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Adam S Burston and Anthony G Tuckett

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Moral distress in nursing: Contributing factors, outcomes and interventions

Adam S Burston and Anthony G Tuckett
The University of Queensland, Australia

Abstract
Moral distress has been widely reviewed across many care contexts and among a range of disciplines. Interest in this area has produced a plethora of studies, commentary and critique. An overview of the literature around moral distress reveals a commonality about factors contributing to moral distress, the attendant outcomes of this distress and a core set of interventions recommended to address these. Interventions at both personal and organizational levels have been proposed. The relevance of this overview resides in the implications moral distress has on the nurse and the nursing workforce: particularly in regard to quality of care, diminished workplace satisfaction and physical health of staff and increased problems with staff retention.

Keywords
Literature review, moral distress, nursing, retention, workforce

Introduction

Moral distress has been widely reviewed across many care contexts[1–6] and among a range of disciplines.[7–10] Interest in this area has produced a plethora of studies, commentary and critique.[11] The definition of moral distress has evolved but at times is poorly defined.[12] Repenshek[13] cautions that some discussions about moral distress may in fact be around the difficulty with moral subjectivity as distinct from moral distress.

In its original form, moral distress was defined by Jameton[14] as '. . . aris(ing) when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action'. Jameton[15] further developed this theory by highlighting two distinct phases: initial and reactive moral distresses, an approach subsequently used by others.[16] An important distinction highlighted by Jameton[15] is that between moral distress (knowing the correct course of action but not being able to pursue this) and moral dilemma (not knowing the correct moral choice when faced with a number of options with different and important values).

Hanna[17] describes moral distress as an inner response by the self when there is a perceived threat to 'an objective good' (p. 119), which suggests that it is our own perception of reality that shapes the moral distress experience. Agreement resides in the view that the perception and contexts of the constraints, the values accorded by the individual involved in the given situation and the contextual specifics of the varied

Corresponding author: Adam S Burston, The University of Queensland, School of Nursing and Midwifery, UQ Ipswich Campus, QLD 4305, Australia.
Email: a.burston@uq.edu.au

clinical climates seem to shape our understanding of moral distress. However, a caution suggests that moral distress should not be solely targeted to the individual nurse, as some sort of failing or personal weakness on his/her behalf.[18]

In many cases, the experience of moral distress is known. However, others experience moral distress yet fail to recognize it;[19] in many cases, the experience of moral distress is a negative one, while others have experienced a heightened sense of autonomy and potential for moral growth.[20,21] Continuing this narrative turn, on the one hand, it is suggested that encounters of moral distress are not frequent, but when confronted, they occur with moderate to high intensity,[18,22] while, on the other hand, Godfrey and Smith[23] suggest that generally '... the problems (attributable to moral distress) were not significant in their drama or publicity, but in their commonness and frequency' (p. 335). There is, however, some accordance.

An overview of the literature around moral distress reveals a commonality among factors contributing to moral distress, the attendant outcomes of this distress and a core set of interventions recommended to address these. The relevance of this literature overview resides in the implications moral distress has on the nurse and the nursing workforce.

Method of literature selection

The objective of this review was to identify literature on moral distress within the aged care environment. Initial searching identified limited literature in this specific area. The search criteria were expanded to include literature from nursing contexts outside of aged care. For this literature review, the following electronic databases were utilized: Cumulative Index to Nursing and Allied Health Literature (CINAHL) 1982–2011, PsycINFO 1980–2011, Medline 1982–2011 and Social Science Citation Index (SSCI) plus Arts and Humanities Citation Index 1982–2011. Each database was searched using keywords: moral distress, moral distress scale, nursing home* and long-term care. Articles were selected based on their relevance and ability to inform about moral distress within and outside the context of nursing practice. Typically, initial search and assessment for inclusion relied on title, abstract and keywords before full-text papers were pearled for inclusion. In addition, the literature reviewed relied on mining articles' reference lists (i.e. snowball sampling) for relevant publications. Articles were limited to those written in English, and the review excluded doctoral dissertations and abstracts to meetings. Furthermore, a number of electronic journal and online content alerts were established using the keywords described above to capture the most recent articles (e.g. Sage journals online). While the review of the literature did not set out to answer a specified question, it was nevertheless conducted in a systematic manner providing a rigorous representation of the literature.

Literature themes

The consequence of the search strategy described above meant that the literature emerged and was grouped under three core themes: Theme 1 specialist critical nursing, Theme 2 specialist nursing and Theme 3 specialist non-nursing (Table 1). For the purpose of this review with its focus on nursing, primarily only that information ('data') pertinent to Theme 2 (specialist nursing) is reviewed here. It was hypothesized that this would provide greater diversity of ideas and thus improve the probability of capturing as many ideas as possible but with an end point. In other words, data saturation and thus a rigorous representation of the literature.[24]

Contributing factors, outcomes and interventions

What follows is an examination of moral distress in terms of contributing factors, outcomes and interventions. Based on our review, it is clear that a cluster of factors contribute to moral distress in nursing with

Table 1. Three core themes from the literature about moral distress.

Theme 1: specialist critical nursing	Theme 2: specialist nursing	Theme 3: specialist non-nursing
Critical care	Military	Medicine
ICU	Medical/surgical	Geneticists
NICU	Palliative	Neurologists
PICU	Mental health	Pharmacy
	Midwifery	Podiatrist
	Nurse practitioner	Psychiatrist
	Personal assistant	Psychologist
	Older person	Respiratory care practitioner
	School nurses	Social worker
	Nurse managers	

ICU: intensive care unit; NICU: neonatal intensive care unit; PICU: paediatric intensive care unit.

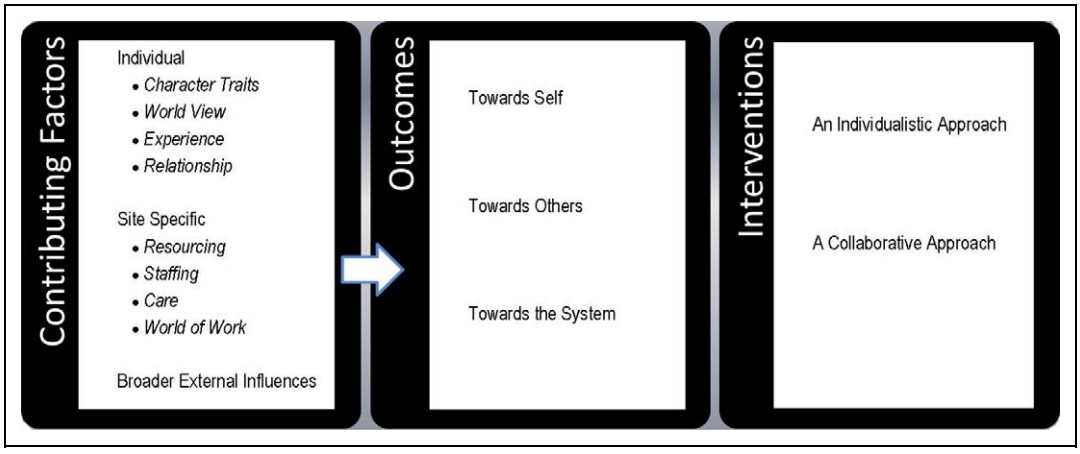

Figure 1. Moral distress in nursing: contributing factors, outcomes and interventions.

attendant outcomes or consequences. Typically, the literature also reveals key interventions that are recommended to counter the effects of moral distress (see Figure 1).

Contributing factors

A mechanism for considering the contributing factors to moral distress is to review three primary sources: individual practitioners, site-specific systems and broader external influences.[6,25–28] It is worth noting that within the literature reviewed here, some of the contributing factors assigned as site specific are not necessarily mutually exclusive from broader external influences. For example, ward-level healthcare delivery is necessarily (but not entirely) influenced by broader policy and economic imperatives, and as such, the two are in many ways intertwined. For instance, funding availability directly impacts on staffing levels and skill mix and an imbalance between care demand and suitable staffing can contribute to moral distress. However, staffing and skill mix issues may originate specifically at a local ward level regardless of broader external influences.

Individual. The experience of moral distress is grounded within the individual, who they are and their perception of events.[17,29,30] This includes individual character traits or personal qualities, a nurse's world view (understood to encapsulate, for example, personal values, role perceptions and culture) and the personal experience a nurse has or has had. In addition, interpersonal relationships directly influence the nurses' experience, or their 'reality', of moral distress.

Character traits/personal qualities. Moral distress is linked to how the nurse perceives their role.[17,29,30] It is known that in whatever role the nurse is, both knowledge[31] and perceived skill level of the nurse and the nurse's confidence all compound the moral distress experience.[18,28] Ohnishi et al.[32] also found an increased level of moral distress related to an increase in the level of authority a nurse had. In addition, the nurse needs to be able to not only communicate ethical dilemmas in a language accessible to medical staff[33] but also have the capacity to make ethical decisions in ethically challenging situations if moral distress is to be avoided.[25] This capacity to make ethical decisions extends to include treatment decision-making[34] with a strength of character to manage different opinions about treatment options between staff and family members.[21] Nurses may at times be viewed as risk averse, with Tiedje[29] suggesting that the courage to take additional risks may be 'the greatest challenge in moving from moral distress to moral action' (p. 40). Ethics education is suggested as instilling practitioners with the confidence to accomplish moral action more effectively,[35] and in fact may have a '. . . significant positive influence on moral confidence and moral action . . .'.[36]

World view. It is apparent from the literature that moral distress can emanate from a variety of causes with variations also between practitioners in the same clinical situation. A nurse's world view such as expectations of standards of care,[37] moral sensitivity[38] and individual ethical perspectives[39] all contribute to the moral distress experience. Additionally, the nurse's value perspective[31] will likewise contribute. This last opinion also resonates in the observation, in the context of midwifery, that the specific elements that contribute to moral distress develop from a combination of our personal value systems and the nature of enculturation to the nursing role.[17,29,30] While the workplace culture then influences moral distress, so too does a person's own cultural background.[34,40]

Experience. Perceptions of moral distress may develop from cumulative life experiences and prior experiences in similar or identical situations. The notion that professional experience is a contributing factor is intriguing. There has been some suggestion made that the length of experience in nursing increased the exposure frequency to episodes of moral distress.[28] Furthermore, nurses lacking experience in addressing ethically challenging situations may be at higher risk of experiencing moral distress.[20] Wilkinson[30] posits that '. . . more experienced nurses probably encounter fewer instances of moral distress' (p. 516). One wonders if this is simply a reduced encounter rate, an evolved perception of what constitutes 'real' moral distress, an improved ability to pre-empt and resolve issues more rapidly or a dampening of the psyche from frequent exposure to morally difficult situations.

Others, however, identified no correlation between nursing experience (along with other demographic detail) and moral distress.[18] Corley et al.[22] describe a significant but low negative correlation between age and moral distress intensity; however, they suggest that experience alone is of only limited help in dealing with it.

Relationship. The hierarchical nature of the nurse/physician relationship may also intensify issues of moral distress. The core of the problem in this relationship may stem from the differing philosophical approaches to healthcare delivery,[25,41] such as a curative as opposed to a care-based approach. As a consequence, conflict in professional relationships is a most common contributor to moral distress.[19] For example, it has been demonstrated that nurses 'felt that they lacked either power to speak against physician's opinions', or 'believed that their opinion would not be accepted'.[25] This affirms both Meaney[20] and

Pendry,[42] who recognize the notion of 'responsibility with no authority' as a contributing factor. As a consequence, nurses become adept at 'politically, manoeuvring information in order to present it in a palatable manner for the physician'.[25] In other quarters, the literature revealed that nurses were '... faced with the choice of either overstepping the boundary and acting, or waiting for the physician, watching the suffering of their patients'.[43]

Other than the nurse/physician relationship as contributing to moral distress, the literature revealed how relationship in terms of closeness to an event and to the client/patient also impacts the moral distress experience. For example, Hanna[17] suggests proximity to and the type of procedure as confounding elements. Moreover, a long-standing relationship with the patient[44] and/or a large amount of contact time[45] also potentially increase the intensity of moral distress.

Site specific. As a contributing factor to the nurse's experience of moral distress, site-specific variables refer to matters such as resourcing (like time and money), staffing, the nature of care being provided and the general organizational structures (what we have termed the 'world of work').

Resourcing. The availability of resources to an industry or imbalances between supply and demand are examples of external influences affecting an institution's ability to garner sufficient resources for service delivery. However, executive decisions regarding allocation of resources within the organization also impact. These decisions may facilitate or directly contribute to situations of moral distress.[21,23,29,37] Typically, this is discussed in the context of a lack of resources.[46,47] For example, in the discussion on humanitarian nursing challenges, Almonte[48] describes the relative inability to provide any tangible level of health care to indigenous populations due to a lack of healthcare resources as a contributing factor to moral distress.

While staffing is also discussed as contributing to moral distress, two limited resources stand out in the literature: time and money. The literature assigns cost containment,[29,49] reimbursement issues[50] or economic,[43] financial constraints[51] as invoking moral distress. Similarly, a lack of time to do what ought to be done is also blamed.[43,49,52]

Staffing. Another external factor that is also arguably attributable to broader external influences and contributes directly or facilitates an environment of moral distress is staffing. Our review suggests that staffing contributes to moral distress in three ways. First, unsafe staffing levels have been found to contribute to the highest intensity *and* frequency of moral distress.[22] Typically, the highest intensity of moral distress is related to low staffing levels within the ward.[32] Others concur with this relationship between moral distress and staffing levels.[47,51,53] Second, staffing patterns that limit access to patient care or implementing managed care policies have been identified as a compounding variable.[54] Finally, staff training, more specifically inadequately trained staff, is another contributing factor.[55]

Care. Dimensions of site-specific care and caring contribute to moral distress. Kälvemark et al.[49] identify a lack of beds for patient care delivery and others an inappropriate environment for the provision of palliative care[47] as contributing factors. In a similar care context, Brazil et al.[55] identified a lack of access to care as a contributor to the moral distress of nurses. Further to this notion of 'lacking', a lack of healthcare knowledge of either parents or other organizational members contributing to ethical issues,[19] a general lack of information[55] and a lack of knowledge (literature/system) regarding the relationship between personal assistants and the disabled person[45] all cause moral distress to occur.

Not surprising, issues pertaining to a number of ethical principles in care were identified in the literature as well. For example, Nordam et al.[46] identified disrespectful care delivery by other practitioners and, in the context of the School Nurse, maintaining client confidentiality[19] as potentiating moral distress. Elsewhere,

a patient's refusal of care deemed appropriate by nursing staff[56] was identified as significant. A similar conflict was noted by Montagnino and Ethier[34] and Kirk,[57] although they identified this situation within the nurse/family member relationship. Concurring, Brazil et al.[55] identified this contributing factor as emerging from patient autonomy in decision-making.

Also not surprising, moral distress has been linked to perceived 'futile' care situations.[28] In their commentary, Couillard and Brownell[58] described a case of a patient with a progressive neurological deterioration causing loss of oral communication. They postulate that moral distress is likely to arise in this situation when members of the healthcare team offer differing opinions about appropriate care options. They '. . . may believe that the care they are providing is actually harming the patient, and yet they have no way to influence the care decision about continuing her life' (p. 161). The provision of overly aggressive or futile treatment is a concept that emerges strongly as one causing moral distress.[47,51,55,59,60]

As stated above, the dimensions of site-specific care and caring contribute to moral distress. It is the case, therefore, that Fry et al.,[16] within the military practice setting, recognize the atypical patient conditions and the military triage system as furthering moral distress for nurses. Of particular interest is the military triage system, where '. . . the least wounded or ill may receive priority treatment, particularly if medical resources are scarce . . . ' (p. 379). Elsewhere, and in concordance, efficiency[29] and a push for efficiency rather than quality of care[61] are invoked as causative agents.

World of work. At the hospital ward level, others describe this contributing factor in terms of the uniqueness of the practice setting (e.g. as dangerous)[16] or in terms of patient and role boundary issues.[62] Others point to the ethical[18,22,63] or moral climate[38] all of which contribute to the nurse's moral distress.

Examples are borne out in the literature demonstrating these organizational structures and the impact of the uniqueness of the nurse's world of work. A number of authors[32,37] identified high frequency of encounters of moral distress in the psychiatric care environment. Ohnishi et al.[32] note that this high frequency (but low intensity) is in contrast to previous findings of other researchers such as Corley et al.[22] who identified low frequency but high intensity of moral distress in the acute care (non-psychiatric) environment. However, Deady and McCarthy[64] also identified low frequency with high intensity but in the *acute care* psychiatric environment. In their investigation into the psychological and ethical cost for midwives exposed to termination of pregnancy for fetal abnormality, Garel et al.[65] identified midwives as reporting low levels of moral distress. This low level of moral distress may be explained by the 'self-selection' of staff who choose to work in this specialized area and who are free from conflict regarding the morality of termination. What is apparent is that despite variations in intensity and frequency, moral distress occurs across multiple clinical settings regardless of clinical specialty or level of acuity.

A further insight is revealed in examining moral distress and the use of the multidisciplinary approach to care. While this approach can have significant benefits for care provision, a poorly functioning team may generate a range of detrimental effects such as discontinuity or omission of care, conflicting advice or education and subsequent poor use of valuable health resources. Deady and McCarthy[64] found that 'while multidisciplinary teams appear to function well on the surface, situations that give rise to moral distress are not always acknowledged or dealt with effectively'. An additional factor that appears to filter out from Sturm's[66] investigations is that the distress experienced by different team members may generate from different elements within the given situation.

Adding to this effect of the multidisciplinary team, at the ward level and more generally is also the decision-making hierarchy,[51] the hierarchical imposition of obedience,[61] discrepancies between authority and a nurse's professional obligations[61] and a clash of responsibility with lack of real authority.[33] It is in this world of work that the ward nurse finds themselves constrained and left feeling unable to pursue the right course of action when it is called for. Elsewhere in the literature, a number of writers concede that matters

are not improved for the hapless ward nurse because of a lack of confidence in reporting systems,[67] a general lack of support[23] specifically related to decision-making[68] and a lack of professional recognition.[46]

Broader external influences. The site-specific variables, could in turn be attributable to broader external influences. For example, at a more macro level, economic factors[53] including issues of efficiency, cost containment and resource allocation[29] all compounding staffing levels[22,47,51,53] and access to care,[55] all in turn contribute to moral distress.

Additionally, the literature reveals the broader healthcare regulations[42] or organizational policy and procedures[19,53] as constraining the nurse in taking the most ethically appropriate course of action. An example of the broader external factors impacting moral distress is the tension caused between hospital practice and evolving evidence-based best practice.[23] Other variables can be reviewed under three streams: standards, the law and other parties. First, nurses are distressed by child protection reporting, pressure to work outside of nursing practice standards[19] and accreditation requirements.[69] Second, nurses can feel constrained in following the most ethical path by legal restrictions[17,52] and more specifically by rules around confidentiality[19,31] or Do Not Resuscitate (DNR) policy.[19] Third, the nurse's capacity to do what is right and good is compromised by the vested interests of third parties[70] to include directives from funding bodies[42] and interagency conflict.[50]

A vivid example of the manner in which macro-policy and the interests of others generate moral distress involves a nurse's scope of practice. Delivery of quality health care frequently requires effective multidisciplinary investment but restrictions related to scope of practice can also contribute to the feelings of disillusionment and distress. Sharing of health information with patients is an area in which conflict can arise when nurses must avoid relaying information that constitutes a 'medical diagnosis'. Avoidance of this conflict through '. . . deception by omission, vague responses and half truths in order to avoid disclosing the truth about diagnoses to patients'[43] has been identified as a mechanism employed by nurses furthering the moral distress they feel.

In summary, the literature reveals a trifocal lens for examining the contributing factors for moral distress. First, the nurse's experience of moral distress comes down to her/his individual traits, their view of the world, what they have or have not experienced and the nature of their professional relationships. Second, site-specific characteristics impact the nurse's experience of moral distress. These include characteristics like a lack of resources; staffing numbers, mix and training, and the composition of work teams; the nature of care and the absence of caring and finally organizational structures. Third, and last of all, there are broader external influences that contribute to the nurse's moral distress, and these do include economic rationalism and the ability or not to meet the requirements of standards, the law and third-party expectations.

Outcomes

Outcomes describe the impact or consequences of moral distress. The overview of literature suggests that nurses are affected primarily in two ways: moral distress has consequences for the self and others and consequences also for the system. The former refers to those consequences of moral distress that a nurse personally feels ('*I would feel* . . . ') and also includes those consequences that would be expressed towards or onto another ('*I would act* . . . '). The latter describes the consequences of moral distress but analyses these as they affect the healthcare system or workplace itself ('*I would do* . . . ').

In general, moral distress predisposes the nurse to stress[42] and risks exacerbating underlying illnesses.[17] While not *all* ethically challenging events invoke a heightened moral distress nor are evaluated negatively,[20,21,65] in *most* cases, moral distress has a deleterious effect on the nurse and the workplace.

Towards the self ('I would feel . . .'). A nurse may feel anger[29,33,59] towards her/himself when knowing the right thing to do and institutional constraints make it nearly impossible to pursue the right course of action.

Under these circumstances, the literature further reveals the nurse experiencing horror and anticipatory dread[17]; and experiencing diminished confidence,[68] self-doubt[31] and an eventual loss of self-esteem.[30] In this context, feeling demoralized, helpless and hopeless[59] with a diminished sense of purpose,[68] the nurse's moral distress produces personal and professional disillusionment.[33] The nurse feels a sense of resignation[17] and ultimately experiences depression.[21]

In addition, the tension between what is done versus what ought to be done produces guilt,[29,59] remorse,[17] pain of regret,[31] pain of failure and a heightened sense of personal grief.[17] The nurse's personal integrity and values are eroded.[33]

It is not surprising then that the literature further bears out the nurse experiencing higher levels of exhaustion[32] including emotional exhaustion[42] and emotional detachment.[31] These latter emotional elements typically delineate a feeling of being 'burnt out',[46] that is, experiencing burnout.[32,50,71,72]

Towards others ('I would act . . .'). A nurse may also express anger[29,33,59] towards another when experiencing moral distress. The literature further reveals being powerless towards the other in the given situation, notably powerlessness over treatment decision-making.[30,31,33,34,46,59] In the ward situation, among patients and peers, the nurse risks becoming callous and bitter,[20] cynical,[32] exasperated[33] and demonstrating shock and dismay.[17] A dominant expression of the nurse's moral distress identified in the literature is frustration.[21,29,33,46,52,59]

Towards the system ('I would do . . .'). It should be alarming that when the morally correct course of action is impossible to pursue, nurses choose not to discuss the problem or take no direct action at all.[73] In the context of care and caring, more alarming still that a nurse would avoid the patient,[30] avoid a conflict situation[31] and on occasions, this led to the nurse ending care delivery altogether.[57] Consequently, moral distress leads to issues with quality of care and patient satisfaction.[42] Contrariwise, some have even reported nurses over-compensating with extra care (guilt response) to counter the negative experience.[30]

Epstein and Hamric[74] describe the 'crescendo effect' as both a contributor to and an outcome of moral distress. The crescendo effect is said to generate from repeated incidents of moral distress, with a resultant moral residue (or what Jameton earlier described as reactive distress) increasing over time. This residual effect creates a new baseline level for an individual's moral distress, which in turn increases the intensity of subsequent incidents. Consequently, an individual may display stronger emotional reactions particularly in situations similar to earlier experiences. It is viewed as a multidisciplinary issue and is evident where '. . . unit, team, or institutional/system dynamics continue to be unaddressed' (p. 333).[74]

An additional and dominant workplace consequence of moral distress is the issue of retention and staff shortages.[42] Nurses not only think about leaving their current position but also consider leaving the nursing profession altogether;[21] and others do change jobs[30,31] and leave the profession.[71,72]

It is obvious then that moral distress has a negative effect on organizational culture.[68] Perhaps even more worryingly, Kälvemark et al.[49] identified instances of practitioners either being forced to act or voluntarily breaking the rules, due to system-based limitations. In the specific context of the nurse practitioner, one of the more concerning strategies was that of 'working around systems constraints'.[23] The inherent danger of this 'working around the system' is the continuation of systemic problems that should otherwise be corrected. At risk then is that a strategy like this aimed at countering moral distress can have a negative effect on broader community relationships.[68]

Interventions

So far, the overview of the literature has examined moral distress in terms of contributing factors and outcomes. This final section highlights some of the interventions deemed appropriate in rectifying nurses'

moral distress. Emerging from the review are two sub-themes: interventions or practices that focus on the individual nurse and interventions that take a more collaborative or involvement of others approach.

An individualistic approach. Education is a key recommendation for improved understanding of and developing coping strategies for moral distress. A positive correlation between ethics education and the moral action of nurses has been demonstrated.[36] Malloy et al.[25] and Meaney[77] concur that education must focus on the individual practitioner and their own ethical skills. In addition, improving communication is a common theme that emerges as a strategy to reduce the frequency and intensity of moral distress.[28,43]

While individuals ought to engage in education and communication strategies to counter the consequences of moral distress, others make more targeted recommendations. For example, Wilkinson[30] insists that practitioners must actively seek assistance in dealing with the consequences of moral distress. Two authors contribute to this, suggesting the individual should seek morally sensitive support[55] and/or chaplaincy support.[59] Others propose that nurses engage in critical self-reflection (conscious reflexivity) as a self-improvement strategy to facilitate personal growth and coping,[17] cultivate coping skills[28] or explore the role emotions play in moral decision-making.[33] Perhaps radically, the nurse is even encouraged to lobby for resource funding,[26] engage in political action[43] or be prepared to leave the profession.[70]

A collaborative approach. An inoculation to moral distress is collective action.[29] Again, education is proposed with a focus on fostering and participation in an inter-professional environment to facilitate greater understanding of the perspectives of other health practitioners[42,49,60,75] and to improve collaboration[28,43,46] and, consequently, interdisciplinary dialogue.[73] Implementation of inter-professional forums is suggested as a worthwhile strategy to develop understandings of other disciplines' decision-making processes[51] as well as the provision of a forum to discuss patient goals.[34]

Not surprisingly, ethics education is also suggested.[35,46,76] Education of this type aims to raise awareness of potential moral issues and provide better understanding of relevant policies and laws.[30] Collective techniques include role plays, scenarios,[42,49,75] ethics rounds and/or staff meetings.[28] Meaney[77] suggests the potential of a 'narrative style' manual that incorporates a history of an individual's or profession's ethical decision-making processes. This latter approach resonates with Tiedje's[29] notion of 'storytelling', which involves describing and discussing the experience of moral distress and VonDras et al.'s[78] use of peer-led discussions and guided reflection. Care with design and implementation of programs must be taken though, as in one instance despite the use of ethical education and forums, participants' moral distress did not change significantly.[79]

Corley et al.[22] implore administrators to particularly target those experiencing high levels of moral distress intensity. Many recommend the use of a mentor or role model to do such a thing.[28,29,73,80] A mentor can offer support, and support definitely finds its place in this literature.[28,46] For example, the male nurses in Nordam et al.'s[46] study suggested that support from co-workers and good patient relationships were key factors in improving the practitioners' experience. A cultural shift towards a more '. . . open, approachable system that engenders trust and confidence'[67] could significantly improve the ability of staff to manage ethical conflicts, reducing the perceived degree of moral distress and its consequences. A supportive culture that respects and values the issues experienced by nurses, their ethical decision-making processes and their moral concerns must be fostered.[41,68,69,81]

Finally, a collective action in the form of practical guidance and discussion forums for sharing of concerns[61] must extend to the patients and their family.[28] Dudzinski and Shannon[56] talk about a 'negotiated reliance response', which they suggest may alleviate distress for practitioners. This involves discussions between all stakeholders, including the patient's family when appropriate, to facilitate a coordinated plan that recognizes the desires of all parties. Kirk[57] also advocates the benefits of including the family unit, suggesting that we owe a moral obligation to all parties.

Conclusion and relevance to clinical practice

A review of the moral distress literature highlights an assortment of interdisciplinary literature. Factors contributing to moral distress stem from individual characteristics, site-specific systems and/or broader external influences. Respectively, these can include, for example, a nurse's personal traits and life experiences, a ward's staffing mix and care context and broader external influences like meeting care standards or third-party expectations.

The attendant outcomes of this distress may manifest internally or externally and are generally deleterious either to the individual (self), others and/or the system. Respectively, these can include, for example, the feelings of anger towards one's self, self-doubt, diminished self-esteem, depression and even burnout and towards another, a feeling of anger, bitterness, cynicism, dismay and frustration. Finally, the effects of moral distress towards the system include the nurse engaging in avoidance behaviours, changing jobs and leaving the profession.

A range of interventions have been proposed, these include education to improve ethical understanding, ethical skills and communication; provision of morally sensitive support mechanisms; individual engagement in critical self-reflection; interdisciplinary dialogue and education; collection of narratives or storytelling; mentorship and enablement of a supportive organizational culture. While most authors offer recommendations, it must be acknowledged that few intervention studies appear to have been undertaken, and engaging this next step is crucial to generate the evidence about what really works.

Moral distress has implications for the nurse and the nursing workforce. Morally distressing situations contribute to decreased quality of care and diminished workplace satisfaction for staff, lead to physical and emotional illness, burnout and staff turnover.

Limitations of the overview of the literature

This overview of the nursing literature did not set out to answer a specified question, but it was conducted in a systematic manner providing a rigorous representation of the literature. The review excluded a critical appraisal and synthesis of the critical care literature. However, the decision to review the extensive literature across the broader sample of nursing specialities gives confidence that the review is both credible (valid) and dependable (reliable). All literature reviews are temporal and thus limited – this overview of literature is no different. For example, in the period 2012, after our search period, the search term 'moral distress' is cited some 80-plus times in this very journal!

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Conflict of interest

The authors declare that there is no conflict of interest.

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