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Turkish Intensive Care Nurses' Experiences of Moral Distress: A Qualitative Study

Türk Yoğun Bakım Hemşirelerinin Ahlaki Sıkıntı Deneyimi: Niteliksel Bir Çalışma

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ABSTRACT Objective: The aim of this study was to explore the experiences of intensive care nurses related to moral distress. **Material and Methods:** In this study, focus group interview, which is a qualitative research technique, was used. This qualitative study was carried out in a university hospital's intensive care unit between April 1, 2019 and June 1, 2019 in the city of Düzce. We conducted semi-structured interviews with a purposive sample of 18 intensive care nurses to explore nurses' experiences related to moral distress. Data were analysed using thematic analysis, utilising the 6 phases outlined by Braun and Clarke. **Results:** After analyzed data, 5 themes were identified; I) Meaning of the moral distress, II) Experiences of moral distress, III) Effects of moral distress, IV) Coping techniques, V) Suggestions and solutions for reducing or preventing moral distress. **Conclusion:** In the study, most of the nurses did not have a clear knowledge about the concept of moral distress and had not heard of it before. With this, it was determined that nurses working in intensive care units have physical and psychological problems due to moral distress. To cope with moral distress, nurses use both effective and ineffective coping methods. In order to prevent or reduce moral distress, managers should develop and design strategies for supporting nurses.

Keywords: Moral distress; intensive care; intensive care nurses

ÖZET Amaç: Bu çalışmanın amacı, yoğun bakım hemşirelerinin ahlaki sıkıntı ile ilgili deneyimlerini incelemektir**. Gereç ve Yöntemler:** Bu çalışmada nitel araştırma tekniği olan odak grup görüşmesi kullanılmıştır. Araştırma 1 Nisan 2019-1 Haziran 2019 tarihleri arasında Düzce'de bir üniversite hastanesinin yoğun bakım ünitesinde gerçekleştirilmiştir. Hemşirelerin ahlaki sıkıntı ile ilgili deneyimlerini belirlemek amacıyla 18 yoğun bakım hemşiresinden oluşan amaçlı bir örneklem ile yarı yapılandırılmış görüşmeler yürütülmüştür. Elde edilen verilerin tematik analizi Braun ve Clark'ın 6 aşamalı yöntemi kullanılarak yapılmıştır. **Bulgular:** Verilerin analizi sonrasında 5 tema belirlenmiştir; I) Ahlaki sıkıntının anlamı, II) Ahlaki sıkıntı deneyimleri, III) Ahlaki sıkıntının etkileri, IV) Başa çıkma teknikleri, V) Ahlaki sıkıntının önlenmesine veya azaltılmasına yönelik öneriler ve çözümler. **Sonuç:** Bu çalışmada, hemşirelerin çoğunun ahlaki sıkıntı kavramını daha önce duymadığı ve bu kavram hakkında bilgi sahibi olmadığı görülmüştür. Bununla birlikte yoğun bakımda çalışan hemşirelerin ahlaki sıkıntı nedeniyle fiziksel ve psikolojik problemler yaşadıkları saptanmıştır. Ahlaki sıkıntı ile baş etmede hemşireler etkili ve etkili olmayan baş etme stratejilerini kullanmaktadır. Ahlaki sıkıntının önlenmesinde veya azaltılmasında yöneticilerin hemşireleri desteklemesi ve bu yönde stratejiler geliştirmesi gerekmektedir.

Anahtar Kelimeler: Ahlaki sıkıntı; yoğun bakım; yoğun bakım hemşireleri

Moral distress is a serious phenomenon that threatens the quality of nursing care, the future of the nursing profession and patient safety. It was first described by Jameton as "A painful feeling or the psychological disequilibrium when nurses know the appropriate action, but can't carry out this situation because of institutional obstacles or constrains".[1] These factors included 3 components: internal factors, clinical conditions, and external factors. Internal stress factors related to caregivers that occur the psychological reactions of nurses such as feeling of weakness and lack of knowledge. Clinical conditions include treatments considered to be of no use and inadequate application of informed consent. And then external stress factors involve environment barriers that may affect patients and health

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care providers can result from the legal system and health service reimbursements of doctors, health administrators, and other employees.[1] The American Association of Colleges of Nursing stated that moral distress is a serious problem, that dissatisfaction regarding the work environment causes physical and emotional stress in nurses, and that it affects the quality, quantity and cost of nursing care, and may even cause nurses to quit their profession.[2] Some studies have found that intensive care units have a much higher risk of moral distress, because ethical decisions are regularly made in them.[3-5] According to many research on this subject, lack of communication and poor cooperation among team members, differing perspectives of health professionals on ethical issues, increased workload due to staff shortages, limited resources, lack of administrative support, incompatibility of the institution with health policies, inappropriate policies, and an adverse ethical climate are other examples of factors that cause moral distress in nurses.[4-7] Studies on moral distress were mostly conducted in clinics such as intensive care unit where decisions about end-of-life care are made. It has been found that variety of negative physical and psychological factors have effects on critical care nurses. On the physical side, it can lead to headache, stomachache, and muscle pain, while on the psychological side, it can cause feelings of burnout, frustration, guilt, weakness, despair, regret, suffering, anger, grief, anxiety, helplessness, shame, embarrassment, loss, sadness, fear, and anguish.[4-7] And also, moral distress causes job-patient dissatisfaction, decreasing quality of care and even they want to abandon their current professional position or leaving their job.[8,9] In Türkiye, the number of quantitative studies that examine the causes of nurses' moral distress is very limited.[10,11] On the other hand, in Türkiye, no research has yet to determine the factors affecting the moral distress and coping strategies of intensive care nurses with qualitative method. No qualitative research on intensive care nurses' moral distress was found in Türkiye. Therefore, this qualitative research is intended to explore the experiences of Turkish intensive care nurses related to moral distress.

MATERIAL AND METHODS

STUDY DESIGN AND SAMPLING METHOD

This study was carried out in a university hospital's intensive care units between April 1, 2019 and June 1, 2019. In this study, focus group interview, which is an exploratory approach research was used. The sample consisted of 18 nurses. Purposive sampling was used, and age, gender, work experience were the key variables considered during recruitment. And the inclusion criteria were as follows: I) Being an intensive care nurse; II) Having worked for at least 6 months in an intensive care unit; III) Having experienced moral distress in their working life; and IV) Consenting to participate in this study. The number of participants was determined according to the principle of "data saturation" in qualitative research.[12] We conducted semi-structured interviews with 18 nurses.

ETHICAL APPROVAL

Hospital permission (number:69898333/307.99/25005) and Düzce University Non-Invasive Health Researches Ethics Committee (date: March 18, 2019, no: 2019/59) were obtained before conducting this research. This research was made in accordance with principles of Helsinki Declaration. The nurses were informed about the purpose of the study and that audio recordings of the qualitative interviews would be made. The nurses were told that their participation was entirely voluntary, and that their names would not be used in the recordings of the focus group interviews. They were also informed that their data would be used only within the scope of the study.

DATA COLLECTION

Three focus group interviews were conducted with nurses working in 3 intensive care units in groups of 6 participants. Semi-structured focus group interviews took approximately 40-60 minutes. The interviews were conducted in a meeting room that was quiet, sufficiently bright and warm, where the nurses could express themselves comfortably. At the beginning of each interview, the study was described, participants were asked if they had any questions and a

code name was assigned by the interviewer to each participant. Each interview was recorded by an audiotape, and the interviewer also took written notes. The focus groups were facilitated by the first author and a second researcher who took notes and recorded the interviews. The interviews were conducted following open-ended questions. The interview questions were: "Share with me your experiences related to moral distress", "How did you feel when you experienced moral distress?", "What are your coping methods?"

DATA ANALYSIS

Interviews were recorded and transcribed for coding and analysis via the NVivo 12 (QSR International, USA) program by 2 researchers. Each participant's responses were performed and analysed using thematic analysis through the six step process.[13] I) Firstly, the recordings were transcribed, we read carefully several times to build a general vision of issues. II) We examined line by line in detail and assigned codes to paragraphs or segments of the text, the same meanings grouped and generated initial codes. III) Similar ideas and concepts were named and grouped into major themes and sub-themes. IV) The themes and sub-themes were reviewed and discussed by all researchers. Each theme was revised by comparing with the participants' statements. V) And, themes and codes were scrutinized independently by an expert. In accordance with their suggestions, final changes were made to the themes. VI) Finally, we obtained themes and subthemes.

RIGOR

Trustworthiness was maintained following four criteria by Lincoln and Guba; credibility, dependability, transferability, and confirmability.[14] All coding was done by the first author in order to ensure consistency. To establish credibility, interview transcriptions were analysed independently by all authors. Dependability was reached through an external expert. Confirmability and transferability were ensured the participant's descriptions and reflextion notes taken by the second author during data collection process.

RESULTS

Of the 18 participants, 7 were female, and 11 were male. Their ages ranged from 22 to 47 years. Eleven nurses were married, and 7 were single. Years of work experience ranged from 2 to 15 years. Five nurses had a pre-bachelor's degree, 11 had an undergraduate degree, and 2 had a graduate degree. We identified 5 themes: I) Meaning of the moral distress, II) Experiences of moral distress, III) Effects of moral distress, IV) Coping techniques, V) Suggestions and solutions for reducing or preventing moral distress. Each theme had several subthemes as Table 1 shows.

Meaning of the Moral Distress

The study found that most of the nurses did not have a clear knowledge about the concept of moral distress and had not heard of it before. They associated it with their own moral and professional values and other difficulties they had at the hospital. Some of the participants associated moral distress with negative situations in the hospital environment and burnout. For example, one participant said:

"*For me, it evokes the concept of conscience. Our jobs require us to have a conscience. If we have a conscience, we do our jobs better and develop a better approach to patients. We earn our daily bread with this job, we need to sleep comfortably when we go home and put our heads on the pillow. In other words, we need to perform well for the money we earn.*" *(Session 2, Participant 6).*

Experiences of Moral Distress

The nurses said that they experienced moral distress due to situations related to resuscitation, caring for terminally ill patients, ambiguities in their job descriptions, and due to the hospital, the hospital administration and patient relatives.

Situations Related to Resuscitation

Futile treatment

The nurses said that some terminal patients were resuscitated unnecessarily, and that "the doctors resuscitated them just to get it done."

TABLE 1: Summary of theme, sub-theme and meaning units.

Theme	Sub-theme	Meaning units
Meaning of the moral distress	Moral values	Morals
		Moral responsibility
		Conscience
		Conscientiousness
		Empathy
	Professional values	Ethical values
		Professional attitudes and behaviors
		Patient confidentiality
		Compassionate care
		Empathy
Experiences of moral distress	Situations with terminally ill patients	Carrying out resuscitation unnecessarily
		Futile or unnecessary treatment
	Ambiguous job descriptions	Doctor's refusal to take responsibility
		Unauthorized nursing interventions
		Unfair work assignments
		Doctors' unwillingness to obey the rules
	Situations with patient relatives	Changes in the treatment of patients
		Unfair patient care due to social status
	Situations related to the hospital environment	Lack of materials
		Unsuitable physical environment
		Lack of personnel
		Lack of communication
	Situations related to the hospital administration	Being assigned to different services
		Inadequate clinical experience
		Unfair treatment of personnel
		Directors' inability to motivate personnel
		Lack of administrative support
Effects of moral distress	Physical effects	Headaches
		Migraines
		Stomach problems
		Sleep problems
	Psychological effects	Burnout
		Reduced job satisfaction
		Depersonalization
		Worry
		Helplessness
		Tension and anxiety
		Remorse
		Feelings of unworthiness
	Social effects	Retreating from social life
		Leading to problems in personal relationships
Coping techniques	Effective coping techniques	Physical exercise, yoga, relaxation and breathing exercises
		Getting support from colleagues
		Finding personal solutions
	Ineffective coping techniques	Withdrawing or retreating
		Ignoring
Suggestions and solutions for reducing or preventing moral distress	Regarding regulations and laws	Regulating duties, authority and responsibilities
		Problems related to specializations
	Regarding the work environment and conditions	Creating a suitable work environment
		Reducing workloads
	Regarding qualified administrative support	Nurses should be heard by and have regular meetings with directors
		In-house social activities
		Administrators should have good leadership qualifications and experience, and full knowledge of the clinical field

They also said that unnecessary treatments of terminally ill patients did not improve their quality of life, but only improved their life expectancy. One nurse gave this example:

"*In intensive care, you know whether a patient will come back or not, will recover or not. Actually, nothing you do will make them come back. There were too many interventions. They irritated a patient so much that his ribs were broken, and his tube was filled with blood. I had to watch the scene without making any movements for two or three minutes. After that, I was horrified. In fact, how could this be done to a human's body? I was horrified.*" *(Session 2, Participant 1).*

Ambiguous Job Descriptions

The nurses said that the doctors did not follow-up patients sufficiently, did not intervene or take responsibility for patients, and then delegated these responsibilities to nurses. The nurses said that they carried out duties in life-threatening situations that were not theirs even though it was not legal for them to do so and when complications developed, the nurses were found guilty. Since the administration focuses on doctors, the nurses are required to perform tasks that are not their assigned duties, that exceed their authority and that increase their workload. One nurse gave this example:

"*I have worked in an intensive care unit for many years. We sometimes have to carry out duties that are the doctor's responsibility even though it is not legal for us to do so. We carry them out when a patient is in a life-threatening situation and we call and cannot reach the doctor; however, there is no law that protects us. For example, arterial blood gas sampling: if we damage the artery, it is on us and we get into serious conflict with the doctors. It is a dilemma. Other examples include nasogastric intubation and urinary catheterization. After an operation, if a patient has bladder over distension and is in pain, we do a urinary catheterization; however, we are held responsible for any infections that develop. They start asking who did the urinary catheterization. This situation puts us in an enormous dilemma*." *(Session 3, Participant 5).*

Situations with Patients and Their Relatives

When the general condition of a patient changes, nurses sometimes have to perform tasks such as physical restraint even though they do not want to do so. The nurses said that this causes moral distress. They also said that the doctors do not treat all patients fairly, for instance, in risky practices such as resuscitation because they hesitate or because of the relatives of some patients. One nurse explained:

"*In this job, one thing I have noticed most is the doctors' behavior regarding social status. For example, there was an elderly patient admitted to the clinic who was a relative of one of the leading wealthy families of our city. The patient had a heart attack, and they did their best to resuscitate the patient. They tried so hard just because of the patient's social connections. The patient was in very poor condition, and we need to have respect for the dead. Even though they knew that patient was going to die, they carried out different operations because the patient's relatives were people with authority*." *(Session 2, Participant 1).*

Situations Related to the Hospital Environment

Lack of Resources

The nurses said that they experienced moral distress due the lack of materials and personnel and the physical structure of their hospital. They said that insufficient or inferior quality materials bought by the hospital, and late doctor orders delay patients' treatments and cause them moral distress. They also said that unavailable doctors and medical staff miscommunication led to difficult situations for patients and nurses. The nurses added that the physical structure of the hospital and lack of personnel increased their workload so that they cannot carry out their actual duty of nursing, which causes them moral distress. One nurse explained:

"*We have to use the cheapest materials bought by the hospital administration, and this affects our quality of care negatively*." *(Session 3, Participant 3).*

"*In my opinion, intensive care units are hospitals' most important clinics. I have been working for*

ten years, and my observation is that there is a lack of personnel: caregivers, doctors and nurses. We know that we need to change patients' position every two hours, but we do not have time, and we are not able to do this. So we do it every three or four hours. In fact, if the shift goes too bad, we may not be able to do it at all and skip it entirely. Or if you are to mobilize an overweight patient by having them stand up, you may not be able to do it because you don't have a caregiver. Not doing these things can cause complications, so this disturbs us." *(Session 2, Participant 3).*

Communication Conflicts in Healthcare Teams

Nurses sometimes have difficulties due to miscommunication among healthcare teams. Not always having a doctor in intensive care unit, having trouble reaching doctors and lacking specific standard practices can cause moral distress. One nurse gave this example:

"*Sometimes a patient needs extra treatment. The things we do alone are not sufficient. You try to reach the doctor, and you cannot. You try to call them using their extension, but it doesn't work. You want to call from your cellphone, but you do not have any reception, so it doesn't work*." *(Session 3, Participant 1).*

Lack of Personnel

"*The number of patients per nurse is important to us. By normal standards, a nurse should look after two patients in tertiary intensive care units. However, we look after three patients. Naturally our workload increases, and this reduces the quality of care and its effectiveness*." *(Session 1, Participant 1).*

Situations Related to the Hospital Administration

The nurses said that they experienced moral distress due to the hospital administration: being temporarily assigned to another clinic, unfair treatment of personnel, administrators being unable to come up with effective decisions and solutions due to their lack of clinical experience, administrators being unable to motivate personnel and not valuing or supporting them. One participant said:

"*Generally, the hospital administrators have no clinical experience, so they do not understand our work conditions, but they order us around constantly. This needs to be changed*." *(Session 1, Participant 5).*

THE EFFECTS OF MORAL DISTRESS

Moral distress affects nurses physically, psychologically and socially. The nurses said that moral distress was a great source of stress for them. They said that they did not want to go to work due to stress, that they sometimes thought about leaving their clinic and even thought about quitting their jobs. They also said that they became apathetic to the health problems of their own family members and close friends, experienced intolerance, withdrew from social activities and did not want to get into touch with other people. One participant said:

"*Stress caused me to start suffering from ulcerative colitis. When I am stressed, the attacks increase. I try to stay away from stress factors as much as possible. I try to avoid stressful environments*." *(Session 1, Participant 4).*

"*We feel helpless. Forget job satisfaction, there are times when I want to leave this department., I really think about leaving. When it occurs to you that your job will be like this for years on end, you think about leaving the job a lot*." *(Session 1, Participant 2).*

COPING TECHNIQUES

The nurses said that they tended to use ineffective coping techniques such as ignoring moral distress, withdrawing or retreating to cope with moral distress, and that they tried to find personal solutions since they lacked administrative support. Some of the nurses said that they used effective coping techniques such as yoga, physical exercise, and relaxation and breathing exercises to cope with stress.

"*To be honest, I do not care much. I do not pay too much attention. So I do not get too involved in anything. Rather than interfering in events, I try to stay away. Otherwise, I get obsessed with them when I go home. Other than that, I generally try to isolate myself. I do not want to do too much because it's unhealthy for me*." *(Session 1, Participant 4).*

Suggestions and Solutions for Reducing or Preventing Moral Distress

The nurses proposed ways to prevent or reduce moral distress: clarifying their duties, authority and responsibilities, making work environments more efficient for employees and more comfortable for employees and patients, employing nurses in departments that are appropriate for their qualifications, increasing the number of personnel (doctors, nurses and caregivers) to reduce workloads, reducing work hours, having administrators observe the difficulties employees face by visiting clinics and in-house activities to increase employees' motivation. One nurse recommended:

"*As a solution, work hours should be reduced, and a stress-reducing environment should be created at the hospital where social activities can take place. They should also minimize stress factors by reducing working hours and employing more nurses. Job definitions for doctors and nurses should be clarified, and operations should be carried out in strict adherence to these rules. Promotions, training and job assignments should be done according to merit.*" *(Session 1, Participant 1).*

DISCUSSION

We identified 5 themes and 15 sub-themes related to the moral distress encountered by Turkish intensive care nurses. The qualitative research in this study provided a noteworthy understanding of the experience of moral distress among nurses. First of all, the results of this study show that Turkish nurses frequently experience moral distress, although they are not familiar with this concept. Most of them stated that they had not heard of this concept. The nurses associated moral distress with the challenges they encountered at their hospital, including situations such as carrying out resuscitation, administering futile or unnecessary treatment to terminally ill patients, dealing with patients' family members, and working in a difficult hospital environment that lacked personnel and resources, good communication, and administrative support. Causes of moral distress vary according to countries, cultures, and participants' experiences.[15-17] In developed countries, problems include patient and relative requests, poor communication and end-of-life care, and pressure on physicians, whereas in underdeveloped countries, these include inadequate and/or ineffectual equipment and the lack of personnel and collaboration among healthcare professions.[18-20] The studies reporting on the causes of moral distress show results similar to ours.[18-20] In addition, the participants emphasized that they experienced distress when carrying out resuscitation and giving futile treatment when providing care to terminally ill patients. This intervention prolongs the patient's life, but causes suffering and reduced quality of life. In some countries, the "do not resuscitate" order is legal, and in some not.[21-25] It is illegal to practice this in Türkiye, but nevertheless, we know it is done most of the time in clinics. Nurses also indicated that they experienced moral distress because of being in the middle between the physician's orders, the patient or relative's request, and the law. Another important factor is that the moral distress experience appears to be mostly related to hospital administration. In Türkiye, many hospitals are managed with a more physician-oriented approach. Consequently, the other health care professions are not included in decision making and receive less support than physicians. Nurses highlighted the fact that their job description was not clear and that they were being assigned tasks by managers that exceed their authority. Therefore, they could not allot sufficient time to their patients and families because of their caregiving workload. This finding underlines the need to provide management support and an appropriate hospital environment so as to increase the quality of care. Most qualitative and quantitative research has reported that moral distress has negative physical, psychological, and social effects on nurses.[4,21,22] These symptoms lead to job dissatisfaction, burnout, depression, feelings of unworthiness and guilt, and even to the intention of leaving their position or job.[8,23,24] The participants interviewed said that they encountered psychological effects such as worry, helplessness, depersonalization, burnout, reduced job satisfaction, anxiety, remorse, and feelings of unworthiness in addition to experiencing physical effects. Strikingly, some of the nurses in our study said they had become insensitive to and disinterested in their families and

experienced difficulties socializing. They also said that they sometimes thought about leaving their positions or quitting their jobs. This is an important consequence that may pose a risk for the future of the nursing profession. We found that the nurses used both effective and ineffective coping techniques to deal with moral distress. Some used effective coping mechanisms to relieve stress, while others ignored it or withdrew. This study also determined that the nurses found their own personal solutions for their moral distress because they lacked administrative support. These findings are similar to those of other studies on this issue.[7,15,24] An experimental study, revealed that there was a significant difference between groups after applying the moral empowerment program on intensive care nurses. The nurses who participated in the moral empowerment program had lower mean scores for moral distress than the control groups.[25,26] Similar coping strategies are used in the workplace, most commonly by seeking support from colleagues and families. Most research dealing with moral distress has demonstrated that critical care nurses who reported a healthy practice environment with a culture of quality care had lower levels of moral distress. It is recommended that successful coping strategies be developed by the managers, such as providing mental health support, allowing expression of nurses' feelings/opinions, and improving work-based programs on moral distress.[27,28]

LIMITATIONS

This study was conducted in three intensive care units of a university hospital. It involved small groups of intensive care nurses and their experiences. The participants' perceptions may have differed from each other because of cultural or religious backgrounds. Because of these limitations, our results cannot be generalized. We recommended that such qualitative studies be carried out by other health care professionals and other units with a larger number of sample groups.

CONCLUSION

The results indicate that moral distress is a common ethical issue for Turkish intensive care nurses. Moral distress affects nurses physically, psychologically and socially. Moral distress has a devastating effect on nurses, patients, and the quality of nursing care. At the same time, it was found that nurses use both effective and ineffective coping methods to deal with moral distress. The nurses have made some suggestions for the prevention or reduction of moral distress: regarding regulations and laws, regarding the work environment and conditions, regarding qualified administrative support. This study can help nursing managers improve strategies for reducing or preventing moral distress among nurses. Thus, the goal for managers should be to provide a healthy hospital environment, improved working conditions, and clarified job descriptions, and to support training programs and regulate hospital rules and laws.

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Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

Authorship Contributions

All authors contributed equally while this study preparing.

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