

Moral distress among nurses in caring COVID-19 patients

Clinical Ethics

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Rosyidah Arafat, Takdir Tahir and Akbar Harisa 

Abstract

During the COVID-19 pandemic, nurses experienced tremendous dilemmas including the need to perform their duties in caring for patients while they have concerns about contracting the disease. This study described the moral distress of nurses in-charge of handling COVID-19 patients which can be used as baseline data for intervention programs in overcoming moral distress among nurses. This descriptive, cross-sectional study was conducted with nurses in-charge of handling COVID-19 treatment rooms. Before conducting the survey, ethical approval was obtained from the Medical Faculty of Universitas Hasanuddin. Questionnaires on moral distress for clinical nurses and the demographic data questionnaire were distributed to 128 respondents. These nurses experienced relatively low levels of moral distress despite the fact that they were generally exposed to morally stressful situations. Education background appeared as a factor influencing this condition, in which higher moral distress was mostly experienced by nurses with undergraduate education.

Keywords

Moral distress, nurses, caring, COVID-19, pandemic

Introduction

Moral distress is a fundamental issue in nursing care,¹ nurses are mentioned to take many ethical resolutions every day,² but in practice, they cannot always serve in conformity with their decisions. According to Jameton³ definition, Moral distress appears when one knows the right thing to do, but the institutional barrier makes it nearly impossible to follow the right course of action. Moral distress is a condition where health workers experience tension/stress caused by a contradictory health care situation they experience, in which, in this situation, they know what to do but cannot do anything. Hence, the nurses act in a way that is contrary to their personal and professional values, which could break their integrity.^{1,4} Burston and Tuckett⁵ stated that the contributing factors for the development of moral distress are individual practitioners, site-specific systems and broader external influences.

Moral distress varies based on the work atmosphere,⁶ COVID-19 pandemic becomes an unexpected and unprecedented challenge.⁷ This pandemic is causing tremendous pressure on health workers, especially nurses, in which they are expected to continue working as usual. On the one hand, they become the forefront of providing services to the patients of COVID-19. On the other hand, they still need to take care of themselves against infected patients with a high risk of transmission.⁸ This condition can cause moral distress for nurses.

During this pandemic, various dilemmas have occurred to nurses, including how to balance their duties in caring for patients, their concerns about the infection of the coronavirus, and their concerns about which they can transmit the virus to their families.⁹ Nurses lacking experience in addressing ethically challenging situations may be at higher risk of experiencing moral distress.¹⁰

This concern tends to be clearer among elder health workers as well as those with limited availability of personal protective equipment (PPE). Nurses struggle physically in unsafe conditions like insufficient supplies of PPE.⁹ In this regard, results of the study by Burston and Tuckett⁵ revealed that the lack of resources may facilitate or directly contribute to situations of moral distress, an imbalance between supply and demand of resources influences affecting an institution's ability for service delivery.

Another thing that can promote moral distress is when encountered with the choice between maintaining ventilator support for patients of COVID-19 with the critical condition in which the patients indeed can no longer survive

Faculty of Nursing, Hasanuddin University, Indonesia

Corresponding author:

Akbar Harisa, Hasanuddin University, Jl. Perintis Kemerdekaan Km 10, Makassar, Sulawesi Selatan 90245, Indonesia.

Email: akbar.harisa.unhas@gmail.com

and giving the ventilator to patients with an excellent prognosis. In the context of the COVID-19 pandemic, healthcare workers are in an uncomfortable position in which they must select the choice to allocate fewer resources to the patients who require them most.¹¹ Dimensions of site-specific care and caring contribute to moral distress.⁵ In a similar care context, Kälveborn et al.¹² identify a lack of beds for patient care dispatch and others in accordance with the environment for the stipulation of palliative as a contributor to the moral distress of nurses.

Nurses worry about their professional, ethical and legal protections when asked to provide care in high-risk situations, like the COVID-19 pandemic.¹¹ The existence of nurses' moral distress is critically important to pay attention to because it can influence clinical decisions, increase the possibility of medical errors, and ultimately increase the risk of fatigue experienced by nurses.^{13, 14} Moral distress has been widely reviewed across many care contexts, but no study was found on the issues of moral distress among nurses in a pandemic situation like a COVID-19 pandemic.

The study aims at discovering the picture of the moral distress experienced by nurses handling the patients of COVID-19, and at determining the relationship between the moral distress of nurses and the sociodemographic factors. This study can be operated as baseline data for intervention programs that can overcome the moral distress of nurses taking care of COVID-19 patients.

Materials and methods

Design

A cross-sectional design was used in this study by using a questionnaire. This research was conducted for 4 months from June to September 2020.

Sample

Convenience sampling was used in the population of nurses handling the patients of COVID-19 working on the COVID-19 unit in four hospitals in the city of Makassar; those are *Wahidin Sudiro* Hospital, *Sayang Rakyat* Hospital, *Unhas* Hospital and *Pelamonia* Hospital. The data collection was conducted by using Google Forms. By inclusion criteria: Nurses who are in charge of handling COVID-19 at the hospital, are willing to participate in research, are working period ≥ 1 year. The survey was sent to 180 participants, but 128 people filled out the questionnaire (71.1%).

Instrument

The questionnaire consisted of a questionnaire of moral distress for clinical nurses and demographic data. Nurses' moral distress was measured using a moral distress questionnaire for clinical nurses.¹⁵ Cronbach alpha value of

0.79; internal consistency: 0.804 consisting of 15 questions using the frequency level, namely as follows: 1 = never at all up to 6 = very often. The moral distress questionnaire for clinical nurses was back-translated, from Indonesian and English versions and vice versa has been affirmed to be the same. The questionnaire of demographic data includes questionnaire number, date of filling in the questionnaire, name, age, gender, length of work, last education, religion and marital status.

Data collection

Questionnaires were sent to the head of the room, then it will be distributed to all nurses in the room. The nurse fills out a questionnaire via a Google form sent via WhatsApp. After completing the questionnaire, the nurses submit it. Then, the data is automatically received by the researcher.

Ethical considerations

Before conducting the survey, ethical approval was obtained from the Medical Faculty of Universitas Hasanuddin, with an ethical number: 547/UN4.6.4.5.31/PP36/2020. Participants were asked to answer voluntarily and anonymously. Although informed consent was not obtained directly, a completed questionnaire was considered a form of consent.

Statistical analysis

The Statistical Package for the Social Sciences, Version 17.0, was used to analyze the data. To assess the level of moral distress, individual analysis was performed for each of the 15 items on the study instrument. A mean score was calculated; higher mean scores indicated a greater frequency of moral distress. Subsequently, depending on the type of data (ordinal, nominal), a two-tailed *t*-test, Spearman correlation, or analysis of variance was performed to examine associations between the moral distress level and subjects' characteristics.

Results

Demography characteristics

As shown in Table 1, the majority of the subjects were married (68%), Islam (92.2%) and females (78.1%). Most received their basic nursing education in baccalaureate or higher programs (55.5%) with an average age of 32.09 years. They worked as nurses for an average of 8.16 years.

Mean levels of moral distress for subjects

The mean score of moral distress was 1.96, with a range of 1.33–2.59. The situation with the highest mean score was 'I was obliged to respond to the patient, who deserved a treatment but did not get it'. Mean scores for the 15

Table 1. Sample characteristics.

Sample characteristics	Response	Percent	Mean \pm SD
<i>Gender</i>			
Male	28	21.9	
Female	100	78.1	
<i>Religion</i>			
Islam	118	92.2	
Protestant	10	7.8	
<i>Education level</i>			
Baccalaureate or higher	71	55.5	
Diploma or associate	57	44.5	
<i>Marital status</i>			
Single	37	28.9	
Married	87	68	
Widow/widower	4	3.1	
<i>Years as a nurse</i>			8.16 \pm 4.4
<i>Age</i>			32.09 \pm 4.88

situations are listed in Table 2. For the 15 items questions, the lowest mean scores were 'I was forced to move a patient to an unsuitable department instead of providing her/him an appropriate treatment in my department'.

Level of moral distress based on characteristics

Table 3 shows the results of the analysis of samples' characteristics and level of moral distress. There was a significant relationship between moral distress and education level ($p < 0.05$). Analyses (t -tests, Spearman correlation and analysis of variance) were performed to determine whether any other demographic data were responsible for the associations between each of these five variables and the level of moral distress. No other associations were identified. There was no significant correlation between gender, marital status, religion, subjects' ages, experience as nurses.

Discussion

The overall frequency of moral distress

This study shows that moral distress can be concluded as a stress response developed when the nurses cannot follow moral values that are believed during caring for COVID-19 patients. In this study, the average score of moral distress of nurses handling the patients of COVID-19 showed a small to moderate scale. However, three categories show a high value which describes three types of moral distress. They are moral constraint distress, moral conflict distress, and moral uncertainty distress.

The first type, when the individual is constrained from doing what she/he thinks is the ethically appropriate action. Some nurses in this study were obliged to respond to the patient, who deserved a treatment but did not get it. In a pandemic situation, nurses fear to exposure the virus, they are not able to perform a physical examination in person, most

Table 2. The items on the moral distress.

Items	Mean \pm SD
I do not have enough time to provide the patient with the care she/he deserves	1,81 \pm 1,33
I was forced to provide care to the patient according to the supervising nurse directions against my professional opinion	1,80 \pm 1,14
I pondered whether to tell the patient (who did not have the means) that he can purchase an expensive medication not included in the "medication basket"	2,97 \pm 1,61
I was forced to invade the patient's privacy due to inadequate conditions (e.g., a patient in a corridor)	1,28 \pm 0,77
I was forced to provide care to the patient according to the physician's directions against my professional opinion	1,64 \pm 0,96
I was forced to provide an incomplete treatment to the patient owing to work overload	1,64 \pm 1,04
I was forced to keep a patient, who needed a treatment, waiting, due to lack of time	1,68 \pm 1,04
I did not give the patient a sufficient attention due to lack of time	1,64 \pm 0,99
I was forced to treat the patient according to the physician's directions against my conscience	1,63 \pm 1,03
I pondered what to do while witnessing deficient treatment provided by another nurse or a physician	3,12 \pm 1,52
I was forced to ignore the patient's questions because the physician was supposed to address them	2,02 \pm 1,06
I was forced to ignore the patient's family questions because the physician was supposed to address them	1,97 \pm 0,99
I was obliged to respond to the patient, who deserved a treatment but did not get it	3,57 \pm 1,64
I was forced to deny an appropriate treatment from a patient due to budget cuts	1,34 \pm 0,78
I was forced to move a patient to an unsuitable department instead of providing her/him an appropriate treatment in my department	1,23 \pm 0,65
Over all of moral distress	1,96 \pm 0,63

*Range 0-6

of the patient care is provided through virtual technology, so they feel frustrated to adjust the new skills, moreover, it eliminates caring touch. This can affect feeling constrained and forced to present suboptimal care.^{16, 17} The second type occurs when two or more stakeholders take opposite opinions about how a moral dilemma should be handled, these conflicts can happen between patient and healthcare team or nurse and physician,³ this is felt by nurses in this research. They are pondered what to do while witnessing deficient treatment provided by another nurse or a physician.

In times of pandemics, it is often the case with nurses on whether there is sufficient personal protective equipment

Table 3. Level of moral distress based on characteristic.

Variables	Mean	R	P
Age ^a		-.111	0,21
Years as a nurse ^a		-.160	0,07
Marital status ^b			0,57
Gender ^c			0,18
Male	2,09		
Female	1,91		
Religion ^c			0,30
Islam	1,97		
Protestant	1,75		
Education level ^c			0,03
Baccalaureate or higher	2,06		
Diploma or associate	1,82		

^aSpearman.

^bAnalysis of variance; post hoc (Scheffe) $P < 0.05$.

^cTwo-tailed t test; $P < 0.05$.

available, whether some respirators for those who need them and whether hospitals provide enough nurses to meet the needs of those affected by COVID-19. Nurses are problem solvers and innovators who demonstrate their skills to address these issues in their clinical practice. Nurses seek to find PPE and gather other supplies they need to meet the needs of their colleagues and patients. However, the constant challenge of maintaining the necessary resources to provide safe, high-quality nursing care can provoke moral conflict distress.^{18,19}

The third type happens when a nurse or other healthcare professional is unconvinced regarding what is the morally right way to continue given the current condition, which can cause these individuals to feel torn, conflicted, frustrated, guilty and upset.³ In this study, almost all of the respondents pondered whether to tell the patient (who did not have the means) that he can purchase an expensive medication not included in the 'medication basket'. This condition occurs in many places in Indonesia, in which not all residents get health insurance,²⁰ especially in the lower economic class in a pandemic situation. Nurses experienced moral uncertainty as treatment options were restricted and unknown. Nurses did not understand if it was safe to give medications whose efficacy when used for COVID-19 was no evidence yet. What if the medication harms the patient? There was much uncertainty about what the correct treatment options were. When convalescent plasma and monoclonal antibodies became available, nurses were not sure if they worked for treating COVID-19 or for how long.²¹ This is also in accordance with the research of,¹⁷ which is nurses said that they have a lack of knowledge and uncertainty regarding how to treat a new illness.

Moral distress situations frequently occur in the process of providing care related to the relationship between nurses, patients, families and doctors. One of the triggers for high moral pressure is working in conditions of insecurity,²² such as during the COVID-19 pandemic. Therefore, this issue is

critical to address. The institutions, where nurses work, are expected to provide supports to develop coping strategies in handling moral pressure; team support can reduce moral distress.^{23,24}

Sample characteristics and moral distress

Previous research has shown there is no relationship between the characteristics of age, religion, marital status and education level.²⁵ However, this study found there was a relationship between education level and moral distress. Nurses with a bachelor's degree have higher average moral distress scores than those with a diploma degree. Moral pressure and professional efficiency are positively correlated. Registered Nurses, possessing more authority than practical nurses, experience moral pressure more than practical nurses. Nurses with high professionalism can set high demands or goals, which can cause moral distress. Nurses with high professional effectiveness may be more morally sensitive, which also encourages moral pressure.⁶

Conclusion

Nurses handling the patients of COVID-19 experienced relatively low to moderate moral distress even though they encountered problematic and risky situations. This condition, nevertheless, requires attention, so that it does not occur in the future. For further studies, it is recommended to explore the factors affecting moral pressure specifically at risky conditions and interventions that can be done to overcome them.

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ORCID iD

Akbar Harisa  <https://orcid.org/0000-0001-9938-8778>

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