



Moral distress in South African professional nurses: Instrument development

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DECLARATION

I, Richelle van Waltsleven, student number 20420595, declare that:

- "Moral Distress in South African Professional Nurses: Instrument development", is my own work and that all the sources I used or quoted are indicated or acknowledged in the bibliography.
- This study has been approved by the Ethics Committee of the Institutional Office of the North-West University (Potchefstroom Campus).
- This study complies with the research ethical standards of the North-West University (Potchefstroom Campus).



Richelle van Waltsleven

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Soli Deo Gloria!

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ABSTRACT

Nurses experience stress, fear and anger while they are trying to reconcile their ideals/ goals about health care with its inadequacies and abuses (Jameton, 1984:5), while at the same time trying to stay true to their convictions (Lindh *et al.*, 2010:552). Moral distress is experienced when nurses cannot adhere to these goals (Corley, 2002:637). Conflicting moral principles, stress-provoking and contradicting demands weaken the nurse's sense of control, power and autonomy (Lützen *et al.*, 2010:213). The current descriptions of moral distress inadequately define the concept, and this might lead to the inconsistent use of the term moral distress. Therefore, conceptual clarity is needed. Current available instruments measure antecedents and situations causing moral distress. Therefore, an instrument measuring the attributes of moral distress is urgently needed. Such an instrument might be used in a variety of clinical departments because it is not based on department-specific situations but on the attributes of moral distress. Moral distress has a great impact on the nurse, patient care and the organization.

This research used Benson and Clark's (1982) method of instrument development as a theoretical framework. It is the aim of this study to develop and validate an instrument to measure moral distress in the clinical health care context of the professional nurse. In order to attain this aim the following objectives were set: To conduct an integrative literature review to identify antecedents, consequences, attributes and empirical indicators of moral distress; to conduct interviews to explore professional nurses' experience of moral distress; to develop an instrument to measure moral distress in professional nurses; to validate the instrument. A qualitative and quantitative research design with explorative, descriptive and contextual strategies was used.

The research process was divided into phases. During Phase One, an integrative literature review was conducted and the population included all available national and international data on moral distress in nurses/ nursing and sampling included all-inclusive sampling. Data analysis was performed through descriptive synthesis. Phase One also included semi-structured interviews and the population included professional nurses working in hospitals and clinics in the North-West Province. The sampling method applied was purposive sampling. Tesch's method was used as data analysis method. During Phase Two, a content validation was conducted and the population included experts in the field of moral distress and instrument validation, and purposive sampling was applied. Data collection was done through the instrument that was developed and data analysis was the content validity index. Phase Two also included a qualitative evaluation which was conducted and the population

consisted of professional nurses working in hospitals and clinics in the North-West Province and purposive sampling was applied. Data was collected through the developed instrument and a focus group session. Data analysis was conducted through a consensus discussion. During Phase Three, a pilot study was conducted and the population was professional nurses working in a hospital with different departments and clinics in the Free State Province. All-inclusive sampling was applied and the instrument that was developed was used as data collection. Data analysis included: Descriptive statistics, factor analysis (exploratory, confirmatory and Bartlett's test of sphericity), Cronbach's alpha coefficient, correlations and ANOVA. According to the results from the face-, content-, exploratory and confirmatory, discriminant- as well as divergent validity, the instrument has been shown to be valid. The Cronbach's alpha for the Moral Distress Instrument was deemed reliable. Finally, the research was evaluated and limitations were identified. Recommendations for nursing education, -practice, research and policy were formulated.

Keywords: Moral distress, professional nurse, instrument development, reliability, validity

UITTREKSEL

Verpleegkundiges ervaar stres, angs en woede terwyl hul poog om hul ideale/doelwitte met betrekking tot die gesondheidsorg, met al die tekortkominge en vergrype/misbruike (Jame-ton, 1984:5) te versoen met hul oortuigings (Lindh *et al.*, 2010:552). Morele nood word ervaar wanneer verpleegkundiges nie getrou kan bly aan hierdie doelwitte nie (Corley, 2002:637). Botsende morele beginsels, stres-veroorsakende en weersprekende eise verswak die verpleegkundige se sin van beheer, gesag en vermoë asook outonomieit (Lützen *et al.*, 2010:213). Die huidige beskrywings van morele nood ontbreek definieëring en dit mag lei tot die teenstrydige gebruik van die term morele nood en daarom is konseptuele duidelikheid nodig. Tans meet die beskikbare instrumente net die voorgaande situasies wat morele nood veroorsaak en die gevolge van morele nood, daarom is 'n instrument wat die eienskappe van morele nood meet, dringend nodig. So 'n instrument kan in verskeie kliniese eenhede gebruik word omdat dit nie op departement-spesifieke situasies gebasseer is nie, maar eerder op die eienskappe van morele nood. Morele nood het 'n betekenisvolle invloed op die verpleegkundige, die pasiënt en die organisasie.

Die navorser het Benson en Clark (1982) se instrument-ontwikkelingsmetode gebruik as teoretiese raamwerk. Die doel van die studie was om 'n instrument te ontwikkel en te valideer om morele nood in die kliniese gesondheidsorg-konteks van die professionele verpleegkundige, te meet. Om hierdie doel te bereik is die volgende doelwitte gestel: om deur 'n integrerende en omvattende literatuur oorsig, voorgaande-, gevolge-, eienskappe en empiriese indikatore van morele nood te identifiseer; om gestruktureerde onderhoude te voer om professionele verpleegkundiges se ervarings van morele nood te verken; om 'n instrument te ontwikkel wat die morele nood van professionele verpleegkundiges kan meet; en om die instrument te valideer. 'n Kwalitatiewe en kwantitatiewe navorsingsontwerp met ondersoekende, beskrywende en kontekstuele strategieë is gebruik.

Die navorsingsproses is in fases ingedeel. Gedurende Fase Een is die integrerende en omvattende literatuur-oorsig uitgevoer en die populasie het alle nasionale en internasionale data, gepubliseer en ongepubliseer (waar moontlik) wat oor morele nood in verpleegkundiges/verpleging handel ingesluit. Die steekproef was alles-insluitend. Data analise is uitgevoer deur 'n beskrywende sintese. Gedurende Fase Een, is daar ook semi-gestruktureerde onderhoude gevoer en die populasie het professionele verpleegkundiges wat werkzaam is in hospitale en klinieke in die Noordwes Provinsie ingesluit. Die steekproef metode wat toegepas is, was 'n doelbewuste steekproef. Tesch se metode van data analise is gebruik.

Gedurende Fase Twee, is 'n inhoudsvalidasie gedoen en is data insameling gedoen deur die ontwikkelde instrument na kundiges te stuur. Die populasie het kundiges in die veld van morele nood en instrument-ontwikkeling ingesluit en doelbewuste steekproefneming is toegepas. Data analise is gedoen deur die inhoudsvalidasie indeks.

Gedurende Fase Twee is 'n kwantitatiewe evaluasie van die instrument gedoen. Die populasie het bestaan uit professionele verpleegkundiges wat werksaam is in hospitale en klinieke in die Noordwes Provinsie en 'n doelbewuste steekproef metode is toegepas. Data is ingesamel deur die instrument wat ontwikkel is en 'n fokus groep was gehou. Data analise is toegepas deur inhoudsanalise en 'n konsensus bespreking.

Gedurende Fase Drie, is 'n loodsstudie gedoen en was die populasie professionele verpleegkundiges wat in 'n hospitaal met verskillende departemente en klinieke in die Vrystaat provinsie werk. 'n Alles-insluitende steekproef is toegepas en die instrument wat ontwikkel is, is gebruik as data-insameling. Data analise het die volgende behels: Beskrywende statistieke, faktor analise (ondersoekend, bevestigend, en Bartlett's se omvangstoets, Cronbach se ko-ëffisiënt, korrelasies en ANOVA. Volgens die uitslae van die gesigs-, inhouds-, ondersoek- en bevestigende geldigheid is die instrument as geldig bevind en bevestig deur die oordeelkundige en afwykende geldigheid. Volgens die Cronbach alpha, is die instrument as geldig geag. Die gevolgtrekking is dat die instrument wat gedurende die navorsing ontwikkel is, as betroubaar en geldig geag kan word. Ten slotte is die navorsing geëvalueer en beperkings is geïdentifiseer. Aanbevelings vir die verpleegonderwys, verpleegpraktyk, verdere navorsing en beleid is geformuleer.

Sleutelwoorde: Morele nood, professionele verpleegkundige, instrument-ontwikkeling, geldigheid, betroubaarheid.

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CHAPTER ONE

CHAPTER ONE

OVERVIEW OF RESEARCH AND PHILOSOPHICAL POSITIONING

1.1 INTRODUCTION

In Chapter One, the reader is given an orientation to the research study. An overview is given of the background and rationale of the study, followed by the problem statement. From the problem statement the research questions were formulated after which the objectives are stated. The researcher's assumptions are discussed and brief descriptions of the research design and research method are given. A brief discussion of the rigour and ethical considerations follows. The chapter concludes with an outline of the structure of this study.

1.2 BACKGROUND AND RATIONALE FOR THE STUDY

Corley (2002:637) states that the goals of nursing are 'to protect the patient from harm, to provide care that prevents complications, and to maintain a healing psychological environment for patients and families' (Redman & Frey, 2000:360). Nurses especially experience stress, fear and anger while they are trying to reconcile their ideals regarding health care with its inadequacies and abuses (Jameton, 1984:5), while trying to stay true to their convictions (Lindh *et al.*, 2010:552). Moral distress is experienced when nurses cannot adhere to these goals (Corley, 2002:637). Conflicting moral principles, stress-provoking and contradicting demands weaken the nurse's sense of control, power and autonomy (Lützen *et al.*, 2010:213). Corley and Minick (2002:7) are of the opinion that there are two aspects that contributes to moral distress, namely the seriousness of the situation causing moral distress and the frequency at which it occurs. Serious problems may cause moral distress even after it only happened once and can affect the individual long after the incident occurred. Less serious situations that happen more frequently may also cause moral distress. Moral distress has been shown to have a negative influence on the work environment and can lead to problems in the work environment (Corley *et al.*, 2005:382), which can effect nurse turnover and job satisfaction (Schluter *et al.*, 2008:313), moral distress is also seen as one of the consequences of the stress nurses have to endure.

According to the literature there are quite a number of factors contributing to moral distress, namely, disagreement with quality of medical care, under-treatment, consent and refusal of treatment, inadequacy of resources, to name but a few (Redman & Frey, 2000:363). Nurses also experience moral distress under the pressure to control health care costs and staff shortages (Corley *et al.*, 2005:382). Due to the fast paced health care environment, nurses are prevented from identifying problems early on and this leads to moral distress (Corley *et al.*, 2005:383). Pauly *et al.* (2009:569) state that the ethical climate can contribute to moral distress. Work overload can contribute to nurses looking past human suffering, resulting nurses not being able to nurture and care for their patients (Corley, 2002:636, 639, 642; Greenglass *et al.*, 2001:214). It is important for nurses to have autonomy to make clinical decisions in the area of their competence and be able to control their own practice, including the practice environment (Aiken *et al.*, 1994:771, 774; Hart, 2005:176; Irvine & Evans, 1995:251; McGrath *et al.*, 2003:561). Nurses experience moral distress when they are unable to give the care the patients require due to a lack of resources which then puts the patients' well-being at risk (Harrowing & Mill, 2010:724). Nurses indicated unsafe staffing as the situation that gives rise to the highest moral distress frequency and intensity (Corley *et al.*, 2005:387; Ohnishi *et al.*, 2010:738). Eizenberg *et al.* (2009:890) found that moral distress was caused by time constraints, shortage of resources and conflicting perceptions between staff (Cameron *et al.*, 2001:440; Shorideh *et al.*, 2012:465). Deady and McCarthy (2010:213) reported that moral distress is caused by 'professional and legal conflict, professional autonomy and scope of practice and standards of care and client autonomy'. Role conflict can also be seen as adding to the nurses' experiencing moral distress. The role conflict is experienced where nurses are expected to meet expectations of different authorities, namely orders from the physicians and the hospital administrators (Corley *et al.*, 2001:251; Bernardin, 2003:328; Oztunc, 2005:360; Irvine & Evans, 1995:249).

To give a clear description of the progress of the concept moral distress, it is necessary to describe the history of the concept and to go as far back as 1984. Andrew Jameton (1984:5) claimed that there was a crisis in health care and that this crisis was reflected by the individuals working in it. He wrote that moral and ethical problems arose from a variety of issues, such as patients, other nurses, supervisors and administrators, physicians, aides, orderlies, attendants, hospitals, potential patients, pharmacists, family and friends of patients and other health care workers.

Jameton wrote from the perspective of a philosopher on bioethical issues as they were shaped in nursing practice (Jameton, 1984:2). Jameton believed that ethics research explored basic moral norms (Jameton & Fowler, 1989:12). He was the first person to coin the term moral distress. Since then, there have been quite a number of articles on moral

distress. In 1993 Jameton further divided moral distress into initial moral distress and reactive moral distress with initial moral distress being the frustration, anger and anxiety a person feels when experiencing interpersonal conflict about values and institutional obstacles (Jameton, 1993:544) and reactive moral distress being the stress a person experiences when they do not act upon the initial distress (Corley, 2002:637). Other researchers merely followed Jameton or added to the existing concepts formulated by him. Sporrang *et al.* (2003:1077) state that initial distress is caused by bureaucratic obstacles and/or disagreeable colleagues. If certain strategies for coping are not implemented during initial distress, reactive distress follows (Sporrong *et al.*, 2003:1077).

Jameton distinguishes between ethics and morals, with ethics being the more formal and theoretical concept and morals being the more informal and personal concept (Jameton, 1984:13). Conventional moral principles in health care are not unconditional orders that can be obeyed, but are seen as general guides for decision-making that, require interpretation, consideration and individual judgement (Jameton, 1984:77). During this time Jameton (1984:5) distinguished between three types of moral and ethical problems: moral uncertainty, moral dilemmas and moral distress. Moral uncertainty is where one is unsure what the moral problem is, as well as which moral principles or values are applicable. Moral dilemma is where two or more moral principles are applicable, and they support inconsistent courses of action. The dilemma lies in figuring out which one to give up, seeing that a loss is inescapable. Moral distress is a knowing of what the right thing is to do, but institutional constraints make it impossible to do the right thing (Jameton, 1984:6).

There are various definitions of moral distress. **Elpern** *et al.* (2005:523) defines moral distress as “painful feelings and/or psychological disequilibrium that occurs in situations in which the ethically right course of action is known but cannot be acted upon. As a result, persons in moral distress act in a manner contrary to their personal and professional values”, moral distress can therefore be seen as a health risk for nurses as well as for their patients. **Wilkinson** (1989:514) is of the opinion that moral distress occurs when situational constraints prevent nurses from implementing moral decisions that they have made. **Nathaniel** (2006:421) describes moral distress as pain that affects body and mind and can occur when a nurse makes a moral judgement about a moral problem thereby acknowledging moral responsibility. **Hanna** (2002:187) describes moral distress as:

“Moral distress occurs in the context of situations that have moral implications embedded within them, where the moral end, an inherent rightness or goodness, is understood to exist and is understood to be or to have been threatened, harmed or violated. There can be a shock-like suddenness or unexpectedness associated with the recognition or threat to the moral end that prompts the experience of moral distress to begin”.

Kelly (1998:1135) describes moral distress as having to act in a way that contradicts personal beliefs and values, and is then experienced as unease or dissonance. **Webster and Baylis** (2000:218) define moral distress as something that occurs when one fails to pursue what one believes to be the right course of action to take. This happens when there's an error in judgement, some personal failing or other circumstances that are beyond one's control. Some authors refer to moral distress as moral stress. **Lützen *et al.*** (2003:318) state that stress contains a moral component; therefore the term moral stress is used. **Zuzelo** (2007:344) defines moral stress as "efforts or attempts to make clinical decisions involving conflicting ethical principles and where patients' autonomy is at risk". According to **Sporrong *et al.*** (2003:1076) stress related to ethical dilemmas are referred to as moral distress.

There is also a difference in opinion regarding what the experience (moral distress) should be termed. Jameton (1984:5), Wilkinson (1989:514), Corley (2002:7), Sporrong *et al.* (2003:1076), Elpern *et al.* (2005:523), Hanna (2002:187), Nathaniel (2006:421), Webster and Baylis (2000:218) and Kelly (1998:1135) use the term moral distress. Zuzelo (2007:344) and Lützen *et al.* (2003:318) use the term moral stress. When looking at all the different definitions of moral distress, it is clear that there is a lack of conceptual clarity.

Just as there are different definitions and use of the term moral distress or moral stress, there are quite a number of instruments reported in the literature to measure moral distress, as well as stress related to ethical dilemmas. All the instruments currently available are international instruments. The different instruments currently available are presented in Table 1.1 to give an overview of the instruments used to measure moral distress. A short discussion follows on the focus of the instruments in Figure 1.1.

Table 1.1 Overview of instruments to measure Moral Distress

Instrument/ Author	What it measures	Year
Questionnaire survey De Veer <i>et al.</i>	To measure the intensity of moral distress within daily care in different health care settings. Measures intensity of moral distress. (De Veer <i>et al.</i> , 2013:102)	2013
Moral distress thermometer Wocial and Weaver	Moral distress thermometer. Adapted from MDS (Moral Distress Scale) from Corley. To help anchor the degree of distress. (Wocial and Weaver, 2013:170)	2013
Revised Moral Distress Scale Hamric <i>et al.</i>	Revised Moral Distress Scale Moral Distress Scale by Corley <i>et al.</i> was revised. Measures frequency and intensity of moral distress. (Hamric <i>et al.</i> , 2012:3)	2012
Moral Distress Scale – Psychiatry Ohnishi <i>et al.</i>	Moral Distress Scale – Psychiatric nurses Moral distress scale from Corley <i>et al.</i> was adopted. Measures intensity and frequency of moral distress. (Ohnishi <i>et al.</i> , 2010:728)	2010
Moral Distress Questionnaire Eizenberg <i>et al.</i>	Moral Distress Questionnaire Developed to test the psychometric properties of a culture-sensitive moral distress questionnaire among nurses. Measures nature and intensity of moral issues and dilemmas. (Eizenberg <i>et al.</i> , 2009:886)	2009

Instrument/ Author	What it measures	Year
Combination of existing instruments (Corley's Moral Distress Scale, Ethics Environment Questionnaire, Hospital Ethical Climate Survey) Hamric and Blackhall	A scale was devised to measure moral distress in physicians and nurses who deliver end-of-life care in ICUs. Used combination of existing instruments. Measures intensity and frequency of moral distress. (Hamric & Blackhall, 2007:423)	2007
Instrument of Moral Distress Sporrong <i>et al.</i>	Assess everyday experiences of health care personnel in a variety of settings. Measures level of moral distress and openness/ tolerance regarding ethical issues. (Sporrong <i>et al.</i> , 2006:419)	2006
Stress of Conscience Questionnaire (SCQ) Glasberg <i>et al.</i>	Measuring stress emanating from a bad conscience. Measures frequency and degree of troubled conscience. (Glasberg <i>et al.</i> , 2006:635)	2006
Moral Distress Assessment Questionnaire Hanna	Measures type, intensity, frequency and duration of moral distress experiences. Measures type, intensity, frequency and duration of moral distress. (Hanna, 2002:279)	2004
Moral Distress Scale Corley <i>et al.</i>	Measures moral distress in nurses in hospitals. Measures frequency and degree of moral distress. (Corley <i>et al.</i> , 2001:252)	2001

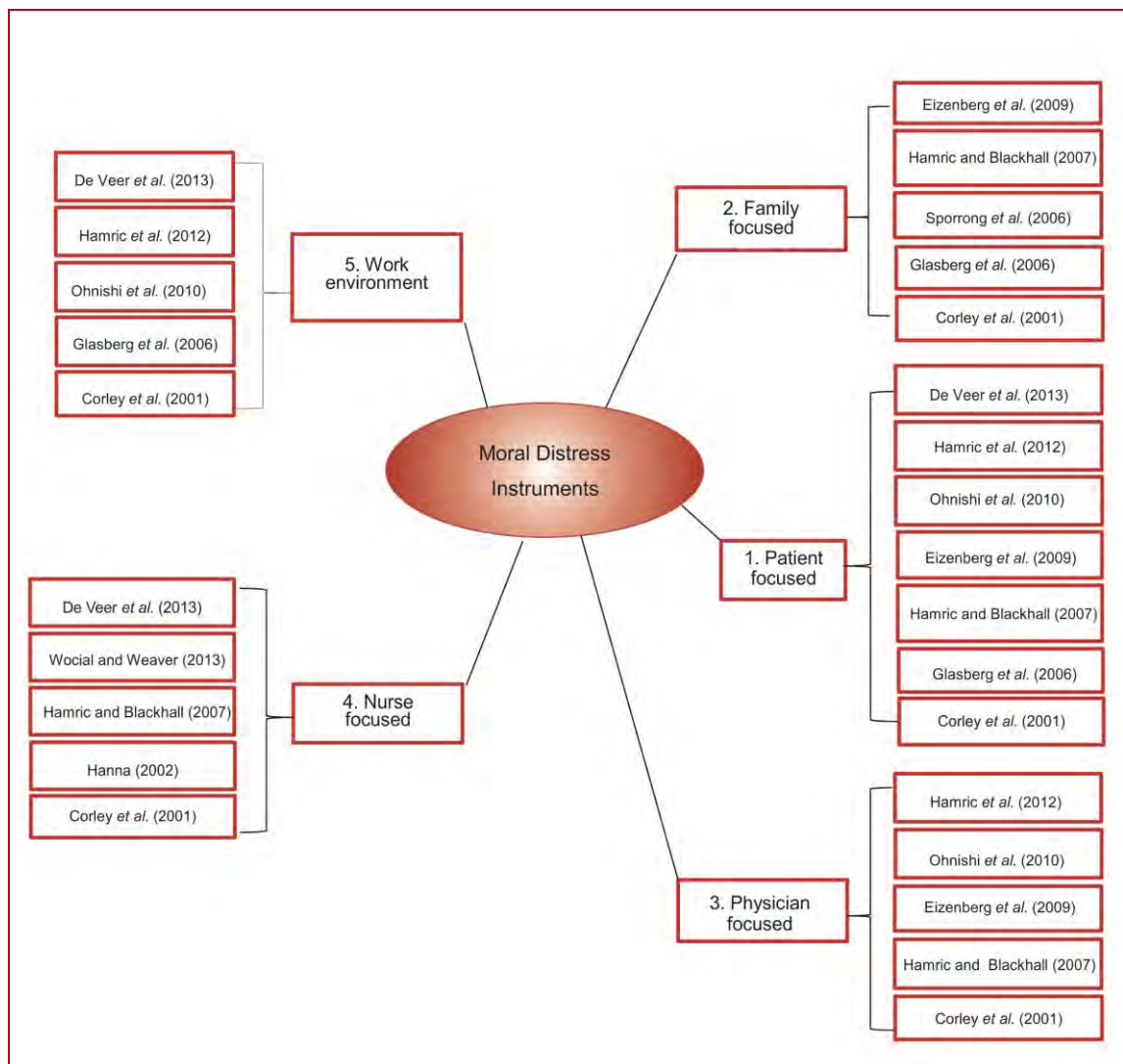


Figure 1.1 Overview of current instruments

The researcher came to the conclusion that there are five areas on which current instruments focus when measuring moral distress (see Figure 1.1). A short summary describing the contents of current instruments measuring moral distress follows:

1. Patient focused items

Items focusing on patient issues in the current instruments included: treatment with unnecessary tests and procedures of terminally ill patients, assisting initiating life-saving treatment when it will only prolong death, preparing terminally ill patients for theatre, lacking time to give proper patient care, avoiding of patients, invading patients' privacy and giving incomplete patient care due to work overload.

2. Family focused items

Items focusing on family focused issues in the current instruments included: following of family wishes even though these are not in the patients' interest or are not the patients' wishes and also following the family's wishes, even if the nurse does not agree with them.

3. Physician focused items

Items relating to physician focused issues in the current instruments included: assisting incompetent physicians, following a physician's request not to discuss death with a dying patient who asks about dying, assisting physicians who are practicing procedures after CPR (cardio-pulmonary resuscitation) was unsuccessful and assisting physicians who perform tests without informed consent.

4. Nurse focused items

Items relating to nurse focused issues in the current instruments included: working with unsafe levels of nursing staff, observing without intervening when health care providers do not respect a patient, ignore situations of suspected patient abuse and avoid taking action when a nurse gave the wrong medication.

5. Work environment focused items

Items relating to work environment focused issues in the current instruments included: having to deal with incompatible demands in the nurse's work, work in health care is so demanding that nurses do not have energy for their families and feel they cannot live up to others' expectations.

According to Corley (2002:638) and Corley *et al.* (2005:383), moral distress is the leading contributor to nurses being frustrated, experiencing burnout, resigning or leaving the profession altogether (Austin *et al.*, 2005:199). Moral distress also has a negative effect on the patient care provided by the nurses (Shepard, 2010:27). Some nurses experience a feeling that they have not done enough for their patients and according to Lützen *et al.* (2006:188) this indicates awareness of the moral nature of a situation. Schluter *et al.* (2008:317) found a positive correlation between decreased job satisfaction and moral distress. This might be due to the fact that nurses are required to make moral judgements in many nursing decisions during the course of their work (Wilkinson, 1987:18). Moral distress manifests itself through physical and psychological symptoms (Corley, 2002:638; Schluter *et al.*, 2008:316; Austin *et al.*, 2005:199; Elpern *et al.*, 2005:529; Maiden *et al.*, 2011:343). These symptoms are then also carried over to the personal life of the nurse. The emotional symptoms experienced are anger, resentment, frustration, sorrow, anxiety, helplessness, powerlessness, compromised integrity, shame, embarrassment, grief, heartache, misery, pain, sadness, dread, sorrow and anguish. The physical symptoms include palpitations, nausea, diarrhoea and hypertension, to name but a few (Corley, 2002:642; Schluter *et al.*, 2008:316; Ulrich *et al.*, 2010:20; Bégat *et al.*, 2005:228; Cropanzano *et al.*, 2001:82; Shorideh *et al.*, 2012:474). Professional nurses also described their experience of moral distress as not feeling whole (Austin *et al.*, 2005:210).

Hanna (2004:73) and Repenshek (2009:734) are of the opinion that the current descriptions of moral distress inadequately define the concept. It is clear that there is inconsistent use of the term moral distress. As evident in this literature review, moral distress has dire consequences for nurse, patient and the clinical facility and therefore, it needs to be measured correctly and efficiently in order to address moral distress. According to Eizenberg *et al.* (2009:886) instruments should be developed to measure the experience of moral distress in nurses, enabling the measurement of moral distress in a manner that is sensitive to the unique culture of nursing, as well as the comparison of results from different contexts in nursing.

In the majority of cases, the instrument as developed by Corley *et al.* (2001:252) formed the point of departure for all other instruments. In some instances researchers incorporated parts of other instruments to form one instrument; in order to accommodate their specific situations (e.g. Wocial & Weaver, 2013; Glasberg *et al.*, 2006; De Veer *et al.*, 2013; Ohnishi *et al.*, 2010). The researcher concluded that the instruments that are currently available measure the antecedents of moral distress, whilst the concept of “moral distress” is not necessarily measured. Current instruments also focus on a specific area, e.g. ICU, in the

health care context, and measures the frequency and/ or intensity of moral distress determined from specific situations.

Therefore, there seems to be a need to develop an instrument to measure the concept of moral distress. The researcher is of the opinion that in order to develop an instrument, an extensive literature review has to be done to identify the antecedents, consequences, attributes and empirical indicators of moral distress and interviews should be conducted to confirm the findings from the integrative literature review. It is necessary to identify the attributes of moral distress, so that when doing so, an instrument can be developed based on the attributes or concept of moral distress and not on antecedents or certain situations that cause moral distress.

1.3 PROBLEM STATEMENT

Nurses work in stressful environments and when they are faced with conflicting moral principles, stress-provoking and contradicting demands, their sense of power, control and autonomy is weakened (Lützen *et al.*, 2010:213). Situations such as those described above, may cause nurses to experience moral distress (Corley *et al.*, 2005:382).

Moral distress can be defined as knowing the ethically right course of action to take, but one cannot act upon it (Elpern *et al.*, 2005:523; Wilkinson, 1989:514; Webster & Baylis, 2000:218; Jameton, 1984:6). There are various definitions of moral distress, and this contributes to the lack of conceptual clarity of the concept.

The term moral distress was first coined by Jameton (1984:5), who wrote from the perspective of a philosopher on bioethical issues. Jameton was also the first researcher to distinguish between initial and reactive moral distress (1993:544). From there several other researchers followed, added or changed the definition and term of moral distress. Corley *et al.* (2001:252) were the first researchers to develop an instrument to measure moral distress.

Just as there are different definitions and uses of the term moral distress, several instruments are reported on in the literature. Current instruments focus on antecedents causing moral distress.

Consequences of moral distress can include: nurses being frustrated, experiencing burnout, resigning or leaving the profession. These have a negative effect on the care provided by the nurses as well as decreasing job satisfaction. Moral distress manifests itself through physical and emotional symptoms (Austin *et al.*, 2005:199; Shepard, 2010:27; Schluter *et al.*, 2008:317; Corley, 2002:638; Maiden *et al.*, 2011:343).

The current descriptions of moral distress inadequately define the concept, and this might lead to the inconsistent use of the term. Therefore conceptual clarity is needed. Because the available instruments measure antecedents and situations causing moral distress, an instrument measuring the attributes of moral distress is urgently needed. Such an instrument might be used in a variety of clinical departments because it is not based on department-specific situations but on the attributes of moral distress. As evidenced from this background discussion, moral distress has a great impact on the nurse, patient care and the organization.

With clarity of the concept and an instrument measuring the attributes of moral distress, specific action might be taken to address moral distress and its consequences in health care. All of the above led the researcher to the following research questions:

- 1 What are the antecedents, consequences, attributes and empirical indicators of moral distress?**
- 2 What are professional nurses' experiences of moral distress within the clinical health care context?**
- 3 How can an instrument to measure moral distress be developed and validated?**

1.4 RESEARCH OBJECTIVES

It is the aim of this study to bring clarity to the concept of moral distress and to develop and validate an instrument to measure moral distress in the clinical health care context of the professional nurse. In order to attain this aim the following objectives were set:

1. To conduct an integrative literature review to identify antecedents, consequences, attributes and empirical indicators of moral distress.
2. To conduct interviews to explore professional nurses' experience of moral distress.
3. To develop an instrument to measure moral distress in professional nurses.
4. To validate the instrument.

1.5 PARADIGMATIC PERSPECTIVE

Burns and Grove (2009:59) are of the opinion that nursing's philosophical views influence its knowledge, as it guides the research method. A philosophy can be defined as a statement of beliefs and values (King & Fawcett, 1997:97), and are statements about what people assume to be true (Christensen & Kenney, 1990:12). The researcher's assumptions forms part of a particular paradigm. Kuhn (1999:40) avers that a paradigm is a shared framework and a shared view that is held by members of a discipline about the discipline, therefore a worldview (Kuhn, 2007:156). Assumptions are statements and these statements are accepted as having a high probability of truth. Assumptions are also the premises upon which concepts are developed, where theories evolve and research is conducted. Assumptions reflect values, beliefs and goals, and holds different aspects together (King & Fawcett, 1997:126). The paradigmatic perspective is divided into meta-theoretical, theoretical and methodological assumptions.

1.5.1 Meta-theoretical assumptions

The researcher's paradigmatic perspective is grounded in Christianity and therefore has a Christian outlook on the world as a whole. The researcher also holds a constructivist view, believing that the world is relative to the observer and knowledge is not passively received but constructed by the individuals' sense of their world (Yilmaz, 2008:162). As a constructivist, the researcher wants to understand the complex world of those who live in it and to construct and clarify the meaning thereof (Schwandt, 2001:118). Constructivism is seen as a metaphor for learning and acquiring knowledge (Fox, 2001:23). Within constructivism realities cannot be understood in isolation, but should be investigated with the entity-in-context to fully understand phenomenon (Lincoln & Guba, 1985:39). Consequently, the process of interaction forms part of understanding (Creswell, 2009:8). Therefore the contribution of each individual is recognized in forming the reality (Lincoln & Guba, 1985:82).

In order to understand the complex concept of moral distress an extensive integrative literature review was conducted. The researcher then conducted interviews with professional nurses to understand moral distress as the entity-in-context, and each interview confirmed to the researcher what was learned from the integrative literature review. This gave the researcher the ability to identify the attributes of moral distress in order to develop empirical indicators (items) to measure moral distress based on the attributes of moral distress. A quantitative evaluation was conducted through which experts on moral distress and instrument development evaluated the instrument for clarity and relevance of the concept of

moral distress, thereby creating valid knowledge. The researcher's view of person, health, environment and nursing is stated to clarify the point of departure for this study.

❖ **Person**

Because Christianity forms part of the worldview of the researcher, a person is seen as a creation of God. The researcher believes in a tri-une God (Father, Son and Holy Spirit), and therefore believes that a person is a tri-une being, having a body, mind and spirit. Every person is a unique creation, created in the image of God and encompasses unique characteristics. Every person has the right to be treated with love, dignity and respect. Freedom of expression forms an integral part of that uniqueness. The person in this research is represented by the professional nurse.

In addition, a person cannot be seen as an isolated being. Rather, every person is in constant interaction with other persons and the environment (King, 1988:20). Barkin (2003:327) states that as constructivists, the structures within which people operate are defined by their social norms and ideas.

In this research the professional nurse is seen as a unique creation of God that embodies all the dimensions of body, mind and spirit. Nurses are seen as functioning in an integrated, interactive manner with the environment in which they find themselves. The person in this study is the nurse working in a health care organization and functions in a professional relationship with others. Because ethics and morality are central to nursing (Jameton, 1984:77) and all nursing acts are fundamentally ethical (Corley, 2002:637), both ethics and morals form part of the person in this research. Jameton (1984:77) argues that ethics are the theoretical reasoning over morality and that morality is personal opinions, therefore the "right and wrong or good and bad" decisions one makes.

❖ **Environment**

The environment includes the internal and external environment in which the nurse functions. The internal environment consists of the dimensions of body, mind and spirit and the external environment incorporates aspects such as the physical, social and spiritual dimensions of the nurse in his or her workplace and daily life (King, 1971:24). The environment forms an integral part of health. Constructivists view people as builders of their cognitive tools and external realities (environment). Therefore knowledge and the world are constantly constructed and reconstructed through their experiences (Ackermann, 2001:91).

In this research the internal environment includes the physical, psychological and cognitive realm of the nurse. The external environment is the health care organization in which the nurse functions. This includes the professional relationship that the nurse has towards others that are occupied with work-related aspects. The nurse must make decisions (internal environment) based on what is happening in the hospital (external environment). This then also forms part of the nurse's perception of morals and ethics. What he/she perceives as good or bad, right or wrong (internal environment) he/ she will tend to implement (the external environment).

During this research the effect that the internal and external environments have on each other will become evident, by looking at what effect moral distress has on the professional nurse's physical and emotional being and how that influences the external environment where the professional nurse finds him/ herself.

❖ **Health**

Health can be seen as a state of well-being, whether in body, mind or spirit. Illness can be seen as disequilibrium of a person whether in body, mind or spirit. Health is determined between the balance of the internal and external environment. Nightingale defines health not only to be the opposite of sickness, but also to be able to use the power that is in us very well. Disease on the other hand is seen as an attempt of the body to correct some problem (cited in Fitzpatrick & Wall, 1996:35). Orem is of the opinion that wellbeing is a perceived state of being and that it is amongst other things an experience of contentment and happiness (cited in Fitzpatrick & Wall, 1996:120). In addition, Parse stated that human health is defined as "the day-to-day unfolding through human-universe interchanges" (cited in King & Fawcett, 1997: 155).

Health in this research refers to the wellbeing of the nurse in the workplace, which will include all three components, namely that of body, mind and spirit. Health will also represent a nurse free of moral distress, therefore free of disequilibrium in body, mind and spirit.

❖ **Nursing**

"Nursing is a professional discipline that encompasses basic, applied and clinical research" (King & Fawcett, 1997:3). Nurses contribute to the wholeness and wellbeing of people. Nightingale distinctly separated nursing and medicine. Nursing is seen as a nurse's concern for the patient who is ill, whereas medicine is concerned about the illness (cited in Fitzpatrick & Wall, 1996:32). Recognizing that there is continuous interaction between person and

environment, nursing is concerned with the wholeness of the human being (King & Fawcett, 1997:97).

In this research nursing is an interactive process where the nurse, as a sensitive therapeutic professional, facilitates the promotion of health through the mobilisation of resources. Nursing is the process where the nurse will have to make decisions on her/ his own morals and ethical assumptions, to reach goals that were set by her/ his and the patient.

1.5.2 Theoretical assumptions

In order to observe and interpret, one needs a framework that will serve as a reference. All observations are made within a frame of reference, a horizon of expectations (Popper, 2002:62). In addition to organizing phenomena, theories are made up of concrete concepts (Barnum, 1998:1). The theoretical framework (see Figure 1.2) that was utilised during this research is that of Benson and Clark (1982:789). It is a framework on the development and validation of an instrument, and guided the researcher throughout the course of this research. The framework consists of four phases, namely: Phase One: Planning; Phase Two: Construction; Phase Three: Quantitative Evaluation and Phase Four: Validation. A comprehensive discussion of the theoretical framework follows in Chapter Two.

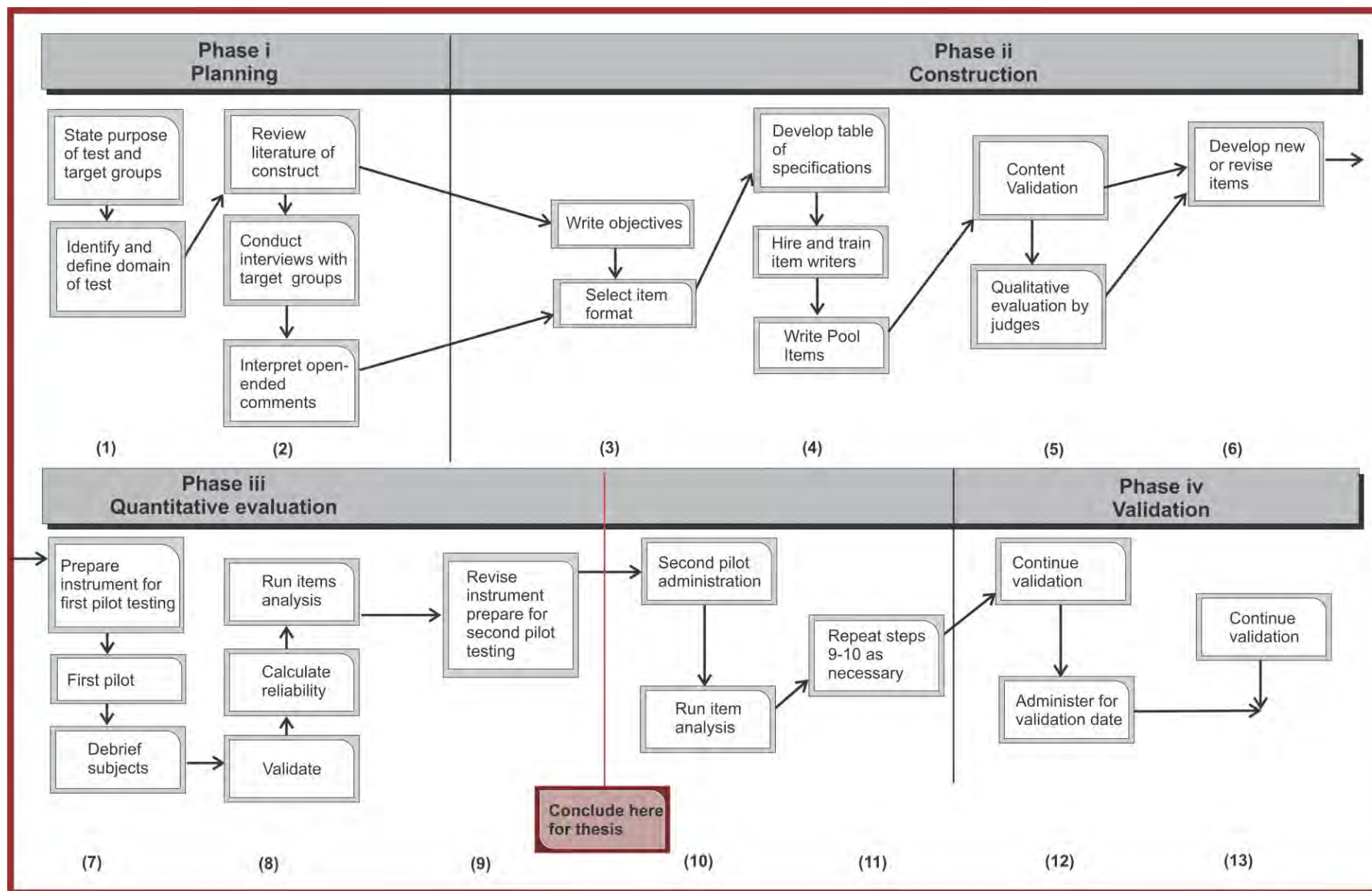


Figure 1.2 Flowchart for Instrument Development (Benson & Clark, 1982:790)

1.5.2.1 Central theoretical statement

The aim of this research was to bring clarity to the concept of moral distress and to develop an instrument to measure the attributes of moral distress, so that specific action might be taken to address moral distress and its consequences in health care. To achieve clarity of the concept an extensive literature review of moral distress was done to identify the antecedents, consequences, attributes and empirical indicators of moral distress. Interviews were conducted to form an understanding of the experience of moral distress in professional nurses and also to serve as confirmation of the data obtained from the integrative literature review. The literature review together with the interviews enabled the researcher to identify the attributes necessary to develop an instrument to measure moral distress, based on the concept of moral distress. The instrument was tested and validated by means of content-, face-, construct- and criterion validity.

1.5.2.2 Conceptual definitions

The following concepts are central to this research and are briefly described:

- *Integrative literature review*

Systematic search strategies can be seen as pieces of scientific research and common sense. The aim thereof is to identify and summarise all research relevant to a specific topic. When collecting all the research, the researcher includes studies irrespective of their results, which removes any biases that might have existed. Integrative literature reviews are considered to provide a broader summary of the literature, compared to e.g. the systematic review process (Webb & Roe, 2007:4). In this research, the researcher included qualitative, quantitative and mixed method studies to include in the integrative literature review in order to collect as much data as possible on moral distress.

- *Instrument*

An instrument is used to measure, indicate or control something (Webster's New World Dictionary, 2002). An instrument can be used to measure variables in a study in research (Burns & Grove, 2009:419). In this research an instrument was developed to measure moral distress.

- *Professional Nurse*

According to the South African Nursing Council (SANC) (Nursing Act No. 33 of 2005), a nurse practitioner is anybody who is registered under the Act. In order to register with the SANC the professional nurse must meet the minimum requirements laid down by this statutory body. In this research professional nurses formed part of the population under study, and may include professional nurses enrolled for post-basic studies as well as professional nurses working in public hospitals and clinics.

- *Nursing profession*

Nursing involves rendering support and care and treating a patient to achieve or maintain health. It is also a caring profession practiced by a person registered under the Act (Nursing Act No. 33 of 2005). The nursing profession includes the practice and environment of nursing as well as the nurse practitioner. In this research professional nurses working in the clinical environment formed part of the population under study.

- *Moral*

Moral is the ability to deal with or distinguish between right and wrong. It is also to act in accordance with what is right and wrong. It can also be one's principles or standards with respect to right or wrong conduct (Webster's New World Dictionary, 2002). In this research the topic under study was moral distress, therefore looking at what professional nurses' experience as moral distress, in the workplace.

- *Distress*

Distress can be defined as causes of misery, suffering, pain or affliction. It can also be defined as a state of danger or trouble (Webster's New World Dictionary, 2002). In this research moral distress was investigated and what nurses experienced as distressing, include the practice environment, patient care and the person (himself/ herself - emotional demands).

- *Moral distress*

Moral distress is to be defined (see Chapter Three, Section 3.3).

- *Clinical health environment*

Clinical health environment can be defined as the surroundings or condition where a person finds him/ herself where disease is studied or observed and where one would strive to be

free of disease (Webster's New World Dictionary, 2002). The clinical health environment during this research will include clinics and hospitals.

1.5.3 Methodological assumptions ions

The methodological assumptions of this research are based on the research model of Botes (1995:6). This model presents the activities of nursing as three levels or orders. These levels are interconnected and function in relation to each other (Botes, 1995:14).

The first order or level can be seen as the empirical reality. Level one represents nursing practice and forms the research domain for nursing.

The second order or level incorporates the theory of nursing and research methodology. The results of nursing research are incorporated and applied to nursing practice.

The third order or level represents the paradigmatic perspective of nursing. The meta-theoretical, theoretical and methodological assumptions form part of the paradigmatic perspective and act as determinants for the research decisions.

While working in the nursing practice the researcher was part of all the difficulties that nurses experience daily. The researcher became aware of the moral distress that forms part of nurses' daily lives (Level 1). Being part of this environment motivated the researcher to investigate the problem (Level 2), and the researcher felt it necessary to be able to measure moral distress by developing an instrument that can measure moral distress. In order to develop an instrument, an extensive integrative literature review and interviews were conducted. Through the literature review and the interviews the attributes were identified whereupon the instrument was developed. Thereafter, the instrument was tested and validated by means of content-, face-, construct- and criterion validity. The researcher felt the need to investigate the problem due to her own paradigmatic perspective (Level 3), which includes principles of constructivism, Christian beliefs and values such as human dignity, respect, justice, tolerance and integrity. Therefore understanding and giving meaning to constructs guided the researcher during this research (see Section 1.5.1).

1.6 RESEARCH DESIGN

An instrument development design was used and included qualitative and quantitative research with explorative, descriptive and contextual strategies (Creswell, 2009:4; Polit & Beck, 2012:604; Botma *et al.*, 2010:256; Bowling, 2009:433; De Vos *et al.*, 2011:436).

1.7 RESEARCH METHOD

Population and sampling, data collection, ensuring rigour and data analysis forms part of the research method (Klopper, 2007:69). As mentioned (see Section 1.5.2), this research used Benson and Clark's (1982:789) method of instrument development as the theoretical framework. A comprehensive discussion on the theoretical framework follows in Chapter Two. The research method will be discussed according to the four phases of the theoretical framework that were followed.

The following table gives a brief overview of the research method that was followed during this research according to the theoretical framework (Benson & Clark, 1982). Only the phases and steps that had a population, sample, data collection and data analysis will be discussed in this section. The entire instrument development process is described in detail in Chapter Two (see Section 2.3).

Table 1.2 Overview of research process

Phase and Step	Research Objective	Research Approach	Population and Sample	Sampling	Data Collection	Data Analysis	Rigour
Phase One: Step 2a (Integrative literature review).	To conduct an integrative literature review to identify antecedents, consequences, attributes and empirical indicators of moral distress.	Integrative literature review.	All available national and international data, published as well as unpublished (where possible) on moral distress in nurses/ nursing. (N=4113) (n=119)	All-inclusive sampling.	The following data was extracted: Study title, type of study, setting, participants, objectives of the study, definition(s) of moral distress, antecedents, consequences, attributes, main findings and outcome of the study.	Descriptive synthesis.	Truth value, applicability, consistency and neutrality.

Phase and Step	Research Objective	Research Approach	Population and Sample	Sampling	Data Collection	Data Analysis	Rigour
Phase One: Step 2b (Semi-structured interviews).	To conduct interviews to explore professional nurses' experience of moral distress.	Qualitative research approach.	Professional nurses working in hospitals and clinics in the North-West Province. (n=9)	Purposive sampling.	Semi-structured interviews. (n=9)	Data was analysed by using Tesch's method.	Truth value, applicability, consistency and neutrality.
Phase Two: Step 5a (Content validation).	To develop an instrument to measure moral distress in professional nurses.	Quantitative research approach.	Experts in the field of moral distress and instrument validation. (N=16) (n=4)	Purposive sampling.	Emails with the content validity index scale were sent to experts. (N=16) (n=4)	Content validity index (CVI).	Validity and reliability.
Phase Two: Step 5b (Qualitative evaluation).	To develop an instrument to measure moral distress in professional nurses.	Quantitative and qualitative research approach.	Professional nurses working in hospitals and clinics in the North-West Province.	Purposive sampling.	Moral Distress Instrument. Focus group interview.	Consensus discussion with promoters.	Validity and reliability. Truth value, applicability, consistency and

Phase and Step	Research Objective	Research Approach	Population and Sample	Sampling	Data Collection	Data Analysis	Rigour
			(N=20) (n=17)		(N=20) (n=17)		neutrality.
Phase Three: Steps 7 and 8 (Pilot test and run item analysis).	To validate (content-; face-; discriminant- and divergent validity) the instrument.	Quantitative research approach.	Professional nurses working in a hospital with different departments and clinics in the Free State Province. (N=500) (n=244)	All-inclusive sampling.	Moral distress Instrument.	Computer software programme SAS and SPSS: - Descriptive statistics - Factor analysis (exploratory, confirmatory and Bartlett's test of sphericity) - Cronbach's alpha coefficient - Correlations - ANOVA	Validity and reliability.

1.8 ETHICAL CONSIDERATIONS

Ethical research is essential to generate sound knowledge for practice. Truth is involved in the whole process of research, and not just in the statements that are being recorded or the data that are gathered (Winter, 2000:12). Nursing research requires honesty and integrity (Burns & Grove, 2009:184). In order to achieve this, the researcher adhered to a few principles.

The researcher followed specific codes of ethics as required by local, national and international bodies. From a local perspective, the researcher was a registered Ph.D. student at the North-West University (Potchefstroom Campus). The student, as researcher, adhered to the University's code of ethics (Ethics Committee: North-West University, 2006:1) (Ref. no. NWU-00036-11-S1) (see Addendum A) as stipulated by the Statute under the umbrella research project, namely RISE (Strengthening the resilience of health care givers and risk groups). From a national perspective, the researcher also submitted to the Constitution of the Republic of South Africa (Act 108 of 1996), as well as the South African Department of Health, ethical approval was obtained (see Addendum B). The researcher, from an international perspective, also adhered to the ethical principles and guidelines as stipulated in the Belmont Report, World Medical Association Declaration of Helsinki and the Nuremberg Code (Guidelines for postgraduate studies, North-West University, 2011:33). An overview of the principles applicable to ethics in research will be discussed:

- **Respect for others**

Every participant should be treated with respect. They have autonomy over their own lives and destiny and have the freedom to conduct their lives as they choose (Burns & Grove, 2009:189). Each participant has the right to choose and make their own decisions (Botma *et al.*, 2010:206).

Every participant in this research was fully informed regarding what the research entailed and what was expected of them. Every participant was allowed to voluntarily choose to take part in this research, and also had the freedom to withdraw at any point during the research. Every participant had to give informed consent, which was obtained by means of an informed consent form (Creswell, 2009:159). "Informed information (consent)" is the information that a participant needs in order to make a decision to be part of the research or not (Oliver, 2010:28). With an informed consent form the participants are guaranteed that they will have certain rights. When they sign the form they agree to be involved in the study and acknowledge the protection of their rights (Creswell, 2009:159). Informed consent was

obtained for the semi-structured interviews (see Addendum C [ii]) and the focus group (see Addendum D [ii]). The participants who completed the instrument gave their informed consent by completing the questionnaire (see Addendum G [i]).

- **Beneficence**

Beneficence refers to the responsibility researchers have to act in a way that benefits the health and well-being of participants (WHO, 2007:7). This principle also involves avoiding doing physical, emotional, spiritual, social, economic or legal harm to participants (Botma *et al.*, 2010:208; Brink *et al.*, 2006:32). Beneficence can include the following (Polit & Beck, 2004:142):

- *Freedom from harm*

That is to do no harm to the participant. The researcher has the responsibility to protect the participants from discomfort and harm, and that was adhered to in this research. The participants knew in advance what was expected of them. They then had the choice whether to participate in the research or not. This was done with the interviews as well as when the instrument was validated, through an information letter, which contained all the necessary information (see Addendum C [i]; Addendum D[i]; Addendum G [i]).

- *Freedom from exploitation*

This refers to not exposing participants to situations that they have not been prepared for. During this research the researcher ensured freedom from exploitation by informing participants of the nature and purpose of the research and by ensuring that each participant participated voluntarily and that all the information that was gathered would be kept confidential, by locking it away.

- *The risk/benefit ratio*

Risks should be kept to a minimum. Risks and benefits of a research study should be shared with the participants so that they will be able to make an informed decision whether they want to be part of the research or not. During the interviews, some of the participants became emotional when describing the situations where they experienced moral distress. When participants became emotional, the researcher supported the participant through letting the participant share their feelings without interruption until they regained their self-control. There were no foreseeable physical, emotional, spiritual, social, economic or legal risks involved in completion of the instrument. Researchers should strive to communicate and maximize the benefits that are applicable to the participants as they are generally

participating to be helpful. The researcher is qualified as a psychiatric nurse and in the event that participants needed psychiatric help and support an advanced psychiatric nurse was available. The researcher informed participants during the interviews as well as on completion of the questionnaire of the contribution they were making in helping to develop the instrument to measure moral distress. Their contribution helped to determine moral distress in professional nurses which then could lead to putting procedures in place to help address moral distress.

- **Justice**

The principle of justice has to do with equality and fairness (WHO, 2007:7). Justice was upheld throughout this research, and includes (Polit & Beck, 2004:142):

- *The right to fair treatment*

Participants have the right to be fairly treated and include respect for cultural- and human diversity, no prejudicial treatment, fair and non-discriminatory selection of participants and honouring of all the agreements between the researcher and the participant. During the semi-structured interviews (purposive sampling was applied), focus group session (purposive sampling was applied) and completion of the instrument (all-inclusive sampling was applied), all the participants who were willing to participate and adhered to the inclusion criteria were included in the sample.

- *The right to privacy*

Research involves intruding into participants' personal lives. It is the responsibility of the researcher to keep the intrusion to a minimum. This can be achieved through anonymity which is where no data can be linked to a participant. Confidentiality also forms part of the right to privacy and is achieved where the researcher pledges that no information will be made public except that which was agreed upon.

Anonymity and confidentiality was ensured by making certain that the names and contact details of all the participants, hospitals and clinics were known only to the researcher. All information collected was kept in a locked filing cabinet at the office of the researcher, and all computers and back-up media on which data was stored, was password protected. Master lists containing contact information and participant names were stored separately from the transcripts and completed instruments. When signing the informed consent forms, participants were assured of their right to fair treatment and privacy. All raw data remains the property of North-West University, and paper versions of the completed instruments will be

destroyed by shredding ten years after the project ends, while electronic data will be deleted upon completion of the project.

- **Scientific integrity**

Scientific integrity forms part of the Department of Health's (2004:3-9) other guiding ethical principles, along with the ethical principles of beneficence, justice and respect for persons. Health research should, according to the Department of Health (2004:3-9), be of a high standard using a sound methodology to answer the research questions posed and should be grounded in literature and open to peer review. During this research, the planning, implementation, analysis and reporting was grounded in literature to the highest possible standard with the whole research process being documented in detail in order for peer review and evaluation to be conducted.

- **Plagiarism**

Plagiarism, an important aspect of scientific integrity, refers to using someone else's ideas, results or words without giving due credit (Polit & Beck, 2012:169), and even presenting these as your own. Due credit was given throughout this study through correct referencing of sources, both in the written text as well as in the bibliography of the study. Direct quotations were identified as such and citations were limited through paraphrasing and summarizing.

1.9 OUTLINE OF THIS THESIS

Chapter One:	Overview of research and philosophical positioning
Chapter Two:	Scientific justification of the research design and research method
Chapter Three:	Phase One: Planning of the instrument
Chapter Four:	Phase Two: Construction of the instrument
Chapter Five:	Phase Three: Quantitative evaluation of the instrument
Chapter Six:	Evaluation of the study, limitations and recommendations for nursing education, -practice, -research and policy

1.10 SUMMARY

In Chapter One an overview of the planned research study was presented. The background of the research problem was discussed, the relevant concepts were defined and the research design and method were briefly outlined. The chapter concluded with a discussion of the ethical issues as applied to this study.

CHAPTER TWO

CHAPTER TWO

SCIENTIFIC JUSTIFICATION OF THE RESEARCH DESIGN AND RESEARCH METHOD

2.1 INTRODUCTION

In Chapter One an overview of the research method was provided. In Chapter Two the research methodology used in this study is discussed in greater detail.

According to Terre Blanche *et al.* (2006:6) methodology refers to the researchers' belief of what can be known and pertains to rules and procedures on how to study that which can be known. The research design is seen as the blueprint for conducting a study and is closely associated with the framework of the study. The design can therefore be used to achieve a detailed research plan (Burns & Grove, 2009:218). Another element in the framework is the research method which involves the population, sample and techniques used for data collection and data analysis (Creswell, 2009:15; Polit & Beck, 2012:12).

2.2 AIM AND OBJECTIVES OF THE STUDY

To remind the reader, it is the aim of this study to bring clarity to the concept of moral distress and to develop and validate an instrument to measure moral distress in the clinical health care context of the professional nurse.

. In order to attain this aim the following objectives were set:

1. To conduct an integrative literature review to identify antecedents, consequences, attributes and empirical indicators of moral distress.
2. To conduct interviews to explore professional nurses' experience of moral distress.
3. To develop an instrument to measure moral distress in professional nurses.
4. To validate the instrument.

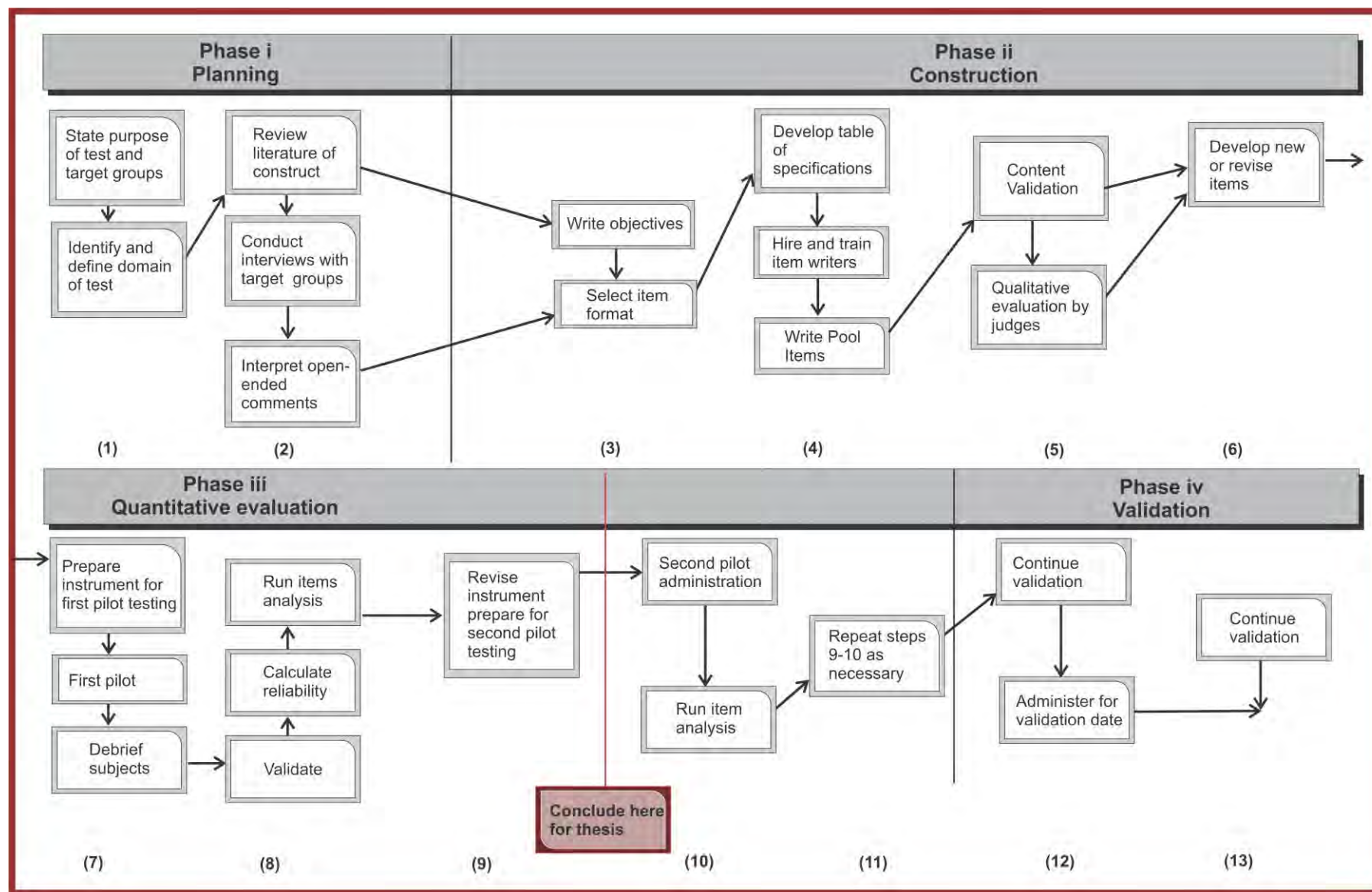


Figure 2.1 Flowchart for Instrument Development (Benson & Clark, 1982:790)

2.3 THEORETICAL FRAMEWORK

The work of Benson and Clark (1982:789) “A Guide for Instrument Development and Validation” was used as the theoretical framework to guide the researcher in developing an instrument to measure moral distress in South African professional nurses. The theoretical framework is discussed and applied in the research design and the research method.

2.4 RESEARCH DESIGN

An instrument development design was used and included qualitative and quantitative research with explorative, descriptive and contextual strategies in nature, so as to achieve the objectives of this study. There are advantages in using both qualitative and quantitative research. According to Creswell (2009:4) the overall strength of a study is greater when using qualitative and quantitative research than when using only one or the other. Research can also be enriched when using both designs (Polit & Beck, 2012:604). When using both designs, there is a concurrence and confirmation of the research results (Botma *et al.*, 2010:256).

It is believed that qualitative and quantitative research complements each other. Complex phenomena can be answered, whereby the validity of the study is enhanced (Polit & Beck, 2012:604; Bowling, 2009:433; Botma *et al.*, 2010:255). Also, using the strengths of each design contributes to enhancing the research study (Bowling, 2009:433; Creswell, 2009:203). It is also said that by using qualitative and quantitative research in the same study, more comprehensive evidence is obtained. One can gather a greater assortment of data (De Vos *et al.*, 2011:436), and obtain a deeper understanding (Bowling, 2009:433).

2.4.1 Qualitative research

Qualitative research is seen as a means to explore and understand phenomena (Creswell, 2009:4). The researcher is given the opportunity to explore the reality of their practice as it is encountered (Neale, 2009:10). According to Botma *et al.* (2010:182) with qualitative research one can shed light on phenomena and produce data in the form of words. Qualitative research also makes use of text as empirical material and is interested in the perspectives of participants as well as everyday practices and knowledge of the issue that is being studied (Flick, 2007:2). Polit and Beck (2012:487) contend opinion that qualitative research has certain characteristics, namely:

- Qualitative research often involves the merging of different data collection strategies
- Qualitative research is flexible and can be adjusted to new information
- Qualitative research strives to understand the whole, making it holistic
- Qualitative research requires researchers to be fully involved
- Qualitative research requires the researcher “to become the research instrument”
- Saturation of data is determined by the on-going process of data analysis

Using qualitative research allowed the researcher to explore, describe and understand moral distress from the perspective of professional nurses in South Africa. By understanding the phenomenon better it gave the researcher the ability to confirm the antecedents, consequences and attributes of moral distress and to construct the empirical indicators (items) for the instrument.

2.4.2 Quantitative research

Quantitative research is an essential tool for generating knowledge (Botma *et al.*, 2010:82) and is systematic in nature (Polit & Beck, 2012:12). The aim of quantitative research is to structure knowledge by determining how much of a specific characteristic is present in the phenomenon under study (Brockopp & Hastings-Tolsma, 2003:21).

Quantitative research is used to describe variables and to examine the relationship that exists between these variables (Burns & Grove, 2009:22). According to Welman *et al.* (2005:8) quantitative research deals with an abstraction of reality and the researcher therefore needs to be detached and objective.

With quantitative research the truth is absolute and therefore a single reality can be defined and measured. To find this truth one should be objective, and then together with the right instrument, behaviour can be measured. Quantitative research also requires control, and therefore use of an instrument in quantitative research is typical (Burns & Grove, 2009:22).

Using quantitative research in this study helped the researcher to develop and validate an instrument to measure moral distress, and to measure the incidence of moral distress among professional nurses in a public hospital in the Free State Province of South Africa.

2.4.3 Explorative research

Explorative research is conducted to explore and understand a specific phenomenon and this is valuable in the sense that it yields new insights (Babbie, 2008:98). Explorative research is also conducted when little is known about the phenomenon under investigation,

and the researcher wants to form an understanding of the phenomenon (Botma *et al.*, 2010:185; De Vos *et al.*, 2011:95).

Brockopp and Hastings-Tolsma (2003:232) explains explorative research as a means to explore what exists on a specific topic. The researcher also wants to give a general picture of a phenomenon (De Vos *et al.*, 2011:96). Explorative research investigates the full nature of the phenomenon under study and is designed to shed light on the manifestation and underlying processes of the phenomenon (Polit & Beck, 2012:18).

This study can be described as explorative in nature as the researcher aimed to explore the main and related concepts of moral distress. This exploration included all available national and international literature sources; both published and, where possible, unpublished. Together with the literature, perceptions of professional nurses on moral distress were investigated through interviews. The results obtained from this explorative research served to identify antecedents, consequences, attributes and empirical indicators of moral distress in order to develop an instrument to measure moral distress. The instrument was then used to explore the incidence of moral distress among professional nurses in a public hospital in the Free State Province of South Africa.

2.4.4 Descriptive research

Descriptive research helps researchers to describe what exists and to discover new meaning in the phenomenon under study (Burns & Grove, 2009:25). Descriptive research can focus on the incidence, meanings and importance of phenomena (Polit & Beck, 2012:18), and aim at providing truthful descriptions of phenomena (Botma *et al.*, 2010:185).

Babbie (2008:99) explains descriptive research as that which the researcher observes and then describes what has been observed. Descriptive research focuses on describing what exists at a given point in time (Brockopp & Hastings-Tolsma, 2003:231), and can classify or measure relationships between phenomena (Terre Blanch *et al.*, 2006:44). Descriptive research can be qualitative or quantitative in nature, and looks intensely at phenomena to describe their deeper meanings (De Vos *et al.*, 2011:96).

In this research study, comprehensive literature searches of all available national and international literature sources, both published and unpublished studies, were done. Interviews were conducted and together with the integrative literature review, the results obtained from this descriptive research helped the researcher with the construction of the instrument to measure moral distress. The instrument was used to measure the intensity of moral distress, and thereafter the instrument was validated.

2.4.5 Contextual research

The context of the research setting is unique to every person (Burns & Grove, 2009:55). To be able to describe the context of the research, the researcher must be sensitive to the setting and the situation. The context of people's lives' should also be taken into account when conducting contextual research because then there is understanding and meanings are understood (Holloway & Wheeler, 2002:11).

Contextual research focuses on a single phenomenon and the phenomenon should be described extensively to allow other researchers to transfer the findings to their context (Botma *et al.*, 2010:194). According to Holloway and Wheeler (2002:11), researchers will find meaning once they understand the context in which the research takes place.

Professional nurses working in the clinical setting formed the population for this research. The sample for the qualitative interviews (Phase One Step 2b) constituted of professional nurses in a post-basic nursing management course and represented various clinical departments in hospitals and clinics. The evaluation by judges (Phase Two Step 5b) comprised professional nurses in a post-basic nursing education course, whom worked in different departments in different hospitals and clinics. The student nurses represented low – medium resource public hospitals and clinics. According to SANC (2013) statistics (n=7 859) female nurses and (n=1 051) male nurses are registered in the North-West Province. The sample for the instrument pilot test (Phase Three Step 7b) comprised of professional nurses working in a public (academic) hospital in the Free State province of South Africa. The hospital that was used for the pilot study were from a medium resource area. According to SANC (2013) statistics N=129 015 nurses are registered in the Free State Province (for more detail see Chapter Five, Section 5.4.3). The hospital that was used for the pilot study had 50 different clinical departments. The instrument developed during this research is applicable to the nursing profession as a whole.

2.5 RESEARCH METHOD

The research method that was followed in this research is discussed. The discussion takes place according to the research aim, objectives and theoretical framework of this study. The research process is discussed according to the theoretical framework (Figure 2.1) with specific reference to the population and sampling, data collection and data analysis. After discussion of the different phases a discussion of the rigour will follow.

2.5.1 Phase One: Planning

The research method of Phase One will be discussed according to the theoretical framework of Benson and Clark (1982) and specifically focus on the integrative literature review and the semi-structured interviews. The two steps that form part of the planning phase are:

Step 1: a) Formulate the purpose of the intended instrument

b) Identify and define domain of test

The purpose of this research was to develop an instrument to measure moral distress, in professional nurses in South Africa. Please refer to Chapter One (see Section 1.4) for more detail regarding the aim and objectives of this study.

Step 2: a) Do a review of the related literature

An integrative literature review was conducted. Please refer to Section 2.5.1.1 for a detailed description of the methods applied to the review and to Chapter Three (see Section 3.2.1.4) for the realisation of the data collection.

Step 2: b) Conduct interviews with target group

Semi-structured interviews were conducted with a group of students of the open distance learning programme doing a nursing management diploma (n=9) on their experience of moral distress. These students were all professional nurses working in public hospitals and clinics in the North-West Province of South Africa. Please refer to Section 2.5.1.2 for a detailed description of the methods applied to this step.

Step 2: c) Interpret open-ended comments

The interpretation of the interviews was done according to Tesch's method (Creswell, 1994:155). Please refer to Section 2.5.1.2 for a detailed description of the method of analysis applied and to Chapter Three (see Section 3.2.2.4) for the realisation of the data collection.

2.5.1.1 Integrative literature review

The systematic search strategy that the researcher implemented during this research is the integrative literature review. The researcher subscribed to the integrative literature review process as described by Evans (2007:139), which consists of the following steps:

- Problem identification
- Location of studies
- Evaluation of studies
- Collection of data from individual studies
- Data analysis

Systematic search strategies can be seen as pieces of scientific research and common sense. The aim thereof is to identify and summarise all research relevant to a specific topic. When collecting all the research, the researcher includes studies irrespective of their results, which removes any biases that might have existed (Webb & Roe, 2007:4). Integrative literature reviews are considered to provide a broader summary of the literature, compared to, for example, the systematic review process. The findings from a range of different research designs can be included (Evans, 2007:137).

During an integrative literature review, both empirical and theoretical literature is reviewed (Evans, 2007:137). Frank-Stromborg and Olsen (1997:5) hold the view that an extensive literature review should be done for the instrument's conceptual basis. When developing an instrument, qualitative data can contribute to the basis for developing the structured instrument (Polit & Beck, 2012:605).

The following table gives a clear summary of the research process that was followed during the integrative literature review and includes the population, sampling technique, sample, data collection and data analysis method. Please refer to Chapter Three (see Section 3.2.1) for a comprehensive discussion of the integrative literature review.

Table 2.1 Research process in Phase One: Planning (Integrative literature review)

Research process	Discussion and application
Population	The population in this phase of the study refers to all the available national and international data, published as well as unpublished (where possible) on moral distress in nurses/nursing, that was obtained through an extensive literature search. The keywords used to conduct the literature searches were: ▪ Nurse or nurses or nursing AND (nurs*) ▪ Moral distress The national and international search engines that were accessed are listed below. In order to be able to identify the sample, multiple sources

Research process	Discussion and application
	were used, such as: • Electronic databases: EbscoHost, Science Direct, Emerald, Scopus, ProQuest and GoogleScholar, Sabinet and SAePublications. • Manual search: GoogleScholar • Grey literature: Dissertations and theses (N=4113)
Sampling	All-inclusive sampling was applied to the integrative literature review. The researcher selected literature which conformed to the inclusion criteria and the proposed research questions. This contributed to the researcher gaining rich data and a comprehensive understanding of moral distress from various sources. The inclusion criteria were: • Studies published since 1984, to include all relevant data to date. Jameton was the first author that discussed moral distress in 1984; therefore the researcher chose 1984 to start the literature search. • Only nurses were included as the researcher focused on nursing, in order to include ethical/ moral situations specific to nurses. • Studies that were conducted in a clinical (hospital/ clinic/ hospice/ old age home) setting as well as literature reviews and concept analyses; in order to include as much information as possible. • Studies written in English as the researcher is proficient in English only. The exclusion criteria were: • Duplicate studies. • Studies involving healthcare professionals, except nurses. • Retrievals without full-text versions available online or through the North-West University library catalogue had to be excluded.

Research process	Discussion and application
	A strict record was kept of the sampling process and all information was documented in order for the researchers' decisions to be tracked, evaluated and/ or replicated. Refer to Chapter Three (see Section 3.2.1.1) for a comprehensive discussion of the process and results of the integrative literature review.
Sample size	The number of sources that were obtained was N=4113. The number of articles and dissertations that were included was n=120. Please refer to Chapter Three (see Section 3.2.1.1) for a detailed discussion.
Data collection	The process of data collection included a review of all data available (see Chapter Three, Section 3.2.1.4) on the concept of moral distress, nationally and internationally published and, where possible, unpublished studies. The researcher categorized the results according to the antecedents (see Chapter Three, Table 3.3), consequences (see Chapter Three, Table 3.6), attributes (see Chapter Three, Section 3.2.1.10), definitions (see Chapter Three, Section 3.2.1.7) and themes (see Chapter Three, Table 3.13) on moral distress. The researcher also looked at the different instruments that were available (see Chapter One, Table 1.1). As well as whether any concept analyses had been done (see Chapter Three, Section 3.2.1.8). This in turn contributed towards identifying the attributes and empirical indicators of moral distress. Refer to Chapter Three (see Section 3.2.1.4) for a comprehensive discussion of the data collection process that was followed.
Data analysis	After data collection, the data was analyzed by making use of descriptive synthesis. In descriptive synthesis the characteristics and the findings of each body of research is summarized in a concise and coherent manner (Evans, 2007:141). The concepts that were identified from the antecedents (see Chapter Three, Table 3.5), consequences (see Chapter Three, Table 3.8), attributes (see Chapter Three, Table 3.10), definitions (see Chapter Three, Table 3.9) and concept analyses (see Chapter Three, Section 3.2.1.8) were grouped together and synthesized until clear themes emerged. Please refer to Chapter Three (see Section 3.2.1.5; 3.2.1.6; 3.2.1.7; 3.2.1.8; 3.2.1.9 and 3.2.1.10) for a detailed discussion.

2.5.1.2 Semi-structured interviews

Interviews can be seen as a way that the researcher interacts with participants and can help the researcher engage with an issue that is part of the knowledge that is being created, and is not merely a representation (Botma *et al.*, 2010:206). Together with the theoretical contribution that accompanies research, interviews form part of understanding the phenomenon under study (Flick, 2007:79).

Confirmatory, explorative, semi-structured interviews were conducted to increase the knowledge of the researcher on moral distress (Burns & Grove, 2009:359). See Table 2.2 for an outline of the interviews. It is suggested to use semi-structured interviews when one explores perceptions, thoughts and feelings (Botma *et al.*, 2010:206). With semi-structured personal interviews, the researcher has certain topics that need to be covered (Welman *et al.*, 2005:166). In semi-structured interviews, the researcher knows what to look for, but cannot predict what the participants would say. The researcher might have questions on a specific topic, and should encourage the participant to talk freely about all the topics and to tell their own stories. This gives the participants the opportunity to provide rich, detailed information about the phenomenon under study (Polit & Beck, 2012:537).

According to Polit and Beck (2012:265) personal (face-to-face) interviews are often costly, but the most respected method for interviews because of the quality of information one obtains. During this research the participants in the semi-structured interviews were recruited from an open distance learning group of students doing a nursing management diploma. The students were all professional nurses working in the North-West Province in a clinical environment. The researcher conducted seven face-to-face interviews and two telephonic interviews, because the participants were far away during the time of data collection. Telephonic interviews might cause the respondent to be uncooperative (Polit & Beck, 2012:265); the researcher however, did not experience this. In total nine (n=9) semi-structured interviews were conducted. In this research the researcher asked three questions, namely:

1. Can you think of situations where you experienced moral distress?
2. Please describe the situations where you experienced moral distress?
3. How did you experience moral distress?

The following table contains a discussion of the research process that was followed and includes the population, sampling technique and sample that was included, followed by data

collection and data analysis. Please refer to Chapter Three (see Section 3.2.2) for a discussion of the results from the semi-structured interviews.

Table 2.2 Research process in Phase One: Planning (Semi-structured interviews)

Research process	Discussion and application
Population	The population in this phase of the study was a group of students of the open distance learning unit programme doing a nursing management diploma. These students were all professional nurses working in hospitals and clinics in the North-West Province of South Africa. These students were recruited as they represented various clinical environments. (N=15) (n=9)
Sampling	Purposive sampling was applied. The researcher decided on purposive sampling in order to include the participants who would be most useful and representative of the phenomenon under study (Babbie, 2008:204). The researcher decided on certain inclusion criteria (Botma <i>et al.</i>, 2010:126) for the sample, namely: 1. Being a professional nurse in the clinical field 2. At least one year's clinical experience 3. Having experienced moral distress The researcher determined this when she had an introductory discussion with the professional nurses that formed part of the population. After the introductory discussion, students volunteered to be part of the semi-structured interviews, and were included according to the inclusion criteria. The departments where the participants worked were; clinic (n=2), theatre (n=1), surgical ward (n=1), medical ward (n=1), labour room (n=1), ICU (n=1), rehabilitation ward (n=1) and clinical training (n=1). Two of the nine semi-structured interviews were telephonic interviews as the participants were far away during the time of the interview (see Chapter Three, Section 3.2.2.3).
Sample size	The sample size was determined by the depth of the information that was needed and when data saturation was reached. According to Botma <i>et al.</i> (2010:200), saturation is reached when no new data emerges.

Research process	Discussion and application
	A total of nine (n=9) interviews were conducted. Please refer to Chapter Three (see Section 3.2.2.2) for a discussion.
Data collection	Semi-structured interviews were recorded on a digital audio-recorder and transcribed word for word. The verbatim transcripts (see Addendum C [iii]) were analyzed by the researcher as well as an independent co-coder. Refer to Chapter Three (see Section 3.2.2.4) for a discussion on the interviews.
Data analysis	The data was analyzed by using Tesch's method. The researcher had an experienced co-coder and the two researchers had a consensus discussion after each identified their categories. The steps that were followed were (Creswell, 1994:155): First the researcher read through the transcripts to get an idea of the whole, and wrote down ideas that come to mind. The researcher selected an interview and went through it with the following question in mind "What is this about?" As the researcher worked through the interview, ideas were written down in the margins. When the researcher had worked through all the interviews, a list was made of all the topics identified. The topics were clustered together and formed into columns. The columns could now be arranged from e.g. major topics and unique topics. The researcher now together with the list returned to the data. The topics were then abbreviated as codes, and the codes are written next to the appropriate segments of the text. This preliminary organizing was to determine whether new categories and codes emerged. The most descriptive wording for the topics were identified and turned into categories. This was done to reduce the total list of categories by grouping together topics that relate to each other. Interrelationships were now indicated by drawing lines between the categories. A final decision was made on the abbreviations for each category and the codes were alphabetized. The data material for each category was put together in one place and the preliminary analysis was performed.

Research process	Discussion and application
	Recoding of existing data was done, where necessary (see Chapter Three, Section 3.2.2.5).

2.5.2 Phase Two: Construction

The research method of Phase Two will be discussed according to the theoretical framework and specifically focus on reasoning strategies, content validation and qualitative evaluation (face validity). The three steps of the construction phase are (Benson & Clark, 1982:792):

Step 3: a) Writing of objectives

b) Select item

An integrated discussion of writing of the objectives and selecting the item follows. The objective for developing the instrument was to measure moral distress without referring to the antecedents or consequences of moral distress, but to measure moral distress based on the attributes thereof. The item format used to develop the questionnaire was a four-point Likert scale (never, rarely, sometimes, often). A Likert scale is used in instruments measuring opinions, beliefs and attitudes, where the item is presented as a declarative sentence followed by varying degrees of agreement (DeVellis, 2012:93). The Likert scale was used during this research and a four-point scale was chosen as an instrument in order to avoid a neutral and ambivalent midpoint (DeVellis, 2012:93). Upon deciding on the format of the items, the statistician was also consulted.

Step 4: a) Develop a table of specifications

b) Hire and train item writers

c) Write pool

An integrated discussion of Step 4 a, b and c follows. After the extensive integrative literature review (N=4113), the information gained from the articles that were included (n=120) were analysed (see Chapter Three, Section 3.2). From this data, antecedents, consequences, attributes and empirical indicators were identified and synthesized (see Chapter Three, Section 3.2). The attributes that were identified were: compromised morals and value system, violated professional autonomy and powerlessness (see Chapter Three, Section 3.2.1.10). Empirical indicators (items) were then formulated to capture the attributes of moral distress, without naming an antecedent or consequence (see Chapter Three,

Section 3.2.1.10). A pool of 77 items was constructed during this process (see Addendum E). The promoters, researcher and statistician revised the pool of 77 items until 21 items that best captured the attributes of moral distress remained (see Addendum G [ii]).

Step 5: a) Content validation

The instrument for content validation had 21 items and was sent to 16 experts, of which four experts completed the content validation questionnaire (see Chapter Four, table 4.2). An I-CVI and S-CVI were calculated from this evaluation (see Chapter Four, Section 4.3.1.3.2).

Step 5: b) Qualitative evaluation by judges (Face validity)

During this step, the researcher did a pilot test of the instrument to determine the clarity of the items. The pilot group was a group of students of the open distance learning unit programme doing a nursing education diploma (N=20; n=17). These students were all professional nurses working in hospitals and clinics in the North West Province of South Africa and were similar to the target group that would be used to test the instrument. After the professional nurses completed the instrument, a focus group was held during which they gave their feedback on the clarity of the items and input. Where applicable the researcher incorporated their input (see Chapter Four, Section 4.3.1.3.2).

Step 6: Develop new or revise items

The feedback from the experts that was received during the content validity processes was incorporated. Eight items were revised and one item deleted. The final instrument consisted of 20 items (see Chapter Four, Table 4.5).

2.5.2.1 Reasoning strategies

Reasoning is described as a process in which ideas are organized and ordered so that conclusions can be made, and meanings are produced. Logical reasoning, according to Polit and Beck (2012:11), uses experience, intellectual faculties and formal systems of thought as a method to solve problems. Reasoning can be classified into inductive and deductive reasoning (Burns & Grove, 2009:11).

Inductive reasoning is where one moves from focusing on a specific (concept) to moving onto the general (concept) (Burns & Grove, 2009:6). Therefore, generalizations can be made from specific observations (Polit & Beck, 2012:11). Deductive reasoning is where one moves by inference from focusing on general principles to a specific principle (Burns &

Grove, 2009:6). One can then make specific predictions from general principles (Polit & Beck, 2012:11).

When the researcher theorises in a deductive direction, abstract concepts that outline the logical connection of concepts moves to form concrete empirical evidence (Neuman, 2006:59). Deductive reasoning plays a crucial role in scientific and professional thought. Inductive reasoning begins with a general topic but evolves into theoretical concepts (De Vos *et al.*, 2011:48). According to Walker and Avant (2005:127), the logic of deductive reasoning should be adequate because of the premises that are true. With inductive reasoning, the logic depends on the amount of empirical support that it has. The advantage of using both qualitative and quantitative research designs implies that the researcher can make use of both inductive and deductive reasoning processes (De Vos *et al.*, 2011:436).

Both inductive and deductive reasoning were used during the course of this research. In order to develop an instrument to measure moral distress, the researcher conducted an integrative literature review and semi-structured interviews. After data collection, the data was analysed and antecedents, consequences and attributes were identified. The attributes were identified from the definitions, concept analyses and themes from previous research (deductive reasoning). Empirical indicators (items) that best described the attribute were generated from the analyses (inductive reasoning) and the findings of previous research (deductive reasoning).

The process of inductive and deductive reasoning during this research is illustrated in the following figure (Figure 2.2).

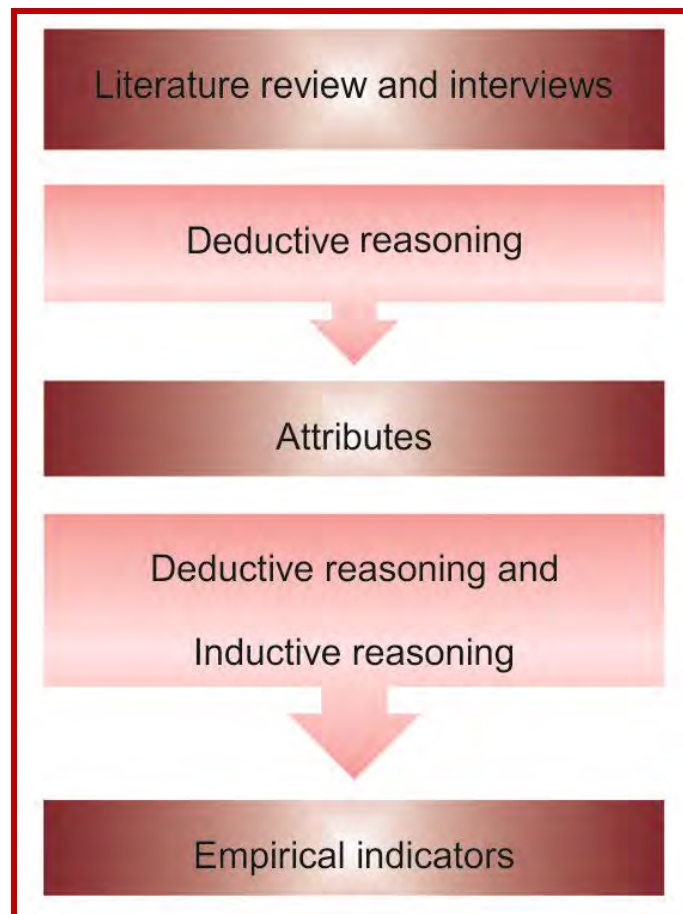


Figure 2.2 Reasoning process

2.5.2.2 Content Validation

Validity encompasses four categories, namely: content validity, face validity, criterion and construct validity (De Vos *et al.*, 2011:175). Content validity refers to whether the instrument measures all of the meanings that are included in a concept (Babbie, 2008:161). According to Polit and Beck (2012:336) content validity occurs where the appropriate extent of items for the construct is measured and therefore they adequately represent the construct.

The following table (Table 2.3) gives a short summary of the research process that was followed during content validation, and includes the population, sampling technique, sample size, data collection and -analysis. Please refer to Chapter Four (see Section 4.3.1.3.1) for a comprehensive discussion.

Table 2.3 Research process in Phase Two: Content validation

Research process	Discussion and application
Population	The instrument for content validation was sent to 16 experts. The experts were authors that have published extensively on moral distress. (N=16) (see Chapter Four, Section 4.3.1.3.1)
Sampling	Purposive sampling was applied. (see Chapter Four, Section 4.3.1.3.1)
Sample size	Four experts completed the content validation. (n=4) (see Chapter Four, Section 4.3.1.3.1)
Data collection	An instrument with a four-point scale was constructed where: 1. = Indicates that the item is not relevant at all and should be deleted. 2. = Indicates that the item is somewhat relevant but needs major revisions. 3. = Indicates that the item is relevant but needs minor revisions to be representative of moral distress. 4. = Indicates that the item is very relevant. The panel of experts was asked to complete the content validation questionnaire and to determine whether the items are relevant and also to determine their clarity (see Addendum F). (see Chapter Four, Section 4.3.1.3.1)
Data analysis	After the content validation process, the content validity index (CVI) is determined. The content validity index is indicated where a numerical value is assigned to the questionnaire and represents the validity of the content (Burns & Grove, 2009:382). After the team of experts validated the instrument (the content validation process), the CVI is determined. There are two types of CVI. The first CVI is the content validity index for items (I-CVI) and involves the content validity for individual items of the instrument and the second type. The content validity index for scales (S-CVI), involves the content validity for the overall scale (Polit & Beck, 2006:492). (see Chapter Four, Section 4.3.1.3.2)

2.5.2.3 Qualitative evaluation (Face Validity)

Face validity refers to the appearance of what is measured. The researcher can ask “Does the measurement technique look as if it is measuring the variable under study?” (Babbie, 2008:161).

The following table (Table 2.4) gives a short summary of the research process that was followed during qualitative evaluation, and includes the population, sampling technique, sample size, data collection and – analysis. Please refer to Chapter Four (see Section 4.3.1.3.3) for a comprehensive discussion.

Table 2.4 Research process in Phase Two: Qualitative evaluation

Research process	Discussion and application
Population	A group of students of the open distance learning unit programme doing a nursing education diploma. These students were all professional nurses working in hospitals and clinics in the North-West Province of South Africa. (see Chapter Four, Section 4.3.1.3.3).
Sampling	Purposive sampling was applied. (see Chapter Four, Section 4.3.1.3.3).
Sample size	The sample size was determined by the number of voluntary participants. (N=20) (n=17) (see Chapter Four, Section 4.3.1.3.3).
Data collection	The Moral Distress Instrument that was developed was used. The participants were asked to complete the instrument. The researcher noted the time it took the participants to complete the instrument. After the completion of the instrument a focus group session was held. (see Chapter Four, Section 4.3.1.3.3).

Research process	Discussion and application
Data analysis	During the focus group session the participants were asked whether the instructions given were clear and whether they knew what was expected of them. The participants were also asked to describe the clarity of the items. The researcher worked through the completed instruments to see if the feedback given during the focus group session corresponded with what was seen in the instrument feedback. The written and verbal feedback was then discussed with the promoters. (see Chapter Four, Section 4.3.1.3.3).

2.5.3 Phase Three: Quantitative evaluation

During the quantitative evaluation phase the instrument is prepared for pilot testing. The following steps included in the quantitative phase are:

Step 7: a) Prepare instrument for pilot testing

b) First pilot testing

c) Debrief subjects

Step 7 a, b and c are discussed simultaneously. A package was compiled with: an information letter (see Addendum G [i]), the final Moral Distress Instrument (see Addendum G [ii]) as well as the two instruments that were used to evaluate discriminant- (Maslach Burnout Inventory – see Addendum I) and divergent validity (Job Satisfaction Survey - see Addendum H). A brief orientation session was held with the data collectors (nurses) who helped with the distribution and collection of the instruments. All together 500 (N = 500) instruments were distributed, and 244 (n = 244) were received back for data analysis.

Step 8: a) Run item analysis

b) Calculate

c) Validation

An integrative discussion on run item analysis and calculate follows. The computer software programmes SAS (SAS OnlineDoc, 2011) and SPSS (SPSS Inc., 2013) were used to calculate the descriptive statistics and evaluate the reliability and validity of the instrument. The following calculations were done:

- Descriptive statistics
- Factor analysis (exploratory, confirmatory and Bartlett's test of sphericity)
- Cronbach's alpha coefficient
- Correlations
- ANOVA

The data analysis is discussed in detail in Chapter Five.

Step 9: Revise instrument

After the statistical data analysis, the instrument was revised. Five of the items were deleted and the final instrument consisted of 15 items. Refer to Chapter Five (see Table 5.8).

This research concluded with Step 9.

Steps 10 to 13 to be continued post-doctorally.

Step 10: a) Second pilot administration

b) Run item analysis

To validate a newly developed instrument is according to Benson and Clark (1982:798), an "on-going process".

Criterion validity involves external criteria against which the researcher can compare the scores of the instrument. *Construct validity* refers to whether the instrument successfully measures the theoretical context; it is therefore involved with the meaning of the instrument. Construct validity can also be determined through factor analysis. *Factor analysis* involves determining of the underlying factors from the data (De Vos *et al.*, 2011:175).

Discriminant validity allows the researcher to identify characteristics that are associated with group membership and can also help to predict group membership. *Divergent validity* is used to measure the opposite of the construct that is being studied and to correlate the data that is collected with an instrument that measures the concept under study (Burns & Grove, 2009:387). Please refer to Chapter Five (see Section 5.3.1) for a comprehensive discussion of the validity of the instrument.

Reliability is indicated where the scores from an instrument are stable and consistent (Creswell, 2009:169). Reliability also refers to the accuracy of information obtained (Polit & Beck, 2004:35). Reliability is the capacity of an instrument to be consistent and repeatable. Therefore, should another researcher decide to use the same instrument, the measurement should be consistent with the previous measurement if the researcher follows the same steps

(Frank-Stromborg & Olsen, 1997:7). Please refer to Chapter Five (see Section 5.4.4.7) for a comprehensive discussion of the reliability of the instrument.

The following table (Table 2.5) summarises the research process that was followed during instrument validation, and includes the population, sampling technique, sample size, data collection and data analysis. Please refer to Chapter Five for a comprehensive discussion.

Table 2.5 Research process in Phase Three: Quantitative evaluation (Instrument validation)

Research process	Discussion and application
Population	The population in this phase of the study was professional nurses, working in a public hospital in the Free State Province. Please refer to Chapter Five (see Section 5.4) for a discussion.
Sampling	All-inclusive sampling was applied. All the departments situated in the public hospital as well as all the professional nurses working in the hospital were included. The criteria for inclusion in this study were: Being a professional nurse Please refer to Chapter Five (see Section 5.4) for a discussion.
Sample size	The sample size was determined by the number of voluntary participants. (N = 500) (n = 244) Please refer to Chapter Five (see Section 5.4) for a discussion.
Data collection	The instrument that was developed to measure moral distress was used to collect data. <i>Job Satisfaction Survey (JSS)</i> The Job Satisfaction Survey (JSS) (1985) was used to determine divergent validity during this research. Only relevant subscales of the JSS were included in the instrument, namely: operating procedures, co-workers, nature of work and communication. The instrument makes use of a six-point Likert scale that ranges from disagree very much, disagree moderately, disagree slightly, agree slightly, agree moderately and agree very much. In total 16 items were used in this instrument during this research. The JSS has been used extensively and has been proven to be valid and reliable. The Cronbach's alpha coefficient achieved for the total scale: .91

Research process	Discussion and application
	(Spector, 1985:700). <i>Maslach Burnout Inventory (MBI)</i> The Maslach Burnout Inventory (1981) consists of three subscales. The emotional exhaustion and depersonalization subscales were used to evaluate discriminant validity and the personal accomplishment subscale was used to evaluate divergent validity during this research. The instrument made use of a seven-point Likert scale and ranged from never, a few times a year or less, once a month or less, a few times a month, once a week, a few times a week to every day. The Maslach Burnout Inventory has been used extensively and has been proven to be valid and reliable. In South Africa, the instrument was used in a national study and the Cronbach's alpha coefficient achieved for all subscales in that study was: > .75 (Klopper <i>et al.</i>, 2012:690). Please refer to Chapter Five (see Section 5.4) for a discussion.
Data analysis	The computer software programmes SAS (SAS OnlineDoc, 2011) and SPSS (SPSS Inc., 2013) were used to calculate the descriptive statistics and evaluate the reliability and validity of the instrument. The following calculations were done: - Descriptive statistics - Factor analysis (exploratory, confirmatory and Bartlett's test of sphericity) - Cronbach's alpha coefficient - Correlations - ANOVA Please refer to Chapter Five (see Section 5.3) for a comprehensive discussion.

2.5.4 Phase Four: Validation

Phase Four, which includes steps 11, 12 and 13 are to be done post-doctorally. Validation requires numerous efforts and is a process that is on-going (Benson & Clark, 1982:798). The following steps form part of the validation phase:

Step 11: Repeat steps 9-10

Step 12: a) Validation

b) Administer for validation data

Step 13: Continue validation

2.6 RIGOUR

Rigour is defined as striving for excellence in research by using discipline to adhere to strict accuracy (Burns & Grove, 2009:34). According to Bowling (2009:152) rigour refers to features that are essential to the research process, such as a systematic approach to the research design, the importance of interpretation and not perception, and thorough and systematic data collection to name but a few.

Rigour is ensured by using the four basic epistemological standards as described by Lincoln and Guba (1985:290), namely: truth value, applicability, consistency and neutrality. Authenticity is added as the fifth epistemological standard.

2.6.1 The truth value of the research findings

Truth value is the confidence the researcher has in the accuracy of the findings. Truth value is usually obtained from the participants and entails their experience of the phenomenon under study (Botma *et al.*, 2010:233). There are different techniques that can be used to ensure truth value. For qualitative research the strategy of credibility can be used and for quantitative research the strategy of internal validity can be used (Lincoln & Guba, 1985:290). Credibility is achieved when the research methods instil confidence in the veracity of the data and the researchers' interpretations of the data (Polit & Beck, 2004:36). Techniques that can be used to ensure credibility are (Lincoln & Guba, 1985:290):

Prolonged engagement – Enough time should be spent on the collection of data in order to obtain an in-depth understanding of the views of the participants. Time was spent on a thorough search of the literature through the integrative literature review. Semi-structured

interviews were conducted until saturation was reached. Thereafter the instrument was piloted, which involved the researcher spending a week collecting data at the site. Furthermore, the researcher is also a clinical nurse specialist and has spent 18 years in the clinical field.

Persistent observation – Interpretations should be pursued in a variety of ways. An integrative literature review, as well as semi-structured interviews to confirm the antecedents, consequences and attributes of moral distress and to develop the instrument were conducted. The instrument was then examined by content experts and judged by members similar to the target group. Thereafter the instrument was piloted and data described and explained, before further validation testing.

Triangulation – Multiple designs and research methods are used to accurately portray phenomena. Qualitative and quantitative research designs were used in this study (refer to Section 2.4 for a detailed discussion of the value added). So also multiple methods were used to develop the instrument, including an integrative literature review, semi-structured interviews, content analysis by experts and quantitative and qualitative review by judges similar to the target group. Thereafter the instrument results were described and the instrument scrutinised with further reliability and validity testing.

Peer debriefing – Objective and expert peer reviews to explore the research process. Content validation, which was performed by experts in the field of moral distress formed part of this research. A peer review of the instrument was performed by professional nurses similar to the target group that would be used to test the instrument. The two supervisors and the statistician continuously provided input into the process.

Member checking – The researcher takes the findings back to the participants to confirm the construction and interpretation of the data. This was done with the semi-structured interviews as well as with the quantitative evaluation during instrument development.

Negative case analysis – The researcher constantly revises and refines her own hypothesis by including disconfirming cases until the hypothesis accounts for all the cases. The Maslach Burnout Inventory (MBI) (1981) was used to determine discriminant and divergent validity and the Job Satisfaction Survey (JSS) (1985) was used to determine divergent validity.

Referential adequacy – Refers to the materials that are available to document the findings. The researcher did a thorough integrative literature review for all data available as well as conducting confirmatory semi-structured interviews to confirm the findings. Experts in the field and professional nurses formed part of the content validation process.

Internal validity – Is indicated where the effects that were detected in the study are a true reflection of reality (Burns & Grove, 2009:222). An integrative literature review was conducted and the findings were confirmed by conducting semi-structured interviews. Internal validity was assured through the following means:

Instrumentation – Instrumentation refers to a change either in the measuring instrument or the person collecting the data (Klopper & Knobloch, 2010:320). During this research, no adjustments were made to the instrument after the content validation from the experts. The instrument remained the same for the first pilot study as well as the second pilot study. The researcher distributed the instruments without discussing the instrument itself with the participants. Each instrument was accompanied by an information letter that contained all the necessary information and instructions. The changes were made after data analysis in consultation with the promoters and statistician.

Selection bias – Selection bias takes place where the researcher ensures that participants are similar in each intervention group prior to the experimental intervention (Klopper & Knobloch, 2010:320). All-inclusive sampling was used to pilot the instrument, so there was no selection bias present, refer to Table 2.5 for further information.

2.6.2 Applicability of the research findings

Applicability refers to the degree to which the research findings can be carried over to a larger population of similar phenomena. The technique that can be used to ensure applicability in qualitative research is transferability and refers to the generalizability of the data. In quantitative research external validity can be used to ensure applicability, which is the extent to which findings can be generalised to other populations and settings (Lincoln & Guba, 1985:293).

Thick description – Thick description can be defined as the in-depth description that the researcher gives to the research context, transactions and processes (Klopper & Knobloch, 2010:320). To ensure transferability a thick description on the background and rationale of the study (see Chapter One, Section 1.2) and the aim and objectives (see Chapter One, Section 1.4) was given in Chapter One and the philosophical assumptions (see Chapter One, Section 1.5) were explained. In this chapter, a detailed description of the research methodology, which includes the design, methods, data collection, data analysis and interpretation of the data and development of an instrument to measure moral distress, was discussed.

Data Saturation – Data saturation is determined by the depth of the information that is needed on the construct under study in order to gain insight into the phenomenon (Klopper & Knobloch, 2010:321). Data saturation during the integrative literature review was obtained by an all-inclusive sampling. During the semi-structured interviews, data saturation was obtained when the researcher recognized the repetitiveness of the results obtained during the semi-structured interviews.

Purposive Sampling - Purposive sampling indicates the deliberate selection of participants (Burns & Grove, 2009:355). Purposive sampling was applied during the selection of the experts for the content validation. Experts on moral distress and instrument development were sought out. Purposive sampling was also applied during the selection of the participants for the semi-structured interviews and the qualitative evaluation of the instrument which included the focus group. The participants were selected because they represented the population which was that they all were professional nurses working in hospitals and clinics in South Africa.

External Validity - In order to ensure external validity, the findings should have the capacity to be generalized beyond the sample of the study (Burns & Grove, 2009:700). External validity was ensured through:

- *Selection effects* – Selection effect refers to striving for a sample large enough to generalise the findings of the study to the general population (Klopper & Knobloch, 2010:321). During the second pilot study, the hospital in the Free State was selected due to the vast number of professional nurses working there (n = 500), which made generalizability of the research findings stronger.
- *Researcher effects* – Researcher effects occur where the participants might be influenced by characteristics or behaviour of the researcher (Klopper & Knobloch, 2010:321). During this research the researcher gave written instructions and information to the participants for the content validation, semi-structured interviews, the focus group as well as the second pilot study. This ensured neutrality during data collection, and that the participants are not influenced in any way by the researcher.

2.6.3 Consistency of the research findings

This refers to the ability to reproduce the study and achieving the same or comparable results by using the same population in a similar context. The technique that can be used in qualitative research is dependability, which refers to the stability of data over a period of time and conditions. Dependability requires certain criteria to be included, namely: dependable

audit trail, traceable variability, stepwise replication of the study, a dense description of the methodology, triangulation of methods, data sources, peer examination and code-recode of data or use of a co-coder (Botma *et al.*, 2010:233). The technique that can be used in quantitative research is reliability which denotes the consistency of results obtained by using an instrument over time on the same person (Lincoln & Guba, 1985:295).

During this research a clear audit trail was established so that another researcher can clearly follow the path of this research. The audit trail was established by describing in detail every step that was taken as well as the results that were obtained.

2.6.4 Neutrality of the research findings

Neutrality refers to an absence of personal biases or interests of the researcher in the research process. The technique to ensure neutrality in qualitative research is confirmability and that is where there is no focus on the characteristics of the researcher but only on the characteristics of the data. The technique to ensure neutrality in quantitative research is objectivity and is achieved where the focus lies on the characteristics of both the researcher and the data (Lincoln & Guba, 1985:290). Confirmability audit and triangulation are ways that the strategy of confirmability can ensure neutrality (Klopper, 2007:18).

A confirmability audit was applied where the researcher stated her meta-theoretical-, theoretical- and methodological assumptions. A clear description was included in order to ensure that the findings of the study were determined by the participants and conditions, versus the researcher's biases, perspectives and motivations. The raw data, data reduction and analysis and instrument information were made available for expert and peer review. A thorough and extensive description of the study's theoretical foundation, the context of moral distress in professional nurses in South Africa, methods, findings and interpretations and auditability contributes to the standard of neutrality in this study.

2.6.5 Authenticity

Authenticity was added as a fifth criterion by Lincoln and Guba (cited in Polit & Beck, 2004:539). Authenticity is indicated where the reader is invited through the portrayal of the researcher of the participants' lives, and the reader can identify with the issues involved. The researcher gives a faithful rendition of the participants' lived experience (Botma *et al.*, 2010:235).

All the raw data gathered during the semi-structured interviews and focus group was transcribed verbatim, and the transcriptions as well as the completed instruments are available for external persons to review.

2.6.6 Validity

Content validity was applied during this research by conducting an extensive integrative literature review and confirmatory semi-structured interviews with professional nurses to gain an in-depth understanding of moral distress, in order to develop an instrument to measure moral distress. Content validity was further applied by selecting experts in instrument and scale development to review the instrument that was developed and to determine whether the items formulated were relevant and clear. Through the quantitative evaluation, face validity was applied where professional nurses completed the instrument and gave feedback and input into the final instrument. Discriminant and divergent validity was applied through simultaneous distribution and analysis of the Maslach Burnout Inventory (MBI) (1981), and through applying the Job Satisfaction Survey (JSS) (1985) divergent validity was applied. See Chapter Five (see Section 5.3.1) for a detailed discussion on validity achieved during this research.

2.6.7 Reliability

In this study, reliability was ensured through an extensive integrated literature review, confirmatory semi-structured interviews, content validation and quantitative evaluation of the instrument prior to testing. A clear audit trail was kept of every step to allow detailed evaluation. The Crohnbach's alpha coefficient was also determined for each of the subscales and were deemed reliable. See Chapter Five (see Section 5.4.4.7) for a detailed discussion on the reliability achieved during this research.

2.7 SUMMARY

In Chapter Two, the methodology of the study was described. The research method was discussed according to the theoretical framework (Benson & Clark, 1982:790) in three phases, namely the planning phase, the construction phase and the quantitative evaluation phase. In each phase the population and sampling, sample, data collection and data analysis was discussed in detail. The chapter concluded with a discussion of the rigour of the study.

CHAPTER THREE

CHAPTER THREE

PHASE ONE: PLANNING

3.1 INTRODUCTION

The aim of Chapter Three is to conduct and describe the integrative literature review and the semi-structured interviews. The integrative literature review was conducted to identify, the antecedents, consequences, attributes, empirical indicators, definitions and themes from previous research and concept analyses. The researcher also examined the instruments currently available to measure moral distress (discussion of the instruments will follow in Chapter Four) and semi-structured interviews were conducted. The realisation of data is discussed with reference to data collection and data analysis.

3.2 REALISATION OF THE DATA

The research design and research method were discussed in detail in Chapter Two (see Sections 2.4 and 2.5). During this research the theoretical framework (Figure 3.1) from Benson and Clark (1982:789) was followed. In Chapter Three, Phase One (planning) is conducted, and a detailed description of each phase is discussed in Chapter Two (see Section 2.3). The phase and sections that will be discussed in this chapter are coloured. Phase One consists of the following, as can be seen in Figure 3.1:

❖ Phase One: Planning (Chapter Three)

- *Step 1:*
 - a) State purpose of test and target group
 - b) Identify and define domain of test
- *Step 2:*
 - a) Review literature of construct
 - b) Conduct interviews with target group
 - c) Interpret open ended comments

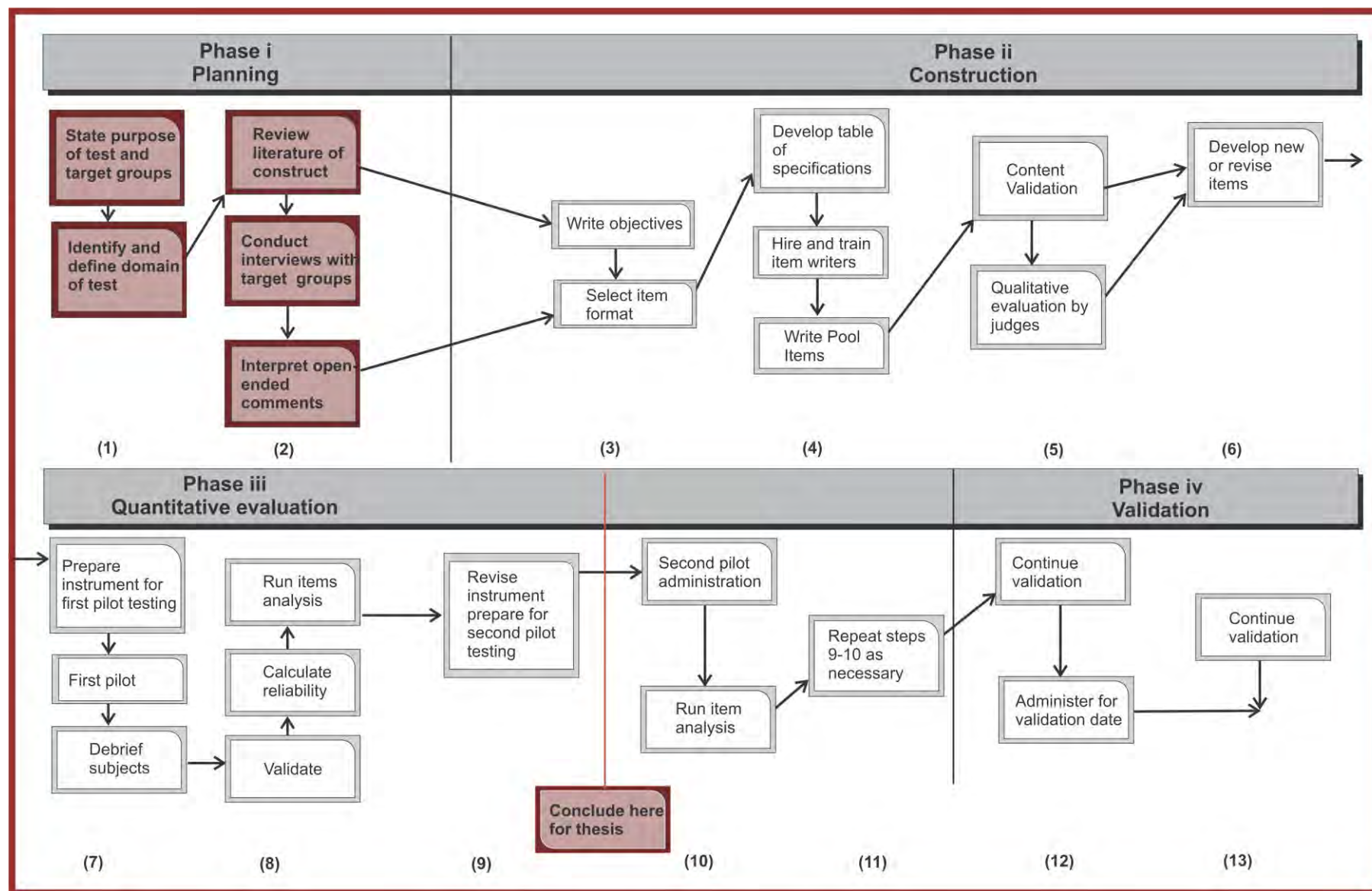


Figure 3.1 Flowchart for Instrument Development (Benson & Clark, 1982:790)

3.2.1 Integrative literature review

According to Burns and Grove (2009:92) the literature review is done to communicate what is known about the topic of interest, and should be done in an organized manner. When doing a literature review, different names are available to describe the literature review, e.g. systematic review, integrative review, structured review and critical review. All these different types of review share one common goal, namely to produce a reliable summary on the topic (Evans, 2007:137).

Integrative literature reviews are considered to provide a broader summary of the literature, compared to, for example, the systematic review process. The findings from a range of different research designs can be included. There is however no widely accepted standard for conducting integrative literature reviews. During this integrative literature review both qualitative, quantitative and mixed method research was included. When including both qualitative and quantitative research, a more comprehensive investigation is being conducted, which leads to a more robust and valid evaluation of the concept under investigation (Evans, 2007:137). Polit and Beck (2012:654) term mixed study review for a literature review that uses quantitative, qualitative and mixed method research.

It is important that one set up general guidelines (a plan) to help the researcher with the search. The researcher should, beforehand, know exactly what should be included as well as excluded during the literature review, as it is necessary to know exactly what is being looked for (Burns & Grove, 2009:94). Once the researcher starts working with the literature, he/ she should start to organize it according to the plan that was formulated when starting (Creswell, 2009:33). The aim should be to identify themes, issues or patterns (McVicar, 2003:635; Aschenbrenner *et al.*, 2012:520; Shimpuku & Norr, 2012:11).

During the integrative literature review, the researcher made use of inclusion and exclusion criteria, figures and tables to organize the review process. It was important to the researcher to work in a systematically and organized manner, since such a vast amount of literature was involved.

In conducting the integrative literature review, the researcher followed a protocol as described by Evans (2007:139). This protocol includes five phases as shown in Figure 3.2.

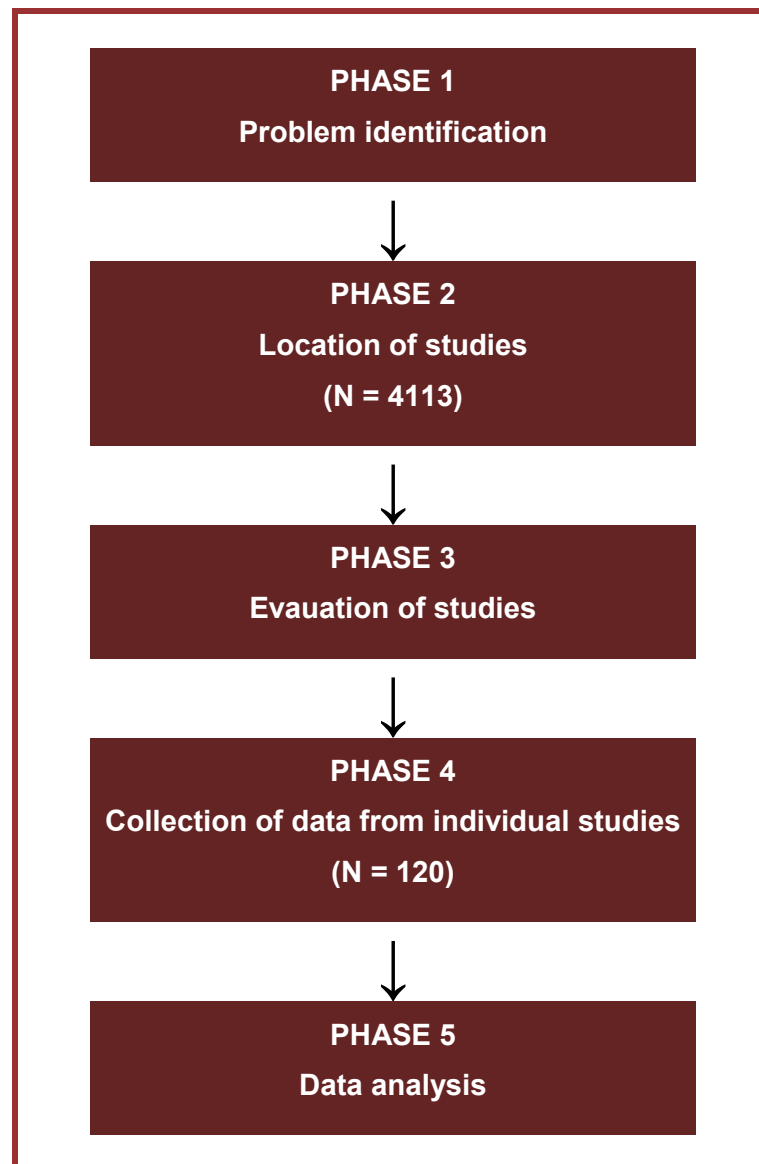


Figure 3.2 Integrative literature review process protocol

During Phase One of the theoretical framework the researcher made use of a process protocol as described by Evans (2007:139) (Figure 3.2) and the protocol were implemented within the theoretical framework.

3.2.1.1 Phase One: Problem identification (Process protocol)

As can be seen in Figure 3.2, during the first phase of the review protocol, the review purpose or question is formulated. The researcher asked four questions, to be answered during the integrative literature review, namely:

Question 1:

Has a concept analysis on moral distress been conducted?

Question 2:

What are the antecedents of moral distress?

Question 3:

What are the consequences of moral distress?

Question 4:

What are the main attributes/ themes of moral distress?

Phase 1 of the protocol (see Figure 3.2) from Evans (2007:139) also includes determining the selection criteria. The criteria should provide a clear description of the variables under study and is derived from the review question. Selection criteria help to avoid inclusion of irrelevant information and make the process more rigorous (Evans, 2007:140). The population identified for this integrative literature review was nationally and internationally published studies and dissertations and theses on moral distress. All-inclusive sampling, according to the inclusion criteria was done. The researcher consulted with the librarian on the integrative literature review to ensure that the best search strategy was implemented as well as to enhance rigour.

3.2.1.1.1 Inclusion criteria

The sample included all studies that met the following criteria:

- Studies published since 1984, to include all relevant data to date. Jameton was the first author that discussed moral distress in 1984; therefore the researcher chose 1984 to start the literature search.
- Only studies on nurses were included as the researcher is focusing on nursing, in order to include ethical/ moral situations specific to nurses.
- Studies that were conducted in a clinical (hospital/ clinic/ hospice/ old age home) setting, as well as literature reviews and concept analyses; in order to include as much information as possible.
- Studies written in English as the researcher is proficient in English only.

3.2.1.1.2 Exclusion criteria

The sample excluded the following:

- Duplicate studies.
- Studies involving healthcare professionals, except nurses.
- Retrievals without full-text versions available online or through the North-West University library catalogue had to be excluded.

3.2.1.2 Phase Two: Locating studies (Process protocol)

Phase 2 of the protocol (see Figure 3.2) from Evans (2007:139) includes locating the relevant sources. The researcher consulted a librarian to identify the correct key words. Search options were done electronically and close documentation was done of the process of the literature searches. The key words used to conduct the literature searches were:

- Nurse or nurses or nursing AND (nurs*)
- Moral distress

The national and international search engines that were accessed are listed below. In order to be able to identify the sample, multiple sources were used, such as:

- Electronic databases: EbscoHost, Science Direct, Emerald, Scopus, ProQuest and GoogleScholar, Sabinet and SAePublications.
- Manual search: GoogleScholar
- Grey literature: Dissertations and theses

These search engines were selected because of their accessibility, user-friendliness and the vast number of databases that were listed. See Figure 3.2 for a schematic depiction of the integrative literature process. Figure 3.3 is based on the process of Smith *et al.* (2009:1628) which was adapted to this research. The aim was to help the researcher in documenting the review process. It shows the number of sources that were obtained, the number of articles that were included and excluded, as well as the number of dissertations and theses that were included and excluded.

The following figure shows the documenting process that was followed during the integrative literature search that the researcher followed.

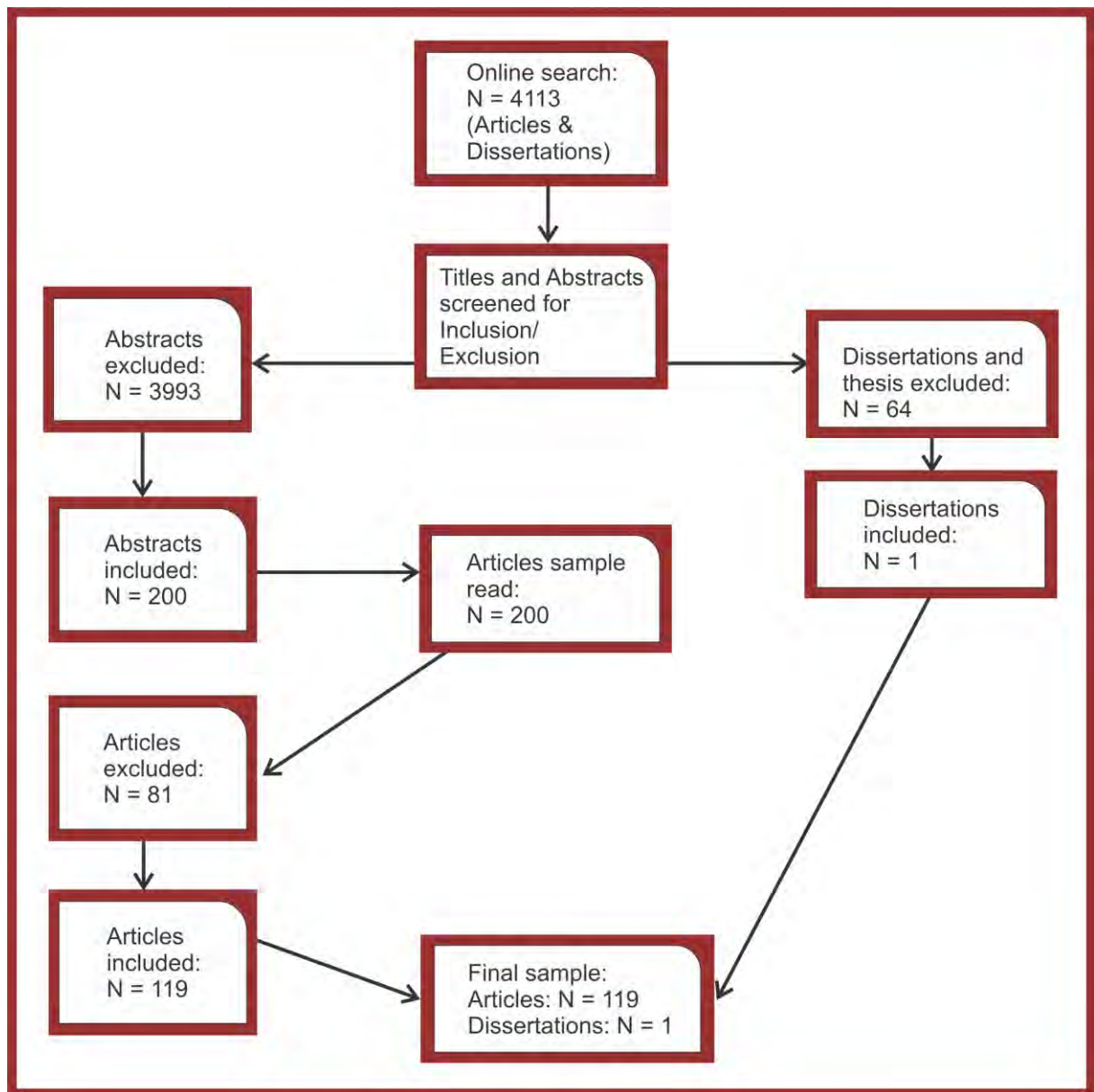


Figure 3.3 Schematic depiction of the Integrative literature review process

The literature that was found was documented and assessed for applicability according to the inclusion criteria before it was added to the list. A total number of 120 sources ($n=120$) of literature was used. The following table (Table 3.1) depicts the databases that the researcher accessed for the integrative literature search.

Table 3.1 Databases accessed through international and national search engines

Database	Date accessed	Keywords	No. of records obtained	Included	Excluded
Scopus	12/9/2012	Nurse or nurses or nursing (nurs*) AND Moral distress	250	76 (Includes concept analysis) 2	174
EBSCO Host (Academic Search Premier, CINAHL, Health Source: Nursing/Academic edition, MEDLINE)	01/11/2012	Nurse or nurses or nursing (nurs*) AND Moral distress	768	33	735
Science Direct	07/11/2012	Nurse or nurses or nursing (nurs*) AND Moral distress	472	2	470
Sabinet	09/11/2012	Nurse or nurses or nursing (nurs*) AND Moral distress	21	0	21
Emerald	12/11/2012	Nurse or nurses or nursing (nurs*) AND Moral distress	25	2	23
Google Scholar	12/11/2012	Nurse or nurses or nursing (nurs*) AND Moral distress	2510	7	2503
Pro Quest	12/11/2012	Nurse or nurses or nursing (nurs*) AND Moral distress	64	0	64
SA ePublications	12/11/2012	Nurse or nurses or nursing (nurs*) AND Moral distress	3	0	3
Total			4113	120	3993

3.2.1.3 Phase Three: Evaluating studies (Process protocol)

During the third phase of the integrative literature review, the researcher evaluated the studies obtained to ensure that only rigorous research was included in the review. Certain criteria, as described in Evans (2007:142), guided the researcher in this process, namely:

- Findings relevant with respect to the review question
- Data, interpretations and conclusions clearly integrated
- Transferability of findings
- Relevance, importance and usefulness of the findings

During this process 3993 studies were excluded while 120 studies were included in the study (see Figure 3.3).

3.2.1.4 Phase Four: Data collection (Process protocol)

The aim of the data collection phase was to ensure that all relevant data, from each study that was to be included, is documented. According to Evans (2007:143) a data collection form should be used to examine the type of data that will be extracted from the studies to be included in the review. In order to guide this process, the researcher designed a form with the following categories:

- Number of study (total of studies per database, as well as total number of studies included)
- Study Title, Author and Year
- Type of study
- Setting
- Participants
- Objective
- Definition(s) used
- Antecedents/ Themes
- Consequences
- Attributes
- Main findings/ Outcome

The researcher then completed the form for every study that was included in the review, to serve as guide and reference during the analysis phase. The type of study, setting, participants, objective, definition and outcome that were listed were stated as such in the particular study. The antecedents were identified in the literature as what preceded moral distress. The consequences were identified in the literature as that which followed when a person became morally distressed. The attributes that were listed was stated as such in the study. The form also served as a summary for future reference. The researcher accurately recorded all the data that was collected (see Table 3.2). The following definitions are described:

- *Antecedent*

Antecedent can be defined as “something which precedes...” (Webster’s New World Dictionary, 2002). Therefore, during this research antecedents are seen as contributors to moral distress, that which precedes the occurrence of moral distress.

- *Consequence*

Consequence can be defined as the outcome or result that occurs (Webster’s New World Dictionary, 2002). During this research the consequences of moral distress are seen as the result that moral distress has on the internal and external environment of the professional nurse.

- *Attribute*

Attributes can be defined as the characteristics or qualities of a concept (Webster’s New World Dictionary, 2002). The attributes identified during this research are used to base the instrument to be developed on.

- *Empirical indicator*

Empirical indicators can be defined as evidence rooted in objective reality (Polit & Beck, 2012:726) and has the ability to be verified (Webster’s New World Dictionary, 2002). The empirical indicators were the items of the instrument, which measured and best described the identified attributes of moral distress.

The source that met the inclusion criteria and was included in this research is shown in the following table. Table 3.2 gives a clear summary of all the studies that was included in the integrative literature review.

Table 3.2 Summary of included studies

SCOPUS										
No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(1) 1	Implications of moral distress on nurses and its similarities with burnout De Lima Dalmolin <i>et al.</i> (2012)	Quantitative	Literature review		To identify literature, the implication that moral distress has on nurses, the similarities between moral distress and burnout, coping strategies	Jameton	Lack of power in making decisions	Frustration, powerlessness, guilt, burnout, resentment, anger, humiliations, embarrassment, sadness, misery, anxiety, fear, insecurity, non-appreciation of work, depression, job dissatisfaction, crying, loss of sleep, loss of appetite, nightmares, feelings of uselessness, tachycardia, headaches, muscle pain, sweating, shivering, gastrointestinal	-	Theme should be further explored

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
								disorders, stress, emotional exhaustion		
(2) 2	How professional nurses working in hospital environments experience moral distress: A systematic review Huffman and Rittenmeyer (2012)	Quantitative	Systematic review		To assist CCN to provide optimal care to their patients and families and use moral distress as a catalyst to create positive changes	Jameton Wilkinson	Lack of support/ resources/ structure/ authority, high responsibility, compassion fatigue, poor staffing, limited finances, weak policies, pain and suffering, unequal power hierarchies, poor interpersonal relationships, repercussions , end-of-life care, ignored patient wishes, devaluing behaviour	Powerlessness, anger, depression, stress reactions, withdraw emotionally, loneliness, guilt, anxiety, physical symptomatology, leaving profession, numb	-	Nurses express a desire for support

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(3) 3	Exploration of the association between professional interactions and emotional distress of ICU nursing personnel Karanikola <i>et al.</i> (2012)	Quantitative	ICU	Nurses	To investigate the degree of satisfaction from interaction among ICU nursing personnel...	-	High workload, work intensity, staff shortages, managerial shortcomings	Sleep disturbances, anxious mood, muscular symptoms, impaired concentration	-	Anxiety leads to impaired concentration. Further qualitative research is needed
(4) 4	Resolving moral distress when caring for patients who smoke while using home oxygen therapy Kayser <i>et al.</i> (2012)	Qualitative	Home-care	Nurses	To describe the experience of moral distress among nurses who care for patients who smoke ...	-	End-of-life care	-	-	A three step process is described to help resolve moral distress
(5) 5	Moral distress in nurses in oncology and haematology units Lazzarin <i>et al.</i> (2012)	Quantitative	Clinical	Nurses	To translate the paediatric version of the MDS from English.	Jameton	End-of-life care	Leaving the profession	-	The instrument was found to be reliable

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(6) 6	Moral distress in nursing practice Malawi Maluwa <i>et al.</i> (2012)	Qualitative	Clinical	Nurse	To explore the existence of moral distress among nurses in Lilongwe District of Malawi	-	Shortage of staff, violating regulations, forced to accept disrespect, lack of resources, behaviour of colleagues, mismanagement by superiors, inadequate provision of patient care by nurses	Frustration, burnout, work stress, job dissatisfaction, absenteeism, turnover, poor patient care	-	The major distressing factors were inadequate resources and lack of respect from patients, guardians, peers and bosses
(7) 7	Stop the Noise! From voice to silence Newton <i>et al.</i> (2012)	Quantitative	Clinical	Nurses	To examine the relationship between voice, moral distress and ethical climate	Jameton Webster and Baylis	Demeaning remarks, unsafe conditions, lack of support from management, patient suffering, loss of dignity	Withdrawing, frustrated, leaving the ward	-	A better understanding of the ethical dimensions of nurses' voice, or lack of voice, has the potential to enhance ethical climates, reduce moral distress and improve patient outcomes

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(8) 8	Perceptions of a strategy to prevent and relieve care provider distress in the neonatal ICU <i>Okah et al.</i> (2012)	Quantitative	Clinical	Nurses	To facilitate communication and consensus building and thereby prevent or address moral distress	Jameton	Physician autonomy, communication, limited engagement	Burnout	-	Helping HCP who were comfortable with expressing distress also felt support by team members
(9) 9	Professional autonomy, collaboration with physicians, and moral distress among European ICU nurses <i>Papathanassoglou et al.</i> (2012)	Quantitative	Clinical	Nurses	To explore levels of autonomy among European critical care nurse and potential associations of autonomy with nurse-physician collaboration, moral distress, and nurses' characteristics	-	Lack of autonomy	-	-	Lower autonomy was associated with increased frequency and intensity of moral distress and lower levels of nurse-physician collaboration
(10) 10	Iranian intensive care unit nurses' moral distress: A content analysis	Qualitative	Clinical	Nurses	Reports the first study of moral distress in Iran. Because of the differences in cultural values	Jameton	Institutional barriers and constraints, communication problems, futile actions,	Feelings of anxiety, discomfort, frustration, anger, conflict, reduced satisfaction,	-	The results demonstrate that moral distress is different

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
	Shorideh <i>et al.</i> (2012)				and nursing education, moral distress may be experienced differently		malpractice, medical care errors, inappropriate allocation of responsibilities/ resources, care worker competencies	burnout, high turnover, severe stress, exhaustion		
(11) 11	Nurses' perceptions of and responses to morally distressing situations Varcoe <i>et al.</i> (2012)	Quantitative	Clinical	Nurses	To report nurses' perceptions of moral distress and ethical issues	Jameton	Workload, incompetency, unnecessary suffering, moral compromise, negative judgements, lack of staffing, no communication	Feeling defeated, powerlessness, sadness, shocked, emotionally drained, anxious, guilt	-	Issues were reported
(12) 12	Consequences of clinical situations that cause critical care nurses to experience moral distress Wiegand and Funk	Quantitative	Clinical	Nurses	To identify clinical situations that caused moral distress and understand the consequence	Jameton	End-of-life care, organ donation, over- and under administration of analgesic medication, medical futility, suffering, prolonged	Frustration, anger, sadness, psychological exhaustion, helplessness, suffering, distress, disappointment, depression, and physical exhaustion, lower standard of care,	-	Nurses described consequences for themselves, patients and families

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
	(2012)						dying, undignified dying, quantity vs. quality of inappropriate care, delayed treatment, prolonged hospitalization, disrespect, inability to be with family, false hope	experiencing conflict, decreased morale and job satisfaction, leaving the profession		
(13) 13	What factors affect nursing retention in the acute care setting? Cummings (2011)	Mixed method	Clinical	Nurse	The research was conducted in an effort to highlight some of the critical factors that impact nurses in the acute care setting and affect their intent to stay	Jameton	Inadequate pay, inadequate staffing, incompetent staff, inadequate training, fear of making mistake/reprimanded	-	-	Professional stress and moral distress items were predictive of the nurses' intent to stay
(14) 14	Surgical nurses; perceptions of ethical dilemmas, moral distress and quality of care	Quantitative	Clinical	Nurses	To describe surgical nurses' perceived levels of ethical dilemmas, moral distress and perceived	Jameton	Inappropriate behaviour, staff shortages, violent nurse/patients/ family, withholding truth,	-	-	There was a relationship between moral distress and perceived quality of care

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
	DeKeyser Ganz and Berkovitz (2011)				quality of care and the associations among them		incomplete informed consent, futile procedures, reporting of medical errors, discrimination			
(15) 15	Early indicators and risk factors for ethical issues in clinical practice Pavlish <i>et al.</i> (2011)	Quantitative	Clinical	Nurse	To explore nurses' descriptions of ethically difficult situations to identify risk factors and early indicators of ethical conflicts	Wilkinson	Unnecessary patient suffering, patient autonomy, questionable professional behaviour, failure to follow standard care, failure to adequately inform patient, fraud, unethical organization practices, truth telling, judgemental stereotyping, conflict, poor communication	Emotional exhaustion	-	Nurses are aware of early indicators. Research should develop interventions to strengthen nurses' voices

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(16) 16	Nursing priorities, actions and regrets for ethical situations in clinical practice Pavlish <i>et al.</i> (2011)	Quantitative	Clinical	Nurses	To explore nurses' descriptions of ethically difficult situations	-	Autonomy, communication, conflict, advocacy, end-of-life care, modern technology, incapable of addressing the prognosis, suffering, inadequate staffing	Regret	-	Evidence-based nurse actions that address ethical conflicts are lacking
(17) 17	Moral distress in certified registered nurse anaesthetists: Implications for nursing practice Radzvin (2011)	Quantitative	Clinical	Nurse	To determine if certified registered nurse anaesthetists experience moral distress in their nursing practice	Jameton Wilkinson	Lack of support, ethically challenging situations	Feelings of guilt, powerlessness, anger and frustration, physical and psychological manifestations	-	The data supports the assumption that CRNAs do experience moral distress in their nursing practice

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(18) 18	Nurses' moral experience of administering PRN anti-seizure medications in paediatric palliative care Rashotte <i>et al.</i> (2011)	Qualitative	Clinical	Nurses	To explore nurses' decision-making related to the administration of PRN ...	-	Decision making	Being scared, frightened, worried, anxious, stressed, distressed	-	Moral dilemmas resulting in moral distress were revealed
(19) 19	The meaning of our work: Caring for the critically ill patient with cancer Wiencek <i>et al.</i> (2011)	Quantitative	Literature review		To address the nurse's experience in caring for the critically ill patient with cancer...	Jameton Nathaniel	-	Physical, emotional, behavioural and spiritual consequences	-	Strategies and resources presented
(20) 20	A study of the situations, features and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress Deady and McCarthy (2010)	Qualitative	Clinical	Nurses	To investigate moral distress in Irish psychiatric nurses	Jameton	Professional and legal conflict, professional autonomy, scope of practice, standards of care and client autonomy	Feelings of self-doubt, guilt, frustration, anger and depression	-	Situations that give rise to moral distress are not always acknowledged or dealt with effectively

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(21) 21	Does good documentation equate to good nursing care? DeWolf Bose and Ring (2010)	Quantitative	Clinical	Nurses	To explore the potential underpinning of poor documentation from an ethical decision-making lens	AACCN	Lack of time, power imbalances, institutional policy or legal limits, inadequate staffing, lack of collegial relationships, lack of administrative support, policies and priorities that conflict with care needs, compromised care due to reduce costs	Lack of awareness/ confidence/ assertiveness, self-doubt, powerlessness, fear	-	It is the ultimate responsibility of the nursing manager to cultivate environments of practice that support ethical decision making
(22) 22	Moral distress among Ugandan nurses providing HIV care: a critical ethnography Harrowing and Mill (2010)	Qualitative	Clinical	Nurses	To describe the manifestation and impact of moral distress as experienced by Ugandan nurses who provided care to HIV people	Jameton	Lack of resources, staff shortages, end-of-life care, withholding truth, working conditions	Helplessness, hopelessness, fatigue, despair, negative attitude, loss, pain, suffering (spiritual, physical, psychological)	-	Moral distress differed somewhat from the experience of nurses in high-income countries.

No.	Study	Type of Study	Setting	Partici- pants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(23) 23	Ethical dilemmas and ethical competence in the daily work of registered nurses Höglund <i>et al.</i> (2010)	Qualitative	Research	Nurses	To describe and explore ethical dilemmas that Swedish research nurses experience	-	Suffering/ harm of patients	-	-	Research nurses frequently experience severe and difficult ethical dilemmas in their daily work
(24) 24	Moral distress and burn-out in nurses on acute geriatric wards Magali-Dewitte <i>et al.</i> (2010)	Quantitative	Clinical	Nurses	To investigate moral distress	-	End-of-life care, lack of engagement in decision making/ lack of debate on ethical issues/ high level of burden	Burnout	-	Moral distress is a problem and is associated with burnout
(25) 25	An institutional ethnography of nurses' stress McGibbon <i>et al.</i> (2010)	Qualitative	Clinical	Nurses	To reformulate the nature of stress in nursing, with attention to important contextual aspects of nurses' practice	Jameton	End-of-life care, closeness to anguish, mistakes, pain, prolonging of life, hierarchical placement, burden of responsibility, doing non-	Crying	-	Nurses' social locations, all but absent in current formulations of stress and vicarious trauma, are surely central to their experience of stress

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
							nursing tasks/ doing jobs of others, decision-making, thinking ahead, navigating/ negotiating patient care, lack of labour union strength			
(26) 26	Moral distress: A consequence of caring Shepard (2010)	Quantitative	Literature review		To review the concept of moral distress and suggest interventions	Jameton	End-of-life care, patient's rights, resources	Emotional, physical and professional implications	-	Professional and administrative support is needed
(27) 27	Moral distress: A growing problem in the health profession? Ulrich <i>et al.</i> (2010)	Quantitative	Literature review		To describe the impact of moral distress	Jameton	Powerlessness, miscommunication, end-of-life care, confrontational dialogue, implicit deception	Powerlessness, guilt, sadness, anger	-	Ethical resolve may provide a sense of resolve and reason to approach difficult questions

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(28) 28	Moral distress: A living nightmare Unruh and Ream (2010)	Quantitative	Literature review		Moral distress in emergency department	-	Unsafe working conditions, violence	Anxiety, fear, frustration, disillusionment	-	Support is needed
(29) 29	Pulling the heartstrings, arguing the case: a narrative response to the issue of moral agency in moral distress Walsh (2010)	Qualitative	Clinical	Nurse	To present a narrative that reflects the emotional nature of moral distress	Jameton	Attitude of personnel	Anger	-	The narrative answers some questions
(30) 30	An overview of moral distress and the paediatric intensive care team Austin <i>et al.</i> (2009)	Quantitative	Literature review		The need to acknowledge moral distress among PICU teams is discussed and an argument made	Jameton	End-of-life care, parents refusing treatment, informed consent, futile care, formal decision-making structures, conflict, lack of respect, trust and power	-	-	Team conversations are needed to understand one another's experience and perspectives

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(31) 31	Facilitated ethics conversations. A novel programme for managing moral distress in bedside nursing staff Helft <i>et al.</i> (2009)	Qualitative	Clinical	Nurses	To find ways to deal with moral distress	-	Non-beneficial treatment, life-prolonging therapy, communication gaps, informed consent	Sorrow, frustration, leaving the profession	-	Facilitators should be trained
(32) 32	A difficult mission to work as a nurse in a residential care home – some registered nurses' experience of their work situation Karlsson <i>et al.</i> (2009)	Qualitative	Clinical	Nurses	To describe registered nurses' experiences of their work environment	-	Being belittled, having no authority, invisible fixer	Feeling boundless and invisible, feeling powerless, exhausted, lonely, frustrated	-	Border of nursing care should be clear
(33) 33	Moral distress: Inability to act or discomfort with moral subjectivity?	Quantitative	Literature review		Critical examination of how the Catholic tradition's normative ethical	Jameton	End-of-life decision making	-	-	The Catholic moral tradition plays a pivotal role in the moral evaluation of life-sustaining interventions for

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
	Repenshek (2009)				framework accounts for moral subjectivity...					end-of-life decision-making.
(34) 34	The effect of a workshop on reducing the experience of moral distress in an ICU setting Beumer (2008)	Quantitative	Clinical	Nurses	To discuss a workshop and its effect on participants' coping with moral distress	Jameton	-	Frustration, anger, anxiety, loss of capacity for caring, loss of sleep, excessive eating/ alcohol, defensiveness, lack of trust, avoidance of patient contact, physical and psychological problems	-	The workshop did diminish the participants moral distress
(35) 35	The professional ills of moral distress and nurse retention: Is ethics education an antidote? Lang (2008)	Quantitative	Literature review		Is ethics education an antidote?	Jameton	When not able to fulfil advocacy, protecting patient from harm, when not able to use moral judgment, not feeling qualified, poor communication	Poor physical care, physical and psychological problems, poor patient care, lack of trust, defensiveness, increased intra-professional conflict	-	The long-term benefit of providing ethics education as a worthwhile investment

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(36) 36	Moral distress reconsidered McCarthy and Deady (2008)	Quantitative	Literature review		To describe the evolution of the concept of moral distress	Jameton Wilkinson Nathaniel Aristotle	-	Emotional and physiological responses e.g. crying, loss of sleep, nightmares, loss of appetite, emotional exhaustion, feelings of abandonment, powerlessness	-	Reconsideration, possible reconstruction and multidisciplinary approach to understanding the experience of all health professionals
(37) 37	Determinants of moral distress in medical and surgical nurses at an adult acute tertiary care hospital Rice <i>et al.</i> (2008)	Quantitative	Clinical	Nurses	To determine the prevalence and contributing factors of moral distress in medical and surgical	Jameton	Futile care, inadequate pain control, staffing level, competence of staff, supervision, disregard patient wishes, communication	Powerlessness, burnout	-	Moral distress is common among nurses in acute medical and surgical units and can be elicited from different types of situations encountered
(38) 38	Nurses' moral sensitivity and hospital ethical climate: a Literature review Schluter <i>et al.</i> (2008)	Quantitative	Literature review		To report findings of a systematic review of the empirical literature on the effects of unresolved moral distress and poor	-	Unsuccessful advocacy, poor collaboration, poor communication, workload, staffing level	Headaches, guilt, anger, neck pain, muscle aches, stomach trouble, disgust, sadness, discouragement, powerlessness, frustration, anger, loss of self-worth,	-	Definitive answers remain elusive

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
					ethical climate and nurse turnover			diarrhoea, depression, withdrawal, productivity declined, turnover increased, poor self-esteem, feeling overwhelmed, leaving the profession		
(39) 39	When nursing practice moves beyond traditional boundaries: An evidence-based example using procedural sedation Davidson <i>et al.</i> (2007)	Qualitative	Clinical	Nurses	A case study to expand responsibilities for duties	-	Scope of practice	-	-	Expansion of responsibilities endorsed
(40) 40	Chinese nurses' ethical concerns in a neurological ward Fen Tang <i>et al.</i> (2007)	Qualitative	Clinical	Nurses	To describe Chinese nurses' experiences of workplace distress and ethical dilemmas on a neurological	-	Restricted resources, distrust of patients/families, high workload, lack of support from management, staff	Powerlessness, frustration, angry, feeling insecurity, anxiety, exhaustion, helplessness, loss of self-worth, loss of self-confidence	-	Lack of resources was perceived as an obstacle

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
					ward		shortages, lack of communication, respect, unsatisfactory interpersonal relationships, lack of time			
(41) 41	Nursing care of AIDS patients in Uganda Fournier <i>et al.</i> (2007)	Qualitative	Clinical	Nurses	To explore the experience and perspectives of Ugandan nurses caring for individuals with HIV illness	-	Challenges to caring: - The ward is congested - Patient has no money - The role of nurses is compromised - Fear of contagion	Coping with challenges: - It is haunting - There is no alternative - Improvising Burnout	-	Provides knowledge for guiding clinical practice and nursing education in resource-constrained countries like Uganda
(42) 42	Moral distress and providing care to dying babies in neonatal nursing Kain (2007)	Quantitative	Literature review		To discuss the links between moral distress and providing care to dying babies	Jameton	Have more responsibility than authority, meet expectations of authorities, lack of time, prolonged dying, understaffing, unsupportive administrators	Stress, burnout, decision to leave profession, anger, frustration, guilt, powerlessness, resentment, sorrow	-	A review of the literature indicates that moral distress and caring for dying babies in neonatal nursing is an under-researched field

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(43) 43	Distressing situations in the ICU: A descriptive study of nurses' responses McClendon and Buckner (2007)	Quantitative	Clinical	Nurses	To describe ICU nurses' levels of moral distress and the effect on their personal and professional lives	AACCN	High workload, family wishes, with-holding drug/ nutrition/ ventilation, competency of co-workers, management, physicians, end-of-life care, communication	Stress, burnout, job dissatisfaction, leaving the job	-	Efforts should be made to retain experienced nurses
(44) 44	The relationship between moral distress and perception of futile care in the critical care unit Mobley <i>et al.</i> (2007)	Quantitative	Clinical	Nurses	To study the relationship between moral distress and futile care in the critical care unit	-	End-of-life care, organ donations	Emotional exhaustion, burnout	-	Moral distress associate with clinical situations representing futile care increased with time in CCU
(45) 45	The experiences of paediatric nurses caring for children in a persistent vegetative state Montagnino and Ethier (2007)	Qualitative	Clinical	Nurses	To gain an understanding of the paediatric nurse's experience of caring for children in a persistent vegetative state	-	Pain, suffering	Feel uncertain, question care, frustration	-	The study suggests that caring for a child in a persistent vegetative state is difficult. They described the experience as emotionally stressful

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(46) 46	Moral distress: Recognizing it to retain nurses Pendry (2007)	Quantitative	Literature review		To recognize moral distress and retain nurses	Jameton	Role conflict, lack of autonomy, conflicting values, end-of-life care, hierarchal processes, communication	Powerlessness, emotional exhaustion, depersonalization, diminished person accomplishment, stress, leaving the job	-	Organizational commitment to addressing the issue of moral distress is needed
(47) 47	Ethical dilemmas and moral distress in oncology nursing practice Cohen and Erickson (2006)	Quantitative	Literature review		To describe ethical dilemmas in oncology practice and how to react to moral troubling situations	Jameton	Situations "that don't feel right", lack of support, fear punishment, powerless, advocacy, autonomy, conflict, lack of resources	Powerlessness, feelings of uncertainty, tension, frustration	-	Evidence suggests nurses may sacrifice own moral integrity to survive in current healthcare settings
(48) 48	Burnout in the caring nurse: learning resilient behaviours Edward and Hercelinsky (2006)	Quantitative	Literature review		Literature was reviewed to offer a discussion related to burnout	-	Inadequate resources	Job satisfaction, exhaustion, anger, cynicism, negativity, depression, feelings of helplessness	-	Nurses should be supported by using knowledge of resilient behaviour

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(49) 49	Nurse moral distress and ethical work environment Corley <i>et al.</i> (2005)	Quantitative	Clinical	Nurses	This study examined the relationship between moral distress intensity, moral distress frequency and the ethical work environment ...	Jameton	Lack of power, unsafe staffing, communication and collaboration	-	-	Results reveal a difference between moral distress intensity and frequency and the importance of the environment to moral distress intensity
(50) 50	Moral distress of staff nurses in a medical intensive care unit Elpern <i>et al.</i> (2005)	Quantitative	ICU	Nurses	To assess the level of moral distress of nurses in a medical intensive care unit, identify situations that result in high levels of moral distress, explore implications and evaluate associations	Jameton	Aggressive care, prolonging life, tests and treatment on terminally ill patients, unsafe staffing/ treatment, unnecessary tests and treatment	Anger, fear, anxiety, depression, traumatic stress disorder, personality changed, feelings of powerlessness, hopelessness, lack of support, loss of self-worth, effects on personal relationships, psychological effects, behavioural manifestations, physical symptoms	-	Experience of moral distress also influences attitudes

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(51) 51	Critical care nurses' perceptions of and responses to moral distress Gutierrez (2005)	Qualitative	Clinical	Nurses	To increase understanding of critical care nurses' experiences of moral distress	-	Aggressive medical treatment, inappropriate utilization of healthcare resources, lack of respect for patients' wishes by physicians, incomplete information given, conflicting goals between physician, family and nurse, lack of established relationships, time constraints, fear of physician backlash, inexperience/ unsupported medical staff, hierarchical power structure, teaching institution	Anger, sadness, physical withdrawal, reluctance to return to work, crying, frustration, grief, powerless	-	Critical care nurses experience suffering as a result of implementing actions incongruent with their moral judgement

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(52) 52	Caring about – caring for: moral obligations and work responsibilities in ICU nursing Cronqvist <i>et al.</i> (2004)	Qualitative	Clinical	Nurses	To analyse experiences of moral concerns in intensive care nursing	Jameton Wilkinson	Prolonging of life, suffering, nurse-physician relationship	Frustration, feelings of stress	-	There is a need to support nurses in difficult intensive care situation, for example by mentoring
(53) 53	Wanted – Nurses Ethical issues and the nursing shortage Erlen (2004)	Quantitative	Literature review		The author addresses the commitment to care for patients and the ethical dilemma with which nurses are grappling	-	Lack of regard for opinions/ decisions, policies and procedures	Fatigue, stress, burnout	-	Recommendations for possible action are included and have the potential to reduce moral distress
(54) 54	Moral distress: The state of the science Hanna (2004)	Quantitative	Literature review		To determine the scope and quality of knowledge in the topical area of moral distress before designing a qualitative study of moral distress	Jameton Wilkinson Hanna	Role morality, truth telling, conflict	Anguish, interior suffering	-	Screening tools will be needed to detect the presence or absence of moral distress

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(55) 55	Perils of proximity: a spatiotemporal analysis of moral distress and moral ambiguity Peter and Liaschenko (2004)	Quantitative	Literature review		To explore proximity using both a moral and geographical lens and offer some insights regarding this practice reality	Jameton	Autonomy, low staffing, incompetence, patient abuse, inadequate resources	-	-	Nurses should move closer to their patients
(56) 56	Critical care nurses' perceptions of futile care and its effect on burnout Meltzer and Huckabay (2004)	Quantitative	Clinical	Nurse	To determine the relationship between critical care nurses' perceptions of futile care and its effect on burnout	-	Difficult workload, conflict, inadequate staffing/ resources, emotional demands, dealing with the ethical aspects of life-sustaining technology, exposure to death and dying, end-of-life care	Burnout, suffering, frustration, decreased productivity, compromising patient care	-	The frequency of moral distress situations that are perceived as futile or non-beneficial to their patients has a significant relationship to the experience of emotional exhaustion

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(57) 57	Understanding and responding to patients' requests for assistance in dying Schwarz (2003)	Qualitative	Clinical	Nurses	To explore how nurses experience and respond to patients' for assistance in dying (AID)	-	-	Guilt, burnout, emotionally detached, distancing themselves from patients and colleagues	-	Most nurses struggled alone and in silence to find a morally and legally acceptable way to help patients who persisted in requesting AID
(58) 58	Why are nurses leaving nursing? Sumner and Townsend-Rocchiccioli (2003)	Quantitative	Literature review		Factors within nursing profession that may contribute to a nurse's unhappiness and dissatisfaction that causes them to leave	-	-	Burnout	-	Suggestions for retention are made
(59) 59	The role of teams in resolving moral distress in ICU decision-making Van Soeren and Miles (2003)	Quantitative	Clinical	Nurses	Through a case presentation processes are reviewed available to help resolve conflict and to improve the outcome	-	End-of-life care	-	-	Mechanisms through which teams can discuss differences and create clarity regarding treatment rationales will therefore improve team function

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(60) 60	Nurse moral distress: a proposed theory and research agenda Corley (2002)	Quantitative	Clinical	Nurses	To propose a theory of moral distress to improve understanding	Jameton Webster and Baylis	Low staffing levels, inadequately trained staff, ineffective pain control, conflict, prolonging of life, policy constraints, effects of cost containment, longer hospital stay, inappropriate care of patients, work overload	Reduced job satisfaction, burnout, high staff turnover, leaving the profession, frustration, anger, guilt, loss of self-worth, depression, nightmares, suffering, resentment, sorrow, anxiety, helplessness, powerlessness, compromised integrity, shame, embarrassment, grief, heartache, misery, pain, sadness, dread, sorrow, anguish, distraction	-	Theory is proposed.
(61) 61	Listening to nurses' moral voices: Building a quality health care environment Storch <i>et al.</i> (2002)	Qualitative	Clinical	Nurse	Explore the meaning of ethics for nurses providing direct care with clients	Jameton Webster and Baylis	Decision-making, conflict, being excluded from decision-making, organizational climate	Low morale, burnout	-	Nurses at staff ... are often the only ones who can speak up or speak out...

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(62) 62	Moral fatigue - a nursing perspective Taylor (2002)	Quantitative	Literature review		Explores dimensions of moral distress among nurses and presents moral fatigue ...	Corley Kelly	-	Fatigue, exhaustion	-	Solutions for moral distress require energy. Once institutions recognize the need to change, will they have the energy?
(63) 63	Moral distress: a pervasive problem Erlen (2001)	Quantitative	Clinical	Nurses	To describe ethical practice, moral distress, the imbalance of power and the nature of an ethical environment	Jameton	Autonomy is violated	Experience of physical, emotional and social problems, job dissatisfaction	-	There is a need that nurse administrators and other health professions should work together to maintain an ethical work environment
(64) 64	Caring for dying infants: experiences of neonatal intensive care nurses in Hong Kong Yam <i>et al.</i> (2001)	Qualitative	Clinical	Nurses	To explore the experiences of neonatal nurses in Hong Kong caring for dying infants	-	Perform invasive procedures following doctors' orders	Feeling ambivalent, disbelieving, helplessness, protecting emotional self, sadness, anger, frustration, resentful, minimize social interaction	-	Nurses found it difficult to accommodate the transition from curative care to palliative care

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(65) 65	Nurses; attitudes toward donation after cardiac death: Implications for nurses' roles and moral distress Antommara and Bratton (2008)	Quantitative	Literature review		To explore nurses' attitude after cardiac death	-	Organ donation/ transplantation	Burnout, staff turnover, feeling negative	-	Addressing the issue will require continued active involvement
(66) 66	Moral distress in peri-natal nursing Tiedje (2000)	Quantitative	Clinical	Nurses	To focus on the emerging concept of moral distress	Jameton	-	Psychological distress, burnout, leaving the profession	-	Research do not accurately describe moral distress
(67) 67	Nursing, morality and emotions: Phases i and ii clinical trials and patients with cancer Krishnasamy (1999)	Qualitative	Clinical	Nurses	To explore the moral agency of the nurses' work	-	Increased responsibility, lack of authority, work environment, lack of perceived moral behaviour	Insecurity, devalued, low self-worth, passivity, mistrust and misunderstanding, discourage to engage, exasperation, feel unsupported and undervalued, frustration, anger, personal conflict,	-	If nurses are to function effectively – the role emotions play in moral decision-making should be explored

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
								powerlessness, feel uncertain, erosion of personal integrity, betrayal of personal values, disillusionment, no place for relationships and caring, confusion, isolation		
(68) 68	Preserving moral integrity: a follow-up study with new graduate nurses Kelly (1998)	Qualitative	Clinical	Nurses	To describe, explain and interpret how new graduate nurses perceived their adaptation to the real world of nursing	-	Inadequate staffing, inexperience, high workload, lack of support, mistreatment/ disrespect of patients, lack of time, medication errors	Self-blame, lack of confidence, guilt, feeling of inadequacy, self-doubt, powerlessness, sadness, leaving the unit/ nursing, avoiding patients, anxiety, frustration, alienation from oneself	-	Moral distress was an acute form of psychological disorientation in which informants questioned their professional knowledge
(69) 69	Stress and distress in paediatric nurses: Lessons from Baby K Perkin <i>et al.</i>	Quantitative	Clinical	Nurse	To investigate the attitudes and perceptions of the nurses who were ordered by the court to provide long-	-	-	Feeling anger, guilt, regret, resentment, physical signs or symptoms, feelings of jeopardizing self/worth, psychological	-	Suffering among caregivers occurs and must be recognized, measures must be taken to reduce distress

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	(1997)				term care for Baby K, a child with anencephaly			discomfort, powerlessness, staff suffering, stress		
(70) 70	Caring for dying children: nurses' experiences Davies <i>et al.</i> (1996)	Qualitative	Clinical	Nurses	To construct substantive theory about nurses' experiences in caring for children who are dying after a prolonged illness	-	End-of-life care	Struggling, grief, avoidance, lack of energy, lack of confidence, fearful of strong emotions, harbouring regret, reluctance to become involved, withdrawal, emptiness, anger, frustration, sadness, powerlessness, sarcasm, crying, leaving nursing	-	The substantive theory has been generated through this study needs to be tested
(71) 71	Moral distress of critical care nurses Corley (1995)	Quantitative	ICU	Nurses	To present findings on moral distress of critical care nurses, using an investigator developed instrument	Jameton	Prolonging of life, following family's wishes, unnecessary treatment and tests, inadequate informed consent, give IV medicine when patient refuse oral	-	-	Mean scores showed somewhat low levels of moral distress, some nurses experience high levels of moral distress

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							medicine, giving hemodynamic stabilizing meds during Code Blue with no CPR, assisting physicians that were practicing, unsafely and inadequate staffing, nurse-physician conflict			
(72) 72	Artificial personhood: Nursing ethics in a medical world Liaschenko (1995)	Qualitative	Clinical	Nurse	To understand the lived ethical experience of two groups of nurses in home care in psychiatry	-	-	Guilt, rage, pain	-	The paper illustrates the harm to nurses as expressed in narratives of their practice

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(73) 73	Patient advocacy and whistle-blowing in nursing: help for the helpers Andersen (1990)	Quantitative	Literature review		To examine the phenomenon of whistle-blowing and its antecedent dynamics	Jameton	Institutional constraints	Feelings of anger, depression, isolation, alienation, loss of self-worth, weeping, palpitations, headaches, diarrhoea, guilt, sleep disturbances	-	We need to be sensitized to the fact that whistle-blowers in nursing are not enemies of the people
(74) 74	Moral distress in nursing practice: Experience and effect Wilkinson (1987)	Quantitative	Clinical	Nurses	To explore the phenomenon of moral distress as experienced by staff nurses working in hospitals	Jameton	Prolonging of life, performing unnecessary tests and treatments, situations involving lying to patients, incompetent/ inadequate treatment	Self-doubt, lack of courage, anger, frustration, guilt	-	Efforts should be made to support nurses who are being sanctioned in moral distress cases

EBSCO HOST

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/Outcome
(75) 1	Moral distress and the contemporary plight of health professionals Austin (2012)	Quantitative	Literature review		Moral distress and contemporary plight of health professionals is addressed	-	Patient pain and suffering, staff shortage	-	-	If moral distress in health professionals is like the proverbial canary in a coalmine, it seems to that there is an urgent need to consider the moral habitability of our practice environments
(76) 2	Tend and befriend in the ICU DeKeyser Ganz (2012)	Quantitative	Clinical	Nurses	To help nurses increase their ability to grow from stressful situations	Jameton	High workload, quick working pace, unsatisfying tasks, lack of clear work directives, poor communication, need for an extensive knowledge base, insecurity	-	-	We have a choice, we can use the stress to grow or leave

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(77) 3	Empirical research on moral distress: Issues, challenges and opportunities Hamric (2012)	Quantitative	Literature review		Research efforts to date are reviewed	Jameton	Perceived powerlessness, lack of knowledge of alternatives, inadequate staffing/ institutional support, incompetent caregivers, unnecessary/ futile treatment, aggressive treatment, inadequately informed consent, lack of truth-telling, false hope	-	-	Experiences of moral distress compromises providers; core values or duties, which are the fundamental ingredient of their moral integrity
(78) 4	Moral distress: A comparative analysis of theoretical understandings and inter-related concepts Lützen and Kvist (2012)	Quantitative	Literature review		To provide an overview and a comparative analysis of the theoretical understandings of moral distress and related concepts	Jameton	Lacking resources	Anxiety	-	An interdisciplinary approach in research and practice broadens our understanding of moral distress and its impact on health care personnel and patient care

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(79) 5	Doing the best I can do: moral distress in adolescent mental health nursing Musto and Schreiber (2012)	Qualitative	Clinical	Nurses	To explore the process used by mental health nurses working with adolescents to ameliorate the experience of moral distress	Jameton Wilkinson	Unsafe circumstances, feeling caught in conflicting values, distressing situations, lack of policy	-	-	An understanding of the process mental health nurses use as they experience moral distress
(80) 6	End-of-life care of the geriatric patient and nurses moral distress Piers <i>et al.</i> (2012)	Quantitative	Clinical	Nurses	To examine moral distress in geriatric nursing care and to identify factors related to moral distress	-	End-of-life care, incompetent colleagues, lack of financial and personnel resources	Pain, fear	-	Providing futile and inadequate care contributes to moral distress
(81) 7	An overview of ethics in maternal-child nursing Callister and Sudia-Robinson (2011)	Quantitative	Clinical	Nurses	To describe coping strategies for dealing with moral distress	-	Powerless	Powerlessness, fear	-	Strategies were described

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(82) 8	Work engagement, moral distress education level, and critical reflective practice in ICU nurses Lawrence (2011)	Quantitative	Clinical	Nurse	To examine how nurses' moral distress, education level, and critical reflective practice related to their work engagement	Wilkinson	Physicians not treating patient with patient's best interest at heart, high workload	Exhaustion, burnout	-	Strategies to promote CRP and reduce moral distress are recommended
(83) 9	Moral distress, compassion fatigue, and perceptions of medication errors in certified critical care nurses Maiden <i>et al.</i> (2011)	Mixed method	Clinical	Nurses	To examine the previously untested relationships between moral distress, compassion fatigue, perceptions about medication errors	Jameton	Levels of staff	Devastation, fear, leaving the profession	-	Results revealed statistically significant correlations between moral distress and compassion fatigue

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(84) 10	Influence of moral distress on the professional practice environment during prognostic conflict in critical care McAndrew <i>et al.</i> (2011)	Quantitative	Clinical	Nurses	To describe critical care nurses; levels of moral distress and the effects of that distress on their professional practice environment	-	Unsupportive colleagues/ managers, insufficient staff, high workload	Staff turnover	-	-
(85) 11	Using the AACN framework to alleviate moral distress McCue (2011)	Quantitative	Clinical	Nurse	To describe a situation in which the nurse executive's values were in direct opposition to those of the chief executive officer	Jameton	-	Sleep difficulties, self-doubt	-	Attention to moral distress is vital to ensure the provision of quality patient outcomes in the existing healthcare environment
(86) 12	Moral distress among health system managers: exploratory research in two British Columbia	Qualitative	Clinical	Nurses	To determine if the concept of moral distress, previously developed and utilized in the analysis of	-	Shortage of resources	-	-	Moral distress is experience in both mid and senior level managers

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	health authorities Mitton <i>et al.</i> (2011)				clinical situations, could be applied					
(87) 13	Moral distress and ethical climate in a Swedish nursing context: perceptions and instrument usability Silén <i>et al.</i> (2011)	Quantitative	Clinical	Nurses	To describe Swedish nurses' perceptions of moral distress and determine whether there were differences in perceptions ...	Jameton	Lack of time/ personnel, inconsistent use of life-sustaining actions, lack of resources, lack of competent personnel, unnecessary tests	Powerlessness, leaving the profession, burnout, frustration, anger	-	A positive ethical climate was associate with less occurrences of moral distress
(88) 14	What factors affect nursing retention in the acute care setting Walton (2011)	Quantitative	Literature review		To address the of moral distress in nursing and the correlation between professional stress and moral distress	-	Nursing shortage, lack of social support	Leaving the hospital/ profession	-	There is a complex relationship between professional stress and moral distress

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(89) 15	What factors affect nursing retention in the acute care setting Walton (2011)	Quantitative	Literature review		To address the of moral distress in nursing and the correlation between professional stress and moral distress	-	Nursing shortage, lack of social support	Leaving the hospital/ profession	-	There is a complex relationship between professional stress and moral distress
(90) 16	Moral courage and the nurse leader Edmonson (2010)	Quantitative	Literature review		To review sources of moral distress among nurse leaders	Jameton	Performance expectations, finite resources, technology advancement	Frustration, anxiety, anger, regret	-	The act of transforming nursing, organizations, and healthcare systems, requires nothing short of moral courage
(91) 17	Understanding and addressing moral distress Epstein and Delgado (2010)	Quantitative	Literature review		To consider both moral distress and moral residue, a consequence of unresolved moral distress	Jameton	Continue life support, inadequate communication, end-of-life care, inappropriate use of resources, inadequate staff/ resources, inadequate pain relief, false hope, fear of losing job, power imbalance, lack of administrative support	Self-doubt, frustration, anger, isolation, numbness, burnout	-	Ways are considered to address moral distress

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(92) 18	Moral courage amid moral distress: strategies for action Iseminger (2010)	Quantitative	Literature review		The article address moral distresses and moral courage from a broad perspective	Jameton	Futile care, communication, inadequate staffing, inadequate pain relief, false hope	-	-	Strategies are proposed
(93) 19	Working in an overcrowded accident and emergency department: nurses' narratives Kilcoyne and Dowling (2010)	Qualitative	Clinical	Nurses	To highlight nursing issues associated with overcrowding in the emergency department	-	-	Elusive care, powerlessness, frustration, anxiety, stress, fear, poor sense of safety and security	-	A distressing picture of nursing in an emergency department has been painted
(94) 20	A moral framework for caring in nursing: Neo-Stoic Eudaemonism Sumner (2010)	Quantitative	Literature review		To put forward an argument in favour of including the theory of Neo-Stoic Eudaemonism as one of the ethical theories to be utilized by nurses	-	High-technology, lack of control and autonomy, conflict, aggressive treatment	Disillusionment, exhaustion, powerlessness, guilt, depression, professional inadequacy, erosion of personal integrity	-	This theory offers universality that is a-contextual

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(95) 21	Chronic moral distress among childbirth educators: is there a cure? Curl (2009)	Quantitative	Literature review		To explore the concept of moral distress, and make suggestions	-	Unsupportive environment	Diminished effectiveness	-	Suggestions are made
(96) 22	Clinical errors, nursing shortage and moral distress: The situation in Jordan Mrayyan and Hamaideh (2009)	Quantitative	Clinical	Nurses	To assess Jordanian registered nurses' perceptions of clinical errors they had committed over the past year	-	Shortage of nurses	-	-	As a result of nursing shortage, untoward clinical incidents frequent themselves and lead to moral distress
(97) 23	Registered nurses' perceptions of moral distress and ethical climate Pauly <i>et al.</i> (2009)	Quantitative	Clinical	Nurses	Review research	Jameton	Poor ethical climate, staff shortage, physician incompetency	-	-	Insights are highlighted for practice and future research that are needed to enhance the development of strategies
(98) 24	How professional nurses working in hospital environments experience	Quantitative	Clinical	Nurses	To explore the best available evidence regarding professional nurses	-	Undermining integrity and authenticity, powerlessness concerning patient's	Feel disempowered, feel unable to fulfil their professional duties,	-	Nurses should be given the opportunity to practise their profession in a way that does not violate

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	moral distress: a systematic review Rittenmeyer and Huffman (2009)				working in hospital environments		treatment, high workload, lack of authority/ time/ resources, high levels of responsibility	powerlessness, burnout, leave the institution/ profession		their core values
(99) 25	Moral distress in healthcare practice: the situation of nurses <i>Austin et al.</i> (2008)	Quantitative	Literature review		To explore phenomenon on moral distress	Jameton Nathaniel	Situational, cognitive, active and emotional dimensions, power imbalance	Frustration, anger, anxiety, guilt, physical reactions, sweating, shaking, headaches, diarrhoea, crying, decreased coping, lead to decreased self-esteem, wholeness, loss of good patient care/ nurse integrity, burnout, leave the profession, lack of courage, self-doubt, physical/ emotional/ spiritual symptoms	-	Broader understanding on moral distress
(100)	Addressing psychological	Quantitative	Literature review		To overview four major	-	Role strain, advocate,	Powerlessness	-	The opportunity should be given to

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26	reactions related to critical care nursing Badger (2008)				psychological reactions critical care nurse interns will likely experience		conflict, organ donation/transplants, communication, workload, compassion fatigue			reflect on their work
(101) 27	A potential neonatal nursing response to care orders that cause suffering at the end-of-life Catlin <i>et al.</i> (2008)	Quantitative	Clinical	Nurses	To explore, solicit and provoke dialogue. This reports the analysis of conscientious use in neonatal care	Jameton	End-of-life care	Pain, powerlessness	-	Empowering nurses to advocate as we were meant to do will decrease moral distress and aid in keeping nurses in the workforce
(102) 28	Moral distress: an emerging problem for nurses in long-term care Pijl-Zieber <i>et al.</i> (2008)	Quantitative	Literature review		To review the literature pertaining to the concept of moral distress, explores the causes and effects of moral distress	Jameton	Lack of resources, unsafe staffing levels, high workload, lack of support, lack of collaboration	Staff turnover, negative feelings, anger, resentment, anguish, despair, anxiety, loss of self-worth, crying, powerlessness, decreased capacity for caring, burnout, leaving the profession	-	Administration needs to support staff through creating an environment that fosters ethical practice

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(103) 29	Exploring the moral distress of registered nurses Zuzelo (2007)	Quantitative	Clinical	Nurses	To describe RN's moral distress and the frequency of morally distressing events	Jameton	Hierarchical structure, conflict, lack of pain management, ignoring patient wishes, inadequate staffing, treating patients as experiments	Frustration	-	RN's sought support and information from nurse managers
(104) 30	Understanding the moral distress of nurses witnessing medically futile care Ferrell (2006)	Mixed method	Clinical	Nurses	To explore the topic of moral distress in nurses related to witnessing futile care	-	Aggressive treatment, end-of-life care, prolonging life	-	-	Instances of futile care evoke strong emotional responses from nurses, and nurses require support in dealing with their distress

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(105) 31	Unable to answer the call of our patients: mental health nurses' experience of moral distress <i>Austin et al.</i> (2003)	Quantitative	Clinical	Nurses	To describe and discuss the moral distress experienced by nurses working in mental health settings	Jameton	Situations of exploitation, exclusion, absence of respect, high work load	Fear of losing their jobs, self-doubt, lack of courage, loss of self-worth, depression, physical symptoms, heart palpitations, diarrhoea, headache, left the profession, anger, frustration, powerlessness, anguish, nightmare, grief, heartache, miserable, painful, ineffective, sad	-	The experience of moral distress shared by research participants seems situated within the expectations and responsibilities society deposits with health practitioners
(106) 32	Development of a model of moral distress in military nursing <i>Fry et al.</i> (2002)	Quantitative	Clinical	Nurses	To describe the development of a model of moral distress in military nursing	Jameton Wilkinson	-	Anger, frustration, guilt, anxiety, powerlessness, ineffectiveness, burnout, emotional exhaustion, depersonalization, discomfort, hurt	-	Models of both the process of military nursing moral distress and the phenomenon itself are proposed

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(107) 33	Moral distress, advocacy and burnout: Theorising the relationships Sundin-Huard and Fahy (1999)	Quantitative	Literature review		To report on part of an interpretive interactionist study concerning nurses' experiences of moral distress	-	Inadequate staffing, level of expertise, life-threatening illness, communication, pressure of time, power differentials	Anger, sadness, disgust, powerlessness, hopelessness, frustration, burnout	-	Burnout has been identified as a major source for the nursing shortage

SCIENCE DIRECT

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(108) 1	Ethical problems experienced by psychiatric nurses in Korea Choe <i>et al.</i> (2012)	Mixed method	Clinical	Psychiatric nurses	Explore psychiatric nurses' ethical problem from their perspectives	-	To unconditionally accept decisions made by patients' family/ doctors Applying compulsory restrictions to those who refuse treatment	Powerlessness, frustration, guilt, agony	-	Unresolved moral conflict leads to moral distress
(109) 2	Determinants of moral distress in daily nursing practice: A cross sectional correlational questionnaire survey De Veer <i>et al.</i> (2013)	Quantitative	Nursing homes	Nurses	To identify individual and job characteristic-ally associated with moral distress in nursing staff	Jameton	Situations in complying with family wishes (when nurse disagrees) Complying with physician (when nurse disagrees) Unsafe staffing levels Leadership behaviour	Powerlessness, subordination, inefficiency, passivity, blunted moral sensitivity Moral distress is associated with job satisfaction and staff turnover	-	The way a team is supports, can raise or decrease moral distress levels Interventions should target organisational issues

EMERALD

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/Outcome
(110) 1	Moral Distress, Moral Residue and the crescendo effect Epstein and Hamric (2009)	Mixed Method	Literature review		To propose preliminary model and describe interrelationship between moral distress & moral residue	Jameton	Violation of core values and duties. Feeling constrained Lack of resources	Frustration, anger, guilt, anxiety, withdrawal, self-blame Powerlessness Dysfunctional communication patterns	-	Model of the crescendo effect
(111) 2	Moral distress in the paediatric intensive care unit: the impact on paediatric nurses Mekechuk (2006)	Case study	PICU	Nurses	To explore the concept of moral distress – paediatric ICU nurse	Jameton Kelly Tiedje	Prolonging life Lack of agreement on treatment	Failure to make eye contact Communication is shut down Emotional exhaustion Burnout Giving up Not caring	-	Moral distress may jeopardize ability to deliver effective care

GOOGLE SCHOLAR

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/Outcome
(112) 1	Influencers of ethical beliefs and the impact on moral distress and conscientious objection Davis <i>et al.</i> (2012)	Quantitative	Clinical	Nurses	To explore influencers – impact on development of ethical beliefs and levels of moral distress	Jameton	Providing care that is not ethically condoned	Leaving profession	-	Ethical beliefs might impact moral distress
(113) 2	Moral Distress Part ii: Critical review of measurement Lerkiatbundit and Borry (2009)	Quantitative	Literature review		To review psychometric properties of various measures of moral distress and to suggest how to improve them	Nathaniel	-	Negative effect on psychological and physical health, quality of care, moral integrity, burnout, job satisfaction and turnover	-	Development of new scales or improvement of existing ones by theory-driven study is urgently needed.

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(114) 3	Developing the moral distress scale in the population of Iranian nurses <i>Khoiee et al.</i> (2008)	Mixed method	Clinical	Nurses	To develop moral distress questionnaire and validate it in a sample of Iranian registered nurses	Jameton	Hierarchy, power imbalance, rules and regulations, instructions and support systems, follow orders without any questions, powerlessness	Stress, restlessness, confusion, crying, leaving the job, introjecting the stress and transferring it home, aggression, psychological pressure, tolerating the pressure, depression, getting nervous in interactions with colleagues, acting contrary to head nurse's orders, not motivating others to enter nursing colleges, losing working motivation, feeling distressed	-	Design and conduction of some interventions to help nurses cope with moral distress caused by their occupation seems necessary
(115) 4	Debriefing after a crisis <i>Hanna and Romana</i> (2007)	Qualitative	Clinical	Nurses	Best way to resolve moral distress	-	End-of-life care Death of co-workers	Sadness, fear, survivor guilt	-	Debriefing helps staff members to identify personal impact of trauma and loss

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/Outcome
(116) 5	Defining and addressing moral distress: Tools for critical care nursing leaders Rushton (2006)	Quantitative	ICU	Nurses	Tools for moral distress	Jameton	Irreconcilable conflict between one's ethical commitment and the action required for congruence between or among them	-	-	Implementation of four A's
(117) 6	Ethical dilemma and moral distress: Proposed new NANDA diagnoses Kopala and Burkhart (2005)	Mixed Method	Clinical	Nurses	To identify and assist decision-makers who are experiencing the associated ethical or moral conflicts	Jameton Proposed definition: Inability to carry out one's chosen ethical/ moral decision/ action	Discontinue treatment End-of-life care	Guilt, anger, frustration	-	Literature supports ethical dilemmas and moral distress
(118) 7	Moral stress and burnout: Qualitative content analysis Severinsson (2003)	Qualitative	Clinical	Nurses	To describe and interpret narratives of nurses	-	High demands, high workload, low level of control, feelings of powerlessness, long working hours, lack of	Resulted in experiences of shortcomings and work-related stress, led to high blood pressure Not able to fulfil moral	-	Nurses' needs have to be recognized. They need emotional support and systematic clinical supervision

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/Outcome
							support, difficulties with management, lack of resources	obligations Loneliness, depression, helplessness, Low self- confidence, guilt Distance self from others Lack of communication Depression		

CONCEPT ANALYSIS

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(119) 1	Moral distress in neuroscience nursing: An evolutionary concept analysis Russell (2012)	Quantitative	Literature review		To conduct a concept analysis	Jameton Wilkinson Webster and Baylis	Competing values Medical futility Dehumanizing Pain/suffering Powerlessness Institutional factors Autonomy	Physical well-being, self-image, spirituality, personal relationships, job satisfaction Physical symptoms (heart palpitations, diarrhoea, headaches, fatigue, insomnia) Loss of self-worth Changes in religious behaviour Changes in personality Loss of focus, reduced patience Burnout Absenteeism, high staff turnover, low workplace morale	Negative feelings Powerlessness Conflicting loyalties Uncertainty <i>Secondary attributes</i> Ineffective advocacy Inability to reduce pain/suffering Patient dehumanization Competing values	The analysis demonstrates the fluidity, complexity, and multifacetedness of moral distress

No.	Study	Type of Study	Setting	Participants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
(120) 2	The lived experience of moral distress: Nurses who assisted with elective abortions Hanna (2002)	Mixed method	Clinical	Nurses	To discover the essence, properties and full content domain of the concept of moral distress	Jameton	<i>Before fieldwork</i> Value/ belief Ability to recognize objective intrinsic/ possible evil Value/ belief commitment is superseded/ replaced Immediacy of situation does not permit escape <i>After fieldwork</i> Value/ belief commitment Ability to recognize goodness/ badness Value/ belief commitments are superseded	Physiological, psychological and sociological signs of anguish, emotional pain and suffering: crying, tense, shaking, trembling, nausea, altered appetite, gastrointestinal distress, decreased sleep quality, nightmares, difficulty falling asleep, waking up early, depression, increased use of alcohol/ substances, fatigue, decreased self-esteem, self-worth, self-consistency, altered self-ideal, increased violence, increased anger Sense of personal loss, disengagement	<i>Before fieldwork</i> Anguish/ suffering Transgression/ impingement on one's personal beliefs/ values Sense of silenced isolation/ disconnection from larger community <i>After fieldwork</i> Anguish/ suffering Transgression/ violation of or impingement on one's personal beliefs/	The definition has been composed in universal terms, but remains tentative, since the full content domain of moral distress was largely but not definitively identified

No.	Study	Type of Study	Setting	Partici- pants	Objective	Definition(s)	Antecedent	Consequence	Attribute	Main Findings/ Outcome
							Immediacy of the situation does not permit escape	from loved ones and co-workers	values Sense of silenced isolation/ disconnec- tion from intimate others	

3.2.1.5 Phase Five: Data analysis (Process protocol)

Phase 5 of the integrative literature review includes the analysis of data. After data collection, the data was analysed by making use of descriptive synthesis. Descriptive synthesis involves a summary of the characteristics and the findings of each body of research in a concise and coherent manner (Evans, 2007:141). Discussion will follow.

Antecedents follow. The following table (Table 3.3) gives a summary of the antecedents that was identified during the integrative literature review. The antecedents were taken from the studies that met the inclusion criteria and put together, in order to identify themes and sub-themes (follows in Table 3.5). Discussion follows.

Table 3.3 List of antecedents of moral distress

Antecedents	
• Lack of power in making decisions (repeat) • Lack of resources (repeat) • High levels of responsibility (repeat) • Compassion fatigue (diminished capacity) (repeat) • Limited/ lack of finances (repeat) • Inadequate pain control (repeat) • Hierarchical (unfair) power structure (repeat) • Poor interpersonal relationships (repeat) • Fear for repercussions • Disregard patient wishes (nurses, physicians, patients family) • Devaluing behaviour (physicians towards nurses, and nurses towards each other) • High workload (repeat) • Staff shortages (repeat)	• Violating regulations (nurses and physicians) • Forced to accept disrespect • Mismanagement by superiors • Poor patient care (repeat) • Demeaning remarks (towards patient) • Lack of support from management (repeat) • Patient pain and suffering (repeat) • Loss of dignity (of patient) • Lack of autonomy – nurse (repeat) • Institutional barriers and constraints (repeat) • Futile actions (repeat) • Medical care errors (repeat) • Inappropriate allocation of responsibilities • Inappropriate allocation/ utilization of resources (repeat)

Antecedents	
• Unsafe staffing (repeat) • Managerial shortcomings • Physician autonomy (high) • Poor/ lack of communication (repeat) • Inadequate pay (distressing for some nurses) • Incompetent staff (nurses, physicians, management) (repeat) • Inadequate training of staff (repeat) • Fear of making mistakes/reprimand • Inappropriate behaviour (nurses and physicians) • Violence towards nurse • Violence towards patients (repeat) • With-holding truth from patient (repeat) • Incomplete informed consent/ information given (to patient) (repeat) • Fear for reporting of medical errors • Discrimination (of patient) • Lack of patient autonomy • Failure to follow standard care (nurses) • Fraud	• Moral compromise • Negative judgements (of patient) • End-of-life care (repeat) • Organ donation (repeat) • Prolonged dying (repeat) • Undignified dying • Prolonging of life (repeat) • Non-beneficial treatment (repeat) • Aggressive care (repeat) • Unsafe treatment • Tests on and treatment of terminally ill patients • Delayed treatment • Prolonged hospitalization (repeat) • Inability to be with own family (due to e.g. long hours) • False hope given to patient (repeat) • Advocacy – not able to advocate (repeat) • Modern technology (some nurses find it distressing) (repeat) • Incapable of addressing the prognosis

Antecedents	
• Unethical organization practices • Judgemental stereotyping (nurses and physicians) • Conflict (between nurses and physicians) (repeat) • Failure to follow scope of practice (nurse) (repeat) • Poor working conditions (repeat) • Closeness to anguish of patient • Burden of responsibility (repeat) • Performing non-nursing tasks/ doing jobs of others • Negotiating patient care (with physician, family, colleagues) • Lack of labour union strength • Parents refusing treatment • Formal decision-making structures • Lack of respect (disrespect) (repeat) • Lack of trust (distrust) (repeat) • Protecting patient from harm (from staff and physician) (repeat) • When not able to use moral judgment • Not feeling qualified • Have more responsibility than authority	• Ethically challenging situations (e.g. abortions) • Decision making concerning patient (some nurses find it distressing) (repeat) • Power imbalances (between nurses and physicians) (repeat) • Institutional policy or legal limits (that limits nurses' conduct) • Policies and priorities that conflict with care needs • Compromised care due to reduced costs (repeat) • Lack of engagement in decision-making (nurses not included when physician makes decisions) (repeat) • Lack of debate on ethical issues • Thinking ahead to avoid mistakes (some nurses find it distressing) • Patient's rights not acknowledged • Confrontational dialogue (between colleagues and physicians) • Implicit deception (of patient) • Negative attitude of personnel • Congested ward • Patient has no money (nurses find it distressing – cannot help patient) • Role of nurses is compromised (through institutional barriers)

Antecedents	
• Lack of time (repeat) • Follow family wishes (when conflicting patient's wishes) • With-holding drug/ nutrition/ ventilation • Lack of collaboration (between physicians and nurses) (repeat) • Conflicting goals between physician, family and nurse • Fear of physician backlash • Inexperience (physicians and nurses) • Mistreatment/ disrespect of patients • Give IV medication when patient refuses oral medication • Giving hemodynamic stabilizing medication during Code Blue with no CPR • Assisting physicians that were practising • Quick working pace • Unsatisfying tasks (for nurses) • Need for an extensive knowledge base (inadequate knowledge is found to be distressing for some) • Insecurity (of nurses) • Performance expectations (from management) • Role strain (nurse)	• Fear of contagion of diseases (repeat) • Role conflict (nurse) • Conflicting values (nurse) (repeat) • Lack of regard for opinions/ decisions • Lack of/ constraints of Policies and Procedures (repeat) • Role morality (nurse) • Patient abuse (through staff) • Emotional demands (nurse) • Dealing with the ethical aspects of life-sustaining technology • Perform invasive procedures following doctors' orders • Lack of authority (nurse) (repeat) • Lack of perceived moral behaviour (nurse) • Incompetent/ inadequate treatment • Lack of knowledge of alternatives • Physicians not treating patient with patients best interest at heart • Unsupportive colleagues • Inconsistent use of life-sustaining actions • Fear of losing job

Antecedents	
• Situations of exploitation (of nurse) • To unconditionally accept decisions made by patients' family/ doctors (repeat) • Applying compulsory restrictions who refuse treatment • Leadership behaviour (poor) • Death of co-workers • Irreconcilable conflict between one's ethical commitment and the action required for congruence between or among them	• Poor ethical climate • Undermining integrity and authenticity (of nurses) • Treating patients as experiments (physicians) • Level of expertise (of nurses and physicians) • Feel constrained (feel cannot do what should be done) (nurses) • Providing care that is not ethically condoned • Follow orders without any questions • Discontinue treatment (when nurse doesn't agree) • Dehumanizing (of patients) • Long working hours • Immediacy of (distressing) situation does not permit escape • Difficulties with management • Ability to recognize objective intrinsic/ possible evil Value/ belief commitment is superseded/ replaced

The researcher then further clustered the antecedents, as identified in Table 3.3, into groups in order to identify the essence of the antecedents of moral distress. The researcher identified the themes and sub-themes through a deductive reasoning process (as described in Chapter Two, Section 2.5.2.1). The reduction process is outlined in Table 3.4.

Table 3.4 The reduction process proceeded from listed antecedents towards clusters grouped together

Antecedents - Grouping			
Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Violence towards nurses Forced to accept disrespect Devaluing behaviour Judgemental stereotyping	Hostility in the work environment		
Lack of collegial relationships Poor interpersonal relationships Lack of established relationships Behaviour of colleagues Lack of respect Lack of trust Lack of collaboration Unsupportive colleagues	Poor workplace relationships	Poor workplace relationships	Practice environment

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Undermining integrity and authenticity Performance expectations from management Poor nurse-physician relationships High physician autonomy Lack of communication Negative attitude of staff Lack of regard for opinions and discussions of nurses			
Conflict Professional conflict Nurse-physician conflict Confrontational dialogue	Conflict in the work environment	Poor workplace relationships	
Fear of physician backlash Fear for repercussions Fear of making mistakes Fear of being reprimanded Fear of losing job Fear of contagion of disease Fear of reporting medical errors	Working in fear	Working in fear	
			Practice environment

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Unfair hierarchical power structure Managerial shortcomings Poor leadership behaviour Fraud Mismanagement by superiors Lack of support by management Poor formal decision-making structure Lack of union strength	Poor leadership	Poor leadership	
Lack of resources Limited/ lack of finances Compromised care due to reduced costs Inappropriate allocation of resources Institutional barriers and constraints Poor working conditions Inadequate pay Unsafe staffing Staff shortages Situations of exploitation (nurses)	Lack of resources	Lack of resources	Practice environment

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Patient has no money			Practice environment
Institutional policy	Inadequate policies	Inadequate Policies	
Violation of regulations			
Policies and priorities that conflict with care needs			
Lack of/ constraints of policies and procedures			
Institutional / policy/ legal limits			
High workload	High Workload	High Workload	Practice environment
Fast working pace			
Lack of time			
Long working hours			
Failure to follow scope of practice			
Inappropriate allocation of responsibilities			
Doing non-nursing tasks			
Unsatisfying tasks			
Congested ward			

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Inadequate provision of care by nurses Medical care errors Failure to follow standard care Level of expertise Inexperience Poor patient care Provide care that is not ethically condoned Physician not treating patient with best interest at heart Negotiating patient care Incompetent/ inadequate treatment Inadequate pain control Delayed treatment	Poor quality of patient care	Poor quality of care	Patient care
Patient discrimination Demeaning remarks toward patient Negative judgement of patient Mistreatment of patient Disrespect toward patient Dehumanizing of patient	Hostility towards patient	Hostility towards patient	Patient care

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Loss of dignity Undignified dying Patient abuse Violence towards patient			
Lack of patient autonomy Ignore patients' wishes Follow family's wishes Parents refuse treatment Give intravenous medication when patient refuses oral medication	Lack of patient autonomy	Lack of patient autonomy	Patient care
Implicit deception False hope With-holding truth Incomplete informed consent/ info given Patients' rights not acknowledged	With-holding truth	With-holding truth	Patient care
Futile actions Aggressive care Non-beneficial treatment Tests and treatment of terminally ill patient	Futile care	Futile care	Patient care

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Assist physicians that practise on patients Applying compulsory restrictions With-holding drugs/ nutrition/ ventilation Discontinue treatment (when not agreeing) Unsafe treatment Perform invasive procedure following doctors' orders Follow orders without questions Give intravenous medication when patient refuse oral medication Giving hemodynamic stabilizing medication Prolonged hospitalization Prolonging of life Treating patient as experiment Inconsistent use of life-sustaining technology/ actions Organ donation	Ethically conflicting treatment	Ethically conflicting treatment	Patient care

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
End-of-life care Prolonged dying	Death	Death	Patient care
Observing patient pain and suffering Protecting patient from harm Ability to recognize objective intrinsic/ possible evil Incapable of addressing prognoses Closeness to anguish Emotional demands Death of co-workers Compassion fatigue Inability to be with own family	Emotional demands	Emotional demands	Person
High levels of responsibility Burden of responsibility Immediacy of situations does not permit escape (remains a responsibility)	Burden of Responsibility	Burden of Responsibility	
Role conflict Role of nurse is compromised Role strain	Role conflict	Role conflict	

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Conflicting values Value/ belief commitment is superseded/ replaced Moral compromise Role morality Not able to use moral judgement Lack of moral behaviour Irreconcilable conflict between one's ethical commitment and the action required Lack of debate on ethical issues Ethically challenging situations Dealing with ethical aspects of life sustaining technology Conflicting goals Modern technology Unethical organizational practices	Conflicting ethics, morals and values	Moral conflict	
Lack of power in decision-making Lack of engagement in decision-making Lack of authority Power imbalance Lack of nurse autonomy	Lack of authority	Lack of authority	Person

Antecedents – Grouping	Reduction 1	Sub-themes	Themes
Unable to advocate Having more responsibility than power To unconditionally accept decisions Feel constrained			
Incompetent staff Inadequate training of staff Insecurity Not feeling qualified Lack of knowledge of alternatives Need for extensive knowledge Decision-making Thinking ahead to avoid mistakes	Need for knowledge Need for knowledge	Need for knowledge Need for knowledge	Person

Through a process of deductive reasoning the following themes and sub-themes were identified from the antecedents. The following table (Table 3.5) summarises the identified themes and sub-themes. Discussion on the themes and sub-themes follow.

Table 3.5 Antecedents: Summary of themes and sub-themes

<u>Antecedents</u>
<u>Theme 1: Practice environment</u> <u>Sub-theme 1.1: Poor workplace relationships</u> Hostility in the work environment Poor workplace relationships Conflict in the work environment <u>Sub-theme 1.2: Working in fear</u> <u>Sub-theme 1.3: Poor leadership</u> <u>Sub-theme 1.4: Lack of resources</u> <u>Sub-theme 1.5: Inadequate policies</u> <u>Sub-theme 1.6: High workload</u>
<u>Theme 2: Patient care</u> <u>Sub-theme 2.1: Poor quality of care</u> <u>Sub-theme 2.2: Hostility towards patient</u> <u>Sub-theme 2.3: Lack of patient autonomy</u> <u>Sub-theme 2.4: With-holding truth</u> <u>Sub-theme 2.5: Futile care</u> <u>Sub-theme 2.6: Ethically conflicting treatment</u> <u>Sub-theme 2.6: Death</u>

Theme 3: PersonSub-theme 3.1: Emotional demandsSub-theme 3.2: Burden of responsibilitySub-theme 3.3: Role conflictSub-theme 3.4: Moral conflictSub-theme 3.5: Lack of authoritySub-theme 3.6: Need for knowledge**3.2.1.6 Antecedents of moral distress**

From the findings (in Table 3.5), the main themes were identified. The themes that were identified were:

- Practice environment
- Patient care
- Person

Practice environment refers to factors from the environment, e.g. hostility in the work environment, poor workplace relationships and lack of resources. Patient care refers to aspects such as poor quality of care, with-holding truth and futile care. Person refers to the nurse and his/ her emotional demands, responsibility and role conflict.

A short discussion follows on the themes identified from the antecedents (see Table 3.5 for a summary of the themes and sub-themes identified from the antecedents). Each sub-theme is a heading, and examples of the sub-themes are given.

3.2.1.6.1 Antecedents: Theme 1: Practice environment category

The practice environment is the environment in which the nurse is working. All antecedents associated with the workplace were categorized and the following sub-themes emerged, namely:

- *Hostility in the work environment*

Hostility in the work environment includes aspects regarding violence and disrespect towards nurses.

- *Poor workplace relationships*

A lack of collegial relationships, lack of trust and collaboration and unsupportive colleagues, were grouped under poor workplace relationships.

- *Conflict in the work environment*

Conflict includes professional conflict, nurse-physician conflict and confrontational dialogue in the work environment.

- *Working in fear*

In the work environment, nurses are working in fear for repercussions, making mistakes, being reprimanded, physician backlash and contagion of diseases.

- *Poor leadership*

Poor leadership includes managerial shortcomings, poor leadership behaviour, lack of support by management and mismanagement by superiors.

- *Lack of resources*

Lack of resources includes human resources (unsafe staffing), lack of finances and compromised care due to reduced costs.

- *Inadequate policies*

Policies and priorities that conflict with care needs, lack of guidance from policies and procedures and violation of regulations are included.

- *High workload*

Included here are the high workload, fast working pace, lack of time and long working hours that nurses have to cope with.

3.2.1.6.2 Antecedents: Theme 2: Patient care

Patient care includes all aspects of the patient that the nurse is working with. All antecedents associated with patient care were categorized and the following sub-themes emerged:

- *Poor quality of care*

This includes inadequate provision of care by nurses, as well as their failure to follow standard care.

- *Hostility towards patient*

Aspects such as patient discrimination, demeaning remarks towards the patient, mistreatment and disrespect of the patient are included.

- *Lack of patient autonomy*

Lack of patient autonomy includes ignoring or disregarding the patient's wishes and the family's wishes are followed.

- *With-holding truth*

Giving patients false hope, withholding truth and incomplete informed consent given, are included in this sub-theme.

- *Futile care*

Futile care includes aggressive care, tests and treatment of terminally ill patients, as well as non-beneficial treatment.

- *Ethically conflicting treatment*

Organ donations, treating patients as experiments, unsafe treatment and discontinuation of treatment when the nurse doesn't agree, are included.

- *Death*

End-of-life care, death of a patient and prolonged dying are included in the sub-theme of death.

3.2.1.6.3 Antecedents: Theme 3: Person

Person includes aspects that affect the nurse directly. All antecedents associated with the person were categorized and the following sub-themes emerged, namely:

- *Emotional demands*

Emotional demands include the nurse's observation of patients' pain and suffering where the nurse is close to anguish and their inability to be with their own family due to the long working hours.

- *Burden of responsibility*

Burden responsibility refers to the high levels of responsibility that nurses have to cope with and the burden that comes with that responsibility.

- *Role conflict*

Role conflict, role strain and the role of the nurse that is compromised are included in this sub-theme.

- *Moral conflict*

Included are the lack of moral behaviour, value and belief commitments that are superseded and the inability of nurses to use their moral judgement.

- *Lack of authority*

Nurses have most of the responsibility but not the power to go with it. They lack authority, autonomy and are unable to put their patients' case.

- *Need for knowledge*

This includes nurses' lack of experience and their need for knowledge for decision-making and the ability to think ahead in order to avoid catastrophes, are included in this sub-theme.

3.2.1.6.4 Concluding statement: Antecedents

Three themes were identified from the antecedents, namely: Practice environment, patient care and person. From the findings it is clear that there are many factors in the practice environment, situations in patient care and personal characteristics and experiences that can contribute to moral distress.

The consequences of moral distress are set out in Table 3.6 and a discussion thereof follows.

During the integrative literature review the consequences of moral distress were identified from the studies that met the inclusion criteria. These consequences are tabled together (Table 3.6).

Table 3.6 List of consequences of moral distress

Consequences	
The nurse feels/ experiences: • Frustration (repeat) • Powerlessness (repeat) • Guilt (repeat) • Burnout (repeat) • Resentment (repeat) • Anger (repeat) • Embarrassment (repeat) • Sadness (repeat) • Misery (repeat) • Anxiety (repeat) • Fear (repeat) • Insecurity • Depression (repeat)	The nurse feels/ experiences: • Stress reactions • Emotional withdrawal • Loneliness (repeat) • Sleep disturbances (repeat) • Impaired concentration • Leaving the profession (repeat) • Leaving the ward • Absenteeism • High turnover of staff(repeat) • Poor/ compromised patient care (repeat) • Withdrawal from patients • Withdrawal from family (repeat) • Feel discomfort (repeat)

Consequences

• Job dissatisfaction (repeat) • Crying (repeat) • Loss of sleep (repeat) • Nightmares (repeat) • Tachycardia • Headaches (repeat) • Muscle pain (repeat) • Sweating (repeat) • Shivering • Gastrointestinal disorders • Emotional exhaustion (repeat) • Physical exhaustion (repeat) • Psychological exhaustion (repeat) • Feel regret (repeat) • Being worried • Disillusionment (repeat) • Feeling boundless and invisible • Loss of capacity for caring	• Conflict (with own family) • Stress – severe (repeat) • Feeling defeated • Shocked • Being emotionally drained • Helplessness (repeat) • Disappointment • Lack of awareness • Lack of confidence (repeat) • Lack of assertiveness • Self-doubt (repeat) • Feel hopeless (repeat) • Feel despair (repeat) • Negative attitude (repeat) • Feel pain (repeat) • Increased intra-professional conflict • Feelings of abandonment • Feel disgust (repeat)

Consequences	
• Excessive eating/ alcohol consumption • Defensiveness (repeat) • Lack of trust (repeat) • Feeling uncertain (repeat) • Question care that is given • Depersonalization (of the nurse) (repeat) • Diminished personal accomplishment • Traumatic stress disorder • Personality change • Effects on personal relationships • Feel anguish (repeat) • Low/ decreased morale (repeat) • Fatigue (repeat) • Feeling ambivalent • Disbelieving • Protecting emotional self • Feel devalued • Passivity (repeat)	• Feel discouragement • Loss of self-worth (repeat) • Productivity decline (repeat) • Poor self-esteem (repeat) • Feeling overwhelmed • Tension (repeat) • Cynicism • Reluctance to return to work • Emotional detachment • Feel shame • Feel grief (repeat) • Heartache (repeat) • Feel dread • Psychological distress • Self-blame (repeat) • Feeling of inadequacy • Avoiding patients • Alienation from oneself

Consequences	
• Feel exasperation • Feel unsupported • Feel undervalued • Erosion of personal integrity (repeat) • Betrayal of personal values • Confusion (repeat) • Isolation (repeat) • Elusive care • Poor sense of safety and security • Fear of losing their jobs • Feeling hurt • Feeling agony • Difficulty with subordination • Blunted moral sensitivity • Loss of moral integrity • Feel restless • Introjecting the stress and transferring it home • Aggression	• Psychological discomfort • Lack of energy • Fearful of strong emotions • Emptiness • Sarcasm • Rage • Palpitations (repeat) • Diarrhoea (repeat) • Lack of courage (repeat) • Feel devastation • Feel numbness (repeat) • Feel unable to fulfil their professional duties • Shaking (repeat) • Decreased coping • Loss of wholeness • Dysfunctional communication patterns • Failure to make eye contact • Giving up

Consequences	
• Psychological pressure • Tolerating the pressure • Getting nervous in interactions with colleagues • Acting contrary to head nurse's orders • Not motivating others to enter nursing colleges • Disengagement from loved ones • Disengagement from co-workers • Increased violence • Sense of personal loss • Altered self-ideal	• High blood pressure • Not being able to fulfil moral obligations • Poor self-image • Changes in spirituality (repeat) • Changes in religious behaviour • Loss of focus • Reduced patience • Feeling distressed (repeat) • Emotional pain • Nausea • Altered appetite • Increased use of alcohol/ substances • Decreased self-consistency

After the listing of the consequences, themes and sub-themes were identified through deductive reasoning. In the following table (Table 3.7) the reduction process of the consequences that were identified, is depicted and grouped together in clusters.

Table 3.7 The reduction process followed from listed consequences towards clusters grouped together

Consequences - Grouping			
Consequences – Grouping	Reduction 1	Sub-themes	Themes
Disengage from co-workers Getting nervous in interaction with colleagues Dysfunctional communication patterns Negative attitude	Poor workplace relationships	Poor workplace relationships	Organization outcomes
Conflict Increased intra-professional conflict	Conflict		
Leaving profession Leaving ward High turnover Giving up	High turnover	High turnover	
Job dissatisfaction	Job dissatisfaction	Job dissatisfaction	
Absenteeism Reluctance to return to work	Absenteeism	Absenteeism	

Consequences – Grouping	Reduction 1	Sub-themes	Themes
Resistance to subordination Acting contrary to head nurses' orders	Insubordination	Insubordination	
Poor compromised care Question care that's given	Poor patient care	Poor patient care	Patient outcome
Insecurity Shocked Feel defeated Disappointment Disillusionment Feel boundless and invisible Discomfort Feel undervalued/ devalued Loneliness Lack of trust Feel ambivalent Disbelieving Devastation Exasperation Lack of courage	Negative emotions	Emotional consequence	Nurse outcomes

Consequences – Grouping	Reduction 1	Sub-themes	Themes
Feel unsupported Feel uncertain Lack of confidence Self-doubt Despair Powerlessness Helplessness Hopelessness Feel abandoned Discouraged Loss of self-worth Poor self-esteem Feel overwhelmed Dread Self-blame Feel inadequate Alienated from self Emptiness Sense of personal loss	Negative emotions	Emotional presentation	Nurse outcomes

Consequences – Grouping	Reduction 1	Sub-themes	Themes
Loss of wholeness Numbness Poor self-image Poor self-consistency Altered self-ideal Diminished personal accomplishment Frustration Guilt Resentment Anger Embarrassment Sadness Misery Anxiety Crying Regret Worry Anguish Disgust	Emotions	Emotional presentation	Nurse outcomes

Consequences – Grouping	Reduction 1	Sub-themes	Themes
Shame Grief Hurt Agony Rage Fear Fearful of strong emotions Fear of losing job			
Withdraw emotionally Emotionally drained Emotional pain Emotional exhaustion Protecting emotional self Emotionally detached Psychological exhaustion Psychological distress Psychological discomfort Psychological pressure Burnout	Emotional exhaustion	Emotional consequences	Nurse outcomes

Consequences – Grouping	Reduction 1	Sub-themes	Themes
Depersonalization Depression Personality changed		Emotional consequences	Nurse outcomes
Loss of capacity to care Elusive care Withdraw from patient Avoid patient	Emotional detachment		
Feel distress Stress reaction Severe stress Traumatic stress disorder Transferring stress to home	Stressed		
Not able to fulfil moral obligations Low morale Blunted moral sensitivity Loss of moral integrity Erosion of personal integrity Betrayal of personal values	Compromised morals and values	Compromised morals and values	Nurse outcomes

Consequences – Grouping	Reduction 1	Sub-themes	Themes
Impaired concentration Loss of focus Lack of awareness	Loss of focus	Intellectual consequence	Nurse outcomes
Changed spirituality Changed religious behaviour	Changed spirituality	Spirituality consequence	Nurse outcomes
Not motivating others to join nursing Not making eye contact Decreased patience Withdraw from own family Effect on own relationships Isolation Tolerating pressure Lack of assertiveness Poor sense of safety and security Disengage from family Defensiveness Decreased coping Cynicism Sarcasm	Negative behaviour Negative behaviour	Social consequence Social consequence	Nurse outcomes Nurse outcomes

Consequences – Grouping	Reduction 1	Sub-themes	Themes
Confusion Aggression Increase in violence			
Decreased productivity Passivity Unable to fulfil professional duties	Decreased productivity	Decreased productivity	
Lack of sleep Nightmares Sleep disturbances Tachycardia Headache Muscle pain Sweating Shivering Gastrointestinal disturbances Tension Heartache Restlessness Palpitations	Physical symptoms	Physical consequence	

Consequences – Grouping	Reduction 1	Sub-themes	Themes
Diarrhoea Shaking Feel pain Lack of energy Physical exhaustion Fatigue Altered appetite Increased use of alcohol/ substances Excessive eating/ drinking			

Through a deductive process, themes and sub-themes were identified from the consequences. The following table (Table 3.8) summarises the identified themes and sub-themes from the consequences.

Table 3.8 Consequences: Summary of themes and sub-themes

<u>Consequences</u>	
<u>Theme 1: Organization outcomes</u>	
<u>Sub-theme 1.1: Poor workplace relationships</u>	
Conflict	
<u>Sub-theme 1.2: High turnover</u>	
<u>Sub-theme 1.3: Job dissatisfaction</u>	
<u>Sub-theme 1.4: Absenteeism</u>	
<u>Sub-theme 1.5: Insubordination</u>	
<u>Theme 2: Patient outcome</u>	
<u>Sub-theme 2.1: Poor patient care</u>	
<u>Theme 3: Nurse outcome</u>	
<u>Sub-theme 3.1: Emotional consequence</u>	
Negative emotions	
Emotional exhaustion	
Emotional detachment	
Stressed	
<u>Sub-theme 2.2: Compromised morals and values</u>	
<u>Sub-theme 2.3: Intellectual consequences</u>	
<u>Sub-theme 2.4: Spirituality consequences</u>	

Sub-theme 2.5: Social consequences

Sub-theme 2.6: Decreased productivity

Sub-theme 2.7: Physical consequences

3.2.1.7 Consequences of moral distress

One of the questions the researcher asked was what the consequences of moral distress are. From the findings three categories were identified, namely:

- Organization outcome
- Patient outcome
- Nurse outcome

Organization outcome refers to those aspects that form part of the organizational environment, e.g. conflict with colleagues and high turnover. The patient outcome refers to aspects that directly affect the patient, e.g. poor quality care. Nurse outcome refers to those aspects that the professional nurse experiences personally, e.g. crying, aggression, guilt and frustration. The findings were divided into the identified themes. As with the antecedents, most of the studies had repeated findings, and the researcher did not record all the repetitions in the summary of consequences. Please refer to Table 3.6 for a summary of the consequences and to Table 3.7 for a reduction of the consequences of moral distress.

A short discussion follows on the themes identified from the consequences (refer to Table 3.8 for a summary of the themes and sub-themes identified from the consequences). The sub-themes are headings and examples that were included under those sub-themes are mentioned.

3.2.1.7.1 Consequences: Theme 1: Organization outcome

The organizational environment is the environment in which the nurse is working. All consequences associated with the workplace were categorized and the following sub-themes emerged, namely:

- *Poor workplace relationships*

The sub-theme includes poor workplace relationships which entails dysfunctional communication patterns and negative attitudes and conflict that includes increased intra-professional conflict.

- *High turnover*

Includes instances in which the nurse wants to leave the ward and/ or the profession and results in the organization having a high turnover.

- *Job dissatisfaction*

This category includes the nurse not being satisfied with the position he/ she holds.

- *Absenteeism*

Absenteeism is where the nurse does not want to go to work, or to return to work and would therefore rather absent themselves.

- *Insubordination*

Insubordination includes instances where the nurse does not want to do as the head nurse instructs them to do.

3.2.1.7.2 Consequences: Theme 2: Patient outcome

The patient outcome includes all aspects where the patient is involved. All consequences associated with the patient were categorized and the following sub-theme emerged, namely:

- *Poor patient care*

Poor patient care refers to situations where the nurse is not rendering optimum patient care, which results from the consequences of the nurse experiencing moral distress.

3.2.1.7.3 Consequences: Theme 3: Nurse outcome

The nurse outcome includes all aspects that involve the nurse. All consequences associated with the nurse were categorized and the following sub-themes emerged:

- *Emotional consequences*

Emotional consequence includes the emotions that the nurse is experiencing, such as powerlessness, hopelessness, dread, self-blame, guilt and fear. This also includes the emotional exhaustion and psychological distress the nurse experiences. The nurse withdraws from the patient and loses the capacity to care for the patient.

- *Compromised morals and values*

This includes the nurse experiencing erosion of personal integrity, betrayal of personal values and low morale.

- *Intellectual consequences*

Intellectual consequences include the impaired concentration; lack of awareness and loss of focus the nurse experiences.

- *Spiritual consequences*

Spiritual consequences include the spiritual and religious changes that occur within the nurse's belief system.

- *Social consequences*

This includes instances when nurses are not motivating others to join nursing, not making eye contact, have decreased patience and withdraw from their own family.

- *Decreased productivity*

Includes passivity and inability in the nurse to fulfil their professional duties.

- *Physical consequence*

Physical consequence includes the physical symptoms that the nurse experiences, such as palpitations, insomnia, lack of energy and altered appetite.

3.2.1.7.4 Concluding statement: Consequences

The consequences that were identified during the integrative literature review were divided into three themes: Organizational outcome, patient outcome and nurse outcome. Moral distress is shown to clearly impact every part of a clinical environment. Not only is the organization affected, by nurses leaving, but also the patient suffers due to the effect it has on the nurse in that there is poor patient care. The outcome on the nurse can be physical,

e.g. tachycardia, headache, muscle pain and sweating and/ or emotional, e.g. hurt, agony, rage and fear, and can have devastating consequences.

3.2.1.8 Definitions of moral distress

The researcher then looked at the **definitions** of moral distress formulated to identify attributes that emerged from the definitions. Only a number of authors changed or revised the definition of moral distress from the original definition as described by Jameton (1984:6). Most of the studies included, made use of the definitions of Jameton (1984:6) and/ or Wilkinson (1989:514). See Table 3.9 for a summary of the definitions that were used for each study included. The following definitions were explored:

Moral distress, according to **Jameton** (1984:6), is knowing the *right* thing to do, but institutional constraints make it *impossible to do* the right thing.

Elpern et al. (2005:523) define moral distress as “painful feelings and/or *psychological disequilibrium* that occurs in situations in which the ethically right course of action is known but cannot be acted upon. As a result, persons in moral distress act in a manner contrary to their personal and professional values”. Moral distress can therefore be seen as a health risk for nurses as well as for their patients.

Wilkinson (1989:514) is of the opinion that moral distress occurs when *situational constraints* prevent nurses from implementing moral decisions that they have made.

Zuzelo (2007:344) defines moral stress as “efforts or attempts to make clinical decisions involving *conflicting ethical principles* and where patients’ autonomy is at risk”.

According to **Sporrong et al.** (2003:1076) *stress* related to *ethical dilemmas* are referred to as moral distress.

Nathaniel (2006:421) describes moral distress as pain that affects body and mind and can occur when a nurse makes a moral judgement about a *moral problem* thereby acknowledging *moral responsibility*.

Hanna (2002:187) describes moral distress as “Moral distress occurs in the context of situations that have moral implications embedded within them, where the moral end, an inherent *rightness or goodness*, is understood to exist and is understood to be or to have been *threatened, harmed or violated*. There can be a shock-like suddenness or unexpectedness associated with the recognition or threat to the moral end that prompts the experience of moral distress to begin”.

Lützen et al. state that stress contains a *moral component*, therefore the term moral stress (2003:318).

Kelly (1998:1135) describes moral distress as the requirement that one has to act in a way that contradicts personal beliefs and values, and is then experienced as unease or dissonance.

Webster and Baylis (2000:218) define moral distress as something that occurs when one fails to pursue what one believes to be the right course of action. This happens when there is an error in judgement, some personal failing or other circumstances that are beyond one's control.

In the following table (Table 3.9) the elements from the definitions are clustered together. Through the process of deductive reasoning, these elements were then grouped together.

Table 3.9 The reduction process from the definitions on moral distress

Definition	Reduction 1
Knowing right thing Ethically right course is known Acknowledge moral responsibility Moral end understood	Right course is known
Cannot do Cannot act Prevent implementing Threatened	Cannot implement the right course
Institutional constraint Situational constraint	Constraint
Painful feelings Psychological disequilibrium Pain affect body and mind	Painful physical and psychological feelings
Moral decisions Clinical decisions Make moral judgement	Decisions with moral component

Definition	Reduction 1
Situations with moral implications Moral component Ethical dilemma	
Act contrary to values Conflicting ethical principles	Conflicting values
Patient autonomy at risk	Patient autonomy at risk
Stress	Stress

3.2.1.8.1 Concluding statement: Elements from the Definitions

From the definitions it is clear that professional nurses can see whether something is “right”, but cannot always implement that which is the right thing to do due to e.g. institutional constraints, and that leads to physical and psychological disturbances. Professional nurses make decisions with a moral component daily and when they are prevented to implement the correct decision it leads to feelings of conflict and stress.

3.2.1.9 Concept analysis of moral distress

The purpose of the integrative literature review was to identify the antecedents and consequences of moral distress, to see if **concept analyses** have been done on moral distress and to gather the themes that were identified by previous researchers during qualitative and mixed method research and to look at the definitions available on moral distress. The concept analyses were included here due to the attributes that formed part thereof. All of this information was needed in order to identify and formulate attributes of moral distress and to be able to formulate the items to be included in the instrument that was being developed.

The researcher identified two studies with a concept analysis of moral distress, namely that of Hanna (2002) and Russell (2012). A short summary of both studies follows.

Hanna (2002:180-183) wrote that distress was the root word for the compound "moral distress" and that moral was considered a modifying word. When looking at distress, it can be used as a noun, verb or adjective and has several meanings. As a noun distress means pain, anguish, sorrow, suffering and exhaustion. As a verb, distress can be used to describe

anguish, cause pain, sorrow, suffering, exhaustion, causing embarrassment and to compel by pain of force or circumstances. As an adjective, distress can be used to indicate a need for help and to describe severe conditions. As a compound term distress is linked to e.g. fetal distress, mental distress, parental distress, behavioural distress, emotional distress and spiritual distress.

Moral pertains to the rules of right conduct and distinguishing between good and evil, therefore moral choice is a choice for the good. As a noun, moral is used to describe principles of right conduct. As an adjective moral contributes to other words so that the sense of doing right or good applies to the root word. As a compound concept, moral distress is a noun naming an interior phenomenon, that is experienced by an individual person.

According to Hanna (2002:183), the critical attributes of moral distress include:

- Extreme anguish or suffering that begins as a pained recognition that the inherent goodness of one or more moral ends has been threatened/ violated
- Transgression or violation of one's personal beliefs or values
- A sense of silenced isolation or disconnection from intimate others

Hanna (2002:184) described the antecedents of moral distress as:

- Value or belief commitments to do what is objectively good
- Ability to recognize the goodness of an inherent moral end
- Value commitments to an objective good is superseded by a human act that threatens inherent good
- Immediacy of the situation does not permit escape

The consequences, according to Hanna (2002:185), include:

- Physiological, psychological and sociological signs of anguish
- A sense of personal loss
- Disengagement from humankind

The empirical referents, according to Hanna (2002:186), were identified as:

- The person exhibits a painful recognition when perceiving a threat of an inherent goodness
- The person tries to leave the situation as soon as possible
- The person might have a need to speak
- The person might be moved to tears or anger

According to Hanna (2002:186), the trans-empirical referents are identified as:

- The person prays for insight into how to handle a situation/ searches for a sense of forgiveness
- The person questions the role one played in a situation
- The person views the situation from the perspective of one's self, and makes a decision based on one's own beliefs and values

Hanna (2002:187), then formulated the definition "Moral distress occurs in the context of situations that have moral implications embedded within them, where the moral end, an inherent rightness or goodness, is understood to exist and is understood to be or to have been threatened, harmed or violated. There can be a shock-like suddenness or unexpectedness associated with the recognition or threat to the moral end that prompts the experience of moral distress to begin."

According to Russell (2012:17), morality can be defined as a moral discourse or statement, and the word moral can be described as relating to principles of right and wrong behaviour. Moral can also pertain to character, and means proper behaviour of a person, and implies accepted notions of society. Because some authors use the term moral and ethical interchangeably, Russell also examined the word ethics. Distress is defined as a state of pain or suffering, and implies external and temporary cause of great physical or mental stress.

Russell (2012:18) then listed antecedents, according to her literature search, as: prolonging of life, inflicting harm, inability to reduce pain and powerlessness. This then was associated with the person feeling angry, frustrated and guilty, also negatively affecting physical well-being, personal relationships, job satisfaction and self-worth (consequences). The attributes that Russell (2012:19) identified were:

Primary attributes

Negative feelings, powerlessness, conflicting loyalties, uncertainty.

Secondary attributes

Ineffective advocacy, inability to reduce pain/ suffering, patient dehumanization, competing values.

Although Russell did the concept analysis of moral distress she did not formulate a new definition of moral distress.

In the following table (Table 3.10) the attributes as identified by Russell (2012) and Hanna (2002) are summarized. The attributes were then clustered together through deductive reasoning and the elements identified (Table 3.11).

Table 3.10 Attributes as identified by Russell (2012) and Hanna (2002)

Identified attributes	
Russell (2012)	Hanna (2002)
<i>Primary attributes</i> - Negative feelings - Powerlessness - Conflicting loyalties - Uncertainty	- Extreme anguish/ suffering Begins as pained recognition Inherent goodness threatened - Transgression/ violation of personal beliefs/ values - Silenced isolation/ disconnection
<i>Secondary attributes</i> - Ineffective advocacy - Inability to reduce pain/ suffering - Patient dehumanization - Competing values	

After the listing of the attributes, elements were identified through deductive reasoning. In the following table (Table 3.11) the elements from the identified attributes from Russell (2012) and Hanna (2002) are identified.

Table 3.11 The reduction process from the identified attributes

Attribute	Reduction 1
Negative feelings Anguish Pained recognition	Negative feelings
Powerlessness	Powerlessness
Conflicting loyalties Competing values Violation of personal beliefs/ values Inherent goodness threatened	Internal conflict due to violation of and conflicting values, beliefs and loyalties.
Uncertainty	Uncertainty
Ineffective advocacy	Ineffective advocacy
Inability to reduce pain/ suffering Extreme suffering	Inability to reduce pain/ suffering
Patient dehumanization	Patient dehumanization
Silenced isolation/ disconnection	Isolation

3.2.1.9.1 Concluding statement: Concept analyses

The attributes that emerged from the concept analyses as performed by Russell (2012) and Hanna (2002) showed that professional nurses experience internal conflict due to violation of and conflicting values, beliefs and loyalties and are subjected to negative feelings, uncertainty, isolation and powerlessness when experiencing moral distress. Professional nurses also experience the inability to advocate effectively on behalf of their patients, and

feel they are unable to reduce their patient's suffering and pain, even dehumanizing their patients.

3.2.1.10 Themes from moral distress

During the integrative literature review, the researcher looked at studies where themes were identified and then grouped the themes together in a table. Themes that were not noted in the antecedents and consequences were identified, and considered in the identification of the attributes. The researcher grouped together all the **qualitative and mixed method studies** (Table 3.12) that met the inclusion criteria of the integrative literature review.

The following table (Table 3.12) gives a clear summary of the **themes** that were identified within the qualitative and mixed method studies that were included.

Table 3.12 Summary of included qualitative and mixed method studies

QUALITATIVE AND MIXED METHOD STUDIES										
No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
1	Ethical problems experienced by psychiatric nurses in Korea Choe <i>et al.</i> (2012)	Mixed method	Clinical	Psychiatric nurses	Explore psychiatric nurses' ethical problem from their perspectives	Moral unpreparedness Moral blindness Moral numbness Moral complacency Moral conflict Moral stress	To unconditionally accept decisions made by patients' family/ doctors Applying compulsory restrictions who refuse treatment	Powerlessness, frustration, guilt, agony, frustration	-	Unresolved moral conflict leads to moral distress

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
2	Moral distress in nursing practice Malawi Maluwa <i>et al.</i> (2012)	Qualitative	Clinical	Nurse	To explore the existence of moral distress among nurses in Lilongwe District of Malawi	Knowledge and experience Causes Effects Coping mechanisms Desire for support services	Shortage of staff, violating regulations, forced to accept disrespect, lack of resources, behaviour of colleagues, mismanagement by superiors, inadequate provision of patient care by nurses	Frustration, burnout, work stress, job dissatisfaction, absenteeism, turnover, poor patient care	-	The major distressing factors were inadequate resources and lack of respect from patients, guardians, peers and bosses
3	Doing the best I can do: moral distress in adolescent mental health nursing Musto and Schreiber (2012)	Qualitative	Clinical	Nurses	To explore the process used by mental health nurses working with adolescents to ameliorate the experience of moral distress	Feeling caught in conflicting values Hearing contradictory messages Experiencing obstructed learning	Unsafe circumstances, feeling caught in conflicting values, distressing situations, lack of policy	-	-	An understanding of the process mental health nurses use as they experience moral distress

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
4	Iranian intensive care unit nurses' moral distress: A content analysis Shorideh <i>et al.</i> (2012)	Qualitative	Clinical	Nurses	Reports the first study of moral distress in Iran. Because of the differences in cultural values and nursing education, moral distress may be experienced differently	Institutional barriers and constraints Communication problems Futile actions Malpractice and medical care errors Inappropriate allocation of responsibilities Resources and care worker competencies	Institutional barriers and constraints, communication problems, futile actions, malpractice, medical care errors, inappropriate allocation of responsibilities/ resources, care worker competencies	Feelings of anxiety, discomfort, frustration, anger, conflict, reduced satisfaction, burnout, high turnover, severe stress, exhaustion	-	The results demonstrate that moral distress is different
5	What factors affect nursing retention in the acute care setting? Cummings (2011)	Mixed method	Clinical	Nurse	The research was conducted in an effort to highlight some of the critical factors that impact nurses in the acute care setting and affect their intent to stay	Professional recognition Lack of confidence Terminal illness Professional patient care Moral distress	Inadequate pay, inadequate staffing, incompetent staff, inadequate training, fear of making mistake/ reprimanded	-	-	Professional stress and moral distress items were predictive of the nurses' intent to stay

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/outcome
6	Moral distress, compassion fatigue, and perceptions about medication errors in certified critical care nurses Maiden <i>et al.</i> (2011)	Mixed method	Clinical	Nurses	To examine the previously untested relationships between moral distress, compassion fatigue, perceptions of medication errors	The need for process Work practice changes to enhance safe medication administration Negative emotions	Levels of staff	Devastation, fear, leaving the profession	-	Results revealed statistically significant correlations between moral distress and compassion fatigue
7	Moral distress among health system managers: exploratory research in two British Columbia health authorities Mitton <i>et al.</i> (2011)	Qualitative	Clinical	Nurses	To determine if the concept of moral distress, previously developed and utilized in the analysis of clinical situations could be applied	Moral distress related to the performance of managerial functions does exist Differences among middle and senior managers	Shortage of resources	-	-	Moral distress is experienced in both mid and senior level managers

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
8	Nurses' moral experience of administering PRN (as needed) anti-seizure medications in paediatric palliative care Rashotte <i>et al.</i> (2011)	Qualitative	Clinical	Nurses	To explore nurses' decision-making related to the administration of PRN ...	Being in the know Marking time Seeking a sense of personal comfort Making the decision	Decision-making	Being scared, frightened, worried, anxious, stressed, distressed	-	Moral dilemmas resulting in moral distress were revealed
9	A study of the situations, features and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress Deady and McCarthy (2010)	Qualitative	Clinical	Nurses	To investigate moral distress in Irish psychiatric nurses	Presence of moral distress The situations that gave rise to moral distress: - <i>professional and legal conflict</i> - <i>professional autonomy and scope of practice</i>	Professional and legal conflict, professional autonomy, scope of practice, standards of care and client autonomy	Feelings of self-doubt, guilt, frustration, anger and depression	-	Situations that give rise to moral distress are not always acknowledged or dealt with effectively

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
						- standards of care and client autonomy The features of moral distress Coping with the experience of moral distress				
10	Moral distress among Ugandan nurses providing HIV care: a critical ethnography Harrowing and Mill (2010)	Qualitative	Clinical	Nurses	To describe the manifestation and impact of moral distress as experienced by Ugandan nurses who provided care to HIV people	Conflict associated with early insights Truth telling Anguish or interior suffering Role morality	Lack of resources, staff shortages, end-of-life care, withholding truth, working conditions	Helplessness, hopelessness, fatigue, despair, negative attitude, loss, pain, suffering (spiritual, physical, psychological)	-	Moral distress differed somewhat from the experience of nurses in high-income countries.

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/outcome
11	Ethical dilemmas and ethical competence in the daily work of registered nurses Höglund <i>et al.</i> (2010)	Qualitative	Research	Nurses	To describe and explore ethical dilemmas that Swedish research nurses experience	Ethical dilemmas Ethical reasoning Attitudes towards research nurses and their work	Suffering/harm of patients	-	-	Research nurses frequently experience severe and difficult ethical dilemmas in their daily work
12	Working in an overcrowded accident and emergency department: nurses' narratives Kilcoyne and Dowling (2010)	Qualitative	Clinical	Nurses	To highlight nursing issues associated with overcrowding in the emergency department	Lack of space Elusive care Powerlessness	-	Elusive care, powerlessness, frustration, anxiety, stress, fear, poor sense of safety and security	-	A distressing picture of nursing in an emergency department has been painted
13	An institutional ethnography of nurses' stress	Qualitative	Clinical	Nurses	To reformulate the nature of stress in nursing, with attention to important contextual	Emotional distress Constancy of presence	End-of-life care, closeness to anguish, mistakes, pain, prolonging	Crying	-	Nurses' social locations, all but absent in current formula-

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
	McGibbon <i>et al.</i> (2010)				aspects of nurses' practice	Burden of responsibility Negotiating hierarchical power Engaging in bodily caring Being mothers, daughters, aunts and sisters	of life, hierarchical placement, burden of responsibility, doing non-nursing tasks/ doing jobs of others, decision-making, thinking ahead, navigating/ negotiating patient care, lack of labour union strength			tions of stress and vicarious trauma, are surely central to their experience of stress
14	Pulling the heartstrings, arguing the case: a narrative response to the issue of moral agency in moral distress Walsh (2010)	Qualitative	Clinical	Nurse	To present a narrative that reflects the emotional nature of moral distress	-	Attitude of personnel	Anger	-	The narrative answers some questions

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/outcome
15	Moral distress, moral residue and the crescendo effect Epstein and Hamric (2009)	Mixed Method	Literature review		To propose preliminary model and describe interrelationship between moral distress and moral residue	-	Violation of core values and duties. Feeling constrained Lack of resources	Frustration, anger, guilt, anxiety, withdrawal, self-blame Powerlessness Dysfunctional communication patterns	-	Model of the crescendo effect
16	Facilitated ethics conversations. A novel programme for managing moral distress in bedside nursing staff Helft <i>et al.</i> (2009)	Qualitative	Clinical	Nurses	To find ways to deal with moral distress	Non-beneficial treatment Informed consent Communication inadequacies	Non-beneficial treatment, life-prolonging therapy, communication gaps, informed consent	Sorrow, frustration, leaving the profession	-	Facilitators should be trained

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
17	A difficult mission to work as a nurse in a residential care home – some registered nurses' experience of their work situation Karlsson <i>et al.</i> (2009)	Qualitative	Clinical	Nurses	To describe registered nurses' experiences of their work environment	Feeling appreciated and valued: <i>Being confirmed to have autonomous knowledge in caring</i> <i>Having the ability to trust and provide support</i> Feeling underestimated and frustrated: <i>Feeling boundless and invisible</i> <i>Having no authority and feeling powerless</i> <i>Being belittled</i> <i>Feeling exhausted</i> <i>Being a lonely and invisible fixer</i>	Being belittled, having no authority, invisible fixer	Feeling boundless and invisible, feeling powerless, exhausted, lonely, frustrated	-	Border of nursing care should be clear

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
18	Developing the moral distress scale in the population of Iranian nurses Khoiee <i>et al.</i> (2008)	Mixed method	Clinical	Nurses	To develop moral distress questionnaire and validate it in a sample of Iranian registered nurses	Hierarchy Power imbalance Rules and regulations Instructions Support systems	Hierarchy, power imbalance, rules and regulations, instructions and support systems, follow orders without any questions, powerlessness	Stress, restlessness, confusion, crying, leaving the job, introjecting the stress and transferring it home, aggression, psychological pressure, tolerating the pressure, depression, getting nervous in interactions with colleagues, acting contradictory to head nurse's orders, not motivating others to enter nursing colleges, losing working motivation, feeling distressed	-	Design and conduction of some interventions to help nurses cope with moral distress caused by their occupation seems necessary

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/outcome
19	When nursing practice moves beyond traditional boundaries: An evidence-based example using procedural sedation Davidson <i>et al.</i> (2007)	Qualitative	Clinical	Nurses	A case study to expand responsibilities for duties	-	Scope of practice	-	-	Expansion of responsibilities endorsed
20	Nursing care of AIDS patients in Uganda Fournier <i>et al.</i> (2007)	Qualitative	Clinical	Nurses	Explore the experience of Ugandan nurses caring for HIV patients...	Caring Coping	Work environment, poverty, lack of resources, fear for own health, staff shortages	Burnout	-	Professional and interdisciplinary support is needed.
21	Debriefing after a crisis Hanna and Romana (2007)	Qualitative	Clinical	Nurses	Best way to resolve moral distress	Conflicted family decision coupled with an unexpected patient outcome	End-of-life care Death of co-workers	Sadness, fear, survivor guilt	-	Debriefing helps staff members to identify personal impact of trauma

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/outcome
						Multiple losses by death and accident among the staff				and loss
22	The experiences of paediatric nurses caring for children in a persistent vegetative state Montagnino and Ethier (2007)	Qualitative	Clinical	Nurses	To gain an understanding of the paediatric nurse's experience of caring for children in a persistent vegetative state	Focusing on the parents Delivering sensorial offensive physical care Enduring conflicting emotions Suffering moral distress Finding relief and comfort	Pain, suffering	Feel uncertain, question care, frustration	-	The study suggests that caring for a child in a persistent vegetative state is difficult. They described the experience as emotionally stressful and ethically challenging
23	Chinese nurses' ethical concerns in a neurological ward	Qualitative	Clinical	Nurses	To describe Chinese nurses' experiences of workplace distress and ethical dilemmas in a	Ethical dilemmas Workplace distress Quality of nursing	Restricted resources, distrust of patients/families, high workload, lack of support from management,	Powerlessness, frustration, anger, feeling insecurity, anxiety, exhaustion, helplessness, loss of self-worth, loss of	-	Lack of resources was perceived as an obstacle

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
	Fen Tang <i>et al.</i> (2007)				neurological ward	Managing distress	staff shortages, lack of communication, respect, unsatisfactory interpersonal relationships, lack of time	self-confidence		
24	Understanding the moral distress of nurses witnessing medically futile care Ferrell (2006)	Mixed method	Clinical	Nurses	To explore the topic of moral distress in nurses related to witnessing futile care	-	Aggressive treatment, end-of-life care, prolonging of life	-	-	Instances of futile care evoke strong emotional responses from nurses, and nurses require support in dealing with their distress

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
25	Critical care nurses' perceptions of and responses to moral distress Gutierrez (2005)	Qualitative	Clinical	Nurses	To increase understanding of critical care nurses' experiences of moral distress	Moral conflict Moral judgement Constraints to moral action Support to nurses experiencing moral distress Effects of moral distress on nurses Effects of moral distress on provision of care	Aggressive medical treatment, inappropriate utilization of healthcare resources, lack of respect for patient wishes by physicians, incomplete information given, conflicting goals between physician, family and nurse, lack of established relationships, time constraints, fear of physician backlash, inexperience/ unsupported medical staff, hierarchical power structure	Anger, sadness, physical withdrawal, reluctance to return to work, crying, frustration, grief, powerlessness	-	Critical care nurses experience suffering as a result of implementing actions incongruent with their moral judgment

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/outcome
26	Ethical Dilemma and Moral Distress: Proposed New NANDA diagnoses Kopala and Burkhart (2005)	Mixed method	Clinical	Nurses	To identify and assist decision makers who are experiencing the associated ethical or moral conflicts	Ethical dilemma Moral distress	Discontinue treatment End-of-life care	Guilt, anger, frustration	-	Literature supports ethical dilemmas and moral distress
27	Caring about – caring for: moral obligations and work responsibilities in ICU nursing Cronqvist <i>et al.</i> (2004)	Qualitative	Clinical	Nurses	To analyse experiences of moral concerns in intensive care nursing	Caring about – caring for: moral obligations and work responsibilities in intensive care nursing. - believing in a good death - knowing the course of events - feelings of distress - reasoning about physicians' doings	Prolonging of life, suffering, nurse-physician relationship	Frustration, feelings of stress	-	There is a need to support nurses in difficult intensive care situation, for example by mentoring

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
						- expressing moral awareness				
28	Understanding and responding to patients' requests for assistance in dying Schwarz (2003)	Qualitative	Clinical	Nurses	To explore how nurses experience and respond to patients' for assistance in dying (AID)	Being open to hear and hearing Interpreting and responding to the meaning Responding to persistent requests for AID Reflections	-	Guilt, burnout, emotional detachment, distancing themselves from patients and colleagues	-	Most nurses struggled alone and in silence to find a morally and legally acceptable way to help patients who persisted in requesting AID
29	Moral stress and burnout: Qualitative content analysis Severinsson (2003)	Qualitative	Clinical	Nurses	To describe and interpret narratives of nurses	Shortcomings and health problems Hovering between suffering and desire Responsibility for oneself	High demands, high workload, low level of control, feelings of powerlessness, long working hours, lack of support, difficulties	Resulted in experiences of shortcomings and work-related stress, led to high blood pressure Not able to fulfil moral obligations	-	Nurses' needs have to be recognized. They need emotional support and systematic clinical supervision

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
							with management, lack of resources	Loneliness, depression, helplessness Low self-confidence, guilt Distance self from others Lack of communication Depression		
30	The lived experience of moral distress: Nurses who assisted with elective abortions Hanna (2002)	Mixed method	Clinical	Nurses	To discover the essence, properties and full content domain of the concept of moral distress	Interior recoil Interior aversion Internal withdrawal	<i>Before fieldwork</i> Value/ belief Ability to recognize objective intrinsic/ possible evil Value/ belief commitment is superseded/ replaced Immediacy of situation does not permit escape	Physiological, psychological and sociological signs of anguish, emotional pain and suffering: crying, tense, shaking, trembling, nausea, altered appetite, gastrointestinal distress, decreased sleep quality, nightmares, difficulty falling asleep, waking up early, depression, increased use of	<i>Before fieldwork</i> Anguish/ suffering Transgression/ impingement on one's personal beliefs/ values Sense of silenced isolation/ disconnection from larger community	The definition has been composed in universal terms, but remains tentative, since the full content domain of moral distress was largely but not definitely identified

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
							<i>After fieldwork</i> Value/ belief commitment Ability to recognize goodness/ badness Value/ belief commitments is superseded Immediacy of the situation does not permit escape	alcohol/ substances, fatigue, decreased self-esteem, self-worth, self-consistency, altered self-ideal, increased violence, increased anger Sense of personal loss, disengagement from loved ones co-workers	<i>After fieldwork</i> Anguish/ suffering Transgression/ violation of or impingement on one's personal beliefs/ values Sense of silenced isolation/ disconnection from intimate others	

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
31	Listening to nurses' moral voices: Building a quality health care environment Storch <i>et al.</i> (2002)	Qualitative	Clinical	Nurse	Explore the meaning of ethics for nurses providing direct care with clients	Organizational climate and policies guiding care Financial, human, and temporal resources available for care Power and conflicting loyalties Resources utilized and resources needed to enable ethical practice Processes used to enact moral agency Implications for nurse leaders as moral agents Moral courage and moral distress	Decision-making, conflict, being excluded from decision-making, organizational climate	Low morale, burnout	-	Nurses at staff ... are often the only ones who can speak up or speak out...

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
						Being a moral compass and supporting nurses ability to be moral agents				
32	Caring for dying infants: experiences of neonatal intensive care nurses in Hong Kong Yam <i>et al.</i> (2001)	Qualitative	Clinical	Nurses	To explore the experiences of neonatal nurses in Hong Kong caring for dying infants	Disbelieving Feeling ambivalent and helpless Protecting emotional self Providing optimal physical care to the infant Providing emotional support to parents Expressing empathy Lack of knowledge and counselling skills	Perform invasive procedures following doctors' orders	Feeling ambivalent, disbelieving, helplessness, protecting emotional self, sadness, anger, frustration, resentment, minimized social interaction	-	Nurses found it difficult to accommodate the transition from curative care to palliative care

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
						Conflicting values in care				
33	Nursing, morality and emotions: Phase i and ii clinical trials and patients with cancer Krishnasamy (1999)	Qualitative	Clinical	Nurses	To explore the moral agency of the nurses' work	Being valued and moral distress Caring in a climate of scientific research Care, cure and consequences for moral reasoning	Increased responsibility, lack of authority, work environment, lack of perceived moral behaviour	Insecurity, devalued, low self-worth, passivity, mistrust and misunderstanding, discouraged to engage, frustration, exasperation, feel unsupported and undervalued, frustration, anger, personal conflict, powerlessness, feel uncertain, erosion of personal integrity, betrayal of personal values, disillusionment, no place for relationships and caring, confusion, isolation	-	If nurses are to function effectively – the role emotions play in moral decision making should be explored

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
34	Preserving moral integrity: a follow-up study with new graduate nurses Kelly (1998)	Qualitative	Clinical	Nurses	To describe, explain and interpret how new graduate nurses perceived their adaptation to the real world of nursing	Preserving moral integrity	Inadequate staffing, inexperience, high workload, lack of support, mistreatment/ disrespect of patients, lack of time, medication errors	Self-blame, lack of confidence, guilt, feeling of inadequacy, self-doubt, powerlessness, sadness, leaving the unit/ nursing, avoiding patients, anxiety, frustration, alienated from oneself	-	Moral distress was an acute form of psychological disorientation in which informant questioned their professional knowledge
35	Caring for dying children: nurses' experiences Davies <i>et al.</i> (1996)	Qualitative	Clinical	Nurses	To construct substantive theory about nurses' experiences in caring for children who are dying after a prolonged illness	Struggling	End-of-life care	Struggling, grief, avoidance, lack of energy, lack of confidence, fearful of strong emotions, harbouring regret, reluctance to become involved, withdrawal, emptiness, anger, frustration, sadness, powerlessness, sarcasm, crying, leaving nursing	-	The substantive theory has been generate through this study needs to be tested

No.	Study	Type of Study	Setting	Participants	Objective	Themes identified	Antecedent	Consequences	Attribute	Main findings/ outcome
36	Artificial personhood: Nursing ethics in a medical world Liaschenko (1995)	Qualitative	Clinical	Nurse	To understand the lived ethical experience of two groups of nurses in home care in psychiatry	Moral distress Moral outrage	-	Guilt, rage, pain	-	The paper illustrates the harm to nurses as expressed in narratives of their practice

After all the themes were identified from the studies that met the inclusion criteria, they were grouped together in the following table (Table 3.13). The researcher then searched for concepts that were not mentioned in the antecedents and consequences that came from the studies that were included. The concepts that were not mentioned before were then typed in **bold**. This helped the researcher in the search for identifying the attributes of moral distress.

Table 3.13 Summary of themes from qualitative and mixed method studies

Themes	
Moral unpreparedness	Institutional barriers and constraints
Moral blindness	Communication problems
Moral numbness	Futile actions
Moral complacency	Malpractice and medical care errors
Moral conflict	Inappropriate allocation of responsibilities
Moral stress	Resources and care worker competencies
Knowledge and experience	The need for process
Causes	Work practice changes to enhance safe medication administration
Effects	Negative emotions
Coping mechanisms	Moral distress related to the performance of managerial functions does exist
Desire for support services	Differences among middle and senior managers
Feeling caught in conflicting values	Being in the know
Hearing contradictory messages	Seeking a sense of personal comfort

Themes	
Experiencing obstructed learning	Making the decision
Professional recognition	Presence of moral distress
Lack of confidence	The situations that gave rise to moral distress:
Terminal illness	- professional and legal conflict
Professional patient care	- professional autonomy and scope of practice
Moral distress	- standards of care and client autonomy
Conflict associated with early insights	The features of moral distress
Truth telling	Coping with the experience of moral distress
Anguish or inner suffering	Emotional distress
Role morality	Constancy of presence
Ethical dilemmas	Burden of responsibility
Ethical reasoning	Negotiating hierarchical power
Attitudes towards research nurses and their work	Engaging in bodily caring
Lack of space	Being mothers, daughters, aunts and sisters
Elusive care	Non-beneficial treatment
Powerlessness	Informed consent
Hierarchy	Communication inadequacies
Power imbalance	Feeling appreciated and valued:

Themes	
Rules and regulations	Being confirmed to have autonomous knowledge in caring
Instructions	Having the ability to trust and provide support
Support systems	Feeling underestimated and frustrated:
Caring	Feeling boundless and invisible
Coping	Having no authority and feeling powerless
Conflicted family decision coupled with an unexpected patient outcome	Being belittled
Multiple losses by death and accident among the staff	Feeling exhausted
Focusing on the parents	Being a lonely and invisible fixer
Delivering sensorially offensive physical care	Workplace distress
Enduring conflicting emotions	Quality of nursing
Suffering moral distress	Managing distress
Finding relief and comfort	Ethical dilemma
Moral judgement	Caring about – caring for: moral obligations and work responsibilities in intensive care nursing.
Constraints to moral action	- believing in a good death
Support to nurses experiencing moral distress	- knowing the course of events
Effects of moral distress on nurses	- feelings of distress
Effects of moral distress on provision of care	- reasoning about physicians' doings
Being open to hear and hearing	- expressing moral awareness

Themes	
Interpreting and responding to the meaning	Shortcomings and health problems
Responding to persistent requests for AID	Hovering between suffering and desire
Reflections	Responsibility for oneself
Interior recoil	Disbelieving
Interior aversion	Feeling ambivalent and helpless
Internal withdrawal	Protecting emotional self
Organizational climate and policies guiding care	Providing optimal physical care to the infant
Financial, human, and temporal resources available for care	Providing emotional support to parents
Power and conflicting loyalties	Expressing empathy
Resources utilized and resources needed to enable ethical practice	Lack of knowledge and counselling skills
Processes used to enact moral agency	Conflicting values in care
Implications for nurse leaders as moral agents	Preserving moral integrity
Moral courage	Struggling
Being a moral compass and supporting nurses ability to be moral agents	Moral distress
Being valued and moral distress	Moral outrage
Caring in a climate of scientific research	
Care, cure and consequences for moral reasoning	

The concepts that were identified during the themes that were not included, as the focus was on moral distress, in the antecedents and consequences were:

- Moral unpreparedness
- Moral blindness
- Moral complacency

No further reduction was performed due to the repetitiveness of the themes compared to the consequences, antecedents, definitions and concept analyses.

3.2.1.11 Attributes of Moral Distress

Identifying the attributes was a very important component of conducting the integrative literature review. The attributes were needed in order to formulate the items that were included in the instrument. The attributes were formulated from the following:

- Definitions from previous research (Table 3.9)
- Concept analyses from previous research (Table 3.11)
- Themes identified from previous qualitative and mixed method research (Table 3.13)

The antecedents and consequences of the integrative literature review, as well as those identified from the interviews were taken into consideration to identify the attributes of moral distress. All of the above contributed to the formulation of the attributes.

3.2.1.11.1 Identified attributes

From the themes, definitions and concept analyses that were conducted through previous research, the researcher came to the conclusion that the attributes of moral distress of professional nurses are:

➤ *Compromised morals and value system*

Each nurse has an inherent moral and value system that directs their decisions and the choices they make. This is the boundaries within which they decide what is right or wrong and with what they feel comfortable. When they have to adapt or change their morals and value system in order to fulfil the expectations within their practice environment or that of patient care, this system is compromised. Examples of a compromised morals and value system are when nurses:

- Feel they cannot act upon that which they know is the right thing to do.
- Feel decisions with a moral component cannot be implemented.
- Feel their personal beliefs and values are disregarded.
- Feel they cannot make/ act on a moral choice.
- Experience conflicting loyalties.
- Experience competing values.
- Are expected to provide care that is not ethically condoned.
- Observe truth is withheld from patients.

➤ ***Violated professional autonomy***

Nurses pride themselves as being independent practitioners who can 'think on their feet'. Professional autonomy is the capacity one has to make independent, informed decisions. However, when nurses are not allowed to practice freely, use their knowledge, experience and expertise to contribute to the care of the patient and collaborate with the physician and multi-disciplinary team, this autonomy is violated. Examples of violated professional autonomy are when nurses:

- Are only expected to follow the physicians order without their input being consulted.
- Feel they cannot collaborate with the physician/ multi-disciplinary team.
- Implement policies and procedures without their consultation.
- Are experiencing lack of regard for their opinions and decisions.
- Feel they cannot be part of the decision-making process.
- Feel they are not respected.
- There is poor communication.
- They have no control over the hierarchical processes.
- They have no input in policies and procedures.

➤ ***Powerlessness***

Nurses are prevented from giving or doing their best for their patients, whether it is through advocacy or relieving their pain, or when they feel excluded in the decision-making process regarding their patient's treatment, they experience a feeling of powerlessness. Powerlessness occurs when the nurse is unable to produce an effect; it might be because they lack power, resources or authority, they are unable to do something or to stop something. Powerlessness is also experienced when the management of the practice environment disregard their input and give them no support. Examples of powerlessness are when nurses:

- Feel unable to protect their patients from harm
- Feel unable to advocate for their patients
- Feel unable to give the care they would want to give, due to lack of resources (lack of staff or/ and lack of equipment)
- Feel helpless
- Feel they are not supported by management
- Feel unable to do anything about patient's pain, treatment or suffering
- Feel unable to work within his/her scope of practice, due to pressure from management or lack of qualified staff
- Feel unable to prevent dehumanization from colleagues and doctors of their patients
- They feel unable to do something when they see their patients are being disrespected
- Are expected to work in poor conditions
- When they are exposed to situations of exploitation (e.g. where they are expected to do the work of more than one person)

3.2.2 Semi-structured interviews

During this research semi-structured interviews were conducted to explore and describe the experience of professional nurses experiencing moral distress and to identify the attributes and empirical indicators of moral distress. The semi-structured interviews also served as confirmation for the results that were obtained during the integrative literature review. The integrative literature review and the semi-structured interviews formed part of Phase One (as discussed in Section 3.2) of the theoretical framework of Benson and Clark (1982:789) that was followed during this study.

Interviews can be seen as a way that the researcher interacts (Botma *et al.*, 2010:206) with participants and can help the researcher engage with an issue that is part of the knowledge that is being created, and is not merely a representation. During interviews, the researcher has a plan of certain topics to cover, while encouraging the respondent to talk freely (Babbie, 2008:336).

During this research, the researcher made use of confirmatory, explorative, semi-structured interviews (see Addendum C) and the reason therefore was to increase the knowledge of the researcher of moral distress (Burns & Grove, 2009:359). Semi-structured interviews help the researcher to gain insight into the beliefs and feelings on and perceptions of a particular topic, while at the same time granting the researcher the opportunity to follow up particular interesting avenues that might emerge during the interview (Botma *et al.*, 2010:208).

The researcher decided on personal (face-to-face) interviews because these are seen as the most respected method of collecting data for instrument development (Polit & Beck, 2012:265). Personal interviews might be more costly, but because of the quality of information one collects, it makes them more worthwhile (Polit & Beck, 2012:265). During this research, the researcher conducted nine interviews.

A reminder of the population, sampling technique, data collection and data analysis follows. A comprehensive discussion is provided in Chapter Two (see Section 2.5.1.2).

3.2.2.1 Population

The population in this phase of the study were a group of students of an open distance learning unit programme doing a nursing management diploma. These students were all professional nurses working in hospitals and clinics in the North-West Province of South Africa.

3.2.2.2 Sample

A sample of nine participants (n=9) was used for the semi-structured interviews. The sample consisted of nine female professional nurses working in different departments. The departments were; clinic (n=2), theatre (n=1), surgical ward (n=1), medical ward (n=1), labour room (n=1), ICU (n=1), rehab (n=1) and clinical training (n=1). Two of the nine interviews were telephonic interviews as the participants were far away during the time of data collection.

3.2.2.3 Sampling

Purposive sampling was applied. The reason purposive sampling was chosen, was to include the participants who will be most useful and representative of the phenomenon under study (Babbie, 2008:204). The inclusion criteria for the sample were:

1. Being a professional nurse in the clinical field
2. At least one year's clinical experience
3. Having experienced moral distress

3.2.2.4 Data collection

Data was obtained by means of semi-structured interviews (n=9) in order to obtain rich descriptive data (Botma *et al.*, 2010:209), and to explore the participants' experience. Interviews were conducted until data saturation was achieved. The length of the interviews varied, based on the need of the participant to talk. The interviews varied between 10 minutes and one hour each.

The participants who agreed to be part of the research were visited to explain the objectives and method of the research as well as the ethical principles that were being followed (see Addendum C [i]). An appointment was then made with each participant for the most appropriate time and place to conduct the semi-structured interview. Some of the semi-structured interviews were conducted at the participants' workplace in a private office or the researcher's office, where it was quiet and private and then the two telephonic semi-structured interviews were in the rooms where the participants were.

The following questions were asked of the participants:

1. Can you think of situations where you experienced moral distress?
2. Can you give me examples of those situations?
3. How did you experience moral distress?

3.2.2.5 Data analysis

Each semi-structured interview was recorded on a digital audio recorder. During each semi-structured interview the researcher also made notes. The recorder was given to an experienced person who transcribed the interviews verbatim. The semi-structured interviews transcribed relatively easily and the data was then analysed by the researcher as well as by an independent co-coder (an experienced researcher) according to Tesch's method (Creswell, 1994:155) (see Addendum C [iii]). The researcher and the co-coder had a discussion until consensus was reached between them. The results are described within the categories that they were identified in (see Table 3.14). Please refer to Chapter Two (see Section 2.5.1.2) for a discussion on the data analysis process.

In the following table an overview is given of the main themes and sub-themes that were identified in the semi-structured interviews that were conducted. The themes were identified together with a co-coder.

Table 3.14 Themes and sub-themes from the semi-structured interviews

THEME 1: Practice environment (Of the professional nurse) Nurse's experience in the practice environment	THEME 2: Person (The professional nurse) Nurse's personal experience	THEME 3: Coping mechanism (Of the professional nurse) Nurse's coping mechanism
Sub-theme 1.1: Staff • Shortage of staff (shortage of qualified staff and increase of students) • Overworked – increased workload, increased work pressure, very busy, not enough time • Disrespect • Incompetent staff • Negative attitude of staff • Lack of support • Work outside scope of practice • Inexperienced - staff • Communication	Sub-theme 2.1: Emotional experiences • Frustrated • Guilty • Angry • Depressed • Stressed • Helpless • Sad • Cried • Person becomes confrontational	Sub-theme 3.1: Personally • Need for personal support (communication)
Sub-theme 1.2: Equipment (stock and medicine) • Not enough resources	Sub-theme 2.2: Physical experiences • Tired • Increase/ decrease sleep • Increase weight • Breathing faster, lock jaws, clench teeth • Low functionality • Disorganised	Sub-theme 3.2: Professionally • Communication (with colleagues and patients)
Sub-theme 1.3: Patients • Death of patients • Patient anguish and suffering		

3.2.2.6 Description of the results: Semi-structured interviews

The results from the interviews are discussed, based on Table 3.14. The sub-themes will be discussed, based on the semi-structured interviews with the professional nurses, which will then be followed by quotes from the interviews and concluded with relevant literature.

3.2.2.6.1 Theme 1: Practice environment

Within the practice environment of the professional nurse, the participants mentioned specific sub-themes in connection to their practice environment and moral distress.

Sub-theme 1.1 Staff

- *Shortage of staff/ shortage of qualified staff*

Shortage of staff/ shortage of qualified staff contribute to professional nurses experiencing moral distress

Most of the participants verbalised during the interviews that the shortage of staff and shortage of qualified staff was of great concern to them. They felt that they couldn't give the nursing care they would want to give, seeing that they struggled just to do the bare minimum so that each patient at least got their immediate needs met and received their medication. More than half of the participants that were interviewed cited shortage of staff to be a major contributor towards moral distress, as can be seen through these statements:

“We worked with less staff, so we had to cope...”

“...not having enough staff...”

“... to put up a drip... (she) doesn't have any clue at all how to access a vein...”

“... The shortage of staff is affecting us...”

Gwede *et al.* (2005:1123), as well as Shamian *et al.* (2003:81), state that shortages of staff are of great concern and are seen as contributors to job-related stressors. Gutierrez (2005:234) found that when staff had to work with inexperienced staff it caused great moral distress in their colleagues. Shortage of resources is of great concern to nurses, whether it is human resources or financial resources. Nurses find it stressful when having to cope with the minimum (Storch *et al.*, 2002:9).

- *Overworked*

Being overworked contributes to professional nurses experiencing moral distress

The participants who partook in the semi-structured interviews claimed that being overworked was a great cause of stress. They felt that they were prone to making mistakes, because they had such a high workload and tried their best to do what is expected of them, but had this fear for making mistakes and forgetting important tasks. The participants feel that they are overworked with the very busy wards, not having enough time to look after all of their patients, and the workload is ever increasing.

“... I am not reaching that target.... I have tried...”

“... stretching yourself to the limit...”

Tyson and Pongruengphant (2003:24) are of the opinion that high workloads are experienced as a major stressful event. When nurses cannot provide the care they want, it leads to moral distress. Time constraints and being overworked are recognized as contributing to moral distress (Gutierrez, 2005:234). Being overworked is reported as one of the causes of moral distress (Fen Tang *et al.*, 2007:821).

- *Disrespect*

Being disrespected contributes to professional nurses experiencing moral distress

Some of the participants felt that they weren't respected in the workplace. The participants shared that in some cultures the elderly person has to be shown respect and listened to, even if that person has a lower rank. For instance, if an assistant nurse (AN) told a professional nurse (PN) to do something (in that specific culture), she/ he had to do it. That was very difficult for some participants to deal with. The participants also felt they weren't respected by some physicians and the management of the institution. The participants feel that they are not respected within the practice environment. They were of the opinion that for nurses to be able to deliver quality, competent care, they have to receive the same courtesy, respect and dignity from the institution, as received by all, where they are working.

“...would say: ‘Sit back!’... I felt very hurt...”

DelBel (2003:4) is of the opinion that when an institutional culture allow minor events to pass without immediate corrective action, this may result in more serious problems in future. Nurses have to cope with disrespect regularly and this is presented in various ways such as physicians yelling at them and not willing to listen to the input of the nurses (Storch *et al.*, 2002:10). It has been found that nurses are sensitive to their patient's autonomy, and when

their patients' wishes are not respected, it leads to nurses experiencing moral distress (Lützen *et al.*, 2003:319).

- *Incompetent staff*

Working with incompetent staff contributes to professional nurses experiencing moral distress

Incompetence seems to be a big problem for the participants. In some cases, colleagues (which included physicians, nurses and management) were reported to be incompetent. The consequence of this was that the expectations and risks were much higher on/ for the participants, as they had to carry all the responsibility. Having to work with incompetent colleagues (nurses as well as doctors) contributes immensely to the participants experiencing moral distress.

“...He (the doctor) did not re-evaluate the patient’s situation!...”

“... to put up a drip... doesn’t have any clue at all how to access a vein...”

“...could not assist with the complications...”

“...there is no knowledge...”

In most cases, when incompetent staff is reported, actions to remedy that individual’s unsafe practice are slow and minimal (Storch *et al.*, 2002:10). Rashotte *et al.* (2011:74), state that when nurses do not know, moral distress arises. Lack of knowledge also results in poor patient care (Fen Tang *et al.*, 2007:817).

- *Negative attitude of staff*

The negative attitude of staff contributes to nurses experiencing moral distress

Participants experienced that having to cope with the negative attitude that colleagues display, makes the practice environment even more difficult to cope with. The attitude of staff seems to be a big problem, especially towards the younger and more inexperienced nurses that they work with. This leads younger and more inexperienced nurses to be too scared to ask for help. The impact the negative attitude of staff has, unfortunately affects the care the patient receives, as participants experienced that some nurses “just don’t care”.

“...making as if we are useless...”

“... it is discouraging.... they are not seeing the potential...”

Nurses experience demeaning remarks and negative attitudes quite often. In a study by Storch *et al.* (2002:10), one nurse was even told that her input was not appropriate because she's on the "bottom of the food chain".

- *Lack of support*

The lack of support contributes to professional nurses experiencing moral distress

Nearly all the participants felt that they weren't supported by management as well as by their colleagues. They felt that not having support made the burden to carry so much more intense and in some cases unbearable. The participants feel that they are not getting support within the practice environment from either the management or from their colleagues and physicians.

"The professional nurse that was working there did not even see that he is not moving...he is not breathing..."

"Management is not giving support to staff..."

"...there is no support..."

When nurses experience a lack of support they are more prone to develop moral distress (Severinsson, 2003:560). Nurses find that having a strong support network give them a means of comfort (Montagnino & Ethier, 2007:443). It has been found that diminished support from superiors is seen as a distressing situation and can result in the nurse experiencing moral distress (Lützen *et al.*, 2003:319).

- *Work outside scope of practice*

When working outside of the professional nurses' scope of practice contributes to moral distress

Professional nurses work with such a limited number of staff that in some instances the lower categories are expected to do work that is not within their scope of practice. Participants reported that working outside of the scope of practice, was a problem. It was not only a problem for them, but also for the lower ranking nurses. When they were expected to perform tasks that were outside of their scope of practice, they had a fear of the repercussions. When lower ranking nurses performed tasks outside of their scope of practice, the professional nurses were held liable if something went wrong; this increased the fear of the professional nurses for repercussions.

"...I told him (the doctor) that I have never intubated a patient..."

Having to do something that they do not know is a great source of moral distress to nurses (Rashotte *et al.*, 2011:74). Having unrealistic demands from nurses causes them to experience moral distress (Severinsson, 2003:63).

- *Not experienced staff*

Working with inexperienced staff contributes to professional nurses experiencing moral distress

According to the participants, working with inexperienced staff contributed to their experiencing moral distress as the responsibility that they felt they carried was sometimes just too much. Participants reported that professional nurses have to work with colleagues that are not used to a particular practice environment which puts extra pressure on the professional nurse in charge. This happens often in the South African setting where there is a shortage of staff and nursing agency personnel are called in to help, and they might never even have been in the ward they are placed.

“...this was my first resuscitation where I was in charge... I did not check the blade of the laryngoscope...I could not see the vocal cords...”

Nurses articulated that working with inexperienced staff was a great source of moral distress (Gutierrez, 2005:234).

- *Communication*

Poor communication contributes to professional nurses experiencing moral distress

Participants shared that professional nurses not only have to deal with verbal abuse, they also have to deal with a lack of communication from management. According to the participants who shared their stories, they were not being heard. Physicians and management seldom – if ever – asked for their contributions in certain instances. Participants felt they were just told to do something, and were not “allowed” to give their input.

“Some (doctors) throw tantrums at us...”

A lack of meaningful communication also contributes to nurses not being part of the decision-making process regarding their patients (Storch *et al.*, 2002:9).

Sub-theme 1.2 Equipment (stock and medicine)

- *Not enough resources*

Working without enough resources contributes to professional nurses experiencing moral distress

A lack of resources was a major concern of the participants. The participants complained that they sometimes cannot perform basic procedures, such as wound care, because there isn't anything to clean the wound with. They sometimes have no disposable gloves to use. The IVAC's (intravascular infusion device) that they have just do not work and no one is trying to fix them or they have equipment in the ward, and have never been told how to use them, so the equipment are just standing there – not being used. This made participants angry and scared, because they felt they couldn't give the care they wanted to and should give to their patients and they sometimes feared that they would contract diseases because of a lack of disposable gloves and masks.

“...there is not enough equipment...”

“... There weren't even tissues or hand paper that you can dry your hands with after you washed them....”

“... There weren't gauze or even a swab that you could stop the bleeding ...”

“...there weren't even non-sterile gloves to work with...”

The lack of resources has been shown to have a negative influence on nursing staff (Severinsson, 2003:64). When nurses feel that they cannot give the care that they feel they should give they become distressed, which in turn leads to feelings of not being able to fulfil one's moral obligation (Severinsson, 2003:60). A lack of resources also impact patients and results in poor patient (Maluwa *et al.*, 2012:204).

Sub-theme 1.3 Patients

- *Difficulty in coping with death of patients/ patient anguish and suffering*

Working with death, anguish and suffering contributes to nurses experiencing moral distress

Participants reported that they as professional nurses struggle to cope with losing their patients and find that when their patients suffer, they suffer too. The nurses verbalised that they found it extremely hard to cope with their patients' suffering and dying. They said that they knew that is an inevitable part of the work, but seeing your patient go through that was very hard for them to cope with. Seeing their patients' pain, suffering and dying, contributed greatly to the emotional responses they experienced, such as crying and feelings of anguish.

“...when I wanted to give it (medication) to her and when I came to her.... she passed away...”

“...we resuscitated for two hours... and told the family he is dead...”

Nurses find it extremely difficult to cope with their patients' suffering and death (Schwarz, 2003:383), and each deals with it in their own way. According to Rashotte *et al.* (2011:63) bearing witness to their (nurses) patients' suffering is extremely distressing to them.

3.2.2.6.2 Theme 2: Person (The professional nurse)

Participants referred to themselves and mentioned the following sub-themes.

Sub-theme 2.1 Emotional experiences

- *Frustrated, guilty, angry, depressed, stressed, helpless, sadness, crying*
- *Person becomes confrontational*

Participants experience emotional disturbances when suffering from moral distress.

Emotional responses seem to be part of the nurses who were interviewed daily, as they have to cope with all the factors that contribute to their experiencing these feelings, such as a lack of resources, not able to help their patient, not able to give the care they would want to give to their patient, shortage of staff and disrespect, to name but a few. All of these situations that have been mentioned are the preceding factors to their experiencing all these feelings. The consequences of moral distress that nurses have to endure are feelings such as mentioned above.

“...I cried until the next morning...”

“I... was very, very, very, very angry...”

“... I was really traumatized...”

“... I felt guilty.... that was the worst feeling for me...”

“... I feel frustrated and angry sometimes...”

“...I (felt) really helpless...”

“...I felt so sad I am crying about the patient...”

“... a lot (of) sadness... a lot of crying... hyper emotional...”

“...My stress levels were very high...”

“...I was very depressed”

Nurses experiencing moral distress often feel guilty and frustrated which leads to their becoming emotionally detached and distancing themselves from patients and colleagues (Schwarz, 2003:383). Distressed nurses exhibit behaviour such as crying, suppressing their feelings, and keeping quiet, to name a few. All of these behaviours have an effect on their patients as well as their families (Maluwa *et al.*, 2012:204). Nurses who experience moral distress are vulnerable to experience long-term health problems (Lützen *et al.*, 2003:319).

Sub-theme 2.2 Physical experiences

- *Tired, Increase/ decrease sleep, Increase weight, breathing faster, lock jaws, clenched teeth, low functionality*

Professional nurses experiences physical disturbances when experiencing moral distress

Participants reported to be experiencing physical symptoms from all the distressing situations. When the participating professional nurses experience moral distress, they sometimes feel that they do not want to do anything. This can be because nurses are exhausted or because they suffer from self-doubt. When the participants felt they cannot do what is expected from them, they distance themselves from their patients. Moral distress can present itself as physical symptoms, as can be seen by the following:

“... I was tired...”

“...itself made me tired all the time...”

“... I used to sleep a lot... like up to twelve hours a day...”

“... and I would eat more...”

“... I would find myself breathing faster...”

“... I would feel my heart pounding in my throat...”

“...I start(ed) feeling that my jaws lock because when I sleep I clenched on my teeth....”

“...my hair fell out...”

“... I gain(ed) a lot of weight...”

Increased work and lack of communication with other nurses can lead to feelings of loneliness and nurses experiencing being “drained” (Severinsson, 2003:63). It has been noted that distressing situations lead to “lack of sleep, physical pain, anger, frustration, sadness, hopelessness and powerlessness” (Maluwa *et al.*, 2012:204).

- *Disorganised (Participants feel their homes are disorganised, because they are too exhausted to do anything)*

Professional nurses have feelings of being disorganized when experiencing moral distress

Participants felt that being so overworked, working with little staff and having all this responsibility made them act in a way that they normally didn't. They became forgetful and they became disorganised and confrontational. They experienced that sometimes everything is their fault, and they become so defensive, that they are confrontational even at home, even if their family did nothing to provoke them. One of the consequences of moral distress seem to be that professional nurses take their feelings and behaviour home to their loved ones as can be seen by the following:

“...at home... I scold the kids...”

“... fighting with my husband...”

“... my husband didn't even greet me...I didn't want to go out of the house...”

“... I didn't want to talk to anyone...”

“... my husband says I am hard on myself...”

“... when you get home... you are fatigued and stressed... you don't even have time for your family and you take it out on them...”

“... it is a mess... a total mess... I am normally very organized...”

The problems that occur in the workplace adversely affect most nurses' personal and family lives with their innocent children and spouses becoming the victims (Maluwa *et al.*, 2012:204).

3.2.2.6.3 Theme 3: Coping mechanism

Participants shared about the need, with regards to coping with moral distress, specifically personal and professional coping mechanisms.

Sub-theme 3.1 Personally

- *Need for support (communication)*

Professional nurses feel the need for support when experiencing moral distress

Participants feel so guilty for the way that they act, that they would push themselves even harder to be there for their families. Participants felt that if only they had more support they would have been able to deal with all the situations that are causing so much distress, that they would have handled them better. Some participants went to see the doctor, in order to get medication to help them cope better with the distress that they are facing and experiencing.

“... I felt so frustrated.....”

“... I felt so guilty...”

“... he (husband) just listens and doesn't say anything most of the times, at times he responds...”

“... we are a team, we have to support one another...”

“... I have to stay healthy... don't get sick unnecessarily...”

“... doctor prescribed supplements ... that helped ... (me to) function better...”

“... we then (have to) improvise...”

Sometimes nurses react as if there is no problem, therefore they do not deal with moral distress effectively. They can ignore or accept the situation, try to forget and suppress their own feelings (Maluwa *et al.*, 2012:204). Nurses found comfort, which they desperately seek when experiencing moral distress, when they have the support of their families or colleagues (Montagnino & Ethier, 2007:443). Nurses have various coping mechanisms when experiencing moral distress; they try to maintain their wholeness that is fading (Wilkinson, 1989:516).

Sub-theme 3.2 Professionally

- *Communication (with colleagues and patients)*

Professional nurses feel the need for better communication when experiencing moral distress

Participants who experience moral distress feel that they do not want to talk to anyone, and that results in their distancing themselves from patients and colleagues. They also lose their self-confidence and feel that they are incompetent, and that they lack the necessary knowledge and skills. Participants felt that if communication was better between themselves, physicians and management, it would have been much easier to function better while facing the distress.

“... I distanced myself from them (patients)...”

“... it made me feel... distanced from my professional responsibility...”

“...maybe to do a course... start with a assessor course first...”

“... being rude and arrogant... it is just a coping mechanism...”

“... there was rivalry... shift leaders stuck together and midwives stuck together...”

Sometimes nurses who suffer from moral distress blame themselves for not being good nurses and experience feelings of low self-confidence and inadequacy (Severinsson, 2003:61). Du Toit *et al.* (2003:73) state that when an organisation implements effective, successful internal communication, it may result in competent and productive employees. It should however be managed effectively. When nurses cannot cope, it leads to their losing their feeling of wholeness and results in their feeling powerless which in turn results in poor/diminished patient care and communication (Wilkinson, 1989:517).

3.2.2.7 Concluding statement: Semi-structured interviews

During the semi-structured interviews one could clearly see the antecedents of moral distress which included shortage of staff, nurses being overworked, disrespect in the practice environment, incompetence of colleagues, negative attitude of staff, lack of support, nurses having to work outside of their scope of practice, inexperience, lack of equipment and patient's pain, suffering and death and a lack of communication. Participants clearly expressed the consequences of moral distress they were going through. The consequences of moral distress that were identified in the semi-structured interviews include emotional feelings such as guilt, frustration, anger, depression, sadness and helplessness.

Professional nurses may feel exhausted, suffer from insomnia, have an increase in weight and felt that they were breathing faster and clenching their teeth. Moral distress not only exhibited itself in the practice environment, but also presented itself at home. At home as well as at work professional nurses complained of being emotional, having low functionality, feeling disorganised and felt there is poor communication between themselves, their patients, colleagues and their own families. During the semi-structured interviews the impact of moral distress could be seen on the organization, the patient and the nurse. The interviews with the professional nurses helped confirm the data that was gathered during the integrative literature review and contributed towards identifying the attributes and empirical indicators.

3.3 CONCLUSION

The following figure (Figure 3.4) depicts the process that was followed, and information gathered, to identify the attributes of moral distress. Through the integrative literature review, interviews, definitions and themes from previous qualitative research, the antecedents and consequences of moral distress were identified. Three categories emerged from the antecedents, namely: practice environment, patient care and person. Three categories emerged from the consequences, namely: organization outcome, patient outcome and nurse outcome. The attributes that were identified were: compromised morals and value system, violated professional autonomy and powerlessness.

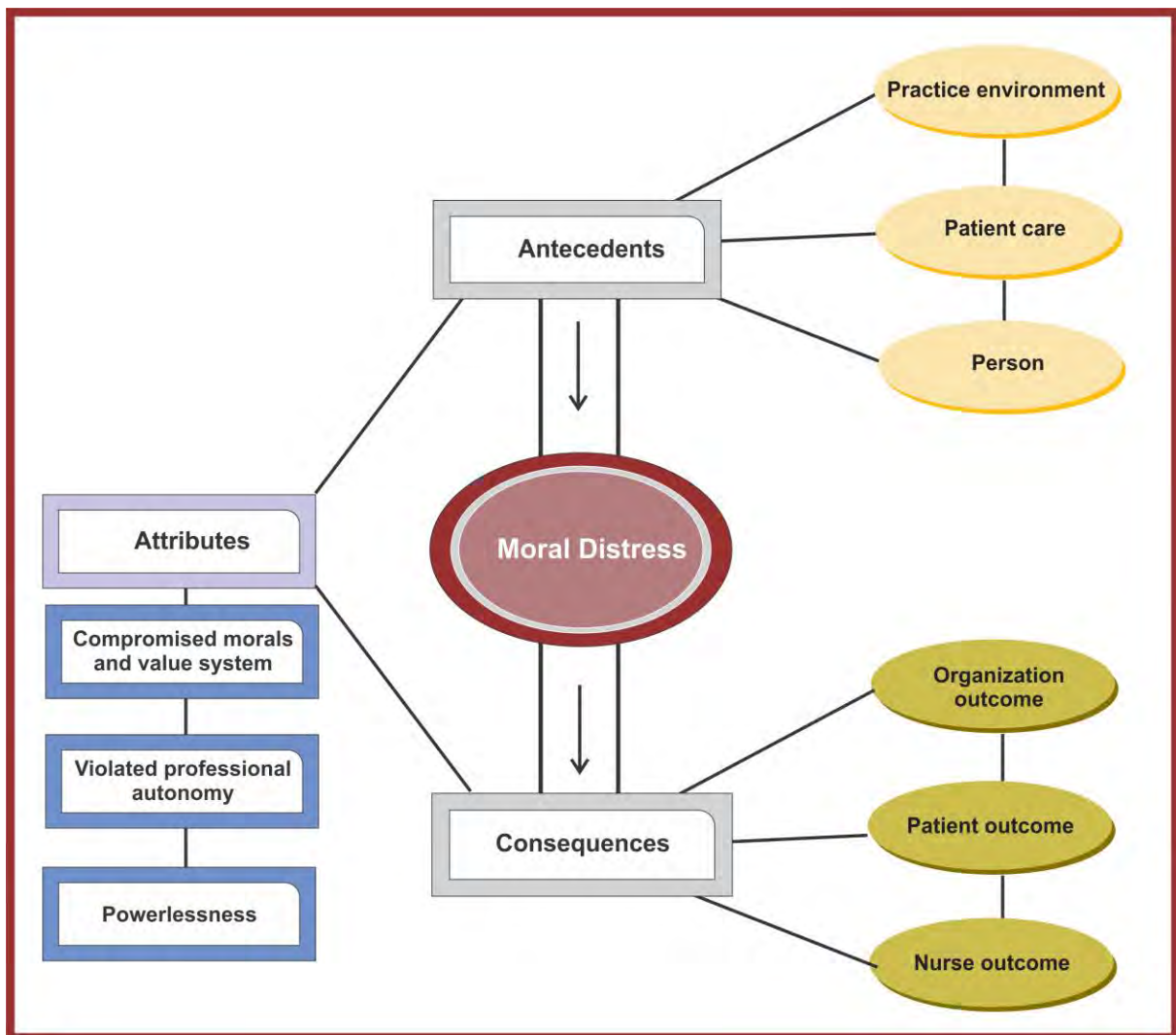


Figure 3.4 Synthesis of research results

From the identified attributes, the following definition of moral distress is proposed:

“Moral distress is when a nurse is faced with a decision with a moral component, and although the nurse is aware or knows the right course of action to take, he/ she cannot implement it, causing their morals and value system to be compromised, their professional autonomy to be violated and leaves him/ her feeling powerless (to care for their patient)”.

3.4 SUMMARY

The objective of Chapter Three was to conduct an integrative literature review and semi-structured interviews. The process of data collection of the integrative literature review was discussed and the descriptive synthesis of the results presented. Data collection and data analysis of the semi-structured interviews were systematically presented. The review questions were answered and a definition of moral distress could be formulated.

CHAPTER FOUR

CHAPTER FOUR

PHASE TWO: CONSTRUCTION OF THE INSTRUMENT

4.1 INTRODUCTION

The aim of Chapter Four is to describe the process involved in developing and validating the Moral Distress Instrument. The process is discussed according to the theoretical framework for instrument development by Benson and Clark (1982:789) that was followed, during this research.

4.2 OVERVIEW

Chapter Four forms part of Phase Two of the theoretical framework (Figure 4.1) (Benson & Clark, 1982:789) which has been comprehensively discussed in Chapter Two (see Section 2.3.2). Phase Two includes:

❖ **Phase Two: Construction (Chapter Four)**

- *Step 3:* a) Write objectives
 b) Select item
- *Step 4:* a) Develop table of specifications
 b) Hire and train item writers
 c) Write pool
- *Step 5:* a) Content validation
 b) Qualitative evaluation by judges
- *Step 6:* Develop new or revised items

In Chapter Three the researcher undertook the integrative literature review and conducted semi-structured interviews. This process was undertaken in order to see what is known about moral distress and to identify the antecedents, consequences, attributes and empirical indicators of moral distress. From previous research the attributes, themes and definitions were used to construct the defining attributes for moral distress in this study. The attributes were needed in order to develop empirical indicators to measure moral distress. During the integrative literature review, the researcher also looked at the instruments that are currently available to measure moral distress.

Table 4.1 gives a summary of the current instruments available to measure moral distress. The table shows the instrument, author, and year the instrument was developed, as well as what the instrument measures.

Table 4.1 Overview of instruments to measure moral distress

Instrument/ Author	What it measures	Year
Questionnaire survey De Veer <i>et al.</i>	To measure the intensity of moral distress within daily care in different health care settings. Measures intensity of moral distress. (De Veer <i>et al.</i> , 2013:102)	2013
Moral distress thermometer Wocial and Weaver	Moral distress thermometer. Adapted from MDS (Moral Distress Scale) from Corley. To help anchor the degree of distress. (Wocial and Weaver, 2013:170)	2013
Revised Moral Distress Scale Hamric <i>et al.</i>	Revised Moral Distress Scale Moral Distress Scale by Corley <i>et al.</i> was revised. Measures frequency and intensity of moral distress. (Hamric <i>et al.</i> , 2012:3)	2012
Moral Distress Scale – Psychiatry Ohnishi <i>et al.</i>	Moral Distress Scale – Psychiatric nurses Moral distress scale from Corley <i>et al.</i> was adopted. Measures intensity and frequency of moral distress. (Ohnishi <i>et al.</i> , 2010:728)	2010
Moral Distress Questionnaire Eizenberg <i>et al.</i>	Moral Distress Questionnaire Developed to test the psychometric properties of a culture-sensitive moral distress questionnaire among nurses. Measures nature and intensity of moral issues and dilemmas. (Eizenberg <i>et al.</i> , 2009:886)	2009

Instrument/ Author	What it measures	Year
Combination of existing instruments (Corley's Moral Distress Scale, Ethics Environment Questionnaire, Hospital Ethical Climate Survey) Hamric and Blackhall	A scale was devised to measure moral distress in physicians and nurses who deliver end-of-life care in ICUs. Used combination of existing instruments. Measures intensity and frequency of moral distress. (Hamric & Blackhall, 2007:423)	2007
Instrument of Moral Distress Sporrong <i>et al.</i>	Assess everyday experiences of healthcare personnel in a variety of settings. Measures level of moral distress and openness/ tolerance regarding ethical issues. (Sporrong <i>et al.</i> , 2006:419)	2006
Stress of Conscience Questionnaire (SCQ) Glasberg <i>et al.</i>	Measuring stress emanating from a bad conscience. Measures frequency and degree of troubled conscience. (Glasberg <i>et al.</i> , 2006:635)	2006
Moral Distress Assessment Questionnaire Hanna	Measures type, intensity, frequency and duration of moral distress experiences. Measures type, intensity, frequency and duration of moral distress. (Hanna, 2002:279)	2004
Moral Distress Scale Corley <i>et al.</i>	Measures moral distress in nurses in hospitals. Measures frequency and degree of moral distress. (Corley <i>et al.</i> , 2001:252)	2001

Research has shown what a negative effect moral distress can have on an organization, patient care and the nurse (see Chapter Three, Section 3.2.1.6). Moral distress is one of the leading contributors to nurses experiencing burnout, and ultimately leaving the profession (Corley, 2002:638 & Corley *et al.*, 2005:383). It is therefore of the utmost importance that a reliable and valid instrument to measure moral distress be developed so that moral distress can be measured and interventions to prevent moral distress can be created.

From Table 4.1 it is clear that there are several instruments to measure moral distress, but as highlighted in Chapter One (see Section 1.2) these instruments all focus on situations that

produce moral distress or the antecedents of moral distress. As apparent from Chapter Three (see Section 3.2.1.5) there are numerous antecedents that lead to moral distress, so all of the current instruments fall short, in that all the antecedents could never be measured by one instrument and so also these antecedents are known to cause similar disorders such as burnout and compassion fatigue (Huffman & Rittenmeyer, 2012:93; Maluwa *et al.*, 2012:204). Thus the importance of the current study is that the defining attributes of moral distress are identified and the empirical indicators are developed from these, in order to measure the construct of moral distress, rather than from all the many antecedents.

The **purpose of this research** is therefore to develop an instrument that measures whether someone experiences moral distress, based on the attributes of moral distress. Therefore, even persons who are not exposed to the specific situations that are used in the current instruments can be measured for moral distress. The instrument that was developed during this research measures a person's own experience of moral distress, regardless of the situations he/ she has been exposed to.

4.3 INSTRUMENT DEVELOPMENT

The instrument development and validation for this research was based on the process of instrument development and validation as described by Benson and Clark (1982:789). The researcher decided to utilise the process as described by Benson and Clark (1982), because of the clarity and specificity with which they described instrument development and validation. Please refer to Figure 4.1 for a graphic portrayal of the process of instrument development and validation from Benson and Clark (1982:790).

In Figure 4.1 the process for instrument development and validation as described by Benson and Clark (1982:790) is presented. The phase and sections that will be discussed in this chapter are coloured.

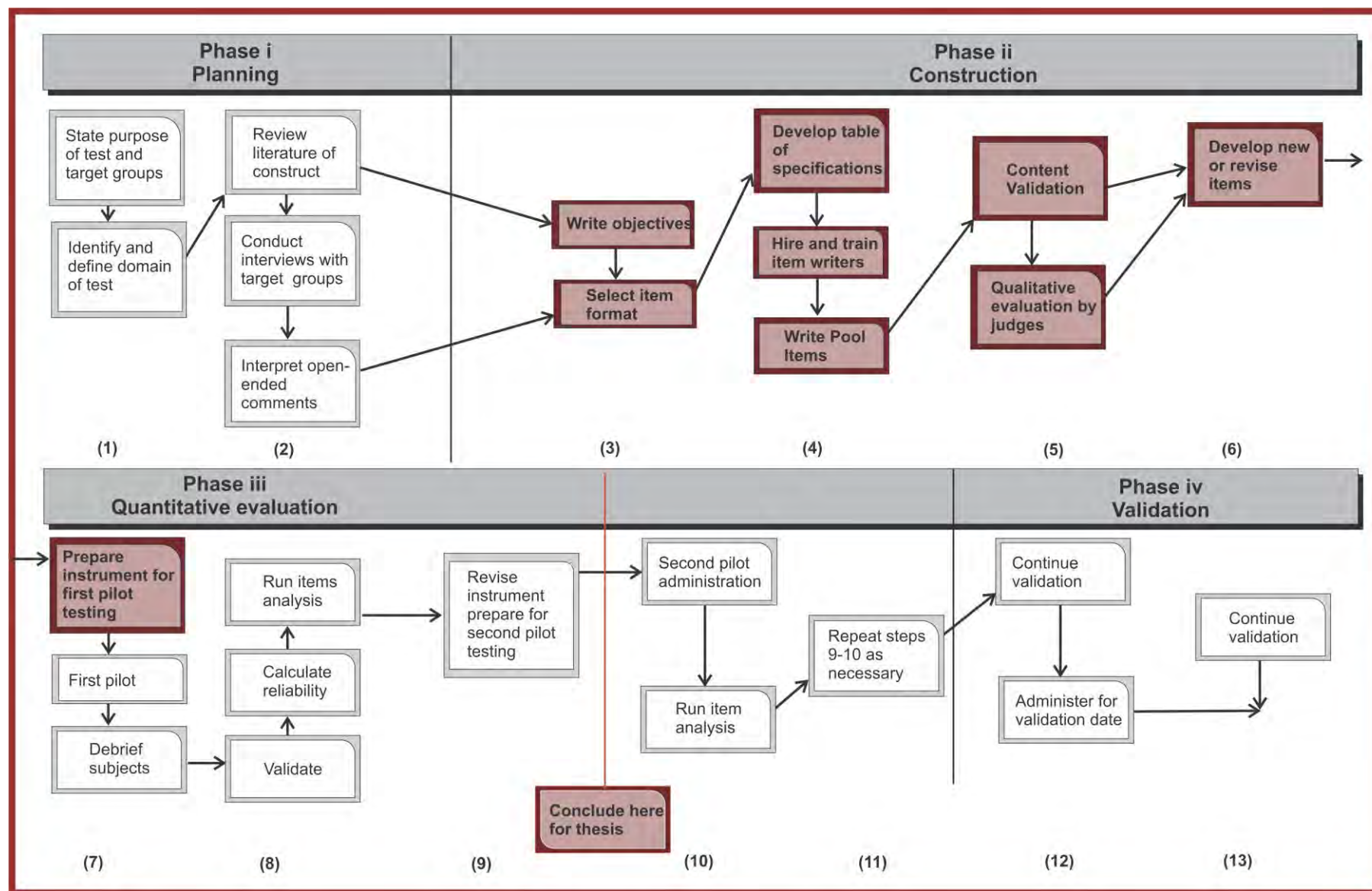


Figure 4.1 Flowchart for Instrument Development (Benson & Clark, 1982:790)

The discussion of developing the instrument during this research will be discussed according to Figure 4.1. Measurement of phenomenon is seen as a fundamental activity of science, and contributes to making sense of phenomenon (DeVellis, 2012:2). Babbie (2008:272) describes a questionnaire as much of a collection of questions as it presents statements, and is seen as a structured way of collecting data (Polit & Beck, 2012:191).

According to Benson and Clark (1982:790) there are four phases in developing and validating an instrument. Phase One to Phase Three focus on instrument development and Phase Four focuses on validation, validation however, already starts in Phase Three.

It is important to note that for this research, the researcher will conclude after data analyses of the first results of data collection (pilot study) of the instrument (first validation). The reason therefore is that the researcher has then achieved the objectives set out for this thesis. Further validation of the instrument is to continue on a post-doctoral level. Phase One was discussed in Chapter Three, therefore the discussion of Phase Two continues.

4.3.1 Phase Two: Construction

Phase Two consists of the following steps:

4.3.1.1 Construction phase: Step 3

Step 3 consists of:

- a) Write objectives
- b) Select item format

The construction of the instrument starts with Step 3. The objectives of the instrument and the purpose of the content should be assessed during Step 3 (Benson & Clark, 1982:792). Objectives can also be seen as the concrete, measureable conception of the plan (De Vos *et al.*, 2011:94), and indicates the central phenomenon (Polit & Beck, 2012:79).

The objective for developing the instrument during this research was to measure the attributes of moral distress and not situations (antecedents) that cause moral distress. During the integrative literature review (as discussed in detail in Chapter Three, Section 3.2.1), attributes, qualitative research themes and definitions from previous research were used to formulate the attributes of moral distress.

The Likert scale was used during this research and a four-point scale (never, rarely, sometimes, often) was chosen to avoid a neutral and ambivalent midpoint (DeVellis, 2012:93). A Likert scale is used in instruments measuring opinions, beliefs and attitudes,

where the item is presented as a declarative sentence followed by varying degrees of agreement (DeVellis, 2012:93). Upon deciding on the format of the items, the statistician was also consulted.

4.3.1.2 Construction phase: Step 4

Step 4 consists of:

- a) Develop table of specifications
- b) Hire and train item writers
- c) Write pool items

Step 4 includes the items of the instrument being formulated (Benson & Clark, 1982:792). According to Babbie (2008:272) there are two ways of formulating the items included in the instrument, by way of questions or statements. Whether questions or statements are used, it is important that the items should be clear and unambiguous. Items should be as short as possible, precise and to the point. When items are generated they should reflect the instrument's purpose and be created with a specific measurement in mind. Each item should reflect the construct under investigation.

Even when creating the pool of items, the focus should be specific. There are no set rules regarding how many items should be included in the instrument. What is important is that internal consistency and reliability is achieved, which is a function of how strongly items correlate with one another and how many items are in the instrument (DeVellis, 2012:79).

The items were written by the researcher in consultation with the promoters and statistician. The construction was started by dividing each of the three attributes that were identified, namely: compromised morals and value system, violated professional autonomy and powerlessness, into columns. Then empirical indicators (items) were formulated to capture the attribute without naming an antecedent or consequence. A list with 77 items was constructed, during this step.

According to DeVellis (2012:80) items can be eliminated because of lack of clarity, questionable relevance or similarity to other items. During this research, long lists of items were formulated (n=77) and then carefully worked through and eliminated (n=56). Finally, by method of consensus discussion with the promoters, items that were similar or lacked clarity were deleted until only 21 items remained. These items were included in the instrument to be sent for content validation to the relevant experts in the field. In order to exclude bias, items were not arranged in order from each subscale, but were arranged interchangeably from the different subscales.

In Table 4.2 the instrument that was sent for content validation to the relevant experts in the field, was presented.

Table 4.2 Content validation: Moral Distress Instrument

CONTENT VALIDATION OF THE: MORAL DISTRESS INSTRUMENT		
MORAL DISTRESS INSTRUMENT – Subscale 1 – Compromised morals and value system		
	Relevance	Clarity
1. I know what is the morally right thing to do when caring for my patient, but I cannot do it.	1 2 3 4	Y N
2. I am expected to do/ be part of procedures that I morally do not agree with.	1 2 3 4	Y N
3. I feel my employer does not expect me to be part of procedures that are against my moral and value system.	1 2 3 4	Y N
4. I am expected to provide care that is not within my moral and value system.	1 2 3 4	Y N
5. I am able to act according to my morals and value system while caring for my patient.	1 2 3 4	Y N
6. I feel my colleagues respect my morals and value system.	1 2 3 4	Y N
7. I feel my employer upholds rules and regulations.	1 2 3 4	Y N
MORAL DISTRESS INSTRUMENT – Subscale 2 – Violated professional autonomy		
	Relevance	Clarity
1. I am expected to carry out the physician's orders, even though I disagree.	1 2 3 4	Y N
2. I feel that the physician respects my opinions and input with regard to patient care.	1 2 3 4	Y N
3. I am expected to implement policies and procedures without any questions.	1 2 3 4	Y N
4. I am excluded from the decision process regarding my patient's care.	1 2 3 4	Y N
5. I feel satisfied with the amount of independent		

decisions that I can exercise in my work.	1 2 3 4	Y N
6. I feel satisfied with the extent to which I can use my skills.	1 2 3 4	Y N
7. I feel excluded from the decision process regarding management issues.	1 2 3 4	Y N
MORAL DISTRESS INSTRUMENT – Subscale 3 – Powerlessness		
	Relevance	Clarity
1. I can always be my patient's advocate.	1 2 3 4	Y N
2. I feel helpless to protect my patient from harm/ suffering.	1 2 3 4	Y N
3. I am unable to respect the wishes of my patient.	1 2 3 4	Y N
4. I am unable to be completely honest with my patient.	1 2 3 4	Y N
5. At the end of the day I feel satisfied with what I accomplished at work.	1 2 3 4	Y N
6. I am unable to provide the care I would like to give to my patient.	1 2 3 4	Y N
7. I feel satisfied with the amount of authority I have at work.	1 2 3 4	Y N

4.3.1.3 Construction phase: Step 5

Step 5 consists of:

- a) Content validation
- b) Qualitative evaluation by judges

During Step 5 the items that would appear on the final instrument were given to experts in the field, for their review (content validation) and thereafter, a target group was selected to review the instrument (qualitative evaluation). Validity forms an important aspect of instrument development and determines the extent to which the construct is measured by the instrument. According to Burns and Grove (2009:380) "Validity addresses the appropriateness, meaningfulness and usefulness of the specific inferences made from

instrument scores". Content validity and face validity formed part of Phase Two and will be discussed.

4.3.1.3.1 Content validity

Content validity is described as the extent to which an instrument contains a comprehensive sample (items) that are relevant to the topic that is being examined (Endacott *et al.*, 2010:65). An instrument is considered to be content valid when the items adequately represent and reflect the process and objectives as determined by the experts' opinion. When one is immersed in the process for so long, items can be clear to the researcher, but may not be clear to the participants (Babbie, 2008:272) and that is what makes the content validation and qualitative evaluation so important. It helps to correct and clarify the final instrument. The items that were formulated for the content validation process can be seen as hypotheses and the experts' review can be seen as confirming or refuting the data (DeVellis, 2012:100).

According to Polit and Beck (2006:490) three or more experts should be used for the content validation. During this research the content validation instrument was sent to 16 (N=16) experts in the field of moral distress and instrument development of which four (n=4) experts completed the content validation. The experts were authors that have published extensively on moral distress. The panel of experts were asked to determine whether the items are relevant and also to determine their clarity. The items relevance was scored on a four-point scale to avoid a neutral and ambivalent midpoint (DeVellis, 2012:93) where:

1	=	The item is not relevant at all and should be deleted.
2	=	The item is somewhat relevant but needs major revisions.
3	=	The item is relevant but needs minor revisions to be representative of moral distress.
4	=	The item is very relevant.

The item clarity was scored on a two-point scale, either yes or no. It is important to add the working definition of one's own research in order for the reviewers to evaluate the relevance of the items (DeVellis, 2012:100). The definition generated from the integrative literature review together with the semi-structured interviews were added, namely: "Moral distress is when a nurse is faced with a decision with a moral component, and although the nurse is aware or knows the right course of action to take, he/ she cannot implement it, causing their

morals and value system to be compromised, their professional autonomy to be violated and leaves him/ her feeling powerless (to care for their patient)”.

During the review, items rated one (1) need to be deleted, items rated two (2) need extensive correction, items rated three (3) need minor corrections and items rated four (4) can be used just as they are. When there are items that the experts do not agree with, those items in question should be discarded. There should be consensus on all the items, and the items where there is uncertainty, should also be discarded. The experts also had to rate the clarity of each item with a Y (yes it is clear) and an N (no it is not clear). When an item was rated an N (not clear), it usually accompanied a rating of one (1), two (2) or three (3) (Polit & Beck, 2006:493). When consensus has been reached, the final instrument can then be constructed according to the remaining and/ or revised items (Benson & Clark, 1982:792).

During this research, the instrument (see Addendum F) that was constructed for the content validity process started with an introduction of the process that was followed to construct the items. Please see Table 4.2 for the instrument (items) that were sent for the content validation. Clear instructions were given to the experts as suggested by Burns and Grove (2009:382) (see Addendum F). The experts were given the purpose of the instrument as well as the instructions on how to review the instrument. The attributes that were identified during the integrative literature review and the semi-structured interviews formed the three subscales of the instrument. Each subscale consisted of seven items. After each item the relevance (1-4) and clarity (Y/ N) followed (as explained above), from which the expert had to choose the most applicable one. After each subscale there were five places for the expert to rank the five best items. There was also a space in which the expert could provide comments or advice, as suggested by Burns and Grove (2009:382).

4.3.1.3.2 Content validity index

After the content validation process, the content validity index (CVI) is determined. The content validity index concerns the degree to which the items adequately constitute the definition of the construct, and the relevance of the instruments' content (Polit & Beck, 2006:492). In the content validity index a numerical value represents the validity of the content (Burns & Grove, 2009:382). After the team of experts validated the instrument (the content validation process), the CVI is determined.

There are two types of CVI. The first CVI is the content validity index for items (I-CVI) and involves the content validity for individual items of the instrument and the second type, the content validity index for scales (S-CVI), involves the content validity for the overall scale. The I-CVI is computed as the number of experts giving a rating of 3 or 4 (thus, narrowing the

scale down to relevant and not relevant, with 3 and 4 being relevant and 1 and 2 being not relevant) divided by the total number of experts. An I-CVI for five or fewer experts should be 1.00, and for six or more experts not lower than 0.78, but preferably .80 (Polit & Beck, 2006:492). Please see Table 4.3 for the results of the I-CVI that was received from the content validity (for items). Seven items did not measure 1.00, all the other items measured 1.00.

The table below summarises the results from the I-CVI (item content validity index) that were received during the content validity (for items). Discussion follows.

Table 4.3 Content validity item index (I-CVI)

I-CVI													
									Best questions				
Item	Expert 1 (E 1)	Clarity	Expert 2 (E 2)	Clarity	Expert 3 (E 3)	Clarity	Expert 4 (E 4)	Clarity	E1	E 2	E 3	E 4	Total I-CVI
Subscale 1													
1	4	Y	4	Y	4	Y	2	N	1	1	1	2	.75
2	4	Y	4	Y	3	N	4	Y	2	2	5	4	1.00
3	2	N	3	Y	2	N	4	Y	4	4	6	5	.50
4	4	Y	4	Y	3	N	4	Y	5		2	6	1.00
5	4	Y	3	Y	4	Y	4	Y			7	7	1.00
6	3	Y	3	Y	4	Y	4	Y					1.00
7	2	N	1	Y	2	N	4	Y					.25

									Best questions				
Item	Expert 1 (E 1)	Clarity	Expert 2 (E 2)	Clarity	Expert 3 (E 3)	Clarity	Expert 4 (E 4)	Clarity	E1	E 2	E 3	E 4	Total I-CVI
Subscale 2													
1	4	Y	4	Y	4	Y	4	Y	1	3	1	1	1.00
2	2	Y	3	Y	4	Y	4	Y	3	1	2	4	.75
3	4	Y	4	Y	3	Y	4	Y	4	4	3	5	1.00
4	4	Y	4	Y	4	Y	4	Y	5	7	4	6	1.00
5	3	Y	3	Y	3	N	4	Y			7	7	1.00
6	2	Y	3	Y	3	N	4	Y					.75
7	3	Y	4	Y	4	Y	4	Y					1.00
Subscale 3													
1	4	Y	2	N	4	Y	4	Y	1	6	1	1	.75
2	3	Y	4	Y	4	Y	2	N	2	3	2	4	.75
3	4	Y	4	Y	4	Y	3	Y	3	2	3	5	1.00
4	3	Y	4	Y	4	Y	4	Y	6	4	4	6	1.00
5	4	Y	3	Y	3	N	4	Y		7	7	7	1.00
6	3	Y	4	Y	3	N	4	Y					1.00
7	4	Y	3	Y	4	Y	4	Y					1.00

The S-CVI for more than two experts (as is the case in this research), is defined as the proportion of items that achieved a rating of three (3) or four (4) by the content experts (Polit & Beck, 2006:491). A S-CVI of .80 or higher is considered to be acceptable (Polit & Beck, 2006:493). There are different ways in calculating the S-CVI; the method used during this research will be discussed. The different methods for calculating the S-CVI have different abbreviations. The different abbreviations indicate which method of calculation was used and are then added to the S-CVI (e.g. S-CVI/Ave). Please refer to Table 4.4 for the results obtained for the S-CVI.

Based on the results obtained from the I-CVI and the S-CVI the following changes were made to the items:

- *Subscale 1*

Item no. 1 and item no. 3: The item formulation was changed.

Item no. 7: After a consensus discussion (between the researcher and promoters), it was decided to delete item no. 7 due to its low I-CVI and S-CVI.

- *Subscale 2*

Item no. 2 and item no. 6: The item formulation was changed.

- *Subscale 3*

Item no. 1: The item formulation was changed.

Where indicated that the item formulation was changed, the wording of the item was revised, based on the results obtained and the comments received from the experts.

The researcher in consultation with the promoters and statistician also revised the following items. These items were revised to either make them positive or negative or to exclude the item from having different interpretations.

- *Subscale 3*

Item no. 3, 5 and item no. 6: the formulation was changed.

The table below summarises the results obtained from the content validity index (S-CVI) (for the total scale). Discussion follows.

Table 4.4 Content validity scale index (S-CVI)

S-CVI						
Item	Expert 1	Expert 2	Expert 3	Expert 4	Number in agreement	I-CVI
Subscale 1						
1	X	X	X	-	3	.75
2	X	X	X	X	4	1.00
3	-	X	-	X	2	.50
4	X	X	X	X	4	1.00
5	X	X	X	X	4	1.00
6	X	X	X	X	4	1.00
7	-	-	-	X	1	.25
Subscale 2						
1	X	X	X	X	4	1.00
2	-	X	X	X	3	.75
3	X	X	X	X	4	1.00
4	X	X	X	X	4	1.00

Item	Expert 1	Expert 2	Expert 3	Expert 4	Number in agreement	I-CVI
5	X	X	X	X	4	1.00
6	-	X	X	X	3	.75
7	X	X	X	X	4	1.00
Subscale 3						
1	X	-	X	X	3	.75
2	X	X	X	-	3	.75
3	X	X	X	X	4	1.00
4	X	X	X	X	4	1.00
5	X	X	X	X	4	1.00
6	X	X	X	X	4	1.00
7	X	X	X	X	4	1.00
TOTAL:						.88

For this research the averaging approach method (S-CVI/Ave) was used, as it was considered adequate for this research, and is also widely recommended (Polit & Beck, 2012:337). The above mentioned approach as explained by Polit and Beck (2006:493) was followed. All the items were listed below each other in a table format. Each of the expert's findings of three (3) or four (4) are then marked with an X (thus, items rated relevant). All the X's were added together and divided by the total number of ratings. In this case: $X's = 74$; $21 \text{ (items)} \times 4 \text{ (experts)} = 84$. $74/84 = .88$.

The S-CVI for this research was: **.88**. Please see table 4.4 for a summary of the results.

4.3.1.3.3 Qualitative evaluation (Face validity)

After the CVI has been determined, the qualitative evaluation starts in order to determine the face validity. Face validity can be described as "looking" valid (Pietersen & Maree, 2007:217). In other words is it measuring what it is supposed to measure? According to Babbie (2008:160) face validity is the quality of an indicator that makes it a reasonable measure. The attributes were used to formulate the items. The relevance of the items was critically examined by experts in the field of moral distress and instrument development, as well as the participants who participated during the qualitative evaluation process who were representative of the target population.

This entails that the instrument be given to participants, not experts in the field, but representative of the target group, to be completed. The participants must judge the clarity of the instrument and the researcher should determine the time it takes to complete the instrument. After completion, the recommendations from the participants are applied to the instrument (Benson & Clark, 1982:793).

During this research the participants for the qualitative evaluation were given the revised instrument, as per recommendation from the experts (see Addendum D). The participants were then asked to comment on the clarity of the items and the researcher determined the time it took for the participants to complete the instrument. The population in this phase of the study was a group of students of the open distance learning unit programme doing a nursing education diploma. These participants were all professional nurses working in different environments in hospitals and clinics in the North-West Province of South Africa. The instrument was given to N=20 participants to complete and n=17 participants completed the instrument. Afterwards a focus group (see Addendum D) was held where the questions' clarity and outlay of the instrument was discussed. All the participants found the questions to be clear and found no items to be confusing or unclear. Three of the participants found the item format "never, rarely, sometimes, often" to be very similar. However, after review (see

Addendum D [iii]) and discussion with the statistician and promoters, the researcher kept the item format the same. It took the participants approximately ten minutes to read through the information leaflet and to complete the instrument.

The following table (Table 4.5) is the completed instrument that was given to participants for completion of the pilot study.

Table 4.5 Moral Distress Instrument

		Never	Rarely	Sometimes	Often
1.	I am restricted from implementing my morals and value system when caring for my patient.	1	2	3	4
2.	I feel satisfied with the amount of authority I have at work.	1	2	3	4
3.	I feel I am able to apply my skills as I would like.	1	2	3	4
4.	I am expected to implement policies and procedures without question.	1	2	3	4
5.	I am expected to provide care that is not within my morals and value system.	1	2	3	4
6.	I feel that the physician respects my input with regards to patient care.	1	2	3	4
7.	I feel I can advocate on my patients' behalf.	1	2	3	4
8.	I am able to be completely honest with my patient.	1	2	3	4
9.	I am expected to be part of procedures that I morally do not agree with.	1	2	3	4
10.	I feel that my skills are valued.	1	2	3	4
11.	I am able to provide the care I would like to give to my patient.	1	2	3	4
12.	I am able to act according to my morals and value system while caring for my patient.	1	2	3	4
13.	I feel excluded from the decision process regarding patient care.	1	2	3	4
14.	I feel my colleagues respect my morals and value system.	1	2	3	4
15.	I feel satisfied with the number of independent decisions that I can exercise regarding patient care.	1	2	3	4

		Never	Rarely	Sometimes	Often
16.	I am expected to carry out the physician's orders, even though I disagree.	1	2	3	4
17.	I feel excluded from the decision process regarding management issues.	1	2	3	4
18.	I am able to respect the wishes of my patient.	1	2	3	4
19.	I feel helpless to protect my patient from suffering.	1	2	3	4
20.	I feel I do everything that I can for my patient.	1	2	3	4

4.4 CONCLUSION

For the I-CVI seven items did not measure 1.00 and the remaining 14 items measured 1.00. The results for the S-CVI were .88. The feedback from the experts that were received during the content validity processes was incorporated, and six items were revised and one item deleted. Three more items were revised in consultation with the statistician and the promoters. During the qualitative evaluation, the items were deemed clear. The results obtained from the content validation and content validity index were deemed reliable.

4.5 SUMMARY

The objective of Chapter Four was to develop and validate the instrument. The process of constructing the items, the content validation, the content validity index and face validity were discussed. The validation process will continue in Chapter Five with the determining of construct-, discriminant- and divergent validity.

CHAPTER FIVE

CHAPTER FIVE

PHASE THREE: QUANTITATIVE EVALUATION OF INSTRUMENT

5.1 INTRODUCTION

In Chapter Four the process regarding the development of the instrument to measure moral distress was discussed. The validation of the instrument is discussed in Chapter Five.

5.2 DATA COLLECTION

Data collection occurred over a period of one week at a public hospital in the Free State (see Chapter Two, Table 2.5). This hospital was chosen based on the vast amount of different clinical departments (see Chapter Two, Section 2.4.5). A meeting was scheduled at the beginning of that week during which the nursing manager, quality control manager and the operational managers of the hospital attended an information session regarding the research. The quality control manager, as well as the operational managers of the hospital was assigned by the nursing manager to assist with the distribution and collection of the instruments. A list of the different departments as well as the professional nurses was obtained from the nursing manager beforehand. All-inclusive sampling was applied (see Chapter Two, Table 2.5).

The instruments (Moral Distress Instrument (see Addendum G [ii]), Job Satisfaction Survey (1985) (see Addendum H [ii]) and Maslach Burnout Inventory (1981)) (see Addendum I) were accompanied by an information letter (see Addendum G [i]) explaining the research study and also contained the contact details of the researcher, should there be any questions or uncertainties. Please refer to Section 5.3.1.4 and 5.3.1.5 for a detailed description of the instruments that were used.

In Figure 5.1 the process, as described by Benson and Clark (1982:790) for instrument development and validation is presented. The coloured section indicates where Chapter Five falls in the process.

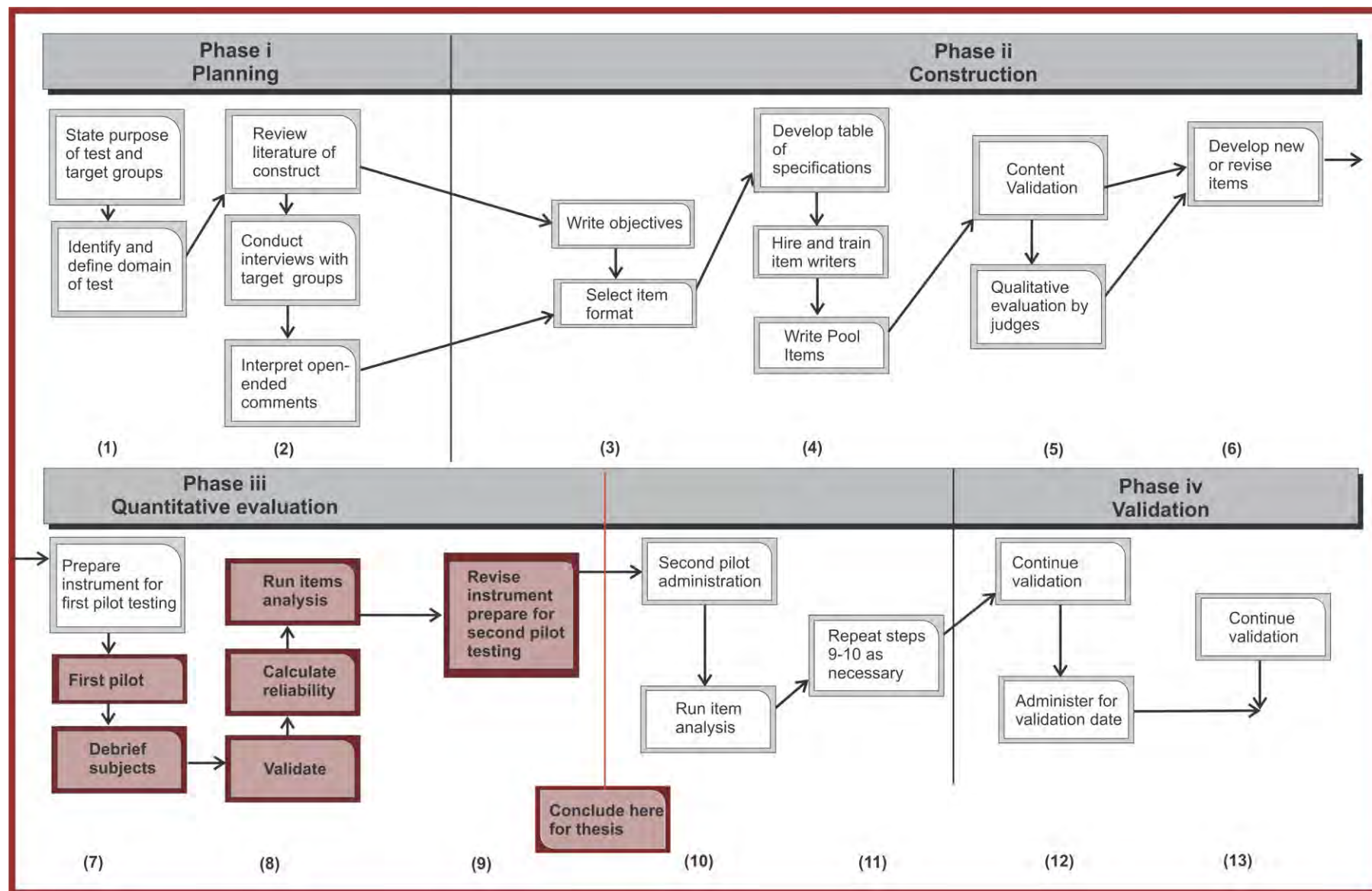


Figure 5.1 Flowchart for Instrument Development (Benson & Clark, 1982:790)

5.3 DATA ANALYSIS

Demographic and clinical facility characteristics were presented by using descriptive statistics that included the mean, standard deviation, frequency and percentage (Burns & Grove, 2009:269). A discussion of the statistical analyses that were performed follows.

Measures of central tendency were used to describe the mean and the standard deviation of the subscales. Central tendency is a statistical procedure used to determine the centre of distribution of scores (Burns & Grove, 2009:471). According to Howell (2004:61) the mean is the sum of the scores divided by the number of scores. One could generally think of the word “average” and that would describe what the mean is. Standard deviation indicates the average amount of deviation from values from the mean (Polit & Beck, 2012:387). A frequency distribution was conducted for each of the items and was used to organize the values data systematically from the lowest to the highest. A count of the number of times that each value was obtained is also reported (see Table 5.4, 5.14 and 5.16), the values are also displayed as percentages and the sum of all percentages should equal 100 (Polit & Beck, 2012:382).

A principle component factor analysis with Oblimin rotation with Kaizer Normalization was used to identify the subscales of the moral distress instrument. Factor analysis is used to identify a number of factors as clusters that correlate with the variables linked together; therefore correlations between variables are identified. Factor analysis usually involves:

- Computing the inter-correlations between the variables
- Extracting initial factors
- Rotating the factors to obtain a clearer picture of the factor content (Terre Blanch *et al.*, 2006:248)

Factor analyses with Oblimin rotation is performed in order to determine which items belong together and are determined in the similarity of answers of the participants and therefore measure the same factor or dimension (Maree *et al.*, 2007:219). Exploratory factor analysis deals with the hypotheses that were formulated about dimensionality of a set of items (Polit & Beck, 2012:363). Confirmatory factor analysis usually follows exploratory factor analysis and determines the statistical significance of the analysis outcomes (Burns & Grove, 2009:485).

The Bartlett’s test of sphericity was used to determine the strength of the relationship between the variables. The probability reported was $p < .0001$ which supported the use of factor analyses. Munro (2005:336) is of the opinion that a Kaizer-Meyer-Olkin (KMO) measure of sampling adequacy between 0.80 – 0.90 supports the use of factor analyses. The KMO was

used to examine sample adequacy and measured .825. Items with a factor loading of above .30 and factors containing at least three items were used for factor interpretation.

Internal consistency was measured through Cronbach's alpha coefficient. Cronbach's alpha is considered the most widely used method for evaluating internal consistency (Polit & Beck, 2012:333). According to Pietersen and Maree (2007:216) internal consistency is also referred to as internal reliability. When a certain construct is measured, there should be a high degree of similarity among the items in a subscale, as they are measuring one common construct. Cronbach's alpha is based on inter-item correlations. Internal consistency is high and close to 1.00 if the items are strongly correlated with each other. If items do not correlate strongly the alpha coefficient will be close to zero and indicates that the items are poorly formulated (Maree *et al.*, 2007:216).

Effect size is used to determine the strength of relationships amongst variables (Polit & Beck, 2012:285). Effect size measures practical significance and is independent of the sample size, and can be explained as determining the importance in practice. A relationship with an effect size of $w \geq 0.5$ is considered practically significant (Ellis & Steyn, 2003:51).

Correlations and ANOVA's were performed to determine associations. ANOVA compares variance within each group with the variance between groups (Burns & Grove, 2009:502). The Chi-squared test is used to determine whether two variables are independent (in other words there is no relationship) or dependent (the variables are related) (Pietersen & Maree, 2007:246). Spearman's rank order correlations were applied to the newly developed Moral Distress Instrument, the Job Satisfaction Survey (1985) (Subscales: work, pay, promotion and supervision) and the Maslach Burnout Inventory (1981) (Subscales: Emotional Exhaustion, Personal Accomplishment and Depersonalization) to determine criterion validity.

5.3.1 Validity

A discussion of the validity of the newly developed Moral Distress Instrument follows.

5.3.1.1 Construct validity

Babbie (2008:161) is of the opinion that construct validity is based on logical relationships among variables, and is the degree to which a measure relates to variables that are part of a theoretical relationship. Construct validity examines the fit between variables, namely that of the conceptual definition and the operational definition. Theoretical constructs are defined within the conceptual definition and provide the basis for the operational definition of the variables (Burns & Grove, 2009:224). Under construct validity there are a variety of sources

of evidence and these include: content validity, face validity, predictive validity, concurrent validity, convergent validity, discriminant validity, known-groups validity and nomological validity (Netemeyer *et al.*, 2003:93).

In this study, the following forms of validity testing were performed, namely: content validity, face validity (see Chapter Four, Section 4.3.1.3.1 and 4.3.1.3.3), discriminant validity and divergent validity (see Section 5.4.7.1 and 5.4.7.2).

5.3.1.2 Content validity

Where the content validation process is followed rigorously, the construct validity will also be strengthened (Polit & Beck, 2012:339). Content validity examines the extent to which the major elements related to the construct are being measured (Burns & Grove, 2009:693). Content validity was ensured through conducting an integrative literature review whereby the antecedents, consequences, attributes and empirical indicators (see Chapter Three, Section 3.2.1.5, 3.2.1.6 and 3.2.1.10) of moral distress were identified. These findings were confirmed by conducting semi-structured interviews (see Chapter Three, Section 3.2.2). Content validity was further ensured through a quantitative evaluation as well as a qualitative evaluation of experts. During the quantitative evaluation (see Chapter Four, Section 4.3.1.3.1), experts from the field of moral distress and instrument development were asked to evaluate the Moral Distress Instrument by evaluating the clarity of the items as well as the relevance of the items that were included. The experts rated this evaluation and the content validity index was determined (see Chapter Four, Section 4.3.1.3.2). The qualitative evaluation was performed by professional nurses working in the clinical field and was representative of the target group. The professional nurses were asked to evaluate the clarity of the items that was included. A focus group session was held after completion of the instrument to discuss the evaluation of the professional nurses (see Chapter Four, Section 4.3.1.3.3).

5.3.1.3 Criterion validity

Criterion validity is sometimes also referred to as predictive validity and implies that an item has empirical association with some criterion, with the value being the strength of the association (DeVellis, 2012:61). Criterion validity determines whether an instrument is measuring what it is supposed to measure and the correlation between the instrument and criterion is an indication thereof (Maree *et al.*, 2007:217).

There are different opinions regarding the use of criterion validity. Convergent-, discriminant- and divergent validity are defined in different ways in most textbooks and online sources, thus in this study; in consultation with the promoters and statistician it was decided to perform discriminant and divergent validity as described by Burns and Grove (2009).

5.3.1.4 Discriminant validity

Characteristics that are associated with group membership can be identified through discriminant validity, which can also help predict group membership (Burns & Grove, 2009:387). Constructs that are similar, unrelated or different are compared to the construct under study. Prior to the construct being measured, the expected relationship between the items and construct are hypothesized. The hypothesis is then either confirmed or refuted through a comparison of associations. If the hypothesis is confirmed, support is provided that the variable has been identified (DeVellis, 2012:69). When working with psychological variables, discriminant validity tests whether concepts or measurements that are supposed to be related are indeed related (Field, 2009:675). Emotional exhaustion (EE) and depersonalization (DP) from the Maslach Burnout Inventory (MBI) (1981) (see Addendum I) was used to determine discriminant validity during this research. It was hypothesized that the moral distress instrument and EE and DP scales of the MBI would be positively correlated. The MBI is an instrument that measures burnout. Burnout is a condition that can occur when working with people and is described as a syndrome of physical and mental exhaustion, reduced personal accomplishment and depersonalization (negative or cynical attitude). The MBI consists of 22 items and three subscales and includes:

Emotional Exhaustion (No. 1, 2, 3, 6, 8, 13, 14, 16 and 20 in questionnaire)

- Includes aspects of depleted emotional resources.
- Feelings of no longer being able to give of the self.

Depersonalization (No. 5, 10, 11, 15 and 22 in questionnaire)

- Includes aspects of negative, cynical attitudes and feelings.

Personal Accomplishment (No. 4, 7, 9, 12, 17, 18, 19 and 21 in questionnaire)

- Includes the tendency to evaluate one negatively.
- Includes feelings of unhappiness and dissatisfaction.

The coefficient alpha achieved for each subscale was .90, .79, and .71 respectively.

5.3.1.5 Divergent validity

Divergent validity is used to measure the opposite of the construct that is being studied and to correlate the data that is collected with the newly developed instrument study (Burns & Grove, 2009:387). If the divergent measure is negatively correlated with the newly developed instrument, validity for each instrument is strengthened. The personal accomplishment (PA) subscale from the Maslach Burnout Inventory (MBI) (1981) and the Job Satisfaction Survey (JSS) (1985) (see Addendum H) (subscales: operating procedures, co-workers, nature of work and communication) developed by Prof P E Spector was used to determine divergent validity. It was hypothesized that the moral distress instrument and the PA subscale of the MBI and the JSS (subscales used: operating procedures, co-workers, nature of work and communication) would be negatively correlated. The JSS was developed to measure dimensions of job satisfaction and was developed in human services. Complex interactions occur between an individual and an organization and job satisfaction is the effect that is produced. The JSS makes use of a six-point Likert rating scale which ranges from disagree very much, disagree moderately, disagree slightly, agree slightly, agree moderately, and agree very much. The JSS has nine subscales, namely: pay, promotion, supervision, benefits, contingent rewards, operating procedures, co-workers, nature of work and communication. The four subscales that were used in this study were: Operating procedures, co-workers, nature of work and communication. The subscales were chosen based on the results from the integrative literature review, and only those subscales that directly linked to the antecedents of moral distress were used and include:

Operating procedures (No. 1, 5, 9 and 13 in questionnaire)

- Includes aspects such as rules and procedures making doing one's job difficult.
- Efforts to do good are blocked by red tape.
- Have too much work to do.

Coefficient alpha: .62

Co-workers (No. 2, 6, 10 and 14 in questionnaire)

- Aspects regarding relationships with colleagues.

Coefficient alpha: .60

Nature of work (No. 3, 7, 12 and 15 in questionnaire)

- Work can feel meaningless.
- Employees enjoy the work that they do.
- Employee has a sense of pride.

Coefficient alpha: .78

Communication (No. 4, 8, 11 and 16)

- Aspects regarding communication with the organization.
- Goals of the organization.
- Knowledge of organization.

Coefficient alpha: .71

The coefficient alpha achieved for the total scale: .91.

5.4 RESULTS

The results of each section are presented.

5.4.1 Response rate

Five hundred (N = 500) questionnaires were distributed amongst the professional nurses of the specific hospital, and of the 500 distributed questionnaires, 244 (n = 244) professional nurses completed the questionnaires (a 49 % response rate) (see Table 5.1). According to Babbie (2008:289) a response rate of 50 % is considered adequate for analysis and reporting.

Table 5.1 summarises the response rate that was obtained. The response rate of 49 % includes the general response rate that was obtained.

Table 5.1 Response rate

Questionnaires distributed	500
Questionnaires completed	244
Response rate	49 %

5.4.2 Department profile

The researcher did not want to include only certain departments in the hospital, but chose to include all departments. Therefore, professional nurses from all departments were included (see Table 5.2). The reason was that the researcher wanted the instrument to be validated for all departments where professional nurses are working and not just certain situations.

Table 5.2 gives an overview of the response rate from the different departments. Each department is mentioned together with the number of questionnaires that was completed from that department as well as the percentage of their contribution.

Table 5.2 Percentage responses from different departments

Department	Number of questionnaires completed	Percentage
ICU (Includes all ICU's)	30	12.3 %
Operating Theatre	29	11.9 %
Emergency Room	3	1.2 %
Medical	44	18 %
Surgical	28	11.5 %
Paediatric	25	10.2 %
Clinics	22	9.0 %
Other	31	12.7 %
Undisclosed	32	13.1 %

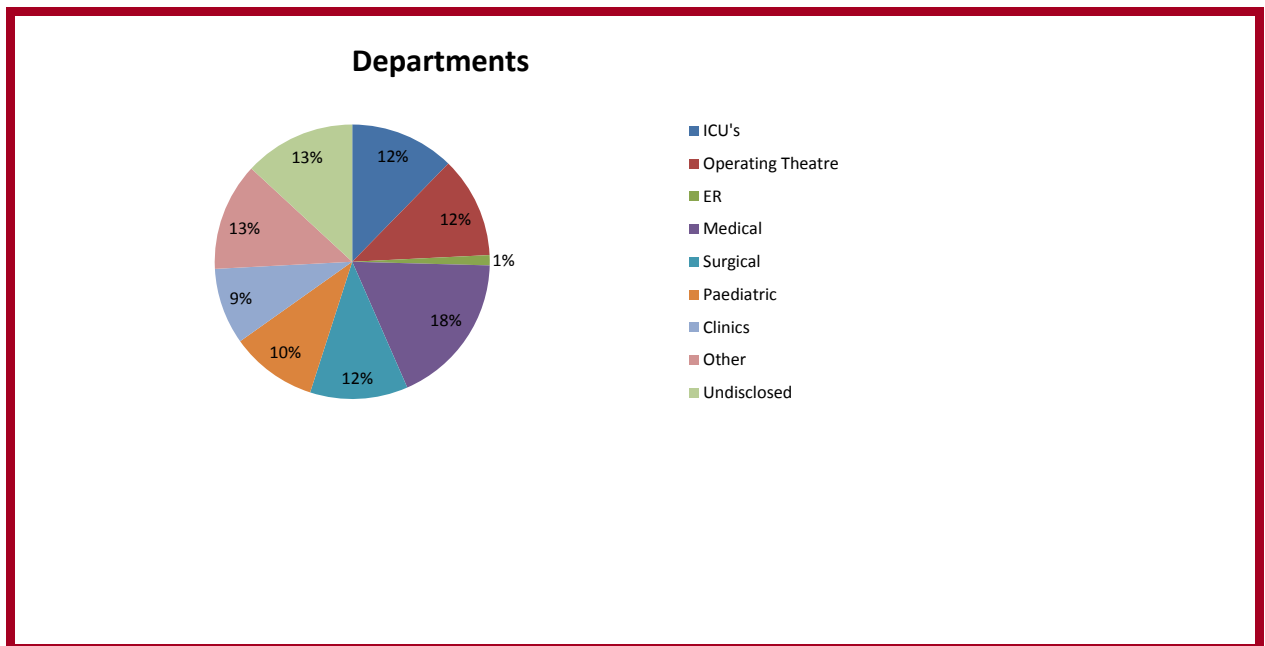


Figure 5.2 Departmental response rates

The greatest single response rate came from the medical wards with 44 completed questionnaires, followed by other with 31 completed questionnaire (departments in the hospital that were not specified on the demographic profile). The response rate of 44 completed questionnaires from the medical wards might be because professional nurses are keen to assist in research regarding moral distress because they may feel it is applicable to their situation where medical wards often have high workloads, moral dilemmas in the care of HIV/AIDS and TB patients and often have staff shortages.

5.4.3 Demographic profile

Table 5.3 summarises the demographic characteristics that were obtained during the data collection.

Table 5.3 Demographic characteristics

	Percentage (%)
Gender	
Male	11.9 %
Female	77.9 %
Undisclosed	10.2 %
Education	
Diploma in Nursing	59 %
Baccalaureate degree in Nursing	11 %
Undisclosed	30 %
Work Schedule	
Fulltime	95.5 %
Part time	1.2 %
Undisclosed	3.3 %

The gender profile of the hospital indicated that the nurses working there were predominantly female (n = 190), 77.9 %, compared to the 11.9 % males (n = 29), this is comparable with South African Nursing Council (SANC) statistics, where 118 198 nurses are female as compared to 6 973 males (SANC, 2013). According to SANC (2013) statistics (n=6 973) female and (n=973) male nurses are currently registered in the Free State Province. The participants' ages ranged from 24 to 64 years old, with the mean age of 45 years and 41 % (n = 100) not disclosing their age. Professional nurses are younger in this study than national statistics, which shows that the largest single proportion is in the age group of 50-59 years (SANC, 2013). Of the participants, 145 (59 %) qualified with diplomas in nursing and 28 (11 %) were educated at Baccalaureate level. This is comparable with SANC (2013) statistics where the majority (nearly two-thirds) of professional nurses registered, completed a diploma in nursing (SANC, 2013).

Working experience of the participants ranged from having worked one year as a professional nurse to 42 years, with the mean number 17 years, working as professional nurse while (n = 56) 23 % did not disclose their years of working as a professional nurse.

Most of the professional nurses who completed the questionnaire were full-time employees 95 % (n = 233) and 1 % (n = 3) of the professional nurses were part-time employees of the hospital. Please see Table 5.3 for a summary of the demographic characteristics.

5.4.4 Moral Distress Instrument

The results for each item from the moral distress instrument will be depicted together with the frequency and percentage of the specific item. The participants had to choose between 1 = Never; 2 = Rarely; 3 = Sometimes and 4 = Often to rate their answer. A discussion follows after Table 5.6.

Table 5.4 Results for moral distress instrument (original) items

No.	Question	Scale	Frequency	Percentage	Mean	Standard deviation
1	I am restricted from implementing my morals and value system when caring for my patient.	1	56	23	2.43	.99
		2	51	21		
		3	95	39		
		4	31	13		
		Missing	11	5		
2	I feel satisfied with the degree of authority I have at work.	1	16	7	2.78	.85
		2	69	28		
		3	103	42		
		4	50	21		
		Missing	6	3		
3	I feel I am able to apply my skills as I would like.	1	16	7	3.11	.88
		2	35	14		
		3	96	39		
		4	95	39		
		Missing	2	.8		
4	I am expected to implement policies and procedures without question.	1	24	9	3.08	1.00
		2	39	16		
		3	67	28		
		4	106	43		
		Missing	8	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard deviation
5	I am expected to provide care that is not within my morals and value system.	1 2 3 4 Missing	83 49 81 22 9	34 20 33 9 4	2.17	1.02
6	I feel that the physician respects my input with regard to patient care.	1 2 3 4 Missing	19 38 103 77 7	8 16 42 32 3	3.00	.89
7	I feel I can advocate on my patients' behalf.	1 2 3 4 Missing	3 31 67 140 1	1 13 28 58 1	3.42	.76
8	I am able to be completely honest with my patient.	1 2 3 4 Missing	1 7 57 178 1	.4 3 23 73 .4	3.69	.54

No.	Question	Scale	Frequency	Percentage	Mean	Standard deviation
9	I am expected to be part of procedures that I morally do not agree with.	1 2 3 4 Missing	87 48 59 47 3	36 20 24 19 1	2.27	1.147
10	I feel that my skills are valued.	1 2 3 4 Missing	19 28 116 79 2	8 12 48 32 .8	3.05	.869
11	I am able to provide the care I would like to give to my patient.	1 2 3 4 Missing	5 20 93 125 1	2 8 38 51 .4	3.39	.72
12	I am able to act according to my morals and value system while caring for my patient.	1 2 3 4 Missing	8 23 90 118 5	3 9 37 48 2	3.33	.78

No.	Question	Scale	Frequency	Percentage	Mean	Standard deviation
13	I feel excluded from the decision process regarding patient care.	1	33	14	2.48	.86
		2	82	34		
		3	97	40		
		4	26	11		
		Missing	6	3		
14	I feel my colleagues respect my morals and value system.	1	18	7	3.08	.91
		2	35	14		
		3	94	39		
		4	92	38		
		Missing	5	2		
15	I feel satisfied with the number of independent decisions that I can exercise regarding patient care.	1	13	5	3.05	.81
		2	34	14		
		3	118	48		
		4	73	30		
		Missing	6	3		
16	I am expected to carry out the physician's orders, even though I disagree.	1	46	19	2.55	1.03
		2	63	26		
		3	76	31		
		4	51	21		
		Missing	8	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard deviation
17	I feel excluded from the decision process regarding management issues.	1 2 3 4 Missing	19 55 77 84 9	8 23 32 34 4	2.96	.95
18	I am able to respect the wishes of my patient.	1 2 3 4 Missing	5 17 52 167 3	2 7 21 68 1	3.58	.71
19	I feel helpless to protect my patient from suffering.	1 2 3 4 Missing	54 42 101 40 7	22 17 41 16 3	2.53	1.02
20	I feel I do everything that I can for my patient.	1 2 3 4 Missing	4 6 54 177 3	2 3 22 73 1	3.67	.60

Each of the subscales will be discussed with regard to the results. The moral distress instrument has three subscales namely:

Subscale 1: Compromised morals and value system

Questions: 1, 5, 9, 12, 14

Reverse score item: 12

Subscale 2: Violated professional autonomy

Questions: 3, 4, 6, 10, 13, 15, 16, 17

Reverse score item: 3, 6, 10, 15

Subscale 3: Powerlessness

Questions: 2, 7, 8, 11, 18, 19, 20

Reverse score item: 2, 7, 8, 11, 18, 20

5.4.4.1 Compromised morals and value system

Forty-eight per cent of participants felt that they were often able to act according to their morals and value system when caring for their patients. Thirty-nine per cent of participants felt that their colleagues sometimes respected their morals and value system and 39 % of the participants felt that they were sometimes restricted from implementing their morals and value system when caring for their patients. In general, the participants most agreed with the item "I am able to act according to my morals and value system while caring for my patient" ($M=3.33$), while they least agreed ($M=2.17$) with the item "I am expected to provide care that is not within my morals and value system".

5.4.4.2 Violated professional autonomy

Thirty-nine per cent of participants felt that they were sometimes to often able to apply their skills as they would like and 43 % felt that they were often expected to implement policies and procedures without question. Forty-eight per cent of participants felt that their skills were sometimes valued. In general the participants most agreed with the item "I feel I am able to apply my skills as I would like" ($M=3.11$), while they least ($M=2.48$) agreed with regard to "I feel excluded from the decision process regarding patient care".

5.4.4.3 Powerlessness

Seventy-three per cent of the participants felt they could often be completely honest with their patients. Seventy-three per cent of the participants claimed that they often felt that they did everything that they could for their patients and 68 % felt that they could often respect the wishes of their patients. In general, the participants most agreed with the item “I am able to be completely honest with my patient” (M=3.69) and least (M=2.53) agreed with the item “I feel helpless to protect my patient from suffering”.

5.4.4.4 Exploratory factor analysis

KMO values between 0.5 and 0.7 are seen as mediocre, between 0.7 and 0.8 are considered good, between 0.8 and 0.9 great and >0.9 superb (Hatcheson & Sofroniou, 1999:76). The KMO for the five factor analyses was found to be .825 and a 62.5 % variance was declared, which is considered good.

During the pattern matrix, Kaisers criterion extracted subscales. In Table 5.5 the pattern matrix as derived from the data, is presented.

Table 5.5 Pattern Matrix (five factor analysis)

Subscale	Item no.	Item	Factor				
			1	2	3	4	5
1	q1n14	Colleagues respect morals and value system	.796		-.263		
3	q1n7	Advocate on patients' behalf	.613		.226		
3	q1n18	Can respect wishes of patient	.603				
1	q1n12	Able to act according to morals and value system	.329	-.214	.209		
2	q1n15	Satisfied with independent decisions exercised	.318			.259	-.290
1	q1n9	Be part of procedures not morally agree with		.739			
1	q1n5	Expected to provide care not within morals and value system		.675			
1	q1n1	Restricted from implementing morals and value system		.471			
2	q1n4	Expected to implement policies and procedures	.214	.452			
2	q1n16	Expected to carry out physicians' orders		.437			.432
3	q1n20	Do everything for patient			.685		
3	q1n8	Able to be completely honest with patient			.517		
3	q1n11	Able to provide care as liked to patient	.260		.401		-.292
3	q1n2	Satisfied with amount of authority at work				.824	
2	q1n3	Able to apply skills as liked	.221			.533	
2	q1n6	Physician respect input		.282	.256		-.547

2	q1n13	Exclusion from decision process (patient care)					.524
3	q1n19	Helpless to protect patient		.207			.400
2	q1n17	Excluded from decision process (management issues)		.251	.253	-.271	.334
2	q1n10	Skills are valued				.285	-.330

- Shaded values indicate best grouping.

With the five factor analyses, the following were included in each factor:

Factor 1 – Item 7, 12, 14 and 18

Factor 2 – Item 1, 4, 5 and 9

Factor 3 – Item 8, 11 and 20

Factor 4 – Item 2 and 3

Factor 5 – Item 6, 10, 13, 15, 16, 17 and 19

From the integrative literature review, the researcher identified three subscales. Therefore the five factor analyses resulted in more factors than anticipated.

According to the results, the following items stood out, namely item 2, 3, 4, 14 and 19. Although the other items grouped well together, the above mentioned did not (when looking at the subscales as determined during the integrative literature review). Each of the items that stood out is discussed separately.

- Item 2 (*I feel satisfied with the degree of authority I have at work*)

It might be that the participants did not understand the question or did not know the degree of authority they have at work.

- Item 3 (*I feel I am able to apply my skills as I would like*)

It might be that the participants did not understand the question. It might also be that the phrasing of the question was ambiguous.

- Item 4 (*I am expected to implement policies and procedures without question*)

It might be that the participants did not understand the question. It might also be that the phrasing of the question was ambiguous.

- Item 14 (*I feel my colleagues respect my morals and value system*)

It might be that the participants did not understand the question. It might also be that the participants felt their colleagues did not know their morals and value system, as these are not discussed at work.

- Item 19 (*I feel helpless to protect my patient from suffering*)

It might be that the participants did not understand the question. It might also be that the question should be phrased differently.

The researcher in consultation with the statistician and promoters decided to do a three factor analysis to see what emerged from the three factor analysis. It was also decided to remove the five (2, 3, 4, 14 and 19) items that did not group well during the five factor analysis.

In Table 5.6 the three factor analysis with the remaining 15 items are presented. A KMO of .811 for the three factor analyses and 49.4 % of variance was explained after the five items were removed.

Table 5.6 Pattern matrix (three factor analysis)

Subscale	Item no.	Item	Factor		
			1	2	3
			Powerlessness	Compromised morals and value system	Violated professional autonomy
3	q1n7	Advocate on patients' behalf	.684		
3	q1n18	Can respect wishes of patient	.600		
3	q1n11	Able to provide care as liked to patient	.599		
3	q1n20	Do everything for patient	.580		
3	q1n8	Able to be completely honest with patient	.485		
1	q1n12	Able to act according to morals and value system	.466	-.258	

2	q1n15	Satisfied with independent decisions exercised	.450		-.378
1	q1n9	Be part of procedures not morally agree with		.771	
1	q1n5	Expected to provide care not within morals and value system		.685	
1	q1n1	Restricted from implementing morals and value system		.489	
2	q1n16	Expected to carry out physicians' orders		.420	.268
2	q1n13	Exclusion from decision process (patient care)			.568
2	q1n17	Excluded from decision process (management issues)	.248	.296	.550
2	q1n6	Physician respect input	.428	.250	-.491
2	q1n10	Skills are valued	.319		-.409

- Shaded values indicate best grouping.

The grouping of the items were more satisfactory with the three factor analysis than with the five factor analysis and it was decided to use the three factor analysis as the final product, the reason being that the groupings correlated well with the subscales that were initially anticipated.

The researcher then did a comparison of the results achieved with the three factor analysis and the initial subscales that were formulated (as discussed in Chapter Three, Section 3.2.1.10).

Table 5.7 Comparison of subscales and factors from three factor analysis

Factor	Item
<i>Factor 1</i> represents:	
Powerlessness	*7, *8, *11, *12, *18, *20
(Subscale 3)	Items 2 and 19 were removed
	Item 12 was added
<i>Factor 2</i> represents:	
Compromised morals and value system	1, 5, 9, 16
(Subscale 1)	Item 14 was removed
	Item 12 was moved
	Item 16 was added
<i>Factor 3</i> represents:	
Violated professional autonomy	*6, *10, 13, *15, 17
(Subscale 2)	Items 3 and 4 were removed
	Item 16 was moved

*Item should be reversed scored

Items that were similar to the initial subscales and corresponded during the three factor analysis were kept within the initial subscale. Item 12 (*I am able to act according to my morals and value system while caring for my patient*) was placed with powerlessness during the three factor analysis. The researcher and promoters agreed with this grouping, and item 12 was moved from compromised morals and value system to powerlessness, but had to be reverse scored. It was argued that item 12 was also applicable to powerlessness. Item 16 (*I am expected to carry out the physician's orders, even though I disagree*) was placed with compromised morals and value system during the three factor analysis. The researcher and promoters agreed with this grouping and item 16 was moved from violated professional autonomy to compromised morals and value system, but had to be reverse scored. It was argued that item 16 was also applicable to compromised morals and value system. Items to be reverse scored were: 6, 7, 8, 10, 11, 12, 15, 18 and 20. The instrument was then finalised.

In Table 5.8 the final instrument is presented. This instrument consists of the 15 remaining items.

Table 5.8 Final Moral Distress Instrument

		Never	Rarely	Sometimes	Often
1	I am restricted from implementing my morals and value system when caring for my patient.	1	2	3	4
2	I am expected to provide care that is not within my morals and value system.	1	2	3	4
3	I feel that the physician respects my input with regard to patient care.	1	2	3	4
4	I feel I can advocate on my patients' behalf.	1	2	3	4
5	I am able to be completely honest with my patient.	1	2	3	4
6	I am expected to be part of procedures that I morally do not agree with.	1	2	3	4
7	I feel that my skills are valued.	1	2	3	4
8	I am able to provide the care I would like to give to my patient.	1	2	3	4
9	I am able to act according to my morals and value system while caring for my patient.	1	2	3	4
10	I feel excluded from the decision process regarding patient care.	1	2	3	4
11	I feel satisfied with the number of independent decisions that I can exercise regarding patient care.	1	2	3	4
12	I am expected to carry out the physician's orders, even though I disagree.	1	2	3	4
13	I feel excluded from the decision process regarding management issues.	1	2	3	4
14	I am able to respect the wishes of my patient.	1	2	3	4
15	I feel I do everything that I can for my patient.	1	2	3	4

5.4.4.5 Confirmatory factor analysis

Confirmatory factor analysis is done in order to determine a particular pattern of relationships that was predicted which was based on previous analytic results (DeVellis, 2012:151). In Section 5.4.4.4 the exploratory factor analysis was discussed and the confirmatory factor analysis was done in order to confirm the factors/ subscales that were determined during the exploratory factor analysis. The confirmatory factor analysis that was performed is presented in Figure 5.3

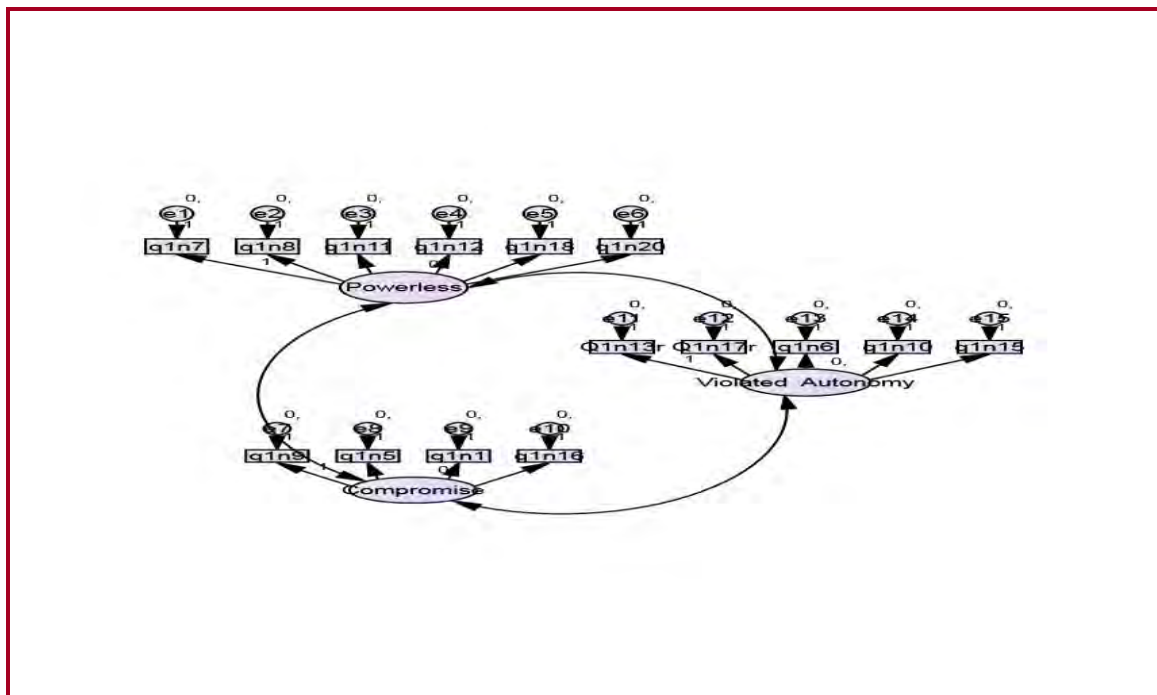


Figure 5.3 Confirmatory factor analysis

In Table 5.9 the regression weights are presented.

Table 5.9 Standardized regression weights

Item no.	Item description		Subscale	Estimate	P-value
q1n7r	Advocate on patients' behalf	<---	Powerlessness	.761	
q1n8r	Able to be completely honest with patient	<---	Powerlessness	.424	<0.001
q1n11r	Able to provide care as liked to patient	<---	Powerlessness	.669	<0.001
q1n12r	Able to act according to morals and value system	<---	Powerlessness	.620	<0.001
q1n18r	Can respect wishes of patient	<---	Powerlessness	.654	<0.001
q1n20r	Do everything for patient	<---	Powerlessness	.403	<0.001
q1n9	Be part of procedures not morally agreed with	<---	Compromised morals and value system	.719	
q1n5	Expected to provide care not within morals and value system	<---	Compromised morals and value system	.705	<0.001
q1n1	Restricted from implementing morals and value system	<---	Compromised morals and	.569	<0.001

Item no.	Item description		Subscale	Estimate	P-value
			value system		
q1n16	Expected to carry out physicians' orders	<---	Compromised morals and value system	.563	<0.001
Q1n13	Exclusion from decision process (patient care)	<---	Violated professional autonomy	.417	
Q1n17	Excluded from decision process (management issues)	<---	Violated professional autonomy	.263	0.002
q1n6r	Physician respect input	<---	Violated professional autonomy	.654	<0.001
q1n10r	Skills are valued	<---	Violated professional autonomy	.585	<0.001
q1n15r	Satisfied with independent decisions exercised	<---	Violated professional autonomy	.700	<0.001

Most regression estimates were statistically significant with $p < 0.05$ (Field, 2009:675). According to the results obtained, item 20 that falls in the subscale powerlessness says the least about powerlessness of the items included in that subscale. In the subscale compromised morals and value system, all the items were considered to represent the subscale very well. Item 17 measured the least in the subscale violated professional autonomy and say the least of violated professional autonomy.

In Table 5.10 the correlations between the subscales are presented.

Table 5.10 Correlations

			Estimate	P-value	Effect
Powerlessness	<-->	Compromised morals and value system	.412	<0.001	Large effect
Violated professional autonomy	<-->	Compromised morals and value system	.322	0.002	Medium effect
Violated professional autonomy	<-->	Powerlessness	.782	<0.001	Large effect

Correlations between the subscales are statistically and practically significant. Powerlessness, compromised morals and value system and violated professional autonomy are positively correlated. Violated professional autonomy and powerlessness; and compromised moral and value system and Powerlessness are strongly correlated.

5.4.4.6 Measures of fit

According to Mueller (1996:83), the Chi-squared test statistic with a $p < 0.001$ is overly strict and should be divided by degrees of freedom. The three-factor model yielded a Minimum Sample Discrepancy divided by Degrees of Freedom (CMIN/DF) value of 2.93 and indicates a good model fit. The investigator's viewpoint largely interprets the size of this value. In practice, ratios as high as 3, 4 or even 5 are still considered a good model fit (Mueller, 1996:83). Hancock and Mueller (2010:379) considered it a good practice to report multiple fit indices, typically from three broad classes. Mueller (1996:83) also describes values above 0.9 as a good overall fit for a Comparative Fit Index. An acceptable Comparative Fit Index (CFI) of 0.82 was found for the three-factor model while a Root Mean Square Error of Approximation (RMSEA) value of 0.089 with a 90 % confidence interval of {0.08;0.10} was obtained, which is acceptable. Blunch (2008:77) states that models with RMSEA values of 0.10 and larger should not be accepted.

5.4.4.7 Reliability

Reliability is an indication that the scores from an instrument are stable and consistent (Creswell, 2009:169). A reliable instrument is seen as an instrument that performs consistently in predictable ways.

A scale is reliable when it represents the true state of the variable that is being assessed (DeVellis, 2012:31). A way of computing reliability is Cronbach's coefficient alpha. The generally accepted value of 0.8 is an appropriate value for cognitive tests and for ability tests 0.7 is more suitable. When one is dealing with psychological constructs, values below even 0.7 can be expected because of the diversity of the constructs that are being measured (Kline cited in Field, 2009:675). The more reliable the scale is the higher the inter-correlation will be (DeVellis, 2012:105). Reliability is calculated after reverse scoring items with a substantial negative phrasing (Polit & Beck, 2012:362). According to Clark and Watson (1995:314) a mean inter-item correlation of .15 - .55 is considered acceptable. The reliability of the results obtained is presented under their subscales, namely:

- *Compromised morals and value system*

The Cronbach's alpha achieved for item 1, 5, 9 and 16 was .73 which is considered acceptable (Kline cited in Field, 2009:675), and a mean inter-item correlation of .40 was achieved.

- *Violated professional autonomy*

The Cronbach's alpha achieved for item 6, 10, 13, 15 and 17 was .69 which is considered acceptable (Kline cited in Field, 2009:675), and a mean inter-item correlation of .31 was achieved.

- *Powerlessness*

The Cronbach's Alpha achieved for item 7, 8, 11, 12, 18 and 20 was .78 which is considered acceptable (Kline cited in Field, 2009:675), and a mean inter-item correlation of .36 was achieved.

As indicated, the Cronbach's alpha for the Moral Distress Instrument is deemed reliable.

In Table 5.11 a summary is presented of the Cronbach's alpha, mean inter-item correlation, mean and standard deviation of the three subscales of the Moral Distress Instrument together with a short description of the results.

Table 5.11 Summary of the Cronbach's alpha, Mean Inter-Item Correlation, Mean and Standard Deviation of the three subscales

Subscale	Cronbach's alpha	Mean Inter-Item Correlation	Mean	Standard Deviation
Compromised morals and value system	.73	.40	2.36	.79
Violated professional autonomy	.69	.31	2.27	.59
Powerlessness	.78	.36	1.49	.47

- Compromised morals and value system

The results of mean scores showed that participants tend to agree that their morals and value system are sometimes compromised.

- Violated professional autonomy

According to the results the autonomy of participants tends to be rarely violated.

- Powerlessness

The results showed that participants tend to rarely feel powerless.

The participants reported having a small degree of moral distress, but so also the results of the JSS and MBI showed a small to moderate degree of job dissatisfaction and burnout.

5.4.4.8 Comparison of moral distress between departments

An ANOVA with Tukey's post hoc test was performed on moral distress between departments. Cohen's d-values are used as a measure of the effect size where values of $d=0.5$ can be regarded as medium important differences in practice (Ellis & Steyn, 2003:51).

The majority of studies on moral distress focused on ICU personnel, and therefore the researcher assumed that the effect size would be larger in the ICU compared to the other departments. To investigate this assumption, the effect size of ICU was compared to the other departments who took part in the study. In Table 5.12 the effect sizes are presented. An interpretation of the largest effect sizes follows.

Table 5.12 Comparison between departments

		Department	N	Mean	Standard Deviation	P-value	Effect size ICU compared to:
Violated Professional Autonomy	1.00	ICU	30	2.25	.64	.39	
	2.00	Theatre	29	2.24	.56		0.01
	4.00	Medical	20	2.32	.60		0.11
	5.00	Surgical	25	2.43	.68		0.26
	6.00	Pediatrics	22	2.35	.52		0.15
	7.00	Maternity	23	2.03	.56		0.34
	10.00	Clinics	22	2.20	.59		0.06
	Total		171	2.26	.60		0.01
Compromised morals and value system	1.00	ICU	30	2.30	.73	.95	
	2.00	Theatre	29	2.17	.70		0.18
	4.00	Medical	20	2.27	.81		0.04
	5.00	Surgical	25	2.33	.79		0.03
	6.00	Pediatrics	22	2.12	.64		0.24
	7.00	Maternity	23	2.30	.84		0.00

		Department	N	Mean	Standard Deviation	P-value	Effect size ICU compared to:
	10.00	Clinics	22	2.22	.66		0.11
	Total		171	2.25	.73		0.07
Powerlessness	1.00	ICU	30	1.46	.53	.085	
	2.00	Theatre	29	1.32	.31		0.24
	4.00	Medical	20	1.48	.67		0.03
	5.00	Surgical	25	1.56	.52		0.18
	6.00	Pediatrics	22	1.54	.37		0.15
	7.00	Maternity	23	1.24	.29		0.39
	10.00	Clinics	22	1.26	.38		0.35
	Total		171	1.41	.46		0.08

5.4.4.8.1 Violated professional autonomy

The results show that violated professional autonomy is higher ($M=2.43$) (although not statistically or practically significant) in the surgical department than in ICU ($M=2.25$). The reason for this might be that participants in the surgical department feel that they are not respected, cannot give their input with regard to patient care, that there is poor communication or that they have to follow the physician's orders without their input.

5.4.4.8.2 Compromised morals and value system

According to the results the compromised morals and value system was high in ICU ($M=2.30$) and the surgical department ($M=2.33$). This might be due to a feeling that decisions with a moral component cannot be implemented in the ICU and surgical department and that their personal beliefs and values are disregarded. These participants might also be experiencing conflicting loyalties and competing values.

5.4.4.8.3 Powerlessness

The effect size (tending towards medium effect size), according to the results, indicate that powerlessness of professional nurses in ICU ($M=1.46$), surgical department ($M=1.56$) and the paediatric department ($M=1.54$) is high. This might be due to a feeling that participants are unable to give the care they want to due to a lack of resources, or that they are not being supported. It might also be due to a feeling that they are unable to do anything about their patient's pain and suffering, as well as having to work outside of their scope of practice and being exposed to situations of exploitation.

5.4.5 Job Satisfaction Survey (JSS)

The Job Satisfaction Survey (JSS) (1985) as well as the Personal Accomplishment (PA) from the Maslach Burnout Inventory (MBI) (1981) were used as a means to determine divergent validity. Divergent validity is used to measure the opposite of the construct that is being studied and to correlate the data that is collected with an instrument that measures the concept under study (Burns & Grove, 2009:387). The subscales that were used from the JSS and the MBI in this research were chosen based on the results from the integrative literature review, and only those subscales that directly linked to the antecedents of moral distress were used. Furthermore, to use the entire JSS would have been too long and the researcher did not want to overburden and exhaust the participants. The following subscales were used from the JSS.

- *Subscale 6: Operating procedures*

Questions: 1, 5, 9, 13

Reverse score item: 1, 9, 13

- *Subscale 7: Co-workers*

Questions: 2, 6, 10, 14

Reverse score item: 6, 14

- *Subscale 8: Nature of work*

Questions: 3, 7, 12, 15

Reverse score item: 3

- *Subscale 9: Communication*

Questions: 4, 8, 11, 16

Reverse score item: 8, 11, 16

In the following table the subscales of the JSS used, together with their results are presented.

Table 5.13 Summary of results of the Job Satisfaction Survey

Subscale	Cronbach's alpha	Mean inter-item correlation	Mean	Standard deviation
Subscale 6 Operating procedures #	.70	.44	2.56	1.21
Subscale 7 Co-workers	.55	.27	4.18	0.95
Subscale 8 Nature of work	.59	.26	4.83	.94
Subscale 9 Communication	.67	.34	3.60	1.14

In the following table the results from the JSS are presented.

Table 5.14 Results of Job Satisfaction Survey

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
1	Many of our rules and procedures make doing a good job difficult.	1	26	11	3.80	1.58
		2	31	13		
		3	37	15		
		4	50	21		
		5	54	22		
		6	38	16		
		Missing	8	3		
2	I like the people I work with.	1	2	.8	5.13	1.03
		2	4	2		
		3	16	7		
		4	20	8		
		5	90	37		
		6	104	43		
		Missing	8	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
3	I sometimes feel my job is meaningless.	1	100	41	2.69	1.76
		2	23	9		
		3	25	10		
		4	44	18		
		5	19	8		
		6	23	9		
		Missing	10	4		
4	Communications seem good within this organization.	1	39	16	3.34	1.59
		2	38	16		
		3	55	23		
		4	33	14		
		5	47	19		
		6	23	9		
		Missing	9	4		
5	My efforts to do a good job are seldom blocked by red tape.	1	30	12	3.54	1.58
		2	39	16		
		3	38	16		
		4	59	24		
		5	34	14		
		6	33	14		
		Missing	11	5		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
6	I find I have to work harder at my job because of the incompetence of people I work with.	1	46	19	3.55	1.71
		2	24	10		
		3	35	14		
		4	50	21		
		5	45	18		
		6	36	15		
		Missing	8	3		
7	I like doing the things I do at work.	1	3	1	5.15	1.00
		2	4	2		
		3	6	3		
		4	32	13		
		5	88	36		
		6	104	43		
		Missing	7	3		
8	The goals of this organization are not clear to me.	1	72	30	2.88	1.61
		2	37	15		
		3	30	12		
		4	56	23		
		5	26	11		
		6	15	6		
		Missing	8	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
9	I have too much to do at work.	1	17	7	4.53	1.56
		2	17	7		
		3	20	8		
		4	35	14		
		5	60	25		
		6	85	35		
		Missing	10	4		
10	I enjoy my co-workers.	1	7	3	4.90	1.18
		2	8	3		
		3	11	5		
		4	25	10		
		5	107	44		
		6	77	32		
		Missing	9	4		
11	I often feel that I do not know what is going on with the organization.	1	37	15	3.62	1.60
		2	27	11		
		3	32	13		
		4	65	27		
		5	44	18		
		6	32	13		
		Missing	7	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
12	I feel a sense of pride in doing my job.	1	9	4	5.06	1.26
		2	3	1		
		3	16	7		
		4	23	9		
		5	68	28		
		6	114	47		
		Missing	11	5		
13	I have too much paperwork.	1	7	3	4.95	1.39
		2	12	5		
		3	18	7		
		4	40	16		
		5	30	12		
		6	130	53		
		Missing	7	3		
14	There is too much bickering and fighting at work.	1	28	12	3.77	1.63
		2	31	13		
		3	34	14		
		4	65	27		
		5	27	11		
		6	50	21		
		Missing	9	4		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
15	My job is enjoyable.	1	11	5	4.82	1.35
		2	11	5		
		3	12	5		
		4	29	12		
		5	84	34		
		6	88	36		
		Missing	9	4		
16	Work assignments are not fully explained.	1	35	14	3.40	1.53
		2	37	15		
		3	43	17		
		4	67	28		
		5	29	12		
		6	26	11		
		Missing	7	3		

Each of the subscales will be discussed with regard to the results, namely:

5.4.5.1 Operating procedures

Fifty-three per cent of participants agreed very much that they have too much paperwork. Thirty-five per cent participants agreed very much that they have too much to do at work and 22 % of participants agreed moderately that many of the rules and procedures make doing a good job difficult. The participants most agreed ($M=4.95$) with the item “I have too much paperwork”, while the item they most disagreed ($M=3.54$) with was “My efforts to do a good job are seldom blocked by red tape”.

5.4.5.2 Co-workers

Forty-three per cent of participants agreed very much that they like the people they work with, 44 % of participants agreed moderately that they enjoy their co-workers and 27 % of the participants agreed slightly that there is too much bickering and fighting at work. The participants most agreed ($M=5.13$) with the item “I like the people I work with”, and least agreed ($M=3.55$) with the item “I find I have to work harder at my job because of the incompetence of people I work with”.

5.4.5.3 Nature of work

Forty-three per cent of participants agreed very much that they like doing the things they do at work, 47 % of participants agreed very much that they feel a sense of pride in doing their job and 36 % of participants agreed very much that their job is enjoyable. The respondents indicated that they enjoy their work. The participants most agreed ($M=5.15$) with the item “I like doing the things I do at work” and least agreed with the item ($M=2.69$) “I sometimes feel my job is meaningless”.

5.4.5.4 Communication

Twenty-seven per cent of participants agreed slightly that they often feel that they do not know what is going on with the organization and 28 % of participants agreed slightly that work assignments are not fully explained. Twenty-three per cent of participants disagree slightly that communication seems good within the organization. The participants most agreed ($M=3.62$) with the item “I often feel that I do not know what is going on with the organization” and most disagreed with the item ($M=2.88$) “The goals of this organization are not clear to me”.

5.4.6 Maslach Burnout Inventory

The Maslach Burnout Inventory (MBI) (1981), subscales Emotional Exhaustion (EE) and Depersonalization (DP) were used as a means to determine discriminant validity. Discriminant validity allows the researcher to identify characteristics that are associated with group membership and can also help to predict group membership (Burns & Grove, 2009:387). The Maslach Burnout Inventory (1981) was used in its entirety. The subscales of the Maslach Burnout Inventory included:

- *Subscale 1: Emotional Exhaustion (EE) – discriminant validity*
(Questions 1, 2, 3, 6, 8, 13, 14, 16, 20)
- *Subscale 2: Personal accomplishment (PA) – divergent validity*
(Questions 4, 7, 9, 12, 17, 18, 19, 21)
- *Subscale 3: Depersonalization (DP) – discriminant validity*
(Questions 5, 10, 11, 15, 22)

Table 5.15 summarises the results for the subscales obtained from the Maslach Burnout Inventory (1981).

Table 5.15 Summary of results of the Maslach Burnout Inventory

Subscale	Cronbach's alpha	Mean inter-item correlation	Mean	Standard deviation
Subscale 1 Emotional Exhaustion	.89	.47	23.81	13.28
Subscale 2 Personal Accomplishment	.76	.29	34.74	8.59
Subscale 3 Depersonalization	.67	.31	6.62	6.15

The results of the Maslach Burnout Inventory indicate subscale 1 (EE) to be moderate; subscale 2 (PA) moderate and subscale 3 (DP) also moderate. Therefore, the results showed that participants have a moderate degree of burnout.

The following table presents the results from the Maslach Burnout Inventory.

Table 5.16 Results of the Maslach Burnout Inventory

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
1	I feel emotionally drained from my work.	0	23	9	3.16	2.01
		1	51	21		
		2	13	5		
		3	48	20		
		4	20	8		
		5	45	18		
		6	38	16		
		Missing	6	3		
2	I feel used up at the end of the workday.	0	29	12	3.44	2.06
		1	29	12		
		2	20	8		
		3	30	12		
		4	32	13		
		5	49	20		
		6	47	19		
		Missing	8	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
3	I feel fatigued when I get up in the morning and have to face another day on the job.	0	40	16	3.24	2.1
		1	29	12		
		2	15	6		
		3	35	14		
		4	25	10		
		5	48	20		
		6	43	18		
		Missing	9	4		
4	I can easily understand how my patients feel about things.	0	9	4	4.57	1.6
		1	4	2		
		2	8	3		
		3	44	18		
		4	23	10		
		5	47	19		
		6	98	40		
		Missing	11	5		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
5	I feel I treat some patients as if they were impersonal objects.	0	165	68	.74	1.46
		1	18	7		
		2	21	9		
		3	6	3		
		4	4	2		
		5	13	5		
		6	2	.8		
		Missing	15	6		
6	Working with people all day is really a strain for me.	0	86	35	1.83	1.92
		1	50	21		
		2	18	7		
		3	32	13		
		4	8	3		
		5	38	16		
		6	5	2		
		Missing	7	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
7	I deal very effectively with the problems of my patients.	0	4	2	4.68	1.61
		1	8	3		
		2	16	7		
		3	34	14		
		4	12	5		
		5	52	21		
		6	106	43		
		Missing	12	5		
8	I feel burned-out from my work.	0	40	16	2.79	2.01
		1	35	14		
		2	30	12		
		3	52	21		
		4	11	5		
		5	34	14		
		6	31	13		
		Missing	11	5		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
9	I feel I'm positively influencing other people's lives.	0	8	3	4.26	1.77
		1	11	5		
		2	23	9		
		3	42	17		
		4	22	9		
		5	41	17		
		6	87	36		
		Missing	10	4		
10	I've become more insensitive toward people since I took this job.	0	90	37	1.89	2.09
		1	41	17		
		2	24	10		
		3	26	11		
		4	7	3		
		5	20	8		
		6	24	10		
		Missing	12	5		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
11	I worry that this job is hardening me emotionally.	0	88	36	1.99	2.15
		1	41	17		
		2	23	9		
		3	18	7		
		4	11	5		
		5	29	12		
		6	22	9		
		Missing	12	5		
12	I feel very energetic.	0	9	4	4.00	1.69
		1	11	5		
		2	28	12		
		3	41	17		
		4	32	13		
		5	61	25		
		6	53	22		
		Missing	9	4		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
13	I feel frustrated by my job.	0	55	23	2.44	2.01
		1	45	18		
		2	20	8		
		3	47	19		
		4	19	8		
		5	28	12		
		6	23	9		
		Missing	7	3		
14	I feel I'm working too hard on my job.	0	29	12	3.43	2.14
		1	31	13		
		2	24	10		
		3	35	14		
		4	23	9		
		5	31	13		
		6	64	26		
		Missing	7	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
15	I don't really care what happens to some patients.	0	195	80	.33	.966
		1	20	8		
		2	5	2		
		3	4	2		
		4	5	2		
		5	2	.8		
		6	1	.4		
		Missing	12	5		
16	Working directly with people puts too much stress on me.	0	91	37	1.50	1.75
		1	57	23		
		2	33	14		
		3	21	9		
		4	11	5		
		5	8	3		
		6	14	6		
		Missing	9	4		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
17	I can easily create a relaxed atmosphere with my patients.	0	7	3	4.60	1.67
		1	14	6		
		2	12	5		
		3	14	6		
		4	37	15		
		5	55	23		
		6	98	40		
		Missing	7	3		
18	I accomplish many worthwhile things in this job.	0	10	4	4.30	1.81
		1	15	6		
		2	20	8		
		3	27	11		
		4	23	9		
		5	55	23		
		6	84	34		
		Missing	10	4		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
19	I feel exhilarated after working closely with my patients.	0	21	9	3.83	1.98
		1	16	7		
		2	17	7		
		3	38	16		
		4	19	8		
		5	50	21		
		6	59	24		
		Missing	24	9		
20	I feel like I'm at the end of my rope.	0	95	39	1.91	2.16
		1	41	17		
		2	18	7		
		3	26	11		
		4	12	5		
		5	14	6		
		6	30	12		
		Missing	8	3		

No.	Question	Scale	Frequency	Percentage	Mean	Standard Deviation
21	In my work, I deal with emotional problems very calmly.	0	2	.8	4.52	1.72
		1	20	8		
		2	19	8		
		3	20	8		
		4	28	12		
		5	43	18		
		6	104	43		
		Missing	8	3		
22	I feel patients blame me for some of their problems.	0	120	49	1.61	2.13
		1	33	14		
		2	18	7		
		3	19	8		
		4	6	3		
		5	14	6		
		6	27	11		
		Missing	7	3		

Each of the subscales will be discussed with regards to the results.

5.4.6.1 Emotional Exhaustion (EE)

Twenty per cent of participants felt that a few times a week they felt used up, 26 % of participants felt that they work too hard every day and 20 % of participants felt fatigued when they get up in the morning and have to face another day on the job a few times a week. The participants most agreed with the item (M=3.44) "I feel used up at the end of the workday" and least agreed with the item (M=1.50) "Working directly with people puts too much stress on me".

5.4.6.2 Personal Accomplishment (PA)

Forty-three per cent of participants felt that they deal very effectively with the problems of their patients every day, 40 % of participants felt every day that they can easily create a relaxed atmosphere with their patients and 40 % of the participants felt that they easily understood how their patients feel about things every day. Participants most agreed with the item (M=4.68) "I deal very effectively with the problems of my patients" and disagreed most with the item (M=3.83) "I feel exhilarated after working closely with my patients".

5.4.6.3 Depersonalization (DP)

Thirty-six per cent of participants never felt that their job is hardening them emotionally, 37 % of participants felt that they never become more insensitive toward people since they took their job and 49 % of participants did not feel that their patients blame them for some of their problems. The participants most agreed with the item (M=1.99) "I worry that this job is hardening me emotionally" and least agreed with the item (M=.33) "I don't really care what happens to some patients".

5.4.7 Evaluation of the validity of the Moral Distress Instrument

In the following table, the discriminant and divergent validity are presented by means of Spearman rank order correlations. Discussion follows after the table. A correlation of .1 is considered small, .3 medium and .5 is considered a large correlation (Field, 2009:667).

Table 5.17 Correlations

	Operating Procedures	Co-workers	Nature work	Communication	Emotional Exhaustion	Personal Accomplishment	Depersonalisation
Violated Professional autonomy							
Correlation Coefficient	-.222**	.262**	-.363**	-.266**	.315**	-.189**	-
Compromised morals and value system							
Correlation Coefficient	-.429**	-	-.311**	-.288**	.429**	-	.255**
Powerlessness							
Correlation Coefficient	-.153*	.153*	-.468**	-.355**	.364**	-.329**	.308**

- * Significant on 5 % level
- ** Significant on 1 % level
- - Not statistically significant

From the table above it is clear than an increase in violated professional autonomy leads to an increase in emotional exhaustion ($r = .315$, medium effect). An increase in compromised morals and value system leads to an increase in emotional exhaustion ($r = .429$, large effect) and an increase in depersonalisation ($r = .255$, medium effect). Furthermore, an increase in powerlessness leads to an increase in emotional exhaustion ($r = .364$, medium effect) and an increase in depersonalisation ($r = .308$, medium effect). As hypothesized, the moral distress instrument and EE and DP scales of the MBI are positively correlated, proving discriminant validity.

5.4.7.2 Divergent validity

From the table above it is clear that an increase in violated professional autonomy leads to a decrease in satisfaction with operating procedures ($r = -.222$, small effect), a decrease in satisfaction with the nature of work ($r = -.363$, medium effect), a decrease in satisfaction with communication ($r = -.266$, medium effect) and a decrease in Personal Accomplishment ($r = -.189$, small effect).

It is also clear that an increase in compromised morals and value system leads to a decrease in operating procedures ($r = -.429$, large effect), a decrease in satisfaction with the nature of work ($r = -.311$, medium effect), and a decrease in satisfaction with communication ($r = -.288$, medium effect).

An increase in powerlessness leads to a decrease in satisfaction with operating procedures ($r = -.153$, small effect), a decrease in satisfaction with the nature of work ($r = -.468$, large effect), a decrease in satisfaction with communication ($r = -.355$, medium effect) and a medium decrease in Personal Accomplishment ($r = -.329$).

As hypothesized, the moral distress instrument and the PA subscale of the MBI, and the nature of work and communication subscales of the JSS are negatively correlated, proving divergent validity.

5.5 CONCLUSION

In conclusion, based on the results from the face-, content-, discriminant- and divergent validity, the Moral Distress Instrument has been proven to be valid. The Cronbach's alpha results confirmed the reliability of the Moral Distress Instrument. According to the results, the participants from this research have shown to have a small to moderate degree of moral distress, job dissatisfaction and burnout.

5.6 SUMMARY

In Chapter Five the process and results from the data analyses performed, were discussed. The three instruments that were used, namely the Moral Distress Instrument, the Maslach Burnout Inventory (1981) and the Job Satisfaction Survey's (1985) results were analysed and discussed. Validity and reliability of the Moral Distress Instrument, JSS and the MBI were presented and

CHAPTER SIX

CHAPTER SIX

EVALUATION OF THE STUDY, LIMITATIONS AND RECOMMENDATIONS FOR NURSING EDUCATION, - PRACTICE, -RESEARCH AND POLICY

6.1 INTRODUCTION

In Chapter Six the researcher retrospectively evaluates this research. The evaluation includes reflecting on the objectives of the research and will be discussed according to the theoretical framework (Benson & Clark, 1982) that was used throughout this research. Limitations to this research are discussed and recommendations are formulated for nursing education, the nursing practice, nursing research and policy.

6.2 EVALUATION OF THE STUDY

It was the aim of this study to bring clarity to the concept of moral distress and to develop and validate an instrument to measure moral distress in the clinical health care context of the professional nurse. In order to achieve this, the following objectives were set for this research:

- 1 To conduct an integrative literature review to identify antecedents, consequences, attributes and empirical indicators of moral distress.
- 2 To conduct interviews to explore professional nurses' experience of moral distress.
- 3 To develop an instrument to measure moral distress in professional nurses.
- 4 To validate the instrument.

These objectives were reached as evident from the conclusions drawn in the following evaluative discussion.

6.2.1 Planning of the instrument

Objective One and Objective Two formed part of the first phase of the theoretical framework that was followed during this study, and was discussed in Chapter Three. Each of the four phases of the theoretical framework was made up of steps, and will be discussed

accordingly. Phase One included planning of the instrument, stating the purpose of the intended instrument and determining the target group as well as the construct to be measured. The research was focused (step 1) on developing an instrument to measure moral distress in professional nurses working in a clinical environment. To achieve this goal an extensive literature review (see Chapter Three, Section 3.2.1) (N=4113; n=120) was conducted in order to identify the **antecedents** (see Chapter Three, Section 3.2.1.5), **consequences** (see Chapter Three, Section 3.2.1.6), **attributes and empirical indicators** (see Chapter Three, Section 3.2.1.10) of moral distress and to formulate an operational definition (see Chapter Three, Section 3.3) of the construct. Semi-structured interviews (see Chapter Three, Section 3.2.2) were conducted to confirm the findings of the literature review (Step 2). The **operational definition** of moral distress that was formulated at the end of Phase One was:

“Moral distress occurs when a nurse is faced with a decision with a moral component, and although the nurse is aware or knows the right course of action to take, he/ she cannot implement it, causing their morals and value system to be compromised, their professional autonomy to be violated and leaves him/ her feeling powerless (to care for their patient).”

From Chapter Three it is evident that the antecedents (see Chapter Three, Section 3.2.1.5) are present in the practice environment, patient care and the person (professional nurse). The antecedents are those situations that give rise to moral distress. The influence that moral distress has is evident in the consequences (see Chapter Three, Section 3.2.1.6), and forms part of the organization's outcome, the patients' outcome and the nurse's outcome. From the definitions (see Chapter Three, Section 3.2.1.7) the concept analyses (see Chapter Three, Section 3.2.1.8) and qualitative and mixed method themes the attributes (see Chapter, Section 3.2.1.10) were formulated. The attributes that were identified were:

Compromised morals and value system – Each nurse has an inherent moral and value system that directs their decisions and the choices they make. This is the boundaries within which they decide what is right or wrong and with what they feel comfortable. When they have to adapt or change their morals and value system in order to fulfil the expectations within their practice environment or that of patient care, this system is compromised.

Violated professional autonomy – Nurses pride themselves as being independent practitioners who can ‘think on their feet’. Professional autonomy is the capacity one has to make independent, informed decisions. However, when nurses are not allowed to practice freely, use their knowledge, experience and expertise to contribute to the care of the patient and collaborate with the physician and multi-disciplinary team, this autonomy is violated.

Powerlessness – Nurses are prevented from giving or doing their best for their patients, whether it is through advocacy or relieving their pain, or when they feel excluded in the decision-making process regarding their patient's treatment, they experience a feeling of powerlessness. Powerlessness occurs when the nurse is unable to produce an effect, it might be because they lack power, resources or authority or they are unable to do something or to stop something. Powerlessness is also experienced when the management of the practice environment disregard their input and give them no support.

The attributes that was identified formed the three subscales of the instrument that was developed, and with that Phase One was concluded.

6.2.2 Construction of the instrument

Objective Three formed part of the second phase of the theoretical framework that was followed in this study, and was discussed in Chapter Four. Phase Two included listing the objectives of the instrument, followed by relating the objectives of the instrument to the items (Step 3) in order to complete the table of specifications so that the items can be written. A pool of N=77 items (Step 4) were written (see Addendum E) and n=21 items were included in the instrument (see Addendum G [ii]). After completion of the writing of the items the content validation (quantitative evaluation) was done (Step 5) by sending the items to experts (N=16; n=4) in the field (see Addendum F) of moral distress and instrument development. The content validity index (CVI) (see Chapter Four, Section 4.3.1.3.2) was then determined and **the items were deemed reliable**. The I-CVI that was obtained included 16 of the 21 items, which had an I-CVI of 1.00 and 5 of the 21 items which had an I-CVI of under 1.00. The S-CVI was .88. A S-CVI of .80 and higher is considered acceptable. In consultation with the promoters and statistician, one item was deleted and eight items were revised.

A qualitative evaluation (face validity) (see Chapter Four, Section 4.3.1.3.3) was then completed by giving the instrument to a group of professional nurses to complete and evaluate. A focus group was held after completion of the instrument where the participants gave feedback (see Addendum D). Feedback was only provided with regard to the item format “never, rarely, sometimes, often” and in consultation with the promoters and statistician, no changes were made to the instrument. The instrument was finalised with 20 items and ready to be tested in the pilot study.

From Chapter Four it is evident that the content- and face validity of the instrument was established and the instrument found valid, as was evident from the results obtained (see Chapter Four, Section 4.3.1.3.2 and 4.3.1.3.3).

6.2.3 Quantitative evaluation of the instrument

Objective Four formed part of the third phase of the theoretical framework followed during this study, and was discussed in Chapter Five. Phase Three included the pilot testing of the instrument (Step 7). After the pilot test, the results were analysed (Step 8). An exploratory factor analysis was conducted and five items were deleted based on the results obtained (see Chapter Five, Section 5.4.4.4) and the final Moral Distress Instrument (see Addendum G [iii]) consisted of 15 items. Thereafter a confirmatory factor analysis was conducted and the factors/ subscales of the exploratory factor analysis were confirmed (see Chapter Five, Section 5.4.4.5). Most regression estimates were statistically significant with $p < 0.05$ (see Chapter Five, Table 5.9). Correlations between the subscales were statistically and practically significant (see Chapter Five, Table 5.10). The three-factor model yielded a Minimum Sample Discrepancy divided by Degrees of Freedom (CMIN/DF) of 2.93 and indicates a good model fit (see Chapter Five, Section 5.4.4.6). An acceptable Comparative Fit Index (CFI) of 0.82 was found for the three-factor model while a Root Mean Square Error of Approximation (RMSEA) value of 0.089 with a 90 % confidence interval of {0.08;0.10} was obtained, which is acceptable. Cronbach's alpha for the Moral Distress Instrument is deemed reliable with .73 for the subscale compromised morals and value system, .69 for the subscale violated professional autonomy and .78 for the subscale powerlessness.

Discriminant- and divergent validity was performed during this phase of the research. For discriminant validity (see Chapter Five, Section 5.4.6) the Maslach Burnout Inventory (MBI), subscales Emotional Exhaustion (EE) and Depersonalization (DP) were used to determine the discriminant validity (see Addendum I). According to the results the Moral Distress Instrument has discriminant validity. Divergent validity (see Chapter Five, Section 5.4.5) was achieved by using the Job Satisfaction Survey (JSS), subscales: operating procedures, co-workers, nature of work and communication (see Addendum H) as well as the Personal Accomplishment (PA) subscale of the MBI. According to the results the Moral Distress Instrument has divergent validity.

From Chapter Five it is evident that the Moral Distress Instrument that was developed during this research exhibited good validity (exploratory-, confirmatory-, discriminant- and divergent validity) and reliability results.

6.2.4 Limitations of this research

The following limitations were identified:

- The integrative literature review started in 2012 and was conducted over a period of a year. There might be new journal articles available that were not included in this research. The researcher did however, from time to time search the literature for new articles.
- The researcher could not find a moral distress expert in South Africa to act on the panel of experts for the content validation. A South African expert on instrument development was involved together with experts on moral distress from around the world.
- Data collection was conducted in only one institution. The institution comprises of a multitude of departments that include clinics, wards, theatre, ICU's, maternity departments, radiology and pathology. The sample size was large enough, therefore the results are deemed statistically significant.

6.2.5 Recommendations

The recommendations for nursing education-, practice- and research follow and are based on the results that were obtained during the process of this study.

6.2.5.1 Recommendations for nursing education

The following recommendations with regard to moral distress for nursing education were formulated:

- Cultivate awareness of moral distress and the detrimental effect that it can have on an organization, patient care and nurses. Training in order to address moral distress to ensure a healthy practice environment and good patient care should be undertaken. Nurses should be made aware of the antecedents, attributes and consequences of moral distress to be able to identify moral distress in themselves or their work environment.
- There should be training on moral distress, especially in management, to ensure low turnover of staff and to prevent nurses from leaving the profession. Nurses studying to complete their diploma in nursing management should be made aware of the antecedents, attributes and consequences of moral distress to be able to identify it in their organization.

- Greater emphasis should be placed on limiting the antecedents and consequences of moral distress because of the detrimental effects moral distress can have.
- A curriculum in nursing science that introduces moral distress and the impact it can have on the healthcare sector should be included in modules pertaining to professional practice.

6.2.5.2 Recommendations for nursing practice

The following recommendations with regard to moral distress for nursing practice are formulated:

- Using the Moral Distress Instrument to determine moral distress amongst South African professional nurses.
- Professional nurses should receive in-service training on the antecedents, consequences, attributes and empirical indicators of moral distress in order to identify whether they are experiencing moral distress.
- Initiate awareness in South African hospitals on the reality of moral distress.
- Taking action against the antecedents of moral distress. See recommendations for policy.
- The activation of strategies to assist nurses when they are experiencing moral distress, e.g. support groups within the practice environment. See recommendations for policy.
- A mentoring programme for nursing managers to give the necessary support to nurses.
- Make social networks amongst nurses more concrete in order to establish strong support networks within each practice environment.
- Encourage the bridging of communication gaps between all levels of the multi-disciplinary team, e.g. team building where teams can realize how much they need each other and that all share a common goal, namely the patient getting better.
- Encourage respect for individual's morals and value systems by giving in-service training on different morals and value systems in order to encourage awareness of differences between personnel.
- Encourage professional autonomy. Nurses should be encouraged by management of the important role they play in caring for the patient to improve the nurses' self-confidence to voice their opinions.
- Empower nurses by including the nursing force in decision-making and policy-formulation. Management should have information sessions where nurses can give their input with regards to decision-making and policy-formulation.

- Establish and maintain healthy practice environments through the social networks of nurses in the organization.

6.2.5.3 Recommendations for nursing research

The following research problems might be meaningful to explore:

- Continuous validation of the Moral Distress Instrument.
- To develop strategies, based on the attributes of moral distress, to combat moral distress.
- To develop mentoring programmes for nursing management on dealing with moral distress and supporting nursing staff.
- To determine the impact that strategies to combat moral distress have on minimising staff turnover.

6.2.5.4 Recommendations for policy

The researcher makes the following recommendation for policy at health care organizations.

- Each health care organization should set up a committee whose primary focus is the physical and psychological well-being of the nursing personnel. This should be a committee independent of the human resource department of each organization with the focus of determining physical and psychological disturbances, giving help and support to the nursing personnel. This committee should also act as activists for the nursing personnel and have the necessary authority to address the moral and ethical problems that have been identified.

6.3 CONCLUSION

In conclusion, current available instruments are based on specific situations and therefore limit the use in some clinical settings. During this research an instrument was developed to measure moral distress, regardless of the clinical setting. This was achieved through conducting an integrative literature review and semi-structured interviews. The antecedents, attributes, empirical indicators and consequences of moral distress were identified and a definition for moral distress was proposed. The attributes of moral distress were used as the subscales of the Moral Distress Instrument, thus making the instrument relevant to be used in any clinical setting.

6.4 SUMMARY

The aim of Chapter Six as the final chapter of this research was to provide a comprehensive overview and evaluation of this research. A critical reflection was done according to the theoretical framework that was used throughout this research. The limitations of the research were investigated and were followed by recommendations for nursing education, nursing practice, nursing research and policy.

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ADDENDUMS

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ADDENDUM A

ETHICAL CLEARANCE FROM NWU



Private Bag X6001, Potchefstroom
South Africa 2520

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Ethics Committee

Tel: +27 18 299 4850
Fax: +27 18 293 5329
Email: Ethics@nwu.ac.za
2012/06/13

ETHICS APPROVAL OF PROJECT

This is to certify that the next project was approved by the NWU Ethics Committee.

PROJECT TITLE "STRENGTHENING THE RESILIENCE OF HEALTH CAREGIVERS AND RISK GROUPS"
SUB PROJECT TITLE "MORAL DISTRESS IN SOUTH AFRICAN PROFESSIONAL NURSES: INSTRUMENT DEVELOPMENT AND VALIDATION".
Project leader: Prof MP KOEN & DR. E DU PLESSIS Student on project: R VAN WALTSEVEN
Ethics number: NWU-00036-11-A1
Expiry date: 2016-05-12

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

The formal Ethics approval certificate will be sent to you as soon as possible.

Yours sincerely

Me. Marietjie Halgryn
NWU Ethics Secretariate

ADDENDUM B

DEPARTMENT OF HEALTH PERMISSION



health

Department of
Health
FREE STATE PROVINCE

25 April 2013

Me R van Waltsleven
Private Bag X 6001
North West University
POTCHEFSTROOM
2520

Dear Me van Waltsleven

Subject: PERMISSION TO PERFORM RESEARCH ON MORAL DISTRESS IN SOUTH AFRICAN PROFESSIONAL NURSES: INSTRUMENT DEVELOPMENT

The above mentioned correspondence bears reference.

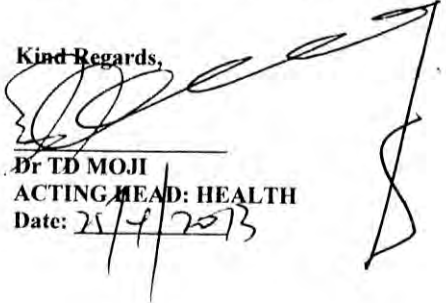
Permission is hereby granted for the above – mentioned research on the following conditions:

- Participation should be by informed consent.
- Study should not interfere with service delivery.
- Confidentiality of information will be ensured and no names will be used
- Copy of final report to be sent to the Head of Department

For further discussions for distribution of questionnaires please contact Prof PJ Pretorius at 051 4079294, email PretoPJ@fshealth.gov.za/LebokoR@fshealth.gov.za

Trust you find the above in order.

Kind Regards,


Dr TD MOJI
ACTING HEAD: HEALTH
Date: 25/4/2013

Head : Health
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ADDENDUM C

SEMI-STRUCTURED INTERVIEWS

i) Information letter



NORTH-WEST UNIVERSITY
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**SKOOL VIR VERPLEEGKUNDE/SCHOOL OF NURSING
SCIENCE**

Tel: (018) 299 1886
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June 2013

To whom it may concern

**Research Title: “Moral distress in South African Professional Nurses:
Instrument development” (Ref no NWU-00036-11-S1).**

Participation:

You are invited to participate in an interview. The interview will take approximately 30 minutes of your time. You will remain anonymous when taking part in this research.

Study purpose: the aim of this research is to develop and validate an instrument to measure moral distress.

Overall research objectives:

1. To conduct an integrative literature review;
2. **To conduct confirmatory, exploratory interviews** to be used together with the empirical indicators to develop an instrument to measure moral distress;

3. To develop an instrument to measure moral distress in professional nurses;
4. To validate the instrument.

Moral distress is when a nurse is faced with a decision with a moral component, and although the nurse is aware or knows the right course of action to take, he/ she cannot implement it, causing his/her morals and value system (*these morals and value system are the boundaries within which he/ she decides what is right or wrong*) to be compromised, his/ her professional autonomy (*professional autonomy is the capacity one has to make independent, informed decisions*) to be violated and leaves him/ her feeling powerless (*powerlessness is when the nurse is unable to produce an effect*) (to care for his/ her patient).

Risks:

Depending on your perception of moral distress, you may feel uneasy when talking about moral distress. You do not have to answer any question or take part if you feel the questions are too personal or make you uncomfortable.

Benefits:

The study will give you the opportunity to give your view on moral distress. The information you share will help the researcher to identify concepts important to measure moral distress. Feedback will be given if so required.

Anonymity: To ensure anonymity, your name will not be recorded with your responses or identified in any way. Results will be published so that your identity or the identity of the hospital will not be revealed in any reports or publications.

Interviews or computer databases will contain no identifiable characteristics and will be stored in locked cabinets and on password protected computers.

Conservation of data:

All information collected (interviews) will be kept in a locked filing system. All computers on which study data will be stored will be password-protected. The data will be accessible only to the researcher and her promoter. The interviews will be kept in locked storage for 5 years.

Voluntary participation:

You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time, for any reason, without consequences. If you choose to withdraw from the study, you may request that all data gathered until the time of your withdrawal be destroyed.

For more information:

If you have any other questions or require more information about the study itself, contact Richelle van Waltsleven (researcher) at the North West University, Potchefstroom Campus. Telephone +27(0) 18 299 1886 or email at richelle.vanwaltsleven@nwu.ac.za.

If you have any questions regarding the ethical conduct of this study, you may contact Dr Emmerentia du Plessis at the North West University, Potchefstroom Campus. Telephone +27(0)18 299 1876 or email at Emmerentia.duPlessis@nwu.ac.za.

Sincerely,

Me R van Waltsleven (M Cur, RN, RM)

Dr SK Coetzee (Ph.D, RN, RM)

Dr E du Plessis (Ph.D, RN, RM)

ii) Consent letter

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

Research Title: “Moral distress in South African professional nurses: instrument development” (Ref no NWU-00036-11-S1).

I, _____ hereby give informed, voluntary consent to participate in the above-mentioned research. The purpose, objectives, benefits, risks and the responsibilities of all parties concerned are clear to me. I am willing to take part in the interview. I know that the face to face interview will be voice recorded. I understand that the results of this research may be published but that my name and the name of the facility will be held confidential. I know that I may withdraw at any time from the research without any consequence. I understand that I will receive no money for participating in this research.

Participant: _____

Witness: _____

Researcher: _____

Date: _____

iii) Semi-structured interviews transcription

I – Interviewer

R – Recipient

I Interview one

R Hello

I Recipient thank you so much for talking to me.

R Hmm.

I I would like to ask you if you can think of any situations where you experienced moral distress?

R At work?

I Yes at work.

R Eish, uhm okay as you know we have got volunteers in our, I am – I am working in the clinic right now.

I Hmm.

R I am acting as an Operational Manager.

I Hmm.

R I am not yet the Personnel Manager but I am acting at that post, so on the end of every month we do compile statistics, that everyone who has done anything, calculates whatever she has done and bring it to me. Like people who talks at HIV, people who council's something's like that.

I Yeah.

R So it happened that last week when I went to the volunteers who council, like I don't know if you know them?

I Yes.

R They council like on the TV.

I Yes I do.

R So when I went to one, to them to say where is the statistics, one of them just say "Sit Back" to me so I was very hurt. So I very hurt and then the night passed to cut a long story,

I Yeah!

R We were called together that I still don't want to work with that lady anymore.

I Ag shame.

R That is the most terrible thing that happened to me at work.

I Recipient one what,

R Hello.

I What did you experience, what uhm did you feel?

R Bad.

I How did it make you feel?

R I felt so small and I was angry, but I didn't want to react the way she did as I am professional and she is not a professional.

I Yeah.

R So I didn't want to react the way she did like as if we were on the street.

I Yeah, exactly.

R And my is an old lady, she used to call us small baby, she is older than us at the clinic but on top of that we are her manager.

I Exactly.

R But she doesn't respect us at all, why we don't know.

I So if you can say what gives you moral distress is when there is no respect towards colleagues and staff.

R Yes, hmm, no respect.

- I Recipient one when you go home, if something like that happened,
- R Hmm.
- I What do you, how do you react, at home?
- R Eish at home, at times I have scold at the kids at times I just sit on the sofa and think, think, think because most of the times I am alone with the kids.
- I Hmm.
- R My little, I have three little kids.
- I Ag jinne.
- R So most of the time in the evenings I am alone with them.
- I Hmm.
- R It becomes better when their father is home, but he is, he just listen and doesn't say anything most of the times, but at times she responds. I don't know if he doesn't respond whether I am talking nonsense or what.
- I I think yeah, maybe he doesn't know what to say.
- R Hmm?
- I Maybe he doesn't know how to respond.
- R Mmm.
- I Mmm.
- R Eish.
- I Recipient one is that the only situation at your workplace that lets you feel uhm moral distressed?
- R Like now we are in the campaign.
- I Hmm.
- R I don't know if you have heard that.
- I No.

- R and Rurals campaign,
- I Yeah.
- R We are given the target if you are given the target to reach, so I am not reaching that target but I have tried my level best.
- I And that makes you,
- R I have immunized all the children in the area around our clinic but I didn't reach the target.
- I And how did that make you feel?
- R Even they have given us more population than we actually have in our – in our clinics.
- I How did that make you.
- R More in the last day of that campaign.
- I How did that make you feel?
- R In a way I am not that stressed, is that I still satisfied because I know I have done what I could, I have given it my best.
- I Hmm.
- R Hmm.
- I And you don't feel the same way that you reacted with the lack of respect.
- R No,
- I Okay.
- R Hmm, is just that everybody is looking, is looking like we didn't do anything but and I was doing it all by myself.
- I Yeah, so,
- R And the clinics were given people from the army, people from the correctional services to help them, but now I was doing it with only my

- I Hmm, recipient one thank you so much for sharing your experience of moral distress with me. I really appreciate this.
- R Okay, okay.

I Interview two.

I Thank you so much for agreeing to talking to me. Uhm we have spoken about what is moral distress; I would like to ask you if you can think of any situations that caused moral distress for you?

R Okay number one in my situation this is now like I have told you an educational situation, so I really you know my students are my first priority so I am, want the best and only the best for them. Because that is why they are here we have to be their mentor but now I have only got one colleague and unfortunately she is not on the same level of expertise as well as uhm as doing and feeling what I feel for my students so at times I have to double my job plus her side. For instance here is now an example. When she sets test papers she is just giving them an essay question and that is it, the never get the opportunity to grow to learn about all the type of questions, she is not really you know testing what should be tested. She is just giving them old question papers from council taking the essay ones out and give it. So this is what is causing me real frustration.

I If you have to describe the feelings that you have, what will they be?

R You know at times, at first I was feeling maybe if I can be of support to her, show her and help her, show her and help her, so I have started that way. I have shown her but still nothing happens, then I will see she is not computer literate, okay so then I says okay you know what I think you should really do something. Then she was actually expecting from me to show her how to use a computer now this is impossible I don't have the time, so luckily in the end after many things that we are struggling with and because I really I am honest with her I tell her "No really this is big issue it can't go on like this we are a team we have to support one another, I can't do everything" so then she decided now to start with a assessor course first. She didn't complete successfully, she has done it at the North West University and I don't know what happened but maybe the workload was too high or I don't know what was the problem but she did not complete and so it is finished. A lot of money that was wasted from the government, the second thing then I says maybe if she use her own money it will change the situation so luckily then I was starting to you know every day probing her and says "You know maybe you should see if there is some courses on computer literacy, maybe you can do that" and luckily there was in Ikageng one that was running and she was aware of that and she was going to take her own money and she has done it. Now it seems they have just done the exams I don't what the outcome will be, but at least she has done it, but then on the other hand she had to

go there every afternoon after one. So I had to take all the afternoon classes again, you see this was double load on my side but now let's wait for the outcome maybe that will be the thing. And then I was so frustrated I think I am overload with work I don't have time for myself luckily I don't have children at home so I don't have someone who I can be irritated with except my mother is living with me and I just have to you know discipline myself cause this is all I can do. I discipline myself and says when I go I am not going to take it out on Ma.

I Hmm

R Because this is not her fault.

I Hmm.

R So that is why I talk to them here, I talk to my colleague and says let's talk about these things and let's see what is happening so it seems that there is maybe difference, let's hope.

I Do you feel that something within you changed?

R Yeah definitely because you know for the better and for the worse, this was so strange. for the better because I was not one, previously I was not one that was coming out and confront you, I didn't like confrontation I hate it, especially when I know this is going to be a, you know maybe it is going to hurt that other one, or whatever the case may be like in this case. So I didn't like it so then I was sitting down and thinking how am I going to do this confrontation, so then I made myself little rules, sometimes I was successful , sometimes it burst out you know the wrong way, the wrong words, the wrong whatever. Then I was feeling so bad afterwards like a guilt feeling, why did I handle it this way, it is not supposed to be that but then I was just go on like this. Then there was times that it was coming out a nice way cause now I have sit down with myself have self-talk, tell myself you know what this is a problem but this in not the end of the world. If you can handle it get the other one, sit together tell exactly and the things you can't do you just don't force yourself because previously I have slept at night around about three of four in the morning, come back here seven you know this was quiet exhausting. So I say Oh I am going to die if I go on like this and no I am not going to do this anymore, I must now think what I am doing and then I says, Okay if I don't have time – I don't have time and that is it. So then I just re planned, re arranged whatever.

I And the negative part?

- R So this was actually the good, the negative part was now this that this times that I was so frustrated that I was saying to them the wrong things, I didn't prepare well for my students that was such a guilt feeling when I stand in front of class, no luckily I have got lots of years of experience,
- I Hmm.
- R But still you know you have to there is little things cause you know your class, you know this one you can't handle it like this you have to present it in another way it will be more applicable to them. I think I didn't have time to make for instance uhm what do we call it, visual aids and stuff, power point presentations I had to do it you know on the spur of the moment so it's not sometimes the things that I want there and this you know this is frustrating really. The other issue I have promised these students that's in class now I will give them CD's where we are going to put all the practical procedures, I going to put it onto video. I don't have time, I don't have time up to now and what is the month, May.
- I Hmm.
- R This is frustrating me because I can do so much more for them.
- I Yeah, do you feel that it has an effect on – on you, what effect does it have?
- R You know the effect that it have on me sometime, number one I have got to much to do, so therefor I have got like a memory loss. The big important personal things I am sort of suppressing it, so I put it down and my own personal matters at home I am not attending as I should.
- I Hmm.
- R For instance my accounts are not paid up, my filing system at home for my household things is not up to date. It is a mess I can just tell you it is a total mess. If you ask me now give me that and that I don't know where it is, so this is the big issue, this is the personal effect that it had on me. Totally and I am not a person like that no I am normally very organized and what.
- I Hmm organized. Thank you so much for sharing with me your feelings and how it affects you this will really

I Interview three.

I Thank you so much for talking to me I really appreciate this, can you please uhm tell me if you can think of any situations where you experienced moral distress, what happened so that you experienced it?

R Uhm there was a situation it was about two weeks ago when I was shift leader on night duty and we had a patient in respiratory distress and I phoned the doctor because his PO2 was between 20 and 30 the whole time since I came on duty. I phoned the doctor at 7:30 when the visitors left; I told him we must intubate this patient, then he told me Yeah he is coming , an hour after that, because the patient was on external ventilation. An hour after that I phoned him again I did a bloodgas again I told him he must come, he didn't come. At around ten o'clock when I was busy double checking the medication of the other patients, they called me and they said that the patient collapsed, no pulse, no respiration. The sister that was working there did not set the monitors alarms so she didn't even see it. They saw it accidentally when they walked past the patient and they see that he is not moving, he is not breathing, the alarms are flashing red, or the monitor but there was no alarms that was set because the volume was off as well and luckily that the last time I phoned the doctor I told him "Doctor I have never intubated before if it is fine with you I am going to get everything ready and when you come can I please intubate because I have never done it before" so I told him that.

I Hmm.

R Then yeah it was about ten o'clock when the patient collapsed and I realized I have to intubate this patient and I couldn't. Luckily for me I did set everything ready for the intubation, so everything was ready but I was in such a panic because it was not my patient but I was the shift leader so I had to do, or do the whole rhesus and the try to do the intubation which I couldn't do. I tried two times and it didn't succeed after the third time when I wanted to try the third time I saw on the lanringoskoop (laryngoscope), they have put on the one who handed the lanringoskoop (laryngoscope), they have put on the size two blade and that is why I didn't succeed, so I ask him "X, I ask him please put on the adult blade as he put it on the doctor came in he took the laryngoscope and intubated the patient, we resussed for two hours, I was, I was in a terrible state because I know it was the first thing that I know I am going to succeed with the intubation.

I Hmm.

- R It is something that you don't want to mess up with and I was prepared that I was going to do it tonight and I am going to succeed and then when the patient collapsed I didn't succeed.
- I Hmm.
- R Uhm because of a blade size and I didn't, I don't have the experience because I am seven months in ICU now, I don't have the experience to look at the small things like a, I thought that they going to give me the right blade on the scope and they didn't and I didn't check for that. So at the end the patient passed away after two hours of rhesus, the patient passed away but I think he could have been alive if he was intubated on time. So yeah that was the, that was a terrible situation for me cause I couldn't, I know if he was intubated on time and if I had the skill to do it, If I, if I just looked at the blade then that patient would have been, cause he went for a uhm hip replacement.
- I Sjoe.
- R Yeah. And then he had a pulmonary embolism that is why he came to ICU and he went into respiratory distress and I think he passed away, I am not blaming myself because it is not in my scope to do an intubation but I could have done it if the blade or if I had the common sense or the experience to look at the blade size, so yeah that was terrible.
- I How did you feel, especially now I can see there is a lot of emotion still going on.
- R Yeah. Now I am better cause I went on Tuesday and it happened last week, on Tuesday and Wednesday I went to theatre on my off days to the one narkotiseur (anesthetist)?
- I Hmm.
- R To practice some intubations so now I am fine, but at that moment, I cried since that patient passed away, I cried until the next morning until luckily it was my last night. I went home everything went wrong at home, my husband didn't even greet me, ag hy is net werk toe, (he just left for work) uhm I was emotional really like crying and disappointed in myself for two days. I didn't go out of the house I didn't want to talk to anyone cause I felt so disappointed in, at first I felt disappointed in myself but the more you think about it, it was not my fault the doctor was informed, I told I am the shift leader but I cannot intubate, I am not pin pointing him but if he came at seven o

clock when I phoned him first that patient, then I wouldn't have had to have this feelings and it is not my husband saying I am hard on myself, yeah maybe I am but I am only going for success and that was the first time that I couldn't succeed in a basic procedure, because afterwards I intubated the corpse and because I know it is the blade and after the second time I knew if I try the longer blade it would have been fine. Afterwards before the mortuary came to get the body I did intubate that patient. With the short one you can't see anything with the long one, augh, the airway was like looking, calling for me.

I Hmm.

R So yeah it is, it was like a disappointment in myself and I was very angry, very, very, very angry so, because how can I make such a simple mistake by not looking at the blade. That was the, I was very angry about that and disappointed cause I was so prepared that my first intubation is going to be a success cause the same with the anterior lines I prepared myself for it and I did it the first time it was a success. I thought my first intubation will be a success and it was not and that was the worst feeling, while we busy resussing I was just standing there with the ambo bag just thinking how can a doctor come in here and take the blade or the laryngoscope out of my hand, we tried I tried two times and now he is taking all the he is the life saver now. I was so, ek was kwaad (I was angry), ek was woedend (I was furious).

I Hmm.

R About that thing. And angry at the doctor cause he dropped me. He is one of the doctors that I really trusted and that I really can rely on and he dropped me, I feel that he dropped me that night cause I told him I want to do this, I want this will be my first and he just didn't come. So.

I If you have to uhm describe to me what you felt at home, did something in you change, did you maybe your husband said something was different in you, was there anything different for you in yourself?

R I was not, I am not an emotional person and I was emotional for two days, luckily I recovered quickly I think there is people that, I was traumatized I was really traumatized and it was my first resus, I have resussed before with other people but it was my first rhesus.

I Hmm.

R Where I had to take the lead and I was, I don't know what happened during that resus my head was just focused on how can, could you not have checked the blade. That was all that was, I didn't mind about the adrenaline later they started him on medication and I didn't worry, I was just standing at that patients head and think how could you have missed that it was your first intubation, you could have done it and you missed a small thing. So at home, I don't know I was just emotional and disappointed in myself. I was very disappointed cause I was so prepared for this thing and I am not used to and yeah you get what do you call it, uhm terugslae (setback), sometimes at work, but not like that. I can take the small things but that was one of my main things that I want to do and I wanted to succeed in it but I couldn't because of a technical problem or a technical fault that we didn't wee. It was just that I was disappointed in myself for two days and then I told myself you have to get over it, it will happen again, the patient passed away yeah, and I felt guilty because I don't want to learn lessons by paying with someone else life. That was the worst feeling for me. I learned a very, very hard lesson but someone paid with his life for that lesson and that was terrible. And the thing is I told the family at seven o clock, the wife and the granddaughter I told them, yeah we gonna intubate him and then oupa (granddad) will be fine. Cause then we have got him more under control. First they are intubated and sedated then they are fine.

I Hmm.

R And after twelve I had to phone them, well sorry he is dead.

I Hmm.

R So yeah that was, I felt that I will never in my life tell a family or visitors anything like, I even told them you know ICU is the, the most difficult place where you can die.

I Hmm.

- R I told them cause we have got everything there cause first you intubate a patient that patient was kind of stable it was just respiratory that he was, even his, yeah his gas looked terrible but the rest was fine.
- I Hmm.
- R And I told them ICU is the hardest place that you can pass away cause we have got everything here.
- I Hmm.
- R I told them it is not in our hands, but yeah when you know you told the family that at seven o'clock and twelve o'clock you have to phone them and tell them he is dead, it is terrible.
- I Yeah.
- R But yeah I think luckily for me I am a, I get over things, I got over it quick or two days and I think that there is people that, cause I was, I was traumatized. First with the rhesus cause I didn't know what was coming and what was going and I was just focusing on the intubation. I don't know emotional and I don't think I was depressed but yeah my husband he accidentally clamped me in the gate, he pressed the button and he thought the gate was going to open more and then the gate closed it just, it hurt but not that bad and I just sat there and cried for I think 30 minutes. It was not painful but it was not on the right moment if it happened at another time that would have been fine.
- I Hmm.
- R But after that night and he did it and the dogs went over my clean kitchen floor I cried. I am not like that but yeah that is what it did to me.
- I Hmm.
- R But now it is fine, it is better now after I did practice my intubations in theater, but I know I can do it, I could have done it.
- I Hmm.
- R I just can't understand how a small technical, not a technical but a blade size, which is actually everything, but why didn't I see it? And the patient is dead, so!

- I Uhm before this were there any other situations where you felt that you couldn't do what you know you are supposed to do, was this the first time?
- R This was the first time?
- I Okay.
- R There was not really, not there was. If there was something it didn't affect me, if there was something that maybe happened in the past, maybe I did something wrong or, but it didn't affect me. I know the one day we had a burn wound patient it was about three or four months ago and we was, we were gonna extubate him that afternoon and I didn't think of taking tragtiale aspiraant (tracheal aspirate) and I went home, and the next day the doctor was looking for tragtiale aspiraant (tracheal aspirate), but I didn't think it was important because he was intubated for I think less than a day.
- I Okay.
- R Yeah so I didn't think it was necessary but then he got a temperature and infections signs and everything and then they wanted the tragtiale aspiraant (tracheal aspirate) and I didn't take and cause I didn't think at that moment it was necessary but then afterwards when, cause obviously the infection was from the burn wounds uhm but they just wanted to excluded that. I felt guilty about it but I had a reasonable reason why I didn't do it but you feel okay yeah next time I should that do what is being asked from me but that was the only, I have never had something like this before.
- I Okay.
- R This was a life changing thing but it really uhm affected me. It was a bad, bad experience.
- I Thank you so much for talking to me and I really wish you a lot of uhm peace after this.
- R Thank you, thank you.
- R Okay then you have got kan ek maar net aangaan (can I just continue)?
- I Yeah just tell me about the amount of patients and staff the ratio that you had that night.
- R Okay that was for all three nights, we were only I was the shift leader, which was the only permanent staff and the four moonlighters.

I Okay.

R And we had an intubated patient, he was on cardio output which I don't really know about, not that I am degrading myself but you can't know anything after seven months in ICU that is things that you learn by time. Uhm then I have put the most experienced moonlighter with that patient so then we had ten other patients which I think four of them were ventilated and the rest were you know normal ICU patients.

I Yeah.

R Ten patients with four staff and the ideal is if you are shift leader you don't have any patients then you just keep an eye on the unit and you keep it running and I had two patients for all three nights, I had two patients and you have to be the shift leader. It was terrible cause you can't get, you don't actually know what is going on in the unit, you just focusing on what need to be done, your patient uhm should be alive and then they call you okay yeah there is a resus, o goodness if. You can't, you can't work like that, so it was terrible the nursing, it was the first time; those three nights were the worst three nights in my life.

I Hmm.

R You can't, as I said it is not as if I degrade myself, you just want someone for backup, someone you can rely on.

I Hmm. How did management react after?

R I was not ready to discuss this with my unit manager yet.

I Okay.

R She was on leave this week but I was also not ready to discuss it with her, but I am starting Monday night again and I am going to refuse to go to work if it is only me and three or four moonlighters with eleven patients, you can't, I am gonna refuse because they abuse the night staff for years now and I am new there I am not going to do it, I am really not going to do it. You don't know what, even if you go home in the morning you phone them six times afterwards and ask them, did I do this – did I do this, will you check this then it is important things that you haven't done like taking the swabs that I forgot the other day, I was in trouble for not taking it but I couldn't there was no time for it.

I Hmm.

R So in the meanwhile you have to check the medications, you have to check the wounds that they opened you have to set the ventilation which you don't, I am not experienced with ventilation but you the person who have to do it. It was no it was bad.

I Hmm.

R And they have to do something, even if you just have a more senior sister, a permanent staff.

I Hmm.

R That will be fine, but yeah you can't work like that.

I Interview four.

I Recipient did you get your consent form?

R Yes I did but I haven't print.

I Recipient uhm,

R Yes.

I Can you think of situations where you experienced moral distress at work?

R Yes, I can uhm. Because we are dealing with patients that are from rural areas mostly.

I Hmm.

R In the mines and they are not learned at such.

I Hmm.

R Sometimes person don't know what operations they came to do in theatre because some days in theater as a theatre scrub sister so it is difficult for patients because sometimes you will ask the patient do you know what you came here for and they don't know.

I Hmm.

R And you will have to explain to them thoroughly in their own language.

I Yeah.

R Yeah.

I Okay, recipient!

R Yes,

I You still there?

R Can you hear me?

I I can hear you, you can continue.

- R Okay, and the other thing as well is, shortage of staff that is affecting us as nurses.
- I Okay.
- R It is really depressing for us because if one of the staff members is sick you feel the tension, it really affects your moral at work.
- I How does it affect you when there is not enough staff, what happens?
- R Because you have to pull yourself all over you will stretching yourself to the limit that at the end when you get home you are fatigued and you are stressed out you don't even have time for your family and you take it out on them.
- I Okay.
- R Yes.
- I And Recipient who is the person responsible to explain to your patients what operations they are coming for?
- R The doctor who is signing the consent is responsible.
- I And what do you think where does the problem come in, why don't they know what operations they are coming for?
- R I – I can say no it is because doctors mostly will be white.
- I Hmm.
- R And our patients are black mostly.
- I Hmm.
- R They will just say yes, yes I understand whereas they don't. So when they come to us and we elaborate in our language they get a clear understanding of like this is what I am coming here from.
- I Okay.
- R I mean here for.
- I Yes.
- R Yes.

- I Recipient can you tell me what happens at work when there is not enough staff?
- R Because sometimes we don't have time to go for lunch.
- I Yeah.
- R There is nobody to relieve you.
- I Hmm.
- R You will be working doing the whole list alone, because doctors are just pushing to finish their list.
- I Yeah.
- R Yes.
- I Are there any other situations what, that you can think of where you experienced moral distress. How would, how does the doctors, how are they towards you, towards the nursing staff? How do they treat you?
- R Okay with us I can say we are fortunate there are only few of them who still throw tantrums at us, making us as if we are useless and and we don't know our job, if like the operation it is frustrating him.
- I Hmm.
- R He will take that out on us.
- I Okay.
- R If something is going wrong maybe there are complications with the operation, there are those particular ones who will be shouting at you, eh at everybody in the theatre as if it is your mistake whereas it is the operation that is not going accordingly.
- I Okay.
- R Yes.
- I Recipient thank you so much for talking to me, are there, is there anything that you would like to add?
- R Eh can I because like at work there is something that is distressing to know.

- I Hmm.
- R It is like the management is not giving support to staff as such.
- I Where do you need support and they aren't providing it, in what circumstances are you needing support that you feel you are not getting?
- R Okay like I can give you an example.
- I Uhum.
- R Like right now I am doing management I am studying towards my B Cur.
- I Yeah.
- R And we don't have a unit manager in our department.
- I Hmm.
- R And I feel I was the person that was supposed to be acting but they have given that to somebody else who is not even doing management or have management, you get my point.
- I Okay.
- R So I feel it is like there is some sort of being biased they having favoritism.
- I Okay.
- R Yes so it, it is really discouraging to a person, to a person mean like are they not seeing some potential in me as person or something or is it something personal, I can't tell.
- I Yeah.
- R Yeah.
- I Okay and what do you think, what can you do about that? What do you think can change that?
- R Okay I think I, maybe I will have to prove myself and show my potential to them so that they can be maybe more involved as well in the management side, helping that one who is acting at the moment.

I Hmm.

R So that they can see as well that I do have potential.

I Okay.

R Yeah.

I How do you feel when there is not enough staff or the doctors take out their frustrations on you, how do you feel then?

R I, I feel frustrated and angry sometimes, because I feel it is not my fault but I feel it is something that I don't have the control over it.

I Hmm.

R And it really frustrates and angers me sometimes and the other thing you end up taking it out on your subordinates as well, because they are putting so, the doctor is pushing so much on me we end up delivering it to the junior staff, like trying to cope with that.

I Yeah.

R Yeah.

I And do you think it has any effect on your family maybe?

R Yes it does because you come home stressed and even when your kids try talking to you, you will just pull them aside and don't have time for them because you will be so tired as well you will just want to take a bath and rest as well.

I Hmm.

R So I think it is having an impact on my family as well.

I Okay.

I Is there anything else that you can add with regards to how you feel when all these things happen, you have mentioned frustration and anger.

R Am I what?

I And that you take out on the others, is there anything else that you can maybe add that you experience personally?

- R I think it, it changes who you are at the end because eh people preserve you as being rude and arrogant to them whereas it is just a copying mechanism that you are trying to use so it that it doesn't get to you as well, but at the end people will feel as if you are also arrogant at the end.
- I Recipient you helped me a lot and all of the issues you have spoken of I hear them across the board from all the nurses, the shortage of staff, doctors taking out their frustrations on nurses and uhm doctors not fulfilling their obligation and with that I mean that they don't make an effort to explain to their patients what operations they are going to have and the management and the management, that there is not enough support to the staff from management side. This is something I am hearing across the board and this is really why I am doing this research and hopefully, I think it is going to take a lot more years but hopefully we will, we will get some solution.
- R Okay my dear.
- I Okay, yeah that is true. Thank you so much I hope you have a lovely evening.
- R Thank you.
- I Thank you so much for your help and for talking to me I really appreciate it.
- R Pleasure bye.

I Interview five.

I Thank you so much for talking to me I really appreciate this.

R It is a pleasure.

I Can you think of any situations where you have experienced moral distress?

R Okay, currently I am two years now uhm after my study, my study years so I am yeah on my second year of working my bursary back, so I haven't that much of a an experience but in my, I remember in one of my student years uhm I can't, I think it was three years back or four years back, there was a patient we were handing out medication me and my one of my colleagues, another student uhm and the one patient yeah her condition wasn't very stable and we handed out medication and was talking to the patient and when I draw up the medication because she had a uhm she cant swallow very, very easily so we crushed the medication and wanted to give it to her and she looked fine although her condition wasn't yeah that stable but and I wanted to give the medication she was reacting and swallowing the first uhm say 5mls and when I wanted to give it to her she, uhm when I turned my back and came to her again she just yeah she passed away and it felt like, didn't I see something, wasn't there any signs yeah. That was one of the things that the patient was dying before me and I was like couldn't I do anything and then we called the sister and everything but, yeah there was nothing to do, that we could have done.

I How did that make you feel?

R Uhm sjoe helpless yeah I was really and because it was in like your second or third year it was like you didn't have all that information and all the knowledge to know what to do.

I Hmm.

R But it felt and as if your hands were cut off, like you wanted to do something but you couldn't.

I Hmm.

- R I think it was my second year if I am correct yeah. So it was actually a shock cause it was actually the first patient that died before me while I was busy working with her, yeah but it felt like yeah, I was as if I could have done something but I didn't know what.
- I How did you feel that night when you went home? What emotions did you experience?
- R Uhm, ag honestly because we are working like weakly with the patients or sometimes second, every second week so you didn't have that uhm relationship with the patient so the thing is, it was sad for me but I immediately cut off my emotional things at work from home so I don't come to home, go home and "it is so sad I am crying about the patient" I am not like that I leave it at work it is fine and it is sad another life is yeah she passed away, it is taken away but it didn't really like heavy affect me.
- I Okay.
- R The other thing was in my first year I remember the first holiday that we worked it was uhm March 2009, yeah then there was also a uhm oupatjie, he was like the beginning of the week, I think we worked two weeks, beginning of the first week he was fine he actually talked, he eat everything and so his condition uhm.
- I Deteriorated.
- R Yeah deteriorated and he yeah started the second week couldn't talk anymore and we didn't know what was wrong but we actually give him the best care, talk to him, just be there for him and you could see he appreciated it.
- I Hmm.
- R And uhm I think at the end of that two weeks, I came because we worked seven the one and the next day one seven and seven one and so we went on. And the second week me and my one friend we came into his bed and okay we going to talk to oupa again and then he was just, yeah was he passed away. So that was a shock because that was my first, first uhm corpse and because we had an relation, yeah bond with him and we talk and we talk and we knew about his family and everything and then his family came and they thought "okay" and they brought him fruit and everything and they though he could have eat it and everything and we like "no it is not going well" and then the next day he passed away. So that was not nice.

I Hmm.

R That was really I was for a week or two I was really sad he was yeah, I didn't feel very nice.

I Hmm.

R That is the one I remember that patient. I don't know if it was, why it was because it was the first time, it was my first corpse maybe and we had a relationship with him because we worked every day with him.

I Hmm.

R But yeah that I didn't, that for two weeks I felt really sjoe couldn't the doctors maybe done something because you are first here you are just doing basic nursing care, so there is no knowledge if you can say it like that and that you could have yeah used vitals and what else. Not much.

I If I can come back to your first scenario or situation where you gave the patient medication, did you perhaps uhm have some doubt in yourself while giving medication or not really, did you see that as a once off.

R Hmm yeah not really as I was talking now I was thinking of the patient was semi-fuller's so she wasn't like lying down and you gave her medication she may be aspirated or something so it wasn't t that and I can remember that. Uhm but yeag nee I don't think like that I give her medication wrong or wrongfully how did you say that uhm yeah nee.

I Okay.

- R But maybe yeah we must when we saw, first saw the patient and see okay something maybe I think we could have called the sister quicker or yeah we always think that then she could have I don't know yeah do something.
- I Hmm, okay so you only experience really the helplessness.
- R Hmm, Yeah the helplessness yeah that is about all. Uhm the current situation where I am working now uhm the patients is not that ill they just come in for physical rehab. So in the past year I didn't have anything like with a patient where I felt helpless or I did something wrong and then the patient passed away, yeah there was nothing like that.
- I Okay, okay.
- R Yeah.
- I Thank you so much for talking to me, this really helps a lot.
- R It is a pleasure.
- I I really appreciate it.

I Interview 6

I Thank you so much for agreeing to talk to me. I would like to ask you if you can think of any situations where you have experienced moral distress.

R Uhm for instance uhm I have experienced it in a labor rooms where uhm the shift leader or the midwife that was assisting me with the delivery were not competent when uhm it came to the uhm handling of a delivery that has a complication. For instance the patient had uhm a ruptured uterus and we and there were more complications that showed that she had a ruptured uterus but the midwife or the shift leader could not assist me or she did not give me permission as shift leader to do my uhm, or to do the things that I need to do to get the patient to theatre, so that was one of the problems that I have experienced and that gave me a lot of distress.

I What did you feel, how did you feel after that?

R Uhm, during the time that that happened I felt incompetent, uhm because my decisions and requests were questioned.

I Uhum.

R And uhm so I felt incompetent and I raised the question within myself uhm but am I right, do I know what I am doing, so I questioned my knowledge, so I felt incompetent at that stage and then I started feeling frustrated because more and more signs actually showed that I was on the right track and this shift leader did not know what was going on so I started getting frustrated and then I started getting angry uhm as she kept on questioning my abilities and then I got furious and afterwards uhm the, it kept on playing around in my head what happened and thank goodness the outcome of the mother and the baby was, was okay but yes I was it, it stuck with me for quite a long time and even now it is already 8 years and I still remember every detail of it.

I Hmm, what impact did it have on your family life, if any?

R Well it had a big impact uhm because I could not sleep for quite some time and I was working night duty at that stage. It happened at night, so during the day I could not sleep properly because this thing kept on playing in my mind, and.

I Hmm.

R Because I could not sleep uhm I was not able to function within my family so I could not prepare meals because I was exhausted, I could not look after my family, I could

not do the washing, I could not clean because of this insomnia that I have experienced and I could not even function at work so yes it had a big impact on my family.

I If you say you couldn't function at work, what do you mean by that?

R Uhm immediately I was still questioning my ability as a midwife, I was scared to take on any new patient that came in that I had to deliver the baby of, uh because I was questioning my ability whether I will be able to uhm identify any problems what so ever or any complications and whether I will be able to react on it properly.

I Do you think, might it be that you distanced yourself from patients?

R Absolutely, absolutely and uhm I distanced myself from, from those, from that midwife as well and I because number one I was scared that patients would like smell my incompetency, they they will pick it up and I questioned the ability, the abilities of most of shift leaders that worked with me at that stage, uhm I was not confident in any shift leader at that stage.

I Okay, what impact did it have on uhm the work environment uhm between the coworkers?

R Well uhm, it was sort of uhm the shift leaders stuck together because it was like uhm we need to protect each other because there was an investigation towards it, so the shit, shift leaders stuck together and the midwives stuck together and so there was a little bit of rivalry and it was also uhm the questioning from the midwives side whether shift leaders are competent to lead a shift. So there were some rivalry but not for long uhm but it was there yes.

I Okay, how was that resolved?

R Well there was an investigation an incident report was written and uhm the investigation took about two weeks, where this rivalry took place, uhm and then the investigation was done towards the midwife, ag the shift leader and myself and uhm the shift leader was demoted to midwife again and she had to go and do some training again towards complications and how to handle complications.

I Okay are there any other circumstances where you can remember, uhm that you experienced moral distress?

- R Well mostly now in the government hospital I do especially towards uhm that there is not enough equipment, that it is very busy.
- I So if you say busy is there not enough staff?
- R There is not enough staff, uhm I think also that some of the staff lack in the pride and joy of being a midwife. Uhm that they are there for the money and just to get it over and done with it is a job, so the passion, is – is not there anymore, uhm and because of that, because I am a passionate person towards midwifery uhm and within practice, I uhm that cause a lot of distress for me. Uhm because it also feels to me that there is no support and because of my previous experiences I – I do tend to be on a high alert then.
- I Hmm.
- R But uhm equipment is quite a big – big problem at this stage.
- I Such as?
- R Especially where you will have problems where you are augmenting a patient, uhm during augmentation we needs to use uhm a ivac machine to bitrate uhm oxytocin into the patient to uhm regulate contractions and the ivacs are not there or the lines are not there to pull to go through the ivacs so you sit with this thing where you are augmenting a patient and uhm, but there is not equipment and the changes of a ruptured uterus or a placenta rupture are so high because you don't have the lines or the equipment.
- I Hmm.
- R It is just not there so it is a free flow uhm controlled by hand uhm situation where you need to observe the patient and the CTG and go on by that.
- I How does that make you feel?
- R Uhm exposed I am feeling exposed because, and vulnerable uhm abused, used. Because uhm for me is that nobody, if something should go wrong nobody will cover me and I will, I will lose my job. But at the end of the day the patient needs to be helped.
- I Hmm.
- R So you can't just leave it, so yes I feel exposed.

I What influence does that have on you work then?

R Uhm, I don't know because I think that we adapt to this whether we want to or not, I don't know whether we do this intentionally or not but I have adapted, uhm and uhm you just function and you improvise and you learn to do crisis control so it hasn't significantly influenced my abilities to do my work, but it pushed me to evolve in a midwife that is adaptable and can make a plan with what I have got so my work has not been influenced as such but I think the type of care that the patient is receiving are being influenced.

I Does it have any influence on you psychologically?

R Oh yes absolutely, uhm I think in a way it, psychologically I feel uhm that I am not doing the best for my patient because I do not have the correct equipment to do it so psychologically I feel although I will not show it to the patient I feel incompetent, although I am doing the best I can with what I have. But yes it – it psychologically I feel incompetent and – and not caring for my patient because I can't give my patient what – what she should have and what she deserves as a patient.

I Is there anything else you would like to add?

R No.

I Thank you very much for talking to me it really helped a lot.

R Okay.

I Interview seven.

I Thank you so much for talking to me. I would like to ask you if you can think of any situations where you have experienced moral distress?

R Uhm if I can uhm look back when I worked at the private sector I don't think that there were any situations that caused me moral distress, I know when I have started to work here at the university we had the instance where we had to do full bed washes with the third, uhm first year students and the patient didn't have anything and I think that was the first time that uhm it caused a little bit of distress if you look at the things that the student wanted to use uhm and not more of less to say what I would use uhm but uhm yes and I think that – that was a little bit distressing.

I Okay and what did you experience what feelings or symptoms did you have?

R I think that I was a little bit frustrated uhm because you wanted to do something for your patient and the equipment was not there uhm even though the students are prepared with their own kits to - to do their work for the patients but I think it was frustration and then the sadness that the institution where you are couldn't supply or uhm have a stock available that you can use for the patients that really don't have the equipment to do something simple like a full bed wash.

I What other stock?

R Uhm I know when, when we also when I worked in, in uhm one of the government hospitals in Klerksdorp with the third year students there weren't even tissues or hand paper that you can dry your hands with after you washed them to prevent infection for the patient so uhm there weren't gauze we had to stop an infusion that were infiltrated uhm there weren't even gauze or even a swab that you could stop the bleeding when you take the jellco out uhm gloves there weren't even non sterile gloves to work with they had to open sterile gloves just to do a simple urine test on a patient for example so that is some of the stock that were that weren't available in the government hospital where uhm I did facilitation for the students, and then we improvised. That was the one thing we used the sterile gloves instead of the non-sterile which is not cost effective and then the other thing is that I sent the student to one of the other wards to see if they don't have the things that we need cause apparently the ward stock hasn't arrived. The unit manager has ordered but it hasn't come yet so uhm then we made other plans.

I Can you elaborate a little more on how you felt when what you needed wasn't there?

- R I felt bad for the patients because I didn't think that they received the proper quality care uhm that I promised myself that I will render to my patients uhm it felt like I have neglected my patients in that way that I couldn't give them uhm the care that they need, that I couldn't protect them uhm against uhm may be getting hospital acquired infections uhm –uhm and that I was putting them at risk, their safety uhm because this patient, the one patient that we had was bleeding quite a lot uhm we couldn't stop the bleeding because we could not apply adequate pressure uhm and that made me felt helpless that I am in this profession I have got all this qualifications and not even having the basic equipment to do the care that I need to render it made me feel, yeah it didn't make me feel good about the profession as well.
- I Okay what effect did it have on you personally?
- R Uhm personally I think that I felt sad and I felt that I was in the position that I had a medical aid that I know I can get the maximum care and the best care that I need and it felt like I want to do something more for this patients that couldn't afford that quality care that I know I can get uhm so I wanted to do more but I know I couldn't uhm out of my own circumstances I cannot supply good care for everybody or be there for everybody and do the best I can uhm yeah, yeah.
- I Okay so it is only the sadness that you that you personally experience.
- R Yes and then feeling that we are not uhm giving the quality care that we promote because in the media we promote this quality care uhm professionalism and you can't really be professional and render that quality care if you don't have the, you can improvise but uhm sometimes even the improvise uhm the things that you improvise with is not to the best for the patient so yeah.
- I Okay did it have any effect on your family life?
- R I think that I try not to take my work at home uhm if there are some things at work then I try to resolve it within myself or I speak with a colleague or ask them what they would do in the same circumstances I think what I took back home was to appreciate what I have got and then to teach my children as well that they must know that there are people that are in much more uhm – uhm hectic or if I can use uhm.
- I Dire!
- R Haglike uhm bad circumstances that they must appreciate and value what they have and not medical uhm uhm – how can I put it, not to take everything for granted to

appreciate what they have and then to value that because uhm because it might be us in that circumstance not having what this patients not having. So I think that is the thing that I take back to my family is to take care of yourself, stay healthy, uhm be warm don't get sick unnecessarily uhm because we can't prevent that, we can prevent that uhm yeah.

I Okay are there any other circumstances or situations where you can think of where you experienced moral distress?

R Uhm not really I think I was very lucky in – in where I have worked before and now with my encounters with uhm shortage of equipment so I was fortunate to have always uhm to have equipment to do my work with to the best of my abilities.

I Have you ever experienced a shortness of staff or is it only the shortness of equipment?

R Yes, no uhm I don't think it was a critical factor but I know where I have worked for before uhm was they implemented acuity levels so we worked with less staff uhm so we had to cope with that but luckily for me we had good team efforts so we could go through uhm a difficult days work with less staff uhm.

I Did it have any impact on you?

R Uhm yes, burnout definitely because we had to leave our admin work uhm behind to help the staff on the floor so you had to take your admin work home and did it after hours so yes I had burnout, was tired was irritated uhm I wouldn't say my immune system had an impact or an effect, I didn't get sick I realized it in time so I got help in time.

I Hmm.

R And what I learned out of that was uhm not to take work home,

I Hmm.

R So I tried to do it at work, if there is not time to do it at work uhm there is the next day so you plan it into the next days' work or schedule, uhm yes.

I What psychological effect did that have on you?

R Uhm the burn out itself made me tired all the time uhm I didn't had any energy to go to work, I did not feel up to go to work uhm my stress levels were very high, uhm

worried and concerned about everything and everyone and I uhm think that that caused on the personal level that caused irritation with my husband and fighting with my husband because he could not understand for him nursing is just a work you do it is like comparing it with being in retail uhm with the more I explain to him but you are working with people's lives you need to be more assertive. Uhm he couldn't understand why I am stressing this much so it definitely had an impact on my home uhm with my children as well I was irritated uhm – uhm being very strict and sometimes shouting on them and all that so and yes, that is why I said no! stop here and refocus again and reorganize everything re plan and then it worked out better and then to say no that was the other thing I learned out of it because sometimes you take on quiet a lot because there is not enough staff you say yes to everything and then you forget about the person inside so yes, uhm.

I Did you experience any physical symptoms during that time?

R Except the tiredness I didn't really felt sick uhm.

I Headaches, nausea?

R No –no –no, I think the headaches is more from sinus and allergy that from uhm stress and all that. I could just say that I was tired so I made efforts that I had a good night's sleep and not deurnag!

I Hmm.

R So uhm yeah but uhm no and I think that one of the symptoms' but I don't know if it is physical really where normally you have got a lot of energy you think about new ideas, so there was a time when I were just blank couldn't think.

I Hmm.

R But I think that that was more mentally not physical really so uhm yes and then my doctor subscribed me some nice supplements and everything so that helped for that, just that the brain can.

I Function better.

R Function better yes, yeah.

I Is there anything that you would like to add?

R Uhm no – no I think if there are not equipment or if there is something that is preventing me from doing my work it will cause stress uhm and what I have learned during the years is not to let that stress back over think of what you have instead of that and then go on from there uhm if it is really something that the family can bring you will call the family to help with that as well if it is like personal belongings or something like that so you will get involved more with the public and community then to help you.

I So you adapt.

R You adapt yes before you die. Yes so yeah.

I Thank you so much for talking to me I really appreciate it.

R That is fine.

I I really appreciate this.

I Interview eight

I Thank you so much for talking to me I really appreciate this.

R Pleasure.

I Can you think of any situation where you have experienced moral distress?

R Uhm I can think of quiet a few instances, the first would be that we don't always have the necessary equipment, uhm not only equipment but uhm disposable for instance there is a prescription for Panado and Codein and we only have panado so the patient does still have pain because the prescription is not fulfilled we can only give panado's or we have to do a uhm, clean a patient change the nappy and there is no clean lined to change this soiled bedding uhm then also a big factor for me is that prescriptions is not always uhm adequate, you may have a patient that may have a broken femur and all that is prescribed for pain is brufen and panado – TDS and there is nothing no meds or scheduled medication.

I Why do you think that is?

R I think sometimes there is a lack of knowledge on the prescribing doctors uhm part and sometimes I think we are in a rut we just do the same thing over and over and they only give three doses of Omnopon and they don't reevaluate the patients situation after that three doses it they they give three doses after surgery but they don't consider it might be an appendix that only needs three doses of onupun instead of a big fracture or uhm multiple fractures for that case and they don't consider the patient's condition after that three doses, when actually, sorry actually this wasn't enough.

I So they don't look at the individual patient then?

R Yes another example of this is wound care, you have a prescription for a basic saline wound or maybe if you are lucky you get melodome with it but sometimes it is a heavily excadating wound you don't even have something like tex uhm a gortex or just a a sponge dressing to apply to that because it is not prescribed and you are not allowed to go out of your scope of practice and prescribe it yourself.

I Hmm. How does that make you feel?

R Very frustrated, I can see that my patient is not getting the needed care and it makes me unhappy and frustrated and I get angry about it.

- R Uhm the other thing is I feel blamed by the patient even though it is not my fault because a patient complains to me that the wound is not healing or that the pain is very severe but my hands are tied. So yeah no and I feel a very big responsibility even though it is a false responsibility I know with my head I feel responsible for this patients anguish and suffering.
- I Do you experience any symptom that comes from all these feelings that you have just described?
- R Can you please clarify the question symptoms such as!
- I Physical symptoms maybe you get headache or?
- R Oeh I get extremely tired.
- I Tired?
- R Yes, I think it is a symptom of of a bit of depression when I was uhm working in circumstances like this for a long period of time. I was very depressed so I used to sleep a lot like up to twelve hours a day and I would eat more, so it is depression.
- I And did you have any physiological symptoms such a sadness or crying or!
- R Yes a lot sadness a lot of crying, hyper emotional. Nobody could bear living with me and then also anger outbursts, uncontrolled anger outbursts.
- I What effect did it have on your home circumstances and your family?
- R Uhm it, well it is only me and my husband but it pulled us apart because he would vermy, uhm he would!
- I Avoid.
- R He would avoid me, because it is just no fun being around me and I would avoid talking to him because all my frustrations I would lash out at him and that is also not fair so we would avoid one another.
- I Okay did you have any avoiding behavior towards your patients?
- R I think I I distanced myself from them emotionally and a symptom that I could see in my ward is that we would joke uhm between brackets about patients complaining or moaning the whole time when it was actually relevant complaints that they raised, but because we felt so helpless we would immediately blame someone for complaining

all the time and moaning all the time so then we would make jokes about it when it was actually not professional or applicable at all, it was relevant complaints.

I So you, would you say then that it influenced your professional behavior?

R Definitely.

I Is there anything else that you experienced or felt that you think you could add?

R I think to a huge extent adding to my professional life, I became angry at doctors not because they were always to blame but because they were sometimes to blame for small things, not writing the right prescription or saying we should use a nasal cannula when the patients actually needs, uhm needed the poly mask and I would get so angry and I would complain to everybody about the uhm, incompetence of doctors, I think it it takes the whole multi-disciplinary team,

I Apart.

R Apart yes.

I What feelings did you have when you worked with an incompetent Doctor as you described?

R Mostly frustration but anger and fear for the patients safety. I did lose a patient because of a doctors incompetence and its I have a lot of unforgiveness about that I still feel angry if I think about it and if I see the same things happening cause we have got such a lot of comserves working without direct supervision I just feel so angry and another sorry I am going back, right back to examples of moral distress a big thing to me is that patients are victimized by doctors sometimes if they do not do the right thing or if they don't use contraception and then they want an abortion even though I don't agree with that you can't victimize a patient for that or if a patient if smoking or even if they just went for a walk when the doctor wanted to see them they get very rude and a example that I have from the last month is a pregnant lady that didn't want a caesarian section and this doctor came bursting into another ward telling another doctor of this idiotic patient and her husband that is going to cause her baby to die and all the patients in that room at the moment was devastated and scared and didn't have any uhm openness towards the doctor to ask the doctor questions regarding their own health. I think I feel they cant protect my patients against outburst like that.

I So also unprofessional behavior from the doctors side.

R Yes.

I Was there always enough staff where you worked?

R No that is also one off a big problem you want to maybe wash a patients hair but you don't have enough time you do not have enough staff to delegate, so that yes thank you is also a very big problem.

I And when that happens how does that make you feel?

R It makes me feel hopeless.

I Yeah.

R Then I would, I would rather I would I would find myself not writing the cardex complete, I would find myself not changing the vacupec in just 15minutes because in any case you would not get done with everything so it makes me feel uhm distanced from, from my professional responsibility in a way, I just want to let it all go, it can all go to pieces because in any way I can't do the little things that really makes a person feel cared for.

I Hmm,

R Sorry I actually answered another question.

I Perfect. Is there anything that you would like to add?

R I actually had this list in my head so ready for you. Oh there is one thing, the incompetence of co workers or also sometimes leads to moral distress.

I Can you give me an example of – that you would describe as incompetence in your co workers?

- R Uhm wound care, I can't necessarily trust my staff nurse to perform a septic wound care cause I don't know where she got trained and I have seen them answering cell phones in the middle of a sterile procedure or in a septic procedure so yes. Another example would be uhm a second year student asking me to put up a drip and I have seen this student before and doesn't have any clue at all how to access a vein for viability so.
- I And how does that make you feel?
- R It worries me, and it adds to my work pressure because I have to forever go back and see, is it done, is it done correctly, is the patient okay afterwards. So it stresses me out.
- I If you say something stresses you out cause you have mentioned that a couple of times what feelings or behavior do you associate with being stressed out?
- R Uhm physically I would find myself breathing faster, I would feel my heart pounding in my throat, I would be angry for no apparent reason it is not necessarily a defined or focused anger, uhm I would feel hurried even though I would have five or ten minutes to sit down and it will make me make mistakes because I am not, my head is not where my hands are at.
- I And if you have the feeling that you are going to make mistakes, does that lead then to other feelings.
- R I am a very angry person.
- I Back to anger.
- R Yes.
- I With that do you not experience self-doubt because you are going to make a mistake, you have now decided that.
- R No I am very good at re directing that, so I always I blame others very well so I rather lash out, not necessarily outward but in my head I think "If he just wasn't so incompetent then this wouldn't have happened and you wouldn't have made me mistakes" so I am very good at blaming others. And then the student who can put up a drip gets it because then I just say "No I will do it myself" yes.

I Anything else you would like to add?

R No I think I went through what all there is to know.

I Thank you very much for talking to me, this really helps really a lot.

R You are very welcome.

I Interview nine.

I Thank you so much for talking to me I really appreciate this.

R It is a pleasure.

I I am going to make notes while we talk so don't worry about me you can just talk.

R Okay that is fine.

I Can you think of any situations where you have experienced moral distress?

R Well as, well especially in the South African setting with the provincial hospitals there is defiantly a shortage in equipment needed for certain procedures for instance as an example uhm send us the invitation for this interview with something as simple as a full bed wash there is not even towels to dry a patient with and sometimes there is in a clinic setting there is not even medication to give to the patient so defiantly in a South African provincial setting I experienced that a lot.

I And when you experience that, how does that make you feel?

R Well it is frustrating but not only for me, if I have to put myself in a patients position it is unfair towards the patient because according to the Batho Pele principles you have to have like good, high quality of care and that is not the case then and on the other hand I also think as a nursing student, it puts me in kind of an advantage position that as towards first year, I mean first world students in learning to improvise.

I Hmm, when you feel frustrated, what uhm symptoms do you experience in other words if you can think of something physical like head ache or, or you experience something like that?

R Yes since my first year I am not a person that, I don't feel stressed I never realize that I am stressed, but I start feeling that my jaws lock because when I sleep I clench on my teeth and my hair fall out and I gain a lot of weight.

I Okay and any physiological uhm symptoms?

R As I said I don't really know when I am stressed and I think physiologically I have a very good support system so when I feel bad about something or yeah bad about something I have people I can talk to so, I don't really.

I And yours exhibit more with the physical symptoms than psychological.

R Yeah more physical yeah.

I Okay.

R Yeah.

I Okay.

R Definitely because I have an outlet for my emotions, people I can out my emotions to.

I What other situations have you experienced that made you to have moral distress? If there are any.

R I don't really except for the work setting, not really, I haven't really.

I When you say shortage of equipment does that include staff?

R Yes, sometimes yeah staff but sometimes but especially there is a shortage of qualified nurses of registered nurses and too much students, whether it is from university or from the colleges nearby. Or ENA and then the workload for those people are very light but the workload for the registered nurses are too much so definitely it could go both ways depending from which view you look at it.

I Hmm have you worked where there was not enough staff on duty.

R Yes I had an experience this year working on ward four, it is a post natal ward, there were one registered nurse in the ward the whole day and she was in theatre the whole day and she left that morning at eight o'clock and she came back at six thirty so I was basically the registered nurse the whole day in the ward.

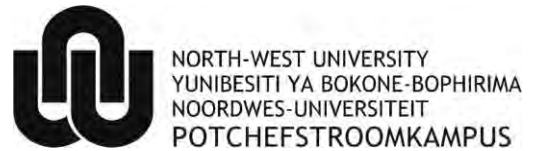
I And how did that make you feel?

- R It was very nerve wrecking because people came to me and asked this patient has this now, what do I do now and then you have to think on your feet and check what is going on and give an answer but on the other hand it made me feel empowered and made me for the first time I actually felt I am ready for this.
- I Okay that is good.
- R Yeah.
- I Is there anything else you would like to add?
- R No I think I have said everything.
- I Okay thank you so much for talking to me.
- R It is a pleasure.
- I I really appreciate this.

ADDENDUM D

FOCUS GROUP

i) Information letter



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June 2013

To whom it may concern

**Research Title: “Moral distress in South African Professional Nurses:
Instrument development” (Ref no NWU-00036-11-S1).**

Participation:

You are invited to participate in a focus group. The focus group will take approximately 30 minutes of your time. You will remain anonymous when taking part in this research.

Study purpose: the aim of this research is to develop and validate an instrument to measure moral distress.

Overall research objectives:

1. To conduct an integrative literature review;
2. **To conduct confirmatory, exploratory interviews** to be used together with the empirical indicators to develop an instrument to measure moral distress;
3. To develop an instrument to measure moral distress in professional nurses;

4. To validate the instrument.

Moral distress is when a nurse is faced with a decision with a moral component, and although the nurse is aware or knows the right course of action to take, he/ she cannot implement it, causing his/her morals and value system (*these morals and value system are the boundaries within which he/ she decides what is right or wrong*) to be compromised, his/ her professional autonomy (*professional autonomy is the capacity one has to make independent, informed decisions*) to be violated and leaves him/ her feeling powerless (*powerlessness is when the nurse is unable to produce an effect*) (to care for his/ her patient).

Risks:

Depending on your perception of moral distress, you may feel uneasy when talking about moral distress. You do not have to answer any question or take part if you feel the questions are too personal or make you uncomfortable.

Benefits:

The study will give you the opportunity to give your view on moral distress. The information you share will help the researcher to identify concepts important to measure moral distress. Feedback will be given if so required.

Anonymity: To ensure anonymity, your name will not be recorded with your responses or identified in any way. Results will be published so that your identity or the identity of the hospital will not be revealed in any reports or publications.

Interviews or computer databases will contain no identifiable characteristics and will be stored in locked cabinets and on password protected computers.

Conservation of data:

All information collected (interviews) will be kept in a locked filing system. All computers on which study data will be stored will be password-protected. The data will be accessible only to the researcher and her promoter. The focus group interview will be kept in locked storage for 5 years.

Voluntary participation:

You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time, for any reason, without consequences. If you choose to withdraw

from the study, you may request that all data gathered until the time of your withdrawal be destroyed.

For more information:

If you have any other questions or require more information about the study itself, contact Richelle van Waltsleven (researcher) at the North West University, Potchefstroom Campus. Telephone +27(0) 18 299 1886 or email at richelle.vanwaltsleven@nwu.ac.za.

If you have any questions regarding the ethical conduct of this study, you may contact Dr Emmerentia du Plessis at the North West University, Potchefstroom Campus. Telephone +27(0)18 299 1876 or email at Emmerentia.duPlessis@nwu.ac.za.

Sincerely,

Me R van Waltsleven (M Cur, RN, RM)

Dr SK Coetzee (Ph.D, RN, RM)

Dr E du Plessis (Ph.D, RN, RM)

ii) Consent letter

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

Research Title: “Moral distress in south african professional nurses: instrument development” (Ref no NWU-00036-11-S1).

I, _____ hereby give informed, voluntary consent to participate in the above-mentioned research. The purpose, objectives, benefits, risks and the responsibilities of all parties concerned are clear to me. I am willing to take part in the focus group. I know that the focus group interview will be voice recorded. I understand that the results of this research may be published but that my name and the name of the facility will be held confidential. I know that I may withdraw at any time from the research without any consequence. I understand that I will receive no money for participating in this research.

Participant: _____

Witness: _____

Researcher: _____

Date: _____

iii) Focus group transcript

I – Interviewer

R – Recipient

I Focus group

I Thank you for completing the questionnaire!

I Can we quickly have a look at question 1? Let's start with the demographic data. Are there anything you feel should be added, taken away or does this cover everything?

R It covers everything. I would like to know, maybe you should add public or private hospital. Because it is only going to be public hospital? It would be good to go to the private hospitals as well.

I Very, very valid question. We'll have a look at that.

I Remember that this is a pilot. So we can make some changes, and later go to the private hospitals – if they would allow us. The private hospitals are very strict with consent, I worked there for several years.

R There are some people working in the private and public hospitals here.

I That doesn't matter now. This is about the clarity of the questions.

R Ok.

I This is not about where one works. Ok, any other suggestions for the demographic data? Ok. Question 1, did you understand it, was it clear, confusing?

R The questions itself isn't difficult. But, the rating, namely the never, rarely, sometimes, often. I feel that is confusing. One can experience something often. Explain to me often.

I What is often?

R I think it's different for Afrikaans speaking people. Nearly never... in Afrikaans...

- I Look at the instructions. It says... 'choose the most correct answer". Remember we are dealing with people of different languages and we have to find a mid-way to accommodate everyone. Therefore, this is about find a mid-way to accommodate everyone completing the questionnaire.
- R The timeframe makes it difficult, can't it be once a month, once a week, etc.?
- I Is it the variance you find confusing?
- R Yes. It's only the categories that is confusing, namely the never, rarely, etc.
- I Ok. And the questions itself?
- R No, there's no problems.
- I Excuse me... any comments with regards to the questions? Are they valid? Everyone? Did you fill in every question? Were there any question where you felt you couldn't answer?
- R No.
- I Ok. Thank you very much.

ADDENDUM E

POOL OF QUESTIONS FOR MORAL DISTRESS INSTRUMENT

1. I believe I am my patients' advocate.
2. I try to be involved in my patients care by being his/ her advocate.
3. I can easily advocate on my patients' behalf.
4. My patients' wishes are adhered to.
5. My patients' family/ the physician interferes with my patients wishes.
6. My patients always get all the information they need.
7. My patients always know what treatment they are getting and why.
8. I feel good about the quality of care that I give to my patients.
9. In my ward my patients always receive the best nursing care.
10. Patient care never suffers due to shortage of staff or negative attitude of staff.
11. I am unable to give the quality of care I would like to give to my patient.
12. I feel that all the nursing staff I work with are competent.
13. I feel I can protect my patient from harm/ suffering.
14. I feel helpless to protect my patient from harm/ suffering.
15. I know what is the morally right thing to do when caring for my patient.
16. I can make and act out the morally correct decisions.
17. I can always work within my scope of practice.
18. I am never expected to work outside of my scope of practice.
19. I have the necessary knowledge to look after my patients.
20. I feel I lack the necessary knowledge to look after my patients.

21. I feel I am part of the decision-making process of my patient.
22. I feel I am part of the multi-disciplinary team.
23. I always follow the physicians requests without saying a word.
24. I am allowed to question the physician regarding his prescribed treatment.
25. I feel that all the physicians I work with are competent.
26. There are good collaboration between the physicians and nurses.
27. There are good communication between the physicians and nurses.
28. There are good communication and collaboration amongst the nurses in my ward.
29. Physicians respect my input.
30. I feel I have input over the hierarchial processes in my institution.
31. I feel part of the team in my institution.
32. There are good communication between management and the nurses.
33. Management respects my input.
34. Management protects me from physicians behaving badly.
35. My input is taken into consideration in my institution.
36. I have input in the compiling of policies and procedures.
37. I have support from my institutions management.
38. There is always enough nursing staff on duty.
39. There are always enough RN's per ward on duty.
40. Lower category nurses (AN's and EN's) are always expected to work outside of their scope of practice, e.g. AN's must do wound care and EN's must give ivi medication.
41. Management supports me when I complain of a lack of staff.
42. Management supports me when I complain of a lack of resources, such as linen.

43. Management supports me when I complain that I do not know how the electronic equipment works.
44. I often feel uncertain when caring for my patient.
45. I often question my own ability when treating my patient.
46. I often question my self-worth.
47. I am worthy of others' respect.
48. I often blame myself when my patients' wishes are ignored.
49. I often blame myself when something goes wrong.
50. I hate myself.
51. I feel defeated.
52. I feel worthless.
53. I feel emotionally detached.
54. I feel insecure about what I do.
55. I can easily open up and interact with my patients.
56. I often distance myself from my patient.
57. I often distance myself from my own family.
58. I often want to be left alone.
59. I am fearful of making mistakes.
60. I feel incompetent.
61. I feel I lack knowledge/ skills to properly care for my patient.
62. I often think of working in another ward.
63. I often think of leaving nursing.
64. I struggle to get up for work in the mornings.
65. I have no job satisfaction.

- 66. I do not feel motivated.
- 67. I often feel frustrated.
- 68. I often feel angry.
- 69. I often feel guilty.
- 70. I often feel sad.
- 71. I often feel disappointed.
- 72. I cry often.
- 73. I feel like doing anything.
- 74. I feel I have no energy.
- 75. I feel depressed most of the time.
- 76. I feel anguish.
- 77. It feels as if I experience pain almost daily.

ADDENDUM F

CONTENT VALIDATION OF THE MORAL DISTRESS INSTRUMENT

The researcher undertook an integrative literature review and conducted interviews to identify the antecedents, consequences and attributes of moral distress.

Three Themes emerged from the antecedents, namely: Practice environment, Patient care and Person. The practice environment refers to factors related to the work environment and the sub-themes that were identified are: poor workplace relationships, working in fear, poor leadership, lack of resources, policies and workload. The second theme, patient care, refers to aspects concerned with the patient and the sub-themes that were identified are: poor quality of care, hostility towards the patient, lack of patient autonomy, with-holding truth, futile care, ethical conflicting treatment and death. Person refers to the nurse and the sub-themes that were identified are: emotional demands, responsibility, role conflict, moral conflict, lack of authority and need for knowledge.

The three categories that emerged from the consequences were: Organization outcome, Patient outcome and Nurse outcome. Organization outcomes refer to those aspects that form part of the work environment. The sub-themes that were identified are: poor workplace relationships, turnover, job dissatisfaction, absenteeism and insubordination. Patient outcome refers to aspects that directly affect the patient, and the sub-theme identified were: challenging care environment. Nurse outcome refers to those aspects that the professional nurse experiences. The sub-themes that were identified from the nurse outcome were: emotional consequence, compromised morals and values, intellectual consequence, spirituality consequence, social consequence, decreased productivity and physical consequence.

The attributes that were identified were: Compromised morals and value system, violated professional autonomy and powerlessness. The attributes that were identified, led to the following definition of moral distress: Moral distress is when a nurse is faced with a decision with a moral component, and although the nurse is aware or knows the right course of action to take, he/ she cannot implement it, causing their morals and value system to be compromised, their professional autonomy to be violated and leaves him/ her feeling powerless (to care for their patient).

Purpose

The purpose of this questionnaire is to rate the content validity, in order for the researcher to determine the Content Validity Index.

Instructions

1. Please rate the *content relevance* of the items reflecting in the MORAL DISTRESS INSTRUMENT using the 4 point rating scale, where:

1 = The item is not relevant at all and should be deleted.

2 = The item is somewhat relevant but needs major revisions.

3 = The item is relevant but needs minor revisions to be representative of moral distress.

4 = The item is very relevant.

Circle the number to the right of the statement that in your judgement reflects the relevance of the item.

2. Rate the *content clarity* by circling 'Y' if the items are clear and 'N' if the items are unclear.
3. Please list the numbers of the five items that in your opinion best reflect each subscale.
4. The Likert scale will include four (4) response options from "strongly disagree to strongly agree", with no neutral midpoint.

Moral distress consists of three subscales, namely: Compromised morals and value system, violated professional autonomy and powerlessness.

MORAL DISTRESS INSTRUMENT – Subscale 1 – Compromised morals and value system

Each nurse has inherent morals and a value system that directs his/her decisions and the choices he/she makes. These morals and value system are the boundaries within which he/she decides what is right or wrong. When he/she have to adapt or change their morals and value system in order to fulfil the expectations within his/her practice environment or that of patient care, his/her morals and value system are compromised.

	Relevance	Clarity
1 I know what is the morally right thing to do when caring for my patient, but I cannot do it.	1 2 3 4	Y N
2 I am expected to do/ be part of procedures that I morally do not agree with.	1 2 3 4	Y N
3 I feel my employer does not expect me to be part of procedures that are against my moral and value system.	1 2 3 4	Y N
4 I am expected to provide care that is not within my moral and value system.	1 2 3 4	Y N
5 I am able to act according to my morals and value system while caring for my patient.	1 2 3 4	Y N
6 I feel my colleagues respect my morals and value system.	1 2 3 4	Y N
7 I feel my employer upholds rules and regulations.	1 2 3 4	Y N

Suggestions for making items clear. Please indicate by number.

In my opinion, the five items that best reflect the subscale of Compromised morals and value system are:

MORAL DISTRESS INSTRUMENT – Subscale 2 – Violated professional autonomy

Professional autonomy is the capacity one has to make independent, informed decisions. When nurses however are not allowed to practice freely, use their knowledge, experience and expertise to contribute to the care of the patient and collaborate with the physician and multi-disciplinary team, this autonomy is violated.

	Relevance	Clarity
1 I am expected to carry out the physicians' orders, even though I disagree.	1 2 3 4	Y N
2 I feel that the physician respects my opinions and input with regard to patient care.	1 2 3 4	Y N
3 I am expected to implement policies and procedures without any questions.	1 2 3 4	Y N
4 I am excluded from the decision process regarding my patient's care.	1 2 3 4	Y N
5 I feel satisfied with the number of independent decisions that I can exercise in my work.	1 2 3 4	Y N
6 I feel satisfied with the extent to which I can use my skills.	1 2 3 4	Y N
7 I feel excluded from the decision process regarding management issues.	1 2 3 4	Y N

Suggestions for making items clear. Please indicate by number.

In my opinion, the five items that best reflect the subscale of Violated professional autonomy are:

MORAL DISTRESS INSTRUMENT – Subscale 3 – Powerlessness

When nurses are prevented from giving or doing their best for their patients, whether it is through advocacy or relieving their pain, they experience a feeling of powerlessness. Powerlessness is when the nurse is unable to produce an effect; it might be because they lack power, resources or authority or they are unable to do something or to stop something.

	Relevance	Clarity
1 I can always be my patient's advocate.	1 2 3 4	Y N
2 I feel helpless to protect my patient from harm/ suffering.	1 2 3 4	Y N
3 I am unable to respect the wishes of my patient.	1 2 3 4	Y N
4 I am unable to be completely honest with my patient.	1 2 3 4	Y N
5 At the end of the day I feel satisfied with what I accomplished at work.	1 2 3 4	Y N
6 I am unable to provide the care I would like to give to my patient.	1 2 3 4	Y N
7 I feel satisfied with the amount of authority I have at work.	1 2 3 4	Y N

Suggestions for making items clear. Please indicate by number.

In my opinion, the five items that best reflect the subscale of Powerlessness are:

Please provide your overall comments on the questionnaire.

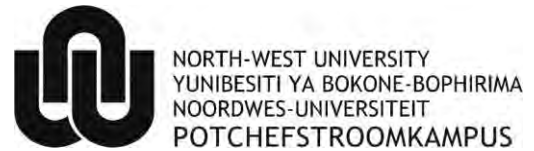
Thank you for your time and effort – it is sincerely appreciated!

Please return this questionnaire to Richelle van Waltsleven
(richelle.vanwaltsleven@nwu.ac.za).

ADDENDUM G

MORAL DISTRESS INSTRUMENT

i) Information letter



Privaatsak/ Private Bag X6001, Potchefstroom
Suid-Afrika/ South Africa, 2520

Tel: (018) 299-1111/2222
Web: <http://www.nwu.ac.za>

**SKOOL VIR VERPLEEGKUNDE/SCHOOL OF NURSING
SCIENCE**

Tel: (018) 299 1886
Fax: (018) 299 1827

E-mail: richelle.vanwaltsleven@nwu.ac.za

October 2013

TO WHOM IT MAY CONCERN

**Research Title: “Moral distress in South African Professional Nurses:
Instrument development” (Ref no NWU-00036-11-S1).**

Participation:

You are invited to participate in completing a questionnaire. The questionnaire will take approximately 20 minutes of your time. You will remain anonymous when taking part in this research.

Study purpose: the aim of this research is to develop and validate an instrument to measure moral distress.

Overall research objectives:

1. To conduct an integrative literature review;
2. To conduct confirmatory, exploratory interviews to be used together with the empirical indicators to develop an instrument to measure moral distress;
3. To develop an instrument to measure moral distress in professional nurses;
4. To validate the instrument.

Moral distress is when a nurse is faced with a decision with a moral component, and although the nurse is aware or knows the right course of action to take, he/ she cannot implement it, causing his/her morals and value system (*these morals and value system are the boundaries within which he/ she decides what is right or wrong*) to be compromised, his/ her professional autonomy (*professional autonomy is the capacity one has to make independent, informed decisions*) to be violated and leaves him/ her feeling powerless (*powerlessness is when the nurse is unable to produce an effect*) (to care for his/ her patient).

Risks:

Depending on your perception of moral distress, you may feel uneasy when completing the questionnaire. You do not have to answer any question or take part if you feel the questions are too personal or make you uncomfortable. The completion of the questionnaire will also require some of your time and this will be time lost for other activities.

Benefits:

The study will give you the opportunity to give your view on moral distress. The information you share will help the researcher to identify concepts important to measure moral distress. Feedback will be given to the hospital and suggestions for interventions will be made.

Anonymity: To ensure anonymity, your name will not be recorded with your responses or identified in any way. Results will be published so that your identity or the identity of the hospital will not be revealed in any reports or publications.

Questionnaires or computer databases will contain no identifiable characteristics and will be stored in locked cabinets and on password protected computers.

Completing the questionnaire indicates your consent.

Conservation of data:

All information collected (questionnaires) will be kept in a locked filing system. All computers on which study data will be stored will be password-protected. The data will be accessible only to the researcher and her promoter. The questionnaires will be kept in locked storage for 10 years.

Voluntary participation:

You are under no obligation to participate and if you choose to participate, you can withdraw from the study at any time, for any reason, without consequences. If you choose to withdraw from the study, you may request that all data gathered until the time of your withdrawal be destroyed.

For more information:

If you have any other questions or require more information about the study itself, contact Richelle van Waltsleven (researcher) at the North West University, Potchefstroom Campus. Telephone +27(0) 18 299 1886 or email at richelle.vanwaltsleven@nwu.ac.za.

If you have any questions regarding the ethical conduct of this study, you may contact Dr Emmerentia du Plessis at the North West University, Potchefstroom Campus. Telephone +27(0)18 299 1876 or email at Emmerentia.duPlessis@nwu.ac.za.

Sincerely,

Me R van Waltsleven (M Cur, RN, RM)

Dr SK Coetzee (Ph.D, RN, RM)

Dr E du Plessis (Ph.D, RN, RM)

ii) Moral Distress Instrument for pilot test

Demographic data				
Please circle the relevant answer.				
Gender:			Male	Female
Unit where you are currently working:	ICU	THEATRE	ER	MEDICAL
	SURGICAL	PAEDIATRICS	MATERNITY	REHAB
	PSYCHIATRY	CLINIC	OTHER	
Please complete the following by writing your answer in the right column.				
Age:				
How many years have you been working as a PN? (Professional nurse)	____ years			
What qualifications do you have?				
Are you currently working full time or part time?	Full time		Part time	

Questionnaire

Please read the following statements. To the right of each statement, you will find numbers, ranging from “1” to “4”, where “1” is never and “4” often. Circle the number which best describes your feelings on the statement provided. What is the frequency with which you experience the following?

		Never	Rarely	Sometimes	Often
1.	I am restricted from implementing my morals and value system when caring for my patient.	1	2	3	4
2.	I feel satisfied with the degree of authority I have at work.	1	2	3	4
3.	I feel I am able to apply my skills as I would like.	1	2	3	4

		Never	Rarely	Sometimes	Often
4.	I am expected to implement policies and procedures without question.	1	2	3	4
5.	I am expected to provide care that is not within my morals and value system.	1	2	3	4
6.	I feel that the physician respect my input with regard to patient care.	1	2	3	4
7.	I feel I can advocate on my patients' behalf.	1	2	3	4
8.	I am able to be completely honest with my patient.	1	2	3	4
9.	I am expected to be part of procedures that I morally do not agree with.	1	2	3	4
10.	I feel that my skills are valued.	1	2	3	4
11.	I am able to provide the care I would like to give to my patient.	1	2	3	4
12.	I am able to act according to my morals and value system while caring for my patient.	1	2	3	4
13.	I feel excluded from the decision process regarding patient care.	1	2	3	4
14.	I feel my colleagues respect my morals and value system.	1	2	3	4
15.	I feel satisfied with the number of independent decisions that I can exercise regarding patient care.	1	2	3	4
16.	I am expected to carry out the physician's orders, even though I disagree.	1	2	3	4
17.	I feel excluded from the decision process regarding management issues.	1	2	3	4
18.	I am able to respect the wishes of my patient.	1	2	3	4
19.	I feel helpless to protect my patient from suffering.	1	2	3	4
20.	I feel I do everything that I can for my patient.	1	2	3	4

iii) Moral Distress Instrument

Moral Distress Instrument				
Demographic data				
Please circle the relevant answer.				
Gender:			Male	Female
Unit where you are currently working:	ICU	THEATRE	ER	MEDICAL
	SURGICAL	PAEDIATRICS	MATERNITY	REHAB
	PSYCHIATRY	CLINIC	OTHER	
Please complete the following by writing your answer in the right column.				
Age:				
How many years have you been working as a PN? (Professional nurse)	_____years			
What qualifications do you have?				
Are you currently working full time or part time?	Full time Part time			

Questionnaire

Please read the following statements. To the right of each statement, you will find numbers, ranging from “1” to “4”, where “1” is never and “4” often. Circle the number which best describes your feelings on the statement provided. What is the frequency with which you experience the following?

		Never	Rarely	Sometimes	Often
1	I am restricted from implementing my morals and value system when caring for my patient.	1	2	3	4
2	I am expected to provide care that is not within my morals and value system.	1	2	3	4
3	I feel that the physician respect my input with regard to patient care.	1	2	3	4
4	I feel I can advocate on my patients' behalf.	1	2	3	4
5	I am able to be completely honest with my patient.	1	2	3	4
6	I am expected to be part of procedures that I morally do not agree with.	1	2	3	4
7	I feel that my skills are valued.	1	2	3	4
8	I am able to provide the care I would like to give to my patient.	1	2	3	4
9	I am able to act according to my morals and value system while caring for my patient.	1	2	3	4
10	I feel excluded from the decision process regarding patient care.	1	2	3	4
11	I feel satisfied with the number of independent decisions that I can exercise regarding patient care.	1	2	3	4
12	I am expected to carry out the physician's orders, even though I disagree.	1	2	3	4
13	I feel excluded from the decision process regarding management issues.	1	2	3	4
14	I am able to respect the wishes of my patient.	1	2	3	4
15	I feel I do everything that I can for my patient.	1	2	3	4

ADDENDUM H

JOB SATISFACTION SURVEY

i) Permission

Page 1 of 2

Richelle Van Waltsleven - RE: Job Satisfaction Survey

From: "Spector, Paul" <pspector@usf.edu>
To: Richelle Van Waltsleven <Richelle.VanWaltsleven@nwu.ac.za>
Date: 2013/09/17 03:09 PM
Subject: RE: Job Satisfaction Survey

Dear Richelle:

You have my permission to use the JSS in your research. You can find copies of the scale in the original English and several other languages, as well as details about the scale's development and norms in the Scales section of my website <http://shell.cas.usf.edu/~spector>. I allow free use for noncommercial research and teaching purposes in return for sharing of results. This includes student theses and dissertations, as well as other student research projects. Copies of the scale can be reproduced in a thesis or dissertation as long as the copyright notice is included, "Copyright Paul E. Spector 1994, All rights reserved." Results can be shared by providing an e-copy of a published or unpublished research report (e.g., a dissertation). You also have permission to translate the JSS into another language under the same conditions in addition to sharing a copy of the translation with me. Be sure to include the copyright statement, as well as credit the person who did the translation with the year.

Thank you for your interest in the JSS, and good luck with your research.

Best,

Paul Spector, Professor
 Department of Psychology
 PCD 4118
 University of South Florida
 Tampa, FL 33620
 813-974-0357
 pspector@usf.edu
<http://shell.cas.usf.edu/~spector>

From: Richelle Van Waltsleven [mailto:Richelle.VanWaltsleven@nwu.ac.za]
Sent: Tuesday, September 17, 2013 7:49 AM
To: Spector, Paul
Subject: Job Satisfaction Survey

Dear Prof Spector

My name is Richelle van Waltsleven and I am a Ph.D student from the North-West University, Potchefstroom in South Africa. I am doing my thesis on moral distress, and would hereby like to ask your permission to use your Job Satisfaction Survey as part of my Data Collection process.

Thank you.

Kind regards,

Richelle van Waltsleven
 Ph.D (c)

ii) Instrument

2. Please circle the one number for each question that comes closest to reflecting your opinion about it.

		Disagree very much	Disagree moderately	Disagree slightly	Agree slightly	Agree moderately	Agree very much
1	Many of our rules and procedures make doing a good job difficult.	1	2	3	4	5	6
2	I like the people I work with.	1	2	3	4	5	6
3	I sometimes feel my job is meaningless.	1	2	3	4	5	6
4	Communications seem good within this organization.	1	2	3	4	5	6
5	My efforts to do a good job are seldom blocked by red tape.	1	2	3	4	5	6
6	I find I have to work harder at my job because of the incompetence of people I work with.	1	2	3	4	5	6
7	I like doing the things I do at work.	1	2	3	4	5	6
8	The goals of this organization are not clear to me.	1	2	3	4	5	6
9	I have too much to do at work.	1	2	3	4	5	6
10	I enjoy my co-workers.	1	2	3	4	5	6
11	I often feel that I do not know what is going on with the organization.	1	2	3	4	5	6

		Disagree very much	Disagree moderately	Disagree slightly	Agree slightly	Agree moderately	Agree very much
12	I feel a sense of pride in doing my job.	1	2	3	4	5	6
13	I have too much paperwork.	1	2	3	4	5	6
14	There is too much bickering and fighting at work.	1	2	3	4	5	6
15	My job is enjoyable.	1	2	3	4	5	6
16	Work assignments are not fully explained.	1	2	3	4	5	6

ADDENDUM I

MASLACH BURNOUT INVENTORY

3. Please mark the response that best describes HOW FREQUENTLY you have each feeling in relation to your current job in this hospital.

		Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
1	I feel emotionally drained from my work.	0	1	2	3	4	5	6
2	I feel used up at the end of the workday.	0	1	2	3	4	5	6
3	I feel fatigued when I get up in the morning and have to face another day on the job.	0	1	2	3	4	5	6
4	I can easily understand how my patients feel about things.	0	1	2	3	4	5	6
5	I feel I treat some patients as if they were impersonal objects.	0	1	2	3	4	5	6
6	Working with people all day is really a strain for me.	0	1	2	3	4	5	6
7	I deal very effectively with the problems of my patients.	0	1	2	3	4	5	6
8	I feel burned-out from my work.	0	1	2	3	4	5	6
9	I feel I'm positively influencing other people's lives.	0	1	2	3	4	5	6
10	I've become more insensitive toward people since I took this job.	0	1	2	3	4	5	6
11	I worry that this job is hardening	0	1	2	3	4	5	6

		Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
	me emotionally.							
12	I feel very energetic.	0	1	2	3	4	5	6
13	I feel frustrated by my job.	0	1	2	3	4	5	6
14	I feel I'm working too hard on my job.	0	1	2	3	4	5	6
15	I don't really care what happens to some patients.	0	1	2	3	4	5	6
16	Working directly with people puts too much stress on me.	0	1	2	3	4	5	6
17	I can easily create a relaxed atmosphere with my patients.	0	1	2	3	4	5	6
18	I accomplish many worthwhile things in this job.	0	1	2	3	4	5	6
19	I feel exhilarated after working closely with my patients.	0	1	2	3	4	5	6
20	I feel like I'm at the end of my rope.	0	1	2	3	4	5	6
21	In my work, I deal with emotional problems very calmly.	0	1	2	3	4	5	6
22	I feel patients blame me for some of their problems.	0	1	2	3	4	5	6

ADDENDUM J

STATISTICAL CONSULTATION SERVICE LETTER



Privatebag X6001 Potchefstroom 2520

Tel (018) 299 1111 Fax (018) 299 2799

<http://www.puk.ac.za>

Statistical Consultation Services

Tel: 018) 299 2016

Fax: (018) 299 2557

23 April 2014

Re: Thesis - Ms R van Waltsleven, student number: 20420595

We hereby confirm that the Statistical Consultation Services of the North-West University had analysed the data and assisted with the interpretation of the results. However, any opinion, findings or recommendations expressed in this document are those of the author and the Statistical Consultation Services of NWU (Potchefstroom Campus) do not accept responsibility for the statistical correctness of the results reported.

Kind regards

A handwritten signature in black ink, appearing to read 'S M Ellis'.

DR. S M ELLIS (Pr. Sci. Nat)

Head: Statistical Consultation Services