration of moral distress and the iteration of moral distress increased with increasing professional autonomy. In other words, nurses' greater emphasis on personal knowledge and decisions caused them to experience more conflicts and thus higher moral distress.

In contrast to our findings, Borhani et al. (2014) reported a lack of professional autonomy to cause moral distress in nurses [19]. Likewise, Papathanassoglou et al. (2012) found an inverse relationship between professional autonomy and moral distress among European intensive care nurses [22]. Enns et al. (2015) concluded that some problems such as depression decreased nurses' professional autonomy [36]. This finding was not in agreement with the results of the present study. The existing relationship between professional autonomy and moral distress highlights the role of these two factors on each other's development. According to our clinical experience, we believe that nurses' increased professional autonomy without adequate support from physicians and relevant authorities, along with low levels of cooperation between nurses and physicians, could have been responsible for the positive relationship between professional autonomy and moral distress. Further research is required to clarify the possible mechanisms involved in the mentioned relationship.

5. Conclusions

In summary, the findings of this research showed that professional autonomy amongst nurses working in pediatric units and pediatric intensive care units was low while moral distress in terms of both intensity and frequency was average. This study also showed that the professional autonomy and moral distress in these two units were not different in terms of intensity. There was a significant positive relationship between moral distress and professional autonomy of nurses' working in the intensive pediatric care unit so that increasing professional autonomy leads to an increase in moral distress. Using these findings and given the positive

relationship between professional autonomy and moral distress, the recommendation is that managers and administrators increase support and inter-profession cooperation. With all efforts in order to increase professional autonomy in nurses, it is important to understand the aspects of professional autonomy benefit and negatively impact patients, nurses, and the healthcare system. Once identified, solutions can be applied in hospitals and care facilities to improve professional autonomy and decrease moral distress. Given the level of moral distress among nurses, nurse managers need to pay more attention in this field.

Conflict of interest

None declared.

Contributors

Mr. Ghodousihad suggested the title of the article, data was collected by Mrs. Sarkoohi, and Mrs. Davaridolatabadi wrote the article.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <http://dx.doi.org/10.1016/j.ijnss.2017.01.007>.

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