How Professional Nurses Working in Hospital Environments Experience Moral Distress: A Systematic Review

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KEYWORDS

- Moral distress • Ethical distress • Moral stress
- Hospital environments

More than 5 million patients with a myriad of challenging illnesses and related health problems are admitted annually to intensive care units (ICUs) in the United States.[1] Caring for these fragile and critically ill patients are the 503,124 critical care nurses employed by hospitals throughout the United States, accounting for an estimated 37% of the total hospital workforce.[2] According to the American Association of Critical-Care Nurses (AACN), critical care nurses work in a nursing specialty that deals specifically with human responses to life-threatening problems and whose responsibility is to ensure that their patients receive optimal care.[2] For some critical care nurses, striving to provide the best possible care for their acutely ill patients amidst an intense, often chaotic and demanding environment, moral distress comes to the forefront and may serve to compromise the patient care they value.

The AACN has addressed concerns regarding moral distress through the creation of a framework to serve as a guide when nurses encounter moral distress. In their document "The 4 A's to Rise Above Moral Distress" nurses are challenged to ask, act, affirm, and assess when confronting issues related to moral distress.[3] The focuses of this paper are on assisting critical care nurses to provide optimal care to their patients and families and use moral distress as a catalyst to create positive changes in their work environment. Further, the AACN in 2008 recognized the seriousness of moral distress in nursing and developed a public policy statement to counteract the convincing evidence that moral distress has a negative impact on the health care environment and retention of nurses in the discipline.[4] The AACN states, "Moral distress is a critical, frequently ignored, problem in healthcare work environments.

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Crit Care Nurs Clin N Am 24 (2012) 91–100
doi:10.1016/j.ccell.2012.01.004 **ccnursing.theclinics.com**
0899-5885/12/$ – see front matter

Unaddressed, it restricts nurses' ability to provide optimal patient care and to find job satisfaction. AACN asserts that every nurse and every employer are responsible for implementing programs to address and mitigate the harmful effects of moral distress in the pursuit of creating a healthy work environment."[4(p1)]

BACKGROUND

Jameton, who first conceptualized moral distress, described it as arising when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.[5] Wilkinson added to Jameton's work and defined 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."[6(p16)] In a position statement on moral distress, The American Association of Colleges of Nursing (AACN) described it as occurring when nurses recognize the appropriate action to take, but are unable to act upon it, and further, act in a manner contrary to their personal and professional values, therefore undermining integrity and authenticity.[7] The AACN further identified moral distress as a significant professional problem affecting the physical and emotional health of nurses and impacting quality, quantity, and cost of nursing care.[7] The Canadian Nurses Association (CNA), in a paper entitled "Ethical Distress in Health Care Environments," differentiates between an ethical/moral dilemma and ethical/moral distress. The CNA states that ethical/moral dilemmas "are situations arising when equally compelling ethical reasons both for and against a particular course of action are recognized and a decision must be made . . . ."[8(p3)] Ethical/moral distress occurs when a decision is made regarding what one believes to be the right course of action, but barriers prevent the nurse from carrying out or completing the action."[8(p3)]

Many researchers have identified the deleterious effects of ethical/moral distress.[9–12] Others, such as Kalvermark and colleagues, recognize that the complexities of health care make ethical dilemmas and moral distress inevitable. In the conclusion of their study, the authors suggested that organizations must provide better support, resources, and structures to prevent moral distress.[13] Hefferman and Heilig contended that feelings of powerlessness regarding treatment decisions, high-intensity medical environments, lack of authority, and high responsibility create a recipe for feelings of futility and moral distress.[14] This is supported by Elpern and coworkers, who studied moral distress among staff nurses in a medical ICU and found that critical care nurses are often faced with situations that are associated with high levels of moral distress, which adversely affect job satisfaction, retention, psychological and physical well-being, self-image, and spirituality.[15] In another study, the effects of moral distress were documented as early as 2 years after graduation. Brighid found that relatively new graduates experienced feelings of moral distress as a consequence of believing that they were not living up to their moral convictions and attempting to preserve their moral integrity.[16] In a study that compared nurse–physician perspectives of moral distress and moral climate in the care of dying patients in ICUs, Hamric and Blackhall found that registered nurses experienced more moral distress than did physicians.[17] Corley's study on moral distress of critical care nurses found that of 111 critical care nurses, 12% vacated a nursing position based on their experience of moral distress. In addition, the nurses perceived their ethical environment as more negative and were more critical of the quality of care provided.[18] In their study of moral distress, compassion fatigue, and perceptions about medication errors in certified critical care nurses, Maiden and colleagues found that nurses who experience higher compassion fatigue have higher moral distress. In addition, the

researchers suggested that moral distress is a contributing factor requiring further study as it relates to medication errors.[19]

REVIEW OBJECTIVE

The overall objective of this systematic review was to appraise and synthesize the best available evidence on how professional nurses working in hospital environments experience ethical/moral distress. The context was professional nurses experiencing ethical/moral distress as a result of their patient care responsibilities.

METHODOLOGY

Criteria for Considering Studies for this Review

Types of studies

The authors considered qualitative evidence that illuminated the experience of moral distress of professional nurses including, but not limited to, phenomenology, ethnography, grounded theory, hermeneutics, participatory action research, and critical theory. Studies from 1995 to 2008 were included in this review.

Types of participants

This review considered studies whose participants were professional nurses, working in hospital environments and who experienced ethical/moral distress. Experience must have been reported by the nurses themselves.

Phenomena of interest

Studies were included if the focus of the study was a description of the participant's own experience with ethical/moral distress and that experience took place in a hospital environment. The context was professional nurses experiencing ethical/moral distress as a result of their patient care responsibilities.

Types of outcome measures

Outcomes of interest were those that represented the voices of the participants as they related their own experiences of ethical moral distress. Outcomes included, but were not limited to, stress reactions, psychological reactions, feelings of powerlessness, a desire to leave the profession, a perceived lack of administrative support, the stress of being in the role of patient advocate, time/staffing constraints, the devaluing of patient wishes, futile care, unnecessary patient pain and suffering, and perceived employment risk when voicing concerns.

Search Strategy

The comprehensive search strategy aimed to find both published and unpublished studies (**Fig. 1**). The search was limited to English-language reports from 1995 to 2008. A three-step search strategy was utilized in each component of the review. An initial limited search of MEDLINE and Cumulative Index to Nursing and Allied Health Literature (CINAHL) was undertaken followed by analysis of the text words contained in the Joanna Briggs Institute (JBI) Library of Systematic Reviews title and abstract, and the index terms used to describe the article. A second search using all identified keywords and index terms was then undertaken across all included databases. Third, the reference list of identified reports and articles was hand searched for additional studies.

The databases that were searched include:

BioMed Central
CINAHL

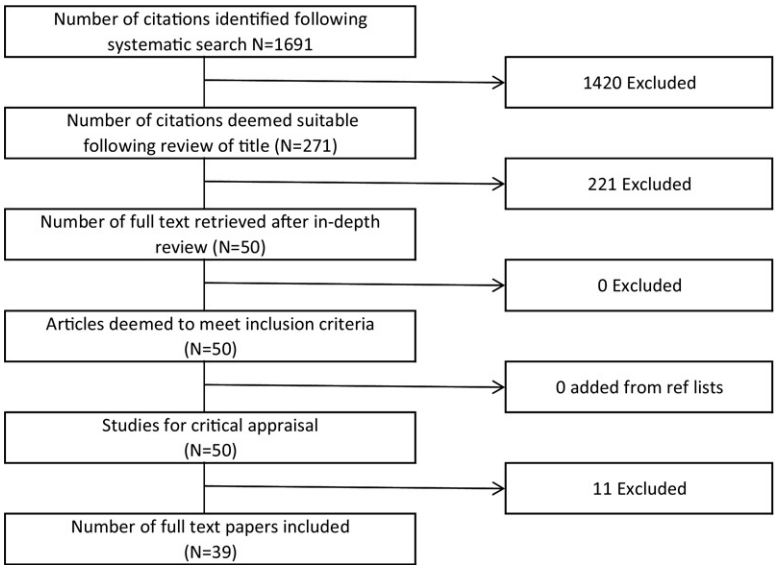

Fig. 1. Search strategies for published and unpublished studies.

Conference Proceedings Current Contents
EBSCOHost Health Source: Nursing/Academic Edition Elsevier Science Direct EMBASE
Institute for Health & Social Care Research (IHSCR)
MEDLINE
New York Academy of Medicine Grey Literature Report
Nursescribe
Proquest Digital Dissertations
PsycINFO
Reference lists of identified studies and review papers
Science Direct
SCOPUS
Sociological Abstracts
TRIP.

Initial keywords used included moral distress, ethical distress, moral concerns, moral decision*, ethical decision*, ethics, morality.* A technique of Boolean Logic and serves as a strategy for on-line library searching. (ie, It helps to identify moral decisions, moral decision-making etc).

Assessment of Methodological Quality

Research papers selected for appraisal were assessed by the two authors for methodologic quality before inclusion. The review used standardized critical appraisal instruments from the Joanna Briggs Institute, specifically the Qualitative Assessment and Review Instrument (QARI). The two authors were experienced nurses and academics as well as qualitative researchers. Consultation with a third reviewer to resolve any disagreements was available as a contingency but was not required. A cutoff point of 6 out of the 10 questions answered with a “yes” was established as a general guideline by the authors. QARI is the software component of the SUMARI

suite that supports the synthesis of qualitative research evidence. QARI facilitates the reviewer's assessment of the congruency between philosophical perspective and research methodology, research question and methods, data collection and methods analysis and interpretation, participants' voices, and ethical conduct in the conduction of research. See **Fig. 1** for search results.

Data Collection/Extraction

Data were extracted from papers included in the review using the standardized data extraction tool from QARI. Data extracted from interpretive and critical research included specific details about the type of text, representation, position, setting, geographical and cultural information, the logic of the argument, and the type of data analysis used to determine conclusions and credibility of evidence. Each finding that was extracted was assigned a level of credibility.

Data Synthesis

Data were synthesized using QARI to pool the findings. This process included the synthesis of findings to generate a set of statements that represent that aggregation through assembling the findings (Level 1 findings) rated according to their quality and categorizing those findings on the basis of similarity of meaning (Level 2 findings). Those categories were then subjected to a meta-synthesis to produce a single comprehensive set of synthesized findings (Level 3 findings) that could be used for evidence-based practice. This review produced 101 findings that were aggregated into 11 categories, resulting in 4 synthesized findings.

RESULTS

Methodologic Quality

Of the 50 critically appraised studies, 11 were excluded, but most for reasons other than methodologic quality. Some of the studies included participants from more than one discipline and it was difficult to identify the voices of the professional nurses; in other studies it was not possible to identify the context of the research and in others moral distress was measured using a tool.

Results of the Meta-Aggregate of Qualitative Research Findings

Meta-synthesis of studies included in the review generated four synthesized findings. These synthesized findings were derived from 102 study findings that were subsequently aggregated into 11 categories. The findings indicated that many nurses express moral distress through biopsychosocial responses such as anger, depression, and stress reactions. There is also a tendency by nurses who experience moral distress to withdraw emotionally from patients. Moral distress was also experienced when nurses felt powerless to implement change or influence decision making The categories of Biopsychosocial Responses, Emotional Withdrawal, and Powerlessness led to the first synthesis finding of Human Reactivity, defined as the experience of moral distress that causes nurses to respond with a myriad of reactions including anger, loneliness, depression, guilt, anxiety, feelings of powerlessness, and emotional withdrawal, all of which lead to related physical symptomatology.

The findings also indicated that when nurses experience moral distress over time there are frequently deleterious effects on the health care system, such as nurses leaving the institution, leaving the profession, or moving to less stressful jobs. Health care system constraints such as limited finances, weak policies, and poor staffing

patterns significantly contribute to the experience of moral distress. In addition, moral distress was experienced when nurses advocated for patients and their voices were not acknowledged. The categories of Adverse Effects to the System, Health Care Constraints, and Patient Advocacy created the second synthesis finding of Institutional Culpability, defined as the experience of moral distress when nurses felt the need to advocate for patients' well-being while coping with institutional constraints. The deleterious effect was often nurses leaving the institution or profession.

Feelings of moral distress were experienced when nurses saw others devaluing the wishes of patients and families. Similar feelings were experienced when nurses perceived that patients were suffering as a result of their treatment or lack of it. This was also true when nurses observed patients being subjected to treatments that they perceived as futile. The categories of Devaluing Patient Wishes, Patient Suffering, and Futile Care created the third synthesis finding of Patient Pain and Suffering. Patient Pain and Suffering is defined as the experience of moral distress when nurses perceive that patients are receiving futile care and their wishes are ignored by physicians, institutions, or families. The perception of patient suffering as result of medical decisions was extremely distressful.

Lastly, moral distress was experienced when there were conflicting professional goals and values that were inconsistent with the science and values inherent in the discipline of nursing. Moral distress was also felt when physicians and others failed to include the nurse as a valuable member of the health care team, capable of contributing to and influencing treatment goals. The categories of Conflicting Professional Goals and Values, and Unequal Authority led to the fourth synthesis finding of Unequal Hierarchies, defined as the experience of moral distress when nurses perceived that physicians and others devalued nursing expertise and displayed a lack of recognition of nursing authority when there was a difference in professional goals and values. The fact that physician authority is assumed and seldom questioned contributes to the perception of inequality.

DISCUSSION

The purpose of this systematic review was to examine the best available evidence on the ways in which professional nurses, working in hospital environments, experience ethical/moral distress. To address this question, qualitative studies using a myriad of methodologies such as phenomenology, descriptive/exploratory, participatory action research, grounded theory, and hermeneutics were identified. Using the JBI-QARI tools from the Joanna Briggs Institute, the authors critically (**Fig. 2**) appraised 50 research reports and retained 39 for data extraction. A total of 101 findings were extracted and these generated 11 categories. These categories were then analyzed to identify four syntheses:

1. Human Reactivity: Nurses who experience moral distress respond with a myriad of biological, psychological, and stress reactions.
2. Institutional Culpability: Moral distress is experienced when nurses feel the need to advocate for patients' well-being while coping with institutional constraints.
3. Patient Pain and Suffering: The perception of patient pain and suffering as a result of medical decisions, of which the nurse has little power to influence, contribute to the experience.
4. Unequal Power Hierarchies: Unequal power structures, prevalent in institutions, exacerbate the problem.

Nurses who experience moral distress responded with a myriad of human reactions including anger, loneliness, depression, guilt, anxiety, feeling of powerlessness, and emotional withdrawal. Nurses not only withdrew within themselves but also withdrew

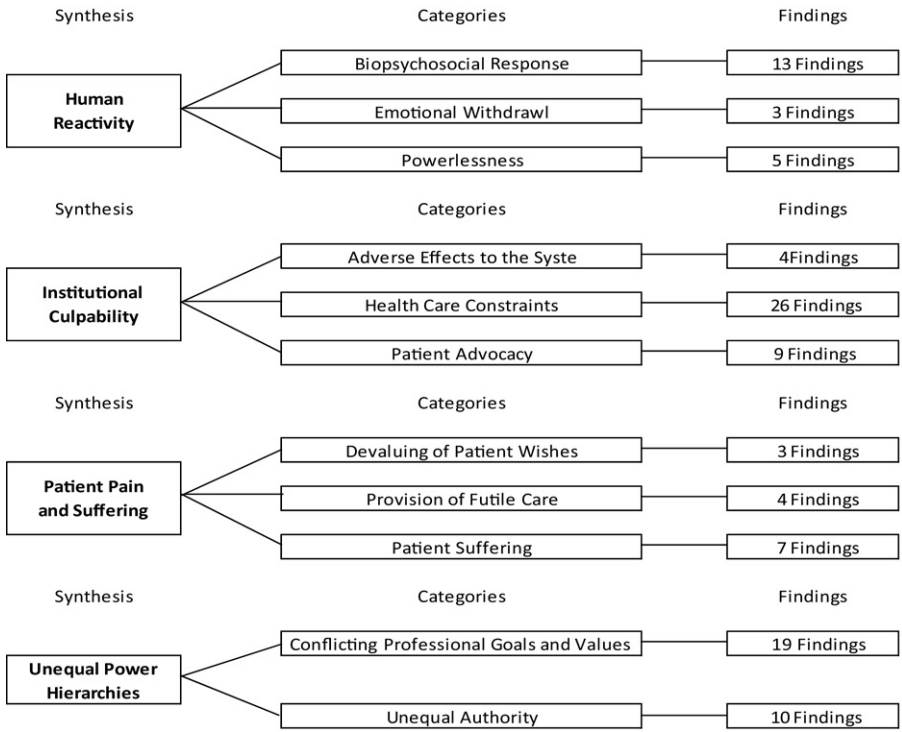

Fig. 2. Syntheses and categories of qualitative studies.

emotionally from patients. The stress from these reactions often led to related physical symptoms. Examples of biopsychosocial responses were prevalent in the findings. Narratives about feeling sick, stressed, powerless, numb, angry, depressed, and frustrated and anxious were rich. Nurses reported that moral distress produced a variety of strong negative feelings, making the work environment an unpleasant place to be.

The participants' narratives suggest that there is an institutional culpability in contributing to the experience of moral distress. This seemed to be true despite the geographical/cultural context. Moral distress is felt most intensely when nurses feel they need to advocate for patients' well-being while coping with institutional constraints. Experiencing moral distress seemed to heighten nurses' sense of patient advocacy. The deleterious effects of this on the health care system were reported as the desire to work part time, leave the unit, leave the institution, or leave the profession. Job satisfaction/retention seems to be one of the major deleterious effects of nurses experiencing moral distress. The constraints imposed by the institutional system sometimes brought some nurses to believe that they could not practice nursing in accordance with their value system. Unrealistic and unsafe staffing patterns causing increased workloads, and the deleterious effects on patient care were common in the narratives. An inability to have interpersonal relationships with patients was often reported as a frustration. Nurses often felt squeezed between what they know they should do and want to do and institutional constraints that focus only on cost containment. Nurses acutely experienced moral distress when they felt an inability to provide quality of care because of financial constraints and staffing cutbacks. Raising concerns about quality of care, dilemmas, and difficulties were experienced by some nurses as feelings of dissonance

between their professional duty to raise concerns and fear of repercussions—from physicians as well as administrators.

Moral distress also seemed to occur when nurses perceived that patients were experiencing unwarranted pain and suffering and they (the nurses) felt little ability to influence the treatment decisions that were causing the pain and suffering. This seemed particularly true when children were involved. The perception of pain and suffering was often connected to the observation that patients were receiving futile care, and physicians, institutions, or families ignored patients' wishes. In all, distress was experienced when nurses believed that the consequences of a current therapy outweighed the benefit. Medical end-of-life decisions that did not consider quality of life were also a situation that produced a climate of distress.

The unequal power hierarchies that are prevalent in institutions also seem to contribute to the experience of moral distress. Moral distress was experienced when nurses perceived that physicians devalued their nursing expertise. Nurses often felt a lack of recognition of nursing authority when there was a difference in professional goals and values. In many narratives physician authority was assumed and almost never questioned. Distress arose when there was a dichotomy between nursing's increased responsibility for and contribution to the care of patients and their families and a recognized lack of authority in which to influence patient care decisions. Nurses experienced "relentless and profound" disillusionment on finding themselves routinely unable to enact their core values. This was often related to nurses and physicians holding different opinions concerning the right treatment or decision for the patient. Overly aggressive medical treatment was an identified theme. Nurses seem to emphasize a patient's right to holistic treatment and care and felt distress when that core value could not be enacted. The hierarchy between different professionals affects how nurses can act upon their own moral position. It was often perceived that ethical problems were sometimes related to nurses' lower position in the hierarchical structure.

SUMMARY

The experience of moral distress for professional nurses working in hospital environments causes a myriad of biological, psychological, and stress-related reactions. There is an institutional culpability in producing an environment where moral distress is experienced. This is particularly true when nurses feel the need to advocate for patients' well-being while coping with institutional constraints. The perception of patient pain and suffering as a result of medical decisions, which the nurse has little power to influence, contributes to the experience. Unequal power structures, prevalent in institutions, exacerbate the problem.

Critical care nurses need to recognize moral distress and its adverse impact on providing optimal patient care. Critical care nurses should make a personal commitment that moral distress will not impact their nursing care and take a leadership role in their units to address this issue with their employing institution and develop strategies to lessen the impact of moral distress. These strategies should be based on the best available evidence such as this systematic review and other relevant appraised works.

Implications for Nursing Practice

From the review and syntheses, several recommendations for practice emerge:

- Institutions need to recognize nursing specialties such as critical care that may be at increased risk for experiencing moral distress.
- Institutions need to consider the implementation of the American Association of Critical-Care Nurses framework addressing moral distress.

- Institutions need to design structures that provide support for nurses who are experiencing feelings of moral distress. These structures need to be genuine, nonjudgmental, and ideally provided by nurses.
- Professional nurses need to have access to the ethics committee of the institution.
- Education programs that teach nurses how to recognize moral distress and the effects it has on the mind and body should be offered and nurses given time to attend.
- Institutions need to provide front line nurses a voice in expressing concerns about health care constraints and invite input on problem solving.
- Institutions need to create an environment of shared respect, acknowledging nurses' contributions and supporting autonomous nursing intervention.
- The nursing value of holistic care needs to be respected by institutions.
- Nurses should not be coerced into violating their own core beliefs about what constitutes good nursing care, especially in their role of patient advocates.

Implications for Research

Several registered nurses experiencing moral distress expressed a desire for an established support system within their employing institution such as easy accessibility to a hospital-based ethics committee, open communications with nurse managers, and established ethical support groups. Further research is needed on the perceived effectiveness of these strategies in addressing the nurses' experience of moral distress and preventing potential nurse burnout.

In addition, further study is warranted on the perceived hierarchal structure of the physician–nurse relationship within the context of the hospital environment. Participants in the included research studies described the inherent "risk" involved in advocating for patients. This risk contributed to their moral distress and was frequently associated with physician decision making that violated the wishes of the patients and required nurses to unwillingly participate in futile care endeavors. An investigation is needed of strategies that provide an equalizing voice for registered nurses and decrease a sense of powerlessness in providing patient-centered care.

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