Article

Nursing Ethics
19(4) 464–478

10.1177/0969733012437988
nej.sagepub.com

Iranian intensive care unit nurses' moral distress: A content analysis

Foroozan Atashzadeh Shorideh
Shahid Beheshti University of Medical Sciences, Tehran, Iran
Tahereh Ashktorab
Shahid Beheshti University of Medical Sciences, Tehran, Iran
Farideh Yaghmaei
Shahid Beheshti University of Medical Sciences, Tehran, Iran

Abstract
Researchers have identified the phenomena of moral distress through many studies in Western countries. This research reports the first study of moral distress in Iran. Because of the differences in cultural values and nursing education, nurses working in intensive care units may experience moral distress differently than reported in previous studies. This research used a qualitative method involving semistructured and in-depth interviews of a purposive sample of 31 (28 clinical nurses and 3 nurse educators) individuals to identify the types of moral distress among clinical nurses and nurse educators working in 12 cities in Iran. A content analysis of the data produced four themes to describe the nurses' moral distress. The four themes were as follows: (a) institutional barriers and constraints; (b) communication problems; (c) futile actions, malpractice, and medical/care errors; (d) inappropriate responsibilities, resources, and competencies. The results demonstrate that moral distress for intensive care unit nurses is different and that the nursing leaders must reduce moral distress among nursing in intensive care.

Keywords
Content analysis, intensive care unit, moral distress, nurse experience, qualitative study

Introduction

Intensive care unit (ICU) nurses make many ethical decisions every day,[1] but in practice, they cannot always act in accordance with their beliefs.[2] Moral distress is defined as painful feelings and/or psychological disequilibrium that results from recognizing an ethically appropriate action, yet not taking it because of such barriers as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations.[3–6]

Because the causes of moral distress vary according to the work situation, ICU nurses may feel a different kind of moral distress from nurses in other settings.[7] Radzvin[8] identified many sources of moral distress

Corresponding author: Tahereh Ashktorab, Department of Medical-Surgical Nursing, Faculty of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Niyayesh Complex, Niyayesh Cross-Section, Vali Asr St., Tehran, Iran
Email: t_ashktorab@sbmu.ac.ir

in ICUs, including aggressive or futile treatment of terminal patients, problems related to informed consent, working with incompetent nurses and physicians, and working under institutional policies that constrain ethical decision making that may interfere with patients' needs. The other sources of moral distress include the perception that aggressive medical treatment is being used, which might increase the burden of suffering[9–12]; inaccurate/incomplete information presented to patients and families by physicians; difficulty with resuscitation decisions and other advance directives[9,12,13]; and the ability to communicate about prognosis and care plans to patients and their families.[10,13,14]

Some authors have mentioned other moral distress factors such as withholding or withdrawal of treatment, including fluids and nutrition[14]; poor symptom assessment and management[10,14]; harm to patients in the form of pain and suffering[4]; medical prolongation of dying without letting the patient or the family know about choices concerning care[15]; and inadequate staffing.[4]

Due to frequency and various effects of moral distress on nurses, understanding moral distress is very important.[4,16,17] Since moral stressors should be identified in the cultural context,[18] it is necessary to perform national and international research.[19] We did not find any research about moral distress in Iran until now. Therefore, we decided to do a qualitative research to understand the experiences of Iranian ICU nurses' moral distress.

Background

Nurses in Iran, like in many other developing countries, face many challenges in their workplaces when performing their duties. These challenges are mainly due to nursing shortages, job dissatisfaction, poor social position of nurses, the gap between theory and practice, lack of community-based nursing care, lack of an appropriate student-recruiting system, and shortages in the nursing educational curriculums.[20] These challenges affect quality nursing care delivery because they lead to increased workload and hence result in wrong actions.[21] Wrong actions can lead to moral distress for nurses.

Moral distress is defined as the psychological disequilibrium and negative feeling state experienced when one makes a moral decision but does not implement it or do the right thing because of other constraints.[22,23] Moral distress is a serious problem in the nursing profession because it affects nurses in all health-care systems. Nurses often make ethical decisions whether knowingly or unknowingly during the course of their work because they are involved with human life's fundamental processes. Moral distress occurs when a person knows an ethically appropriate action to take but is unable to act upon it. Instead, the person acts in a manner contrary to personal and professional values, which undermines the integrity and authenticity of the individual.[4] There are situations where a nurse knows what ought to be done but fails to perform efficiently due to one or a combination of the identified constraints.

Moral distress is a phenomenon that requires serious attention because of its impact on patient care and service delivery. Moral distress may be responsible for the loss of experienced nurses in the health-care facilities in Iran. Knowledge and management of moral distress can assist nurses to handle or solve ethical issues competently and remain in the profession because a person is in control of what is known but is controlled by what is unknown.[24] There is therefore a great need to study the concept of moral distress.

In Iran, undergraduate nursing students should pass 135 units, including 26 basic sciences course units, 20 general course units, and 89 specialized course units to gain a bachelors degree. A course on nursing history, development, and ethics equivalent to one course unit was offered until 1983 and then upon revision of the curriculum, a separate course under this title was eliminated in 1995; however, issues on nursing ethics were included in all specialized courses. Curricula in most nurse faculties in Iran have put less emphasis on the aspect of moral distress, thus students graduate with little knowledge of the phenomenon. For

example, nursing ethics is taught during early days of the student nurse-training program, but it is not enough. The curriculum mainly focuses on the principles of ethics, while the course content puts more emphasis on how to manage patients' stress without adequately addressing the issue of nurses' moral distress. These factors have implications for the understanding and application of ethics to nursing practice and decision making. Most nurses are not confident with their ethical and moral decision-making skills; consequently, they are prone to suffer from moral distress. There are no ethics committees in Iran's hospitals. Thus, the nurses cannot solve the ethical problems in these committees. Therefore, there is not any suitable context in hospitals for practical training about ethical issues and problems.

Despite this emphasis and due to the fact that a successful training depends on various factors, including qualification of the instructors, content of the texts, teaching method, individual backgrounds of students, and methods of evaluation of professional ethics, the extent of success in learning the ethical topics differs at various faculties.[25]

An efficient nursing care system can be attained when nurses are able to handle or solve ethical issues competently, but there is a lack of ethics program in the nursing curriculum, especially in BSc degree. As the students after graduating will work in a hospital, they cannot handle ethical problems, properly.[26,27] In other words, development of professional ethics in relation to different students and educational systems has specific features. This is due to the nature of ethical issues that takes different dimensions in various sociocultural contexts. Thus, examining professional ethical competency in different cultures and work circumstances may lead to discovery of new findings.[25]

Aim

The purpose of this research was to explore the phenomenon of moral distress among ICU nurses in Iran.

Method

A qualitative approach (content analysis) was used to explore moral distress experiences among ICU nurses. In this study, a purposive sampling technique was used. Purposive sampling is judgmental sampling that involves the conscious selection by the researcher of certain subjects or elements to include in a study.[28]

This research used a qualitative method involving semistructured and in-depth interviews of a purposive sample of 31 (28 clinical nurses and 3 nurse educators) individuals to identify the types of moral distress among clinical nurses and nurse educators working in 12 cities in Iran. The approach in this research is face to face. All participants were informed about the purpose of the study by the first author, both verbally and in writing. The participation was voluntary, and all the participants were assured regarding their confidentiality and anonymity. After obtaining written informed consent, the participants were scheduled for interviews at their first convenient. At the beginning of each meeting, the study was described, and participants were asked if they had any questions. Participants were asked to narrate their experience of moral distress. The first author initiated the interviews with a general question about the experience of moral distress and proceeded with more specific questions. Some of the questions were:

1. Would you please describe any situation that you encountered in your workplace as a nurse where you failed to follow the hospital rules or regulations?
   What was the situation?
   What did you do?
   How did you feel?
   How was your patient affected?

2. Would you please describe a situation where you felt you needed to do something for your patient but you did not?
   What was the situation?
   What hindered you?
   What did you do?
   How did you feel?
   What were the effects on the patient?
3. What barriers have you experienced that prevented you from carrying out your responsibilities as a nurse?
4. What person, institutional policies, or other factors conflicted with your responsibility to the patient?

Participants were encouraged to provide detailed descriptions of the incidents they selected. The interviews were tape-recorded and transcribed. Demographic data were also collected using the interview guide. The interviews took place in the participants' workplaces in Iran. The researcher explained clearly about the research project and allowed the participants to ask questions for clarification. The estimated time for the interview varied from 50 to 100 min. The first author collected data from March to November 2010. Each participant was assigned a code number for the interview to insure confidentiality of the data. We interviewed a minimum number of nurses and then continued interviewing until no new causes of moral distress were identified. The nurses appeared comfortable and were not reluctant to discuss their experiences.

Data analysis

In this study, a qualitative data analysis was done simultaneously with data collection. A content analysis was used to analyze the incidents described in the interviews. Manifest and latent content analyses were chosen as the responses to the open-ended questions did not contain much detail. A manifest content analysis refers to the fact that the codes and subcategories are descriptive and close to the text in order to provide a structural surface.[29] This method was used to identify the perspective inherent in the nurses' descriptions, which was physically presented in the text. The analysis of what the text says deals with the content aspect and describes the visible, obvious components, referred to as the manifest content. In contrast, latent content is an analysis of the text that deals with the relationship aspect and involves an interpretation of the underlying meaning of the text.[30] Berg[31] suggests the use of both manifest and latent content whenever possible. The specific procedure of a qualitative content analysis used in the present study was based on the methods described by Graneheim and Lundman.[30]

Digital recordings of each interview were transcribed to create verbatim written accounts. The transcription was done at the end of each day as recommended by Burns and Grove.[32] The transcripts were read and reread in order to understand the meaning within the context of significant words or phrases. The texts were read through several times to obtain a sense of the whole. Sections (meaning units) that corresponded to the aim were underlined, condensed, and coded.[30] Initially, the authors read and analyzed the texts independently.

The first author analyzed the total data, while the three authors compared the codes, and minor disagreements were resolved after discussion. Then the codes (and meaning units) were read several times and compared to the context. The codes were grouped together to form subcategories and categories. The final four categories were examined by the authors, in order to ensure a clear difference between them. Meaning units within all subcategories were checked for accuracy. Minor revisions were made thereafter. After categorization of the data at the group level, the researchers returned to the individual level to ensure that the categories were differentiated at an equal level of abstraction.

The analysis was an inductive process, and the goal was to create a detailed description and list of themes or categories related to the phenomenon under investigation, that is, moral distress. Choosing participants

Table 1. Themes and subthemes of moral distress

Subtheme	Theme
1. Legal and organizational conditions	Institutional barriers and constraints
2. Medical supervision	
3. Accountability	
4. Ignoring and injustice to nurse	
5. Large financial burden to the patient	
6. Having a CPR code	
7. Relatives' reaction to communication	Communication problems
8. Communication with the patient	
9. Communication problems with colleagues	
10. Neglect of patients and family autonomy	Futile actions, malpractice, and medical/care errors
11. Lack of physicians' moral obligation in conducting research on the patient	
12. Staff negligence and irresponsibility of treatment	
13. Improper care	
14. Medical and caring errors	
15. Hiding and justifying errors	
16. Futile care at the end of life	
17. Lack of clinical skills/education of nurses and doctors	Inappropriate allocation of responsibilities, resources, and care worker competencies
18. Ambiguity of the nursing job description and nurse role	
19. The nurse shortage and lack of time	
20. Inadequate and inefficient equipment	

CPR: cardiopulmonary resuscitation.

with various experiences, age, and gender; a prolonged engagement with participants; and peer checking were used to establish credibility. To facilitate transferability, a clear and distinct description of culture and context, selection and characteristics of participants, data collection, process of the analysis, and providing enough quotes were used to ensure that the findings fit the data. For dependability, two external researchers were asked to view the data separately. A decision trial (records of decisions made) was used to support confirmability.[30–33] Short examples or typical quotes from participants were included to support the interpretations drawn from the interviews. Sources of these quotations were identified with a digit number representing the participants (e.g. Participant 3) to provide for confidentiality.

During the process of the content analysis, 1268 meaning units and 118 codes were extracted and then in the process of the analysis and continuous comparison of data, the number was reduced to 85 codes, and finally, the 20 subthemes and 4 themes were obtained (Table 1).

Ethical aspects

Research ethics approval was obtained from Shahid Beheshti Medical Sciences University Research Ethics Board in Tehran. Participants were asked to sign a consent form and were informed that they could withdraw from the study at any time. Code numbers were placed on the audiotapes or transcripts, which were stored in a locked location.

Results

Of the 31 nurses, 21 were female nurses (67.74%) and 10 were male nurses (32.26%). Their mean age was 38.5 years. Occupational status of participants included 8 head nurses, 20 nurses, and 3 nurse educators. The

participants' average year of work in ICU was 10 years. The nurses had worked for more than 12 months in ICU and were aged 24 years and above.

The four themes formulated are presented below, illustrated by quotations. The main themes are ''institutional barriers and constraints''; ''communication problems''; ''futile actions, malpractice and medical/care errors''; and ''inappropriate allocation of responsibilities, resources and care worker competencies.''

Institutional barriers and constraints

Institutional barriers and constraints is one of the four themes in this research identified by nurses as a cause of moral distress. This theme has six subthemes: legal and organizational conditions, medical supervision (by interns, residents, and attending), accountability, ignoring and injustice to nurse, large financial burden to the patient, and forced to cardiopulmonary resuscitation (CPR) code.

Almost all participants in this study claimed that the institutional barriers and constraints were the main cause of moral distress in working with patients. Among the factors related to institutional barriers and constraints, participants mentioned the legal situation as a major obstacle in their work. In Iran, the government regulates the nursing job description. The Ministry of Health and Medical Education (MoHME)'s Nursing Council approves the nursing responsibilities, policies, and job description. Nursing has no other legal supporting organization. So, the nurses cannot do any intervention based on ethical codes that conflicts with legal requirements.

If the nurses did not do what they felt they should do for the patient because they were not permitted to do it by hospital policy, then they experienced moral distress. One of the participants said:

> Sometimes the nurses aren't doing tasks outside of job description for patients due to institutional barriers or legal reasons for patients. In this situation, if something bad happens to the patient, nurses suffer a tormented conscience, and they will not forgive themselves. (Participant 1)

Medical supervision (by interns, residents, and professors) is the second subtheme of the institutional barriers and constraints theme. Some participants said medical supervision by different categories of physicians caused confusion. For example, one of the participants said:

> One intern comes to visit the patient and order some drugs for him. Shortly afterwards, the first year resident visits the patient and changes the previous orders. Then the second year resident sees him and may change the previous orders. Sometimes we do the earliest orders. Sometimes they are wrong and they may be harmful for the patients. But we can't say anything to the interns or residents. They also don't believe we have knowledge and experience to question them. (Participant 29)

Accountability is the third subtheme of the institutional barriers and constraints theme. In nursing, accountability and responsibility are very important. The participants believe the contradictions between accountability and institutional policies cause moral distress. If the nurses work contrary to rules, policies, and organizational work conditions to benefit the patient, they will be held accountable. They believe that they are responsible and accountable for their actions. They believe that if they objected to the system, they will be questioned and reprimanded. One of the participants said:

> Lack of management and low environmental standards, causes a lot of stress for nurses, I complain a lot of times, but they reprimand me! (Participant 12)

The fourth subtheme of the institutional barriers and constraints theme of this research ignore the nurses. When the nurses declare that some hospital policies are wrong, they lose their points (such as salary) in job. The following statements indicate such moral distress:

> I see some of hospital's policies are wrong. They may be expensive for the patients ... they may be harmful to them ... When I say anything about wrong things in our hospitals, the managers are embarrassed ... so, I lose my points ... they lowered my salary ... I have to do work on unwanted shift ... (Participant 25)

The participants were upset when their opinions and clinical skills were ignored, and their patients subsequently deteriorated.

> My patient's condition deteriorated. I reported his condition to the resident several times. The resident said his lab tests looked normal. The patient had low BP and tachypnea. Finally he coded. (Participant 27)

Another participant also cited lack of experienced nurses:

> Assigning novice nurses in the ICU is a crime in my opinion. We believe many of our problems in ICU are due to lack of skills of the novice nurses. (Participant 10)

Large financial burden to the patient is the fifth subtheme of the institutional barriers and constraints theme. The unnecessary hospitalization of patients in ICU caused moral distress for most of the participants in this research. The nurses (participants) said that inappropriate hospitalization of patients in ICU is unethical and leads to the high financial burdens for the patients. For example one of them said:

> I don't know why the doctors hospitalize the patients who don't require ICU ... some of patients catch cold only but they are admitted to the ICU!! ... It is expensive for them ... (Participant 16)

Finally, the last subtheme of the institutional barriers and constraints theme is a physician order for a CPR code. Sometimes, CPR code is not ordered for some patients, but the nurses must do CPR for them, because according to the instructions of Islam, no one can end the life of another person. Although they know it is a wasteful intervention, one of the participants said:

> I remember one of patients who had metastatic cancer. He was no code. When he arrested, we had to initiate CPR, because we must help him according to Islam and national law ... (Participant 5)

Communication problems

Communication problems were the second theme of this study. This had three subthemes: ''relatives' reaction to communication,'' ''communication with the patient,'' and ''communication problems with colleagues.''

Participants expressed that inappropriate communication behaviors on the part of patients and their relatives in treatment cause moral distress for nurses. In fact, since nurses have the greatest representation on the treatment team and regularly interact with different people, they are affected by communication problems more than other treatment team members. Many participants reported experiencing moral distress after inappropriate and improper communication with patients' relatives. One participant said:

> Sometimes people don't know what I did for the patient; they came and shout at me. Now I know the relative is agitated, and he is right, and I have to calm him. But sometimes they insult us, it makes us feel distressed. The nurses are made out of iron. These behaviors affect them; they can irritate the nurses. They affect consciously and unconsciously their nursing care ... so, they go against the ethical code ... they do less for the patient ... (Participant 18)

In the communication problems theme, the issues most cited by participants were problems with the relatives' emotional response to the patient's condition. One nurse said:

> I feel uncomfortable when the patient's relatives are sad. I feel uncomfortable emotionally with their grieving ... I like to discuss their relative's condition ... but I can't ... I see they suffer ... (Participant 10)

Communication problems were not limited to relatives' communication with the nurses. Many nurses got upset when they could not communicate with their patients. They were unable to provide the care because they did not understand the patient's needs. One of the participants said:

> Sometimes patients want to say something with body language, but the nurse doesn't understand. For example the patient has pain, but the nurse doesn't understand it. Occasionally these patients die and/or their condition worsens, and only then is the nurse aware of their needs; but it is too late. It makes me distressed. (Participant 4)

Another participant said:

> When I have a patient who can't tell me about her needs, I feel distressed. Sometimes our patients use nonverbal communication with us. But I can't understand what they need ... this is very terrible for me. (Participant 13)

Nurses not only suffer from communication problems with patients and patients' relatives but also experience discomfort with hierarchical problems between physicians and nurses. Sometimes a person who is lower in the hierarchical structure has to carry out orders from a superior that are against his or her own conviction. Another participant said:

> In our hospitals, physicians believed they are above us. They order for patients and they expect us to obey them and not tell them about wrong orders. We are obliged to carry out their orders without asking any question. (Participant 6)

Futile actions, malpractice, and medical/care errors

The third theme of this study was futile actions, malpractice, and medical/care errors. This theme had seven subthemes: neglect of patients and family autonomy, lack of physicians' moral obligation in conducting research on the patient, staff negligence and irresponsibility of treatment, improper care, medical and caring errors, hiding and justifying errors, and futile care at the end of life.

When medical staff do not feel a moral obligation by doctors to obtain consent from the patients/family to perform research, nurses reported this as a source of moral distress. The patient and his or her family autonomy have been greatly emphasized in ethics. Lack of attention to the patients' demands and decision making for the patient without the patient and family awareness creates moral distress for nurses. The following statements indicate such discomforts:

> Most patients are not conscious in intensive care unit. No one knows that you work correctly or incorrectly ... we don't give him right information ... we don't get him informed consent ... we must have conscience ... we must see the god all of the times ... (Participant 2)

> Do you think anyone gives information to the unconscious patient? In the first patient hospitalization, the patient signs one informed consent form for all treatment and is never given the opportunity to reconsider ... they don't consider patient a human ... ignoring the rights of patients is cruel. (Participant 7)

Research on the patient without informing him or her and his or her family was one of the distressing factors to nurses. This statement is one of the participants' claims:

> Our doctors think patients are objects and they belong to them. They do some research on them without informing them and/or getting permission from them. Our doctors don't tell the family that these treatments are for their research. We have to be quiet and not say anything. (Participant 17)

Negligence and irresponsibility of the treatment team are moral distress factors that can cause poor consequences. One participant said:

> The doctor was at the bedside during a code and was yelling at the staff. I had to call a resident about another patient's condition. The patient had experienced respiratory distress. The resident never came. I attempted five times to have the resident see the patient, but he didn't come. Then the patient's condition deteriorated and he arrested. I had to call a code for this patient. Finally the chief resident came. He was very angry at me. (Participant 4)

Some participants mentioned that reporting these types of problems to coworkers and head nurses causes the loss of their privileges (such as desirable shifts). Many nurses decided not to say anything, even though they were suffering. One of the participants said:

> Finally, when I want to protest to management that something is wasteful or that it affects patient care, I am ignored. It will reflect on my work, and I will lose my job. (Participant 10)

In addition, negligence and irresponsibility, the improper care, and medical errors cause irreparable damage to the patients and moral distress for the nurses:

> We have a lot of mistakes (doctors and nurses). Most of the mistakes are related to resuscitation. Most of us don't know it well. Although we train, our success rate in CPR is very low and our errors are many. (Participant 9)

> Some of our coworkers are truly unconscionable. They don't care about patients. I always argue with them. They don't like to provide care for the patient like changing the patient's positions, providing mouth care, and or giving a massage. The patient comes to hospital with a single problem and leaves with dozens of bed sores and infections and will come back again with these major problems ... (Participant 17)

Hiding and justifying errors is also one of the other factors producing moral distress and reducing quality of care. Some participants mentioned that they had to be quiet and not say anything about medical and nursing errors. This causes moral distress for them.

> Sometimes I want to say something, but I can't. If I do say something, it will result in legal problems for my colleague. I remember a patient wanted to go to the washroom and the practical nurse would not help her; he suffered apnea there and died. I did not mention anything about practical nurse's failure. But what I did at that time was a mistake. When I think of that day, I feel guilty. (Participant 10)

Futile care is the last subtheme of the third theme in this research. Some of participants believe unnecessary procedures cause moral distress. One of the participants said:

> I know all the testing and counseling are useless for end stage patients. Why patients should suffer?

Inappropriate allocation of responsibilities, resources, and care worker competencies

The fourth theme that emerged from this study was the inappropriate allocation of responsibilities, resources, and care worker competencies. It has four subthemes: lack of clinical skills/education of nurses and doctors, ambiguity of the nursing job description and nurse roles, the nurse shortage and lack of time, and inadequate and inefficient equipment.

Inadequate clinical skills/education of health-care workers, especially doctors and nurses, was one of the important moral distress factors for the participants. One of the participants said:

> We have a famous doctor; he ruptured a patient's intestine, during transplantation ... he is very incompetent ... (Participant 9)

Many participants believe that the job stress in nursing is the same as that of moral distress, and we cannot separate them from each other. They mentioned that the nursing job description is ambiguous, and they are faced with an ambiguous role. They pointed to many problems such as lack of motivation, lack of job security, inadequate income, and nurse shortage that can reduce quality of care and produce moral distress for them. The following statements indicate one of the participants' claims:

> We have a lot of difficulties in nurse's job description, and it should be revised. They tied our hands ... they limit us. Sometimes the patient needs intubation, doctors are responsible for that, but they don't come on time and we can't do anything, if we tried to intubate, we should be accountable to nursing office and physicians. So we get frustrated and disappointed. (Participant 24)

Another participant said:

> Lack of motivation and many job stresses in nursing is the same as moral distress. Because job stress affects quality of care ... With diminished quality of care, the patient may be suffered ... so this leads to moral distress (Participant 14)

In the last decades, Iran is faced with a serious nursing shortage. This leads nurses to work harder than previously, resulting in fatigue and burnout. Some of the participants expressed dissatisfaction and felt fatigued. The following statement is one example of the participants' claim:

> Lack of human resources is a major pressure, leading to fatigue. We have to work on long day and/or evening-night shifts ... Consecutive shifts reduce our effectiveness ... it can reduce quality of care ... it produces burnout ... It bothered me ... (Participant 16)

And another participant said:

> Nurse shortage, lack of equipment, lack of drugs, and lack of job motivation in our nurses cause disturbances in working, also all of them reduce quality of nursing care and produce moral distress. (Participant 20)

Discussion

This study identified themes of Iranian ICU nurses' moral distress. We identified 4 themes and 20 subthemes. This article has provided an important understanding of the experience of moral distress among ICU nurses. In Iran, this qualitative research showed that ICU nurses experience moral distress from a wide range of causes. Institutional barriers and constraints have a major role in producing moral distress.

According to Jameton, moral distress occurs when nurses are conscious of the morally appropriate action a situation requires but cannot carry out that action because of institutionalized barriers.[4,17,34] Feelings of anxiety, discomfort, frustration, and anger are experienced when the person is confronted with institutional barriers and individual values in conflict with others.[3] The nurses sought to respond, and they tried to care for patients, but the needs and demands of the patients and their families, on the one hand, and institutional constraints such as lack of facilities and inadequate power, on the other, caused moral distress and reduced their quality of care.

Corley[4] stated that the goals of the profession of nursing are ethical. When the nurses cannot achieve these professional goals to protect patients from harm, to provide care that prevents complications, and to maintain a healing psychological environment for patients and families, they suffer from moral distress. According to Corley, moral distress will occur if insufficient numbers of staff, inadequately trained staff, and organizational policies and procedures make it impossible for nurses to meet the patients' and their families' needs. As the current research findings indicate, a close relationship exists among moral distress and nurses' performance, management system, and structural constraints. Ignoring and injustice to nurses is one of the subthemes in the first theme of this research. Lack of attention to nurses' problems and difficulties may lead to an increase in patient dissatisfaction and a decrease in the quality of nursing care.[20]

Ineffective legal and policy structures of the organization for managing bioethical problems can lead to moral distress. In Iran, we have not developed strategies for managing conflict in our hospitals. If the organization has not developed strategies for managing conflict that arises between patients and family members or among patient care staff over treatment decisions, nurses who do not advocate effectively for patients experience moral distress. These findings are similar to those reported by Corley et al.[34]

The second theme of this research was communication problems. Establishing and continuing communication to support the patient is required for optimal care. Communication problems, lack of awareness of the patient's needs, and reporting worsening patient condition to their family were other sources of moral distress in the current research. Inadequate collaboration among coworkers and physicians affect nursing care and lead to reduced satisfaction, burnout, and high turnover, the findings also reported by Corley et al.[34] and Çobanoğlu and Algier.[16] Effective communication and collaboration between physicians and nurses are essential for high-quality health care. Collaboration between nurses and physicians has been defined as nurses and physicians working together, sharing responsibility for solving problems, and making decisions to formulate and execute plans for patient care.[16] In Iran, there is a rigid hierarchy between physicians and nurses. Nursing is often considered as subordinate to medicine. In addition, most physicians are males, and most of the nurses are females. In accordance with traditional sex roles, physicians are encouraged to be decisive and to act with authority. Studies indicate that physicians view themselves as omnipotent. Nurses are often expected to follow decisions or recommendations given by physicians.

A commitment to truth telling is a rule to guide nursing professional behavior as in this research.[23] Not telling the truth caused moral distress for many of the health-care providers who believed they were being asked to lie to the patients, an action they considered to be unacceptable and unethical.[35] Providing incomplete or inaccurate information that gives patients or their family unrealistic hope or expectation regarding their outcome or survival creates strong moral conflict for nursing staff. In Iranian culture, the maintenance of hope is considered very important in the care of the dying, as hope creates a positive attitude and prevents suffering by avoiding despair. Likewise, in other countries, patients have also noted unrealistic hope to be a burden rendering them vulnerable and disheartened with their care.[17] However, lying or providing false information to patients and families cause further suffering when the truth is revealed. Nurses in the present research could not usually define why lying was wrong; instead, they focused on the consequences of it. Hamric and Blackwell[11] reported, just as in this study, that withholding information about a diagnosis or prognosis caused moral distress for nursing staff. In the current research, as Gutierrez[36] also found, when medical staff provide erroneous information on the risks or benefits of a treatment or on a patient's prognosis, nursing staff experience moral conflict and distress.

Unnecessary and futile care, neglect or abuse of patients, and medical errors comprise the third theme of this research. This theme is described by participants as unnecessary tests, unnecessary and expensive medication for patients at the end stages of life, unnecessary counseling, and unnecessary CPR. The nurses experienced distress and discomfort resulting from these actions to the patient and family. Moral distress has been shown to be caused by providing poor-quality/futile care, unsuccessful patient advocacy, and the provision of unrealistic hope for patients and their families.[17] Futile care prolongs suffering, does not improve

quality of life, and fails to achieve a good outcome for the patient.[37] Decreased job satisfaction, the inability to provide appropriate care, and futile care have all been positively linked with moral distress. Situations that create the highest moral distress for nurses commonly include providing unwarranted aggressive treatment.[11]

Although autonomy, nonmaleficence, beneficence, and justice are ethical principles for nursing practice,[38] these principles are difficult to apply in providing care. Many ICU nurses are unable to solve all ethical problems because they do not have enough experience and expertise. Nurses are expected to understand the implications of their patients' medical condition and to become familiar with the customs, feelings, and attitudes of the family. They should be involved in the decision-making process and facilitate this process for the family.[39]

Although the withholding of therapy was a relatively common practice, ''Do Not Resuscitate'' (DNR) orders were infrequently written for the patients in this study. In some countries, DNR orders are legal,[40] but in Iran, it is not legal. Iranian physicians are reluctant to write such orders because there have been no published guidelines, position papers, legislation, or official statements concerning end-of-life care, making them fearful of legal problems and criminal prosecution. In Iran, it is not legal for physicians to withhold complete or partial CPR (including endotracheal intubation, cardiac massage, cardiac defibrillation, resuscitative drugs, pacemakers, and mechanical ventilation). Thus, they cannot write DNR in their orders. So, conflict between legally act true and morally act wrong produces moral distress.[41] DNR decisions are difficult and complex but can be even more so in ICUs because these units have the overriding goal of sustaining the lives of the most critically ill patients. Although seemingly contradictory to the aggressive style of intervention inherent in ICUs, the withdrawal or withholding of life support is common under these conditions and often precedes death. Unfortunately, there are no ethics committees in hospitals. Thus, the nurses have no access to ethics consultation.

Inappropriate allocation of responsibilities, resources, and care worker competencies is the last theme of this research. Inappropriate resource allocation can conflict with moral values, and it produces moral distress.[42] The ambiguity in the job description, physicians failing to include nurses in consultation about a patient's condition and treatment, staff attitude, lack of human resources, low job motivation, inadequate resources, and inefficient equipment were identified by some participants. Heavy workloads, lack of resources, and a nurse shortage are factors affecting nurses' moral distress in Iran. All participants reported that nurse shortage is one of the causes of moral distress. Most hospitals in Iran experience inadequate material resources, which mainly results from limited availability of funds to purchase equipment and supplies for the increased number of patients.[20] Such situation is very difficult for nurses to perform efficiently and effectively[24] and thus results in moral distress for the nurses.

These findings supported by the studies of Corley et al, Zuzelo, and Brazil et al.[34,43,44] show that personnel shortage results in nurses' loss of knowledge and motivation, exhaustion, burnout, and severe stress.[45,46] Like many other countries, Iran is faced with a serious nursing shortage. This leads nurses to work more than their required 192 h per month, potentially adding 150 h per month of overtime in some parts of the country.[47] Most nurses are employed in hospitals where they are responsible for many different tasks, thus making it difficult for them to become engaged in policy development. Tschudin[48] reported on a study in Iran that provided insight into Iranian nurses' inner selves as they recounted moments of deep understanding of their work. It was clear that these nurses believed it was important to be able to provide care for their patients that blended spiritual/ethical values with scientific methods. In addition, human resource management insufficiency (fewer nurses and more patients) is recognized to be related to nurses' practice errors and danger of patient trauma.[49] These errors can produce moral distress for nurses.

Çobanoğlu and Algier[16] reported that unavailability of suitable equipment, lack of competent medical team, and poor job motivation prevent quality nursing care. These findings are consistent with those of Gutierrez[36] and Brazil et al.[43] The similar findings of the current research emphasize the importance of addressing moral distress in the Iranian health-care system.

Having too many patients and not enough time created moral distress because nurses are responsible for each patient. Lack of time, resources, or training to perform their nursing responsibilities satisfactorily affected their job performance negatively. For instance, the nurses were severely reprimanded if any pressure sores were detected, despite the fact that the shortage of nurses reduced the time available to care properly for patients. Another example of the mismatch between responsibility and capability was in patient education situations when the nurses felt a lack of the competence needed to support the patient adequately, as also reported by Tang et al.[50]

Most of the themes that emerged in this study were similar to other studies in the world, but some of them such as insufficient human resources and equipment, poor job motivation, and lack of time are similar to Turkish studies.[16] Perhaps similarity of culture and religion in Iran and Turkey is the reason for such common themes.

Finally, it should be mentioned that ICU nurses faced moral conflicts. Moral conflict is considered a serious problem for them and causes dissatisfaction. Moral distress is defined as the feelings and experiences that result from a moral conflict where one knows the correct action to take, but constraints lead to either inability to implement this action or an attempt to carry out moral action that fails to resolve the conflict.[22,36] Moral distress affects relationships between nurses and patients, and it can affect quantity and quality of nursing care. Nurses who are suffering from moral distress may lose their caring capacity and fail to provide the best care to the patients. Therefore, it is essential that workplace conditions be improved by the management system. Managers should develop and design clear job descriptions for nurses. They must also design strategies to reduce conflict-causing conditions, improve decision-making strategies, and try to diminish moral distress factors.

Limitations

Although the participants shared their experiences with researchers, this study has several limitations. First, it was conducted in highly specialized units, and the findings cannot be generalized beyond the population surveyed. Second, our findings may not apply to nonteaching hospitals. We suggest that such qualitative research be done in other units, nonteaching hospitals, and with other health-care professionals in Iran.

Acknowledgments

This study is a part of a nursing doctoral dissertation and a research proposal which is approved by Shahid Beheshti University of Medical Sciences and Clinical Services. The authors appreciate all the authorities in Shahid Beheshti University of Medical Sciences and Clinical Services who financially supported this research and also all the hospitals affiliated to the Ministry of Health's universities of Medical Sciences. The authors also wish to thank the participants. The authors would like to thank Dr Mary Corley for revising and commenting on their manuscript. Her feedback is much appreciated.

Funding

The funding was provided by the Shahid Beheshti Medical Science University.

Conflict of interest

The authors declare that there is no conflict of interest.

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