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Review Article

Moral Distress and the Factors Affecting It: A Review Study

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Abstract

Background and aims: Moral distress is a significant ethical problem in nursing. The aim of this study was to review the studies into nurses' moral distress and its contributing factors.

Methods: This was a narrative review. Data were collected through searching several online Persian and English databases, namely Magiran, SID, IranMedex, PubMed, Scopus, and Google Scholar. Search keywords were "moral distress", "moral stress", "ethics", and "nurse". Eligibility criteria were publication in English or Persian, publication between 2010 and 2020, relevance to moral distress, and accessible full-text. Review studies were not included.

Results: A total of 44 eligible articles were included. Nurses' moral distress was at moderate level and its contributing factors were personal, psychological, and organizational factors as well as factors related to care quality.

Conclusion: Nurses' moral distress is moderate. Personal, psychological, and organizational factors as well as factors related to care quality contribute to moral distress among nurses. Effective management of these factors can prevent damage to nurses and patients and improve the quality of nursing care.

Keywords: Moral distress, Ethics, Nurses

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Introduction

Provision of high-quality healthcare services and enhancement of client satisfaction with healthcare services are among the most important goals of healthcare systems and among the most important responsibilities of healthcare managers (1). Nurses are actively involved in day and night clinical care provision to healthcare clients (2). And are legally and ethically responsible for quality care provision (3). Therefore, they should be able to effectively manage ethical challenges and problems (4). Moral distress (MD) is one of the most important ethical problems among nurses (5). By definition, MD is a state of mental imbalance experienced when an individual cannot do what he/she knows is right or does something that he/she knows is wrong (6). Previous studies reported varying levels of MD among nurses (7). For example, a study showed that 23.1% of nurses had low MD, 45.1% of them had moderate MD, and 31.8% of them had severe MD (8). Another study reported low level of MD among nurses (9). Moreover, a study showed that 75% of pediatric nurses and 58.8% of critical care nurses experienced low MD and 25% of pediatric nurses and 41.2% of critical care nurses experienced moderate MD. Moreover, the mean score of MD among critical care nurses was significantly more than pediatric nurses (58.02 vs. 37.48) (10). MD may be associated with many different problems for nurses such as burnout, low job satisfaction, low quality of care, and intention to leave the profession (10-12). A study reported that 36.9% of nurses intended to leave their profession due to MD (13). MD is affected by many different factors. A study reported that the most important contributing factors of MD among healthcare providers were limited professional competence (49.6%), limited adherence to the principles of ethical practice (53.4%), and futile clinical measures (54%) (14). Two other studies reported that MD had significant relationship with professional autonomy (15), work conditions, emotional and psychological burnout, work shift, and affiliated ward (16). Despite the wealth of studies into nurses' MD and its contributing factors, there is no review study in this area. Therefore, the present study was conducted to review the studies into nurses' MD and its contributing factors in order to provide nursing managers with the necessary evidence for developing strategies and programs to prevent and manage MD among nurses.

Methods

This was a narrative review study. Data were collected through online search in several Persian and English databases, namely Magiran, SID, IranMedex, PubMed, Scopus, and Google Scholar. Search keywords were "moral distress", "moral stress", "ethics", and "nurse".

Eligibility criteria were publication in English or Persian, publication between 2010 and 2020, relevance to MD, and accessible full-text. Review studies were not included in the study. Initially, 550 articles were retrieved, from which 44 articles met the eligibility criteria and were included in the study (Figure 1).

Results

Most reviewed studies (27 studies) had been conducted in multiple hospital wards (Table 1). Studies had been conducted in Iran (33 studies), the United States (five studies), Brazil (four studies), Ethiopia, and Barbados. The level of MD among nurses was moderate (Table 2) and the contributing factors of MD were personal, psychological, and organizational factors as well as factors related to care quality (Figure 2 and Table 3). Some of the contributing factors such as environmental empowerment, work affiliation, professional performance, perceived managerial support, job satisfaction, ethical climate, and professional self-efficacy had negative relationship with MD. However, some of the contributing factors such as intention to stay in the profession, organizational support, and quality of nursing care did not have significant relationship with MD.

Discussion

The aim of this study was to review the studies into nurses' MD and its contributing factors. Findings revealed that the contributing factors of MD were personal, psychological, and organizational factors as well as factors related to care quality.

Personal factors

Some studies reported lower MD among nurses with higher age and greater work experience (14, 17,18). However, a study found that MD had no significant relationship with age and work experience (19). A study also reported that nurses who worked in several hospitals had higher MD than those who worked in just one hospital (17). Another study revealed environmental empowerment as a factor with negative relationship with MD (20). Moreover, some studies reported employment status, time limitation due to excessive working hours, and inability to challenge the decisions of other healthcare professionals as the contributing factors of MD (5,10,16,13,21,22). Given the significant relationship of MD with age and work experience, nurses with lower age and work experience should work with older and more experienced colleagues in order to experience lower MD. Moreover, improving nurses' professional competencies and skills through in-service training programs is recommended to reduce

Table 1. The settings of the reviewed studies

Setting	N
Emergency department	7
Oncology ward	1
Burn care unit	1
Critical care unit	5
Critical care unit and emergency department	1
Pediatric critical care unit	2
Multiple wards/units	27

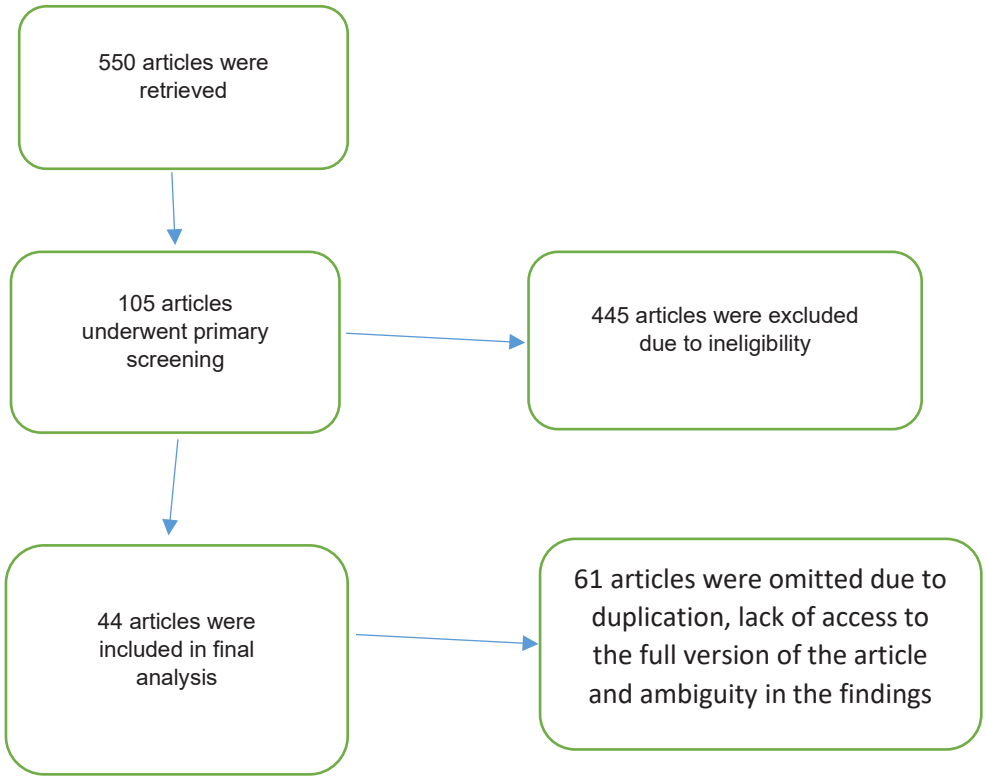

Figure 1. The flow diagram of the study.

Table 2. The characteristics of the reviewed studies

Author	Method	Results
Zavotsky et al (37)	Survey on 198 emergency nurses Tool(s): Ethical Distress Compatibility Questionnaire	The mean of moral distress was 80.19 ± 53.27. Moral distress had significant negative relationship with age and work experience and significant positive relationship with some coping mechanisms.
Azarm et al (4)	Descriptive correlational study on 545 nurses selected through a census Tool(s): Ethical Scale and Patient Care Scale	Moral distress was at moderate level with a mean of 141.89 ± 29.6, quality of nursing care was relatively desirable with a mean of 195.97 ± 28.05, and there was no significant correlation between moral distress and quality of nursing care. Influential factors on moral distress were low-quality care, unsafe care, and nursing staff shortage.
Sadeghi et al (18)	Descriptive-analytical study on 261 nurses Tool(s): Corley Moral distress Scale	The severity and the frequency of moral distress were moderate. Moral distress had significant negative correlation with age ($P<0.001$) and work experience ($P=0.01$) and had no significant relationship with employment status ($P<0.05$).
Otagi et al (23)	Descriptive-analytical study on 155 nurses Tool(s): MDS-R Moral Distress Questionnaire and questions on futile care perception	The level of perceived futile care provision was high (77.8%) and moral distress was at moderate level (54%). Moral distress had significant relationship with repetitive futile care (r = 0.407; B = 0.263; $P=0.034$), understanding the intensity of futile care (r = 0.381, $P<0.01$), and work experience in critical care wards (B = 0.209; $P=0.023$)
Robaee et al (26)	Descriptive correlational study on 120 nurses selected through random sampling Tool(s): Personal Profile Form, Perceived Organizational Support Assessment, and Moral Distress Scale	The level of perceived organizational support was low with a mean of 2.63 ± 0.79 and the level of moral distress was high with a mean of 2.16 ± 0.58. Moral distress had no significant relationship with perceived organizational support (r = 0.01; $P=0.86$).
Shafiei et al (27)	Descriptive-analytical study on 91 nurses working in medical wards through a census Tool(s): Corley Moral Distress Scale and Maslach Job Burnout	Moral distress had significant positive relationship with burnout (r = 0.404; $P=0.001$). Monthly working hours had significant relationship with the personal accomplishment (r = 0.284; $P=0.007$) and the depersonalization (r = 0.327; $P=0.002$) dimensions of burnout.
Fernandez-Parsons et al (9)	Descriptive cross-sectional study on 51 nurses Tool(s): 21 questions in a self-report questionnaire	The level of moral distress was low with a mean of 3.18. Situations that caused moral distress included performing unnecessary orders, using measures that were likely to prolong death, working with incompetent colleagues, and observing decline in care quality due to poor teamwork.
Behbodi et al (17)	Descriptive study on 111 nurses Tool(s): Corley Moral Distress Scale	The mean of moral distress severity was 37.48 in pediatric ward and 58.2 in pediatric intensive care unit. Moral distress had significant relationship with age and work shift. Moreover, nurses who worked in several hospitals had higher moral distress than those who worked only in one hospital (P ‹0.05).
Mardani Hamooleh et al (8)	Cross-sectional descriptive study on 195 nurses Tool(s): Moral Distress Questionnaire	Moral distress was moderate in 45.1% of participants, high in 31.8% of participants, and low in 23.1% of participants. The most important causes of moral distress were non-standard care and treatment due to staff shortage, implementation of medical orders for unessential diagnostic and therapeutic measure, and providing care without having the necessary professional competence. Moral distress had significant relationship with gender (P = 0.001), work setting ($P=0.01$), and work experience ($P=0.001$).
Mahdavi-Fashtami et al (35)	A cross-sectional census study on 125 nurses Tool(s): Ham Rick Moral Distress Questionnaire 2012	Emergency nurses suffered from moderate moral distress. Moral distress had significant positive relationship with the number of nurses and beds in the ward ($P<0.01$). The mean scores of moral distress and its frequency and severity were 160.14 ± 2.38, 1.4 ± 0.58, and 1.74 ± 0.92, respectively.
Yeganeh et al (15)	Correlational study on 180 ICU nurses selected through a census Tool(s): Varjuss Professional Autonomy Questionnaire and Corley Moral Distress Scale	The mean of professional autonomy was 77.04 and the mean of moral distress was 140.85 ± 5.45. Moral distress of most nurses was at moderate level (55.6%). There was significant positive relationship between professional autonomy and moral distress (r = 0.33; $P<0.001$).
Keighobadi et al (16)	Descriptive-analytical study on 265 nurses selected through convenience sampling Tool(s): Moral Distress Scale and Emotional Exhaustion Questionnaire	The mean of moral distress was 4.99 ± 0.91. Moral distress had significant correlation with work conditions (r = 0.33; $P<0.001$) and emotional burnout had significant correlation with shift work (r = 0.38; $P=0.000$) and affiliated ward (r = 0.173; $P=0.03$). Moral distress also had significant correlation with emotional and psychological burnout (r = 0.25; $P=0.001$).
Wolf et al (38)	Qualitative analytical study Tool(s): Semi-structured focus group discussions	The contributing factors of moral distress were the feeling of dysfunctional performance, deprivation, adaptive/maladaptive coping, and perceived inability to provide quality care.
Naboureh et al (39)	Cross-sectional descriptive-analytical study on 185 intensive and emergency nurses selected through a census Tool(s): Corley Moral Distress Scale and Diggs Job Self-Efficacy Questionnaire	The severity and frequency of moral distress and the level of self-efficacy of critical care and emergency nurses were moderate. Perceived self-efficacy had significant relationship with moral distress severity (r = 0.14; $P=0.04$,) and frequency (r = 0.19; $P=0.01$).
Anami et al (10)	Descriptive-analytical study on 175 emergency nurses selected through a census Tool(s): Atashzadeh Nurses Moral Distress Questionnaire	Moral distress was at moderate level with a mean of 1.87 ± 0.89. The mean of moral distress in the area of non-adherence to moral principles was 2.00 ± 1.02. Moral distress had significant positive correlation with shift work history and employment status ($P<0.05$).
Joolaee et al (30)	Cross-sectional descriptive-analytical study on 210 nurses Tool(s): Corley Moral Distress and Minnesota Job Satisfaction Questionnaire	The mean of moral distress was 1.77 (in the possible range of 1–4) and the mean of job satisfaction was 3.17 (in the possible range of 1–5). There was significant inverse relationship between moral distress and job satisfaction (r = –0.38; $P=0.001$).

Table 2. Continued

Author	Method	Results
Schaefer et al (13)	Cross-sectional descriptive study on 268 nurses Tool: Moral Distress Risk Criterion	Factors contributing to moral distress were stress, problems related to the physical structure of the institution, physical, mental, and emotional exhaustion, health system problems, time limitation due to excessive working hours, lack of equipment and resources, commercialization of healthcare, heavy workload, staff shortage, limited professional value, inappropriate behaviors of family members, inappropriate organizational regulations and norms, inappropriate use of available resources, delay in care, and inability to challenge the decisions of other healthcare professionals.
Jalali (19)	Descriptive-analytical study on 180 nurses Tool: Moral Distress Questionnaire	Moral distress was at moderate level with a mean of 4.93 ± 1.08. Moral distress was very high in the dimensions of professional performance (with a mean of 5.21 ± 1.17) and unsafe conditions (with a mean of 5.55 ± 1.45).
Etebari-Asl et al (21)	Cross-sectional study on 118 nurses selected through a census Tool(s): Corley Moral Distress Scale	The mean of moral distress was 10.25 ± 24.18. Moral distress had significant relationship with organizational position (P = 0.025), work shift (P = 0.011), marital status (P = 0.004), and educational level (P = 0.033).
Ebrahimi et al (5)	Descriptive-analytical study on 418 nurses selected through multi-stage random sampling Tool(s): MDS Ethical Standard Scale	The mean of moral distress was 148.49 ± 32.93 and 53% of nurses had severe moral distress. Critical care nurses obtained the highest moral distress score (mean = 152.72 ± 33.36). Moral distress had significant relationship with educational level, work shift, and occupational status.
Ameri et al (14)	Descriptive-analytical study on 148 nurses Tool(s): Corley Moral distress Scale	Moral distress had significant positive relationship with the ignorance of obtaining informed consent from patients, performing unessential diagnostic measures in the last stage of life, age, work experience, and employment status (P < 0.05). The highest dimensional mean score of moral distress was related to the futile actions dimension.
Silvino et al (40)	Survey on 95 nurses Tool(s): Labor question and frequency and severity scale of moral distress	The highest frequency of moral distress was related to poor working conditions and professional competence.
Shafipour et al (41)	Descriptive-analytical study on 172 nurses selected through a census Tool(s): Corley Moral Distress Scale	The mean score of moral distress severity was 10.55 ± 52.39. Moral distress had significant relationship with educational level (P = 0.011).
Abdolmaleki et al (42)	Descriptive-correlational study on 173 nurses Tool: A questionnaire designed for professional self-efficacy and moral distress	Moral distress had significant inverse relationship with occupational self-efficacy, age, and level of professional autonomy.
Ameri et al (7)	Descriptive study on 122 nurses selected through selective sampling Tool(s): Corley Moral Distress Scale	The frequency and severity of moral distress were high. Moral distress had significant relationship with affiliated ward, age, and perceived support by head nurse (P < 0.05).
Mohammadi Nafchi et al (20)	Descriptive study on 300 nurses selected through quota sampling Tool(s): Corley Moral Distress Scale and Randalloff and Blanchard 30-item Environmental Competency Questionnaire	The severity and frequency of moral distress had significant inverse relationship with environmental empowerment (P < 0.05), denoting that empowering nurses can reduce their moral distress.
Borhani et al (22)	A cross-sectional descriptive study on 110 nurses Tool(s): Corley Moral Distress Scale	The mean scores of moral distress severity and frequency were above the moderate level. Moral distress frequency had significant relationship with the type of hospital and ward.
Mohammadi et al (32)	Descriptive-analytical study on 260 nurses selected through convenience sampling Tool(s): Corley Moral Distress Scale and Figley Patient Fatigue Questionnaire	Moral distress had significant positive relationship with compassion fatigue (P < 0.05). The mean scores of moral distress severity and frequency were respectively 3.5 ± 0.8 and 3.9 ± 0.55 (in the possible range of 1–5)
Soleimani et al (33)	Annual Congress of Medical Ethics and Nursing Ethics, 193 Nurses Tool(s): 20-item Spiritual Health Scale and Moral Distress Scale 21 revised	The mean score of spiritual health was 94.73 ± 15.89 and the mean score of moral distress was 109.56 ± 58.70. Marital status and job satisfaction were the determinants of spiritual health, while gender and educational level were the contributing factors of moral distress. The significant predictors of moral distress were age, work shift, and intention to leave the profession.
Borhani et al (28)	Descriptive-analytical study with quota sampling Tool(s): Corley Moral Distress Scale and Maslach Burnout Questionnaire	The mean scores of moral distress, its severity, and its frequency were 4.5, 3.54, and 3.11, respectively. Burnout had significant positive relationship with moral distress severity (r = 0.4) and frequency (r = 0.8) (P < 0.05).
Sadeghi et al (29)	Descriptive-correlational study on 60 nurses selected through a census Tool(s): Corley Moral Distress Scale, Common Tendency to Leave the Job Questionnaire, and Maslach Burnout Questionnaire	Intention to leave the profession had significant positive relationship with the emotional exhaustion (r = 0.611) and the depersonalization (r = 0.509) dimensions of burnout (P < 0.05) and significant negative relationship with organizational position (r = –0.441) (P < 0.001)
Abbaszadeh et al (43)	Cross-sectional descriptive study on 220 nurses Tool(s): Corley Moral distress Scale	The mean scores of moral distress severity and frequency were respectively 2.25 and 2.11 (in the possible range of 1–5). Moral distress had significant relationship with participants' affiliated ward (P < 0.05).
Abbaszadeh et al (31)	Descriptive communication study on 184 nurses Tool(s): Moral Distress and Work Affiliation Questionnaire	The level of moral distress severity was moderate. Moral distress severity had significant relationship with nurses' work affiliation (r = 0.188; P = 0.011).
Abbaszadeh et al (44)	Descriptive-analytical study with census-based sampling Tool(s): Corley Moral Distress Scale and Professional Retention Questionnaire	The mean score of moral distress was 2.25 ± 0.6. Moral distress had no significant relationship with the intention to stay in the profession (P > 0.05).

Table 2. Continued

Author	Method	Results
Beikmoradi et al (6)	Cross-sectional descriptive study Tool(s): Corley Moral Distress Scale	The mean score of moral distress was 99.34 ± 46.61. Personal characteristics had no significant relationship with moral distress, while moral distress had negative effect on professional performance.
Abbaszadeh et al (25)	Cross-sectional descriptive study on 140 nurses Tool(s): Moral Distress Questionnaire	The level of moral distress was high. Moral distress had significant relationship with age, work experience, level of professional collaboration between physicians and nurses, decision to resign, sense of job security, and managerial support ($P<0.05$).
Ramos et al (45)	Cross-sectional study on 1226 Brazilian nurses Tool(s): Moral Distress Questionnaire	Moral distress severity and frequency were at moderate level. The highest level of moral distress was related to recognition, power, professional identity, and teamwork, while the lowest moral distress was related to support for values and rights.
Berhie et al (46)	Cross-sectional study on 423 nurses selected through simple random sampling Tool(s): Revised MDS-R Moral Distress Questionnaire	Poor team communication, poor decision making, staff shortage, and inadequate care were significantly associated with moral distress.
Vaziri et al (47)	Descriptive-analytical study on 264 nurses selected through random sampling Tool(s): Corley Moral Distress Scale	Moral distress was moderate to high. The highest mean score was related to unsafe practice and the lowest mean score was related to intravenous drug administration to the patient who refused it.
Ramos et al (48)	Cross-sectional study on 1226 nurses Tool(s): Moral Distress Questionnaire in Brazilian Nurses, Labor Force Questionnaire and List of Ethical Principles and Elements Used for Ethical Counseling	The most important contributing factors of moral distress were patients' beliefs, culture, and values as well as tangible and intangible elements.
Asayesh et al (24)	Cross-sectional study on 117 ICU nurses Tool(s): 17 items of Futile Care Perception Questionnaire and Jameton Moral Distress Questionnaire	Perceived care futility and work experience were the significant predictors of moral distress among nurses in intensive care unit ($P<0.05$)
Sannino et al (49)	Cross-sectional study on 136 nurses selected through convenience sampling Tool(s): Modified Italian version of the Moral Anxiety Scale (MDSNPV pediatric neonatal version).	The clinical situations identified as the major causes of moral distress among nurses in the present study involved end-of-life care and resuscitation.
Wachholz et al (50)	Cross-sectional study on 141 nurses Tool(s): Job Satisfaction Index and Brazilian version of the Moral Distress Scale	Nurses are vulnerable to moral distress. Autonomy and rewards had significant positive effects on moral distress, while poor work conditions and limited professional competence had negative effects on it.
Bayat et al (36)	Descriptive-analytical study on 300 nurses selected through convenience sampling Tool(s): Moral Distress Questionnaire and Olson Hospital Ethical Climate Scale	Moral distress was at moderate level. Moral distress frequency had significant negative correlation with ethical climate and colleagues, patients, hospitals, and physicians dimensions.

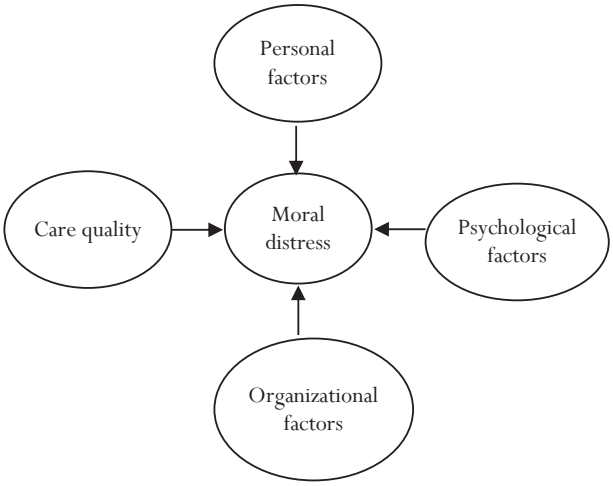

Figure 2. Factors contributing to moral distress.

nurses' MD.

Psychological factors

Nurses' perception of the inessentiality of some care services increases their MD (23,24). A study showed that limited perceived organizational support was associated with high MD (25), while another study reported no significant relationship between MD and perceived organizational support (26). Moreover, several studies reported that burnout can cause MD (16,27,28) and a study showed that MD had no significant relationship with burnout (29). Several other studies reported lower MD among nurses with higher job satisfaction (15,30) and greater work affiliation (31). Other psychological factors contributing to MD include stress, physical, mental, and emotional exhaustion, limited professional value, observation of colleagues' inappropriate behaviors13, compassion fatigue (32), and intention to leave the profession (33). Therefore, strategies such as periodic managerial monitoring of nurses and care process are needed to minimize nurses' exposure to and perception of unessential care provision and its associated stress (34). Moreover, tangible and intangible incentives for nurses are needed to improve their job motivation and reduce their job burnout.

Organizational factors

Provision of low quality and unsafe care due to nursing staff shortage (4,13) and low nurse-patient ratio (35) can lead to MD among nurses. Moreover, nurses may experience MD due to factors such as unnecessary medical orders, colleagues' limited professional competence, inappropriate physical structure of workplace, inefficiency

Table 3. Factors contributing to moral distress

Factors	
Personal	Age, gender, educational level, marital status, employment status, work experience, shift work, employment in several hospitals, organizational position, professional practice of ethics and bioethics principles
Psychological	Compassion fatigue, burnout, feeling of dysfunctional performance, deprivation, understanding of futile care, tendency to leave the profession, perceived organizational support, observing mistreatment of patients, feeling of undesirable service, perceived self-efficacy, sense of job insecurity, perceived inability to make decisions, coping mechanisms
Organizational	Staffing level, number of beds, barriers to education, professional autonomy, poor working conditions and work environment, poor interprofessional communication, inappropriate organizational regulations and norms, high patient-nurse ratio, problems with the physical structure of the organization, problems in healthcare system, Lack of resources and equipment, inappropriate use of available resources, hierarchical structure of physician-nurse interaction, ethical climate among colleagues, time limitation, lack of professional autonomy, limited professional value
Care quality	Inappropriate care due to staff shortage, unessential diagnostic and care measures, limited professional competence, ignorance of obtaining informed consent from patients, performing unnecessary diagnostic measures in the last stage of life, delay in care, and commercialization of healthcare

of the healthcare provision system, shortage of equipment and resources, inappropriate use of the available resources, and inappropriate organizational regulations and norms (9,13). The ethical climate of an organization is also a significant factor contributing to MD (36). Therefore, hospital managers need to improve the level of staffing in their work environment and provide their staff with quality in-service training in order to improve their professional competence.

Factors related to care quality

Resuscitation measures which prolong the process of patient dying as well as low care quality due to poor communication among healthcare providers can increase nurses' MD (9). Other factors related to care quality which can increase nurses' MD include non-standard care and treatment due staff shortage, unessential diagnostic and therapeutic measures, implementation of care-related measures without the necessary professional competencies, commercialization of healthcare services, and delay in care provision (4,8,13). Specialized healthcare provision teams are needed to improve care quality and patient safety and thereby, reduce MD among nurses.

Limitations

Although we attempted to retrieve the most relevant studies, some relevant studies were not included in the study due to their inaccessible full-texts. Moreover, review studies were not included in this study.

Conclusion

This study suggests that nurses' MD is moderate and is affected by personal, psychological, and organizational factors as well as factors related to care quality. Given the negative effects of MD on nurses' performance and care quality, the managers of hospitals and other healthcare settings should employ strategies for the effective management of these factors to reduce nurses' MD and thereby, improve care quality and prevent potential injuries to patients. Systematic reviews and meta-analyses are recommended to evaluate these factors and their effects on MD.

What does this paper contribute to the wider global clinical community?

- MD is an important challenge in nursing.
- Unmanaged MD among nurses can be associated with negative outcomes such as burnout, low job satisfaction, low care quality, and intention to leave the profession.
- The level of MD among nurses varies according to the immediate organizational environment and regulations.
- Given the negative effects of MD on nurses' performance and care quality, effective management of its contributing factors is needed to reduce nurses' MD and thereby, improve care quality and prevent potential damage to patients.

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Conflict of Interests

The authors declare no conflict of interests.

Ethical Approval

Not applicable.

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