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An Analysis of Moral Distress Experienced Among Nursing Students

By

Katherine Merchent Johnson

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in Partial Fulfillment
of the Requirement for the Degree of
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III

Abstract

The purpose of this senior honors thesis was to obtain descriptive data about the moral distress experienced by nursing students during clinical rotations in nursing school. This senior honors thesis is significant to nursing because, although moral distress is a well-researched topic, little to no information has been gathered regarding moral distress among the nursing student sub-culture. Nursing students are likely one of the most important groups in which moral distress needs to be explored, because experiencing it could lead to fewer people wanting to become a part of the nursing profession. The research design used quantitative methodology. The approach was a descriptive survey, with the survey being developed by the researcher. The nursing students' perspectives were evaluated by asking questions about the student's experiences in the clinical setting with faculty, health care providers within the hospital, and fellow students. The survey contained 25 questions. Twenty-four students signed consents to complete the survey in the graduating classes of Fall 2016 and Spring 2016. Twenty-two students responded and completed the survey. It was found that although only 9 of 22 students answered that they had experienced moral distress, more than half of the students answered yes to questions that focused on ethics-related experiences they had encountered. Also, more than half indicated unpleasant symptoms experienced after witnessing an unethical action, which typically might be described as moral distress. It was found that the nurses employed by the organizations were the main group that were perceived to be practicing unethically.

Keywords: moral distress, ethics, nursing students, clinical rotations

Dedication

This project is dedicated to my wonderful family; including my parents: Bob and Vicki

Merchent, my loving husband: Seth, and my 2 beautiful, intelligent, and witty children: Jayce

and Avery. I also want to dedicate this project to my very best friend who has been by my side

through nursing school: Abigail Dean.

Your strength, love, and support has carried me to the finish line and I will be forever grateful for

the sacrifices you all have made to ensure I succeed.

Acknowledgements

The success and final outcome of this project would not have been possible without my thesis advisor, Dr. Karen Rich. Thank you for all the time you spent mentoring and advising me throughout the entirety of this project. Your intelligence and dedication to the nursing profession is unmatched.

I would also like to acknowledge Dr. Patsy Anderson for taking the time to provide guidance for this project. Additionally, I would like to acknowledge the faculty of USM Gulf Coast College of Nursing for providing me with the knowledge and confidence to excel in the nursing profession. Finally, I would like to thank the nursing students who participated in my descriptive survey and made this project possible.

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Chapter I

Introduction

"Human reasoning does not depend on our ability to cast answers at one another, but our ability to find the sources of our disagreement" (Jameton, 1984, p.6). In providing healthcare services, professionals often are faced with stressful situations and ethical dilemmas that can lead to disagreements. Nurses come in contact with ethical dilemmas throughout their daily work due to the paternalistic nature of the healthcare field, for example, a hospital's policy to collect a complete blood count specimen from all admitted patients regardless of need. This imposes a costly and unnecessary risk for the patient. Nurses do not have the necessary resources to change the practice due to their lack of authority (Jameton, 1984, p.6). "Doctors and nurses feel trapped by the competing demands of administrators, insurance companies, lawyers, and patients' families, and they are forced to compromise on what they believe is right for the patients" (Theobald, 2013, p.5).

These ethical situations experienced by healthcare workers were collectively termed *moral distress* in 1984 by the philosophy professor, Andrew Jameton. When moral distress was first coined by Jameton, it was defined as, "arising when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p.6). Jameton taught many nursing students and saw the students' morals were often being contested when working in clinical settings. In his findings, he discovered many of his nursing students were being morally challenged and thus were placed under significant moral distress. These students were suffering before they even finished school and had to quickly learn to adapt to their new profession (McCarthy & Gastmans, 2015, p. 132).

After Jameton first defined the concept, other authors of nursing literature have defined and described the experiences that constitute moral distress. "Moral distress or suffering can be experienced when nurses attempt to sort out their emotions when they find themselves in situations that are morally unsatisfactory" (Butts & Rich, 2005, p. 118). The American Association of Critical Care Nurses' (AACN, 2008) definition of moral distress is, "when you know the appropriate action to take, but the nurse is unable to act upon it, or you act in a manner contrary to your personal or professional values which undermines your integrity and authenticity" (AACN, 2008, p.1).

Purpose Statement

The purpose of this senior honors thesis was to obtain descriptive data about the moral distress experienced by nursing students during clinical rotations in nursing school.

Significance to Nursing

The American Association of Critical Care Nurses (AACN, 2015) proposed that

Moral distress is a serious problem in nursing which contributes to nurses feeling a loss of integrity and dissatisfaction with their work environment. Studies demonstrate that moral distress is a major contributor to nurses leaving the work setting and profession. (para. 1)

Extensive research has been done with the intent to identify and correct the issues involving moral distress in the workplace (e.g. Corley, Elswick, Gorman, & Clor, 2001; Weaver & Wocial, 2012). However, little research has been focused on the moral distress affecting nursing students who must work with healthcare professionals in a clinical setting in order to fulfill their Bachelor of Science in Nursing (BSN) curriculum requirements.

This senior honors thesis is significant to nursing because, although moral distress is a well-researched topic, little to no information has been gathered regarding moral distress among the nursing student sub-culture. Nursing students are likely one of the most important groups in which moral distress needs to be explored, because experiencing it could lead to fewer people wanting to become a part of the nursing profession.

Chapter II

Literature Review

Factors Associated with Moral Distress

Nurses have different sources of moral stressors due to differences in personalities, character traits, worldviews, experiences, and relationships. There are external and internal influences that can contribute to moral distress in nursing (McCarthy & Gastmans, 2015). Moral distress can surface through personal and interpersonal issues, violence in the work place, physician-nurse conflicts, ethical dilemmas, patient/family-nurse conflicts, staff shortages, policies and practices, fear, and the healthcare environment (Baldwin, 2013).

An example of a personal moral distress incident is when the nurse knows that what she is doing is not in alignment with her moral values and yet she does it anyway. Another personal issue of moral distress might result from the nurse's religious values. If the nurse is a Christian and family members of the patient voice negative feelings about God for not helping them through the patient's life threatening situation, the nurse may become sad and uncomfortable. Interpersonal distress occurs when a professional colleague the nurse is working with is performing a task that the nurse believes is unethical, and the nurse struggles about reporting it because of her relationship with the professional (Baldwin, 2013).

Violence in the workplace can cause a stressful, unsafe work environment. In an effort to minimize violence in the workplace and the distress it can cause to the hospital staff, it is important for hospital administrators to have clearly written policies and procedures for handling workplace violence and educate their professional staff about how to handle such situations in the course of providing healthcare services to the public (Baldwin, 2013). Physician- nurse conflict is probably one of the most common forms of moral distress, and actually a form of

violence, since physicians often feel more powerful and dominant in their work over that of a nurse. In most situations involving physician-nurse interactions, the nurse must remember that the physician is not her boss. The nurse typically reports to another person of authority. This allows the nurse some degree of autonomy and, thus, should lessen the anxiety if a situation of moral distress occurs during the course of physician-nurse interactions. An example of moral distress resulting from a physician-nurse interaction is when a physician prescribes medication that the nurse believes is inappropriate for the patient; and after telling the physician of her concerns, the physician remains insistent that the nurse administer the medication. One potential course of action to alleviate this potential moral distress situation is to ask the physician to provide a reasonable explanation for prescribing the medication. An explanation could be solicited by the nurse in a non-threatening tone that implies that the information is being sought as a learning experience.

Patient/family- nurse conflict in nursing may occur if a family member of a dying patient wants professionals to resuscitate their family member, but the patient has a do not resuscitate (DNR) order on file at the hospital or physician's office (Braddock & Durbenwick, 2014). Another example of patient/family-nurse conflict is if an Alzheimer's patient has lost his ability to swallow food. He has been admitted to the hospital multiple times throughout the year, but one of the patient's children keeps insisting that a feeding tube be inserted. The nurses know that the feeding tube would not be good for the patient due to his condition, and he becomes aggressive during insertion of the tube (Epstein & Delgado, 2010).

Staff shortages are one of the most prominent issues causing moral distress. This can create a situation in which the nursing staff must attempt to care for more patients than is reasonably possible. Undue stress may ensue; and as a consequence, it could cause a nurse to

perform potentially unsafe services. The nurse may feel pressured to address the needs of each patient assigned to her care, but she does not have the time or means to do so (Baldwin, 2013).

Moral distress in nursing is often related to the level of peer support available for the nurse. Some nurses work mostly by themselves or work together poorly due to their lack of ability to work well with other people with different personalities. This can cause the nurse to feel alone and inadequate. An example of a nurse who may feel this way is a home healthcare nurse (Wilson, 2013).

Nursing students experience high levels of moral distress during their clinical learning settings. Unfortunately, there is a lack of research regarding the effects of moral distress experienced by nursing students. Students are expected to enter their clinical settings with a professional attitude and a strong moral compass (Monrouxe, Rees, Dennis, & Wells, 2015). There are often professional dilemmas that nursing students' encounter that are detrimental to their morality, such as watching nurses perform procedures that are no longer necessary. "Professional dilemmas are ethically problematic events for a learner in which they witness or participate in something they think is improper, wrong, or unethical" (Mounrouxe et al., 2015, p. 2). It has been discovered that the most abundant issues regarding moral distress among nursing students involve breeches of patient and student safety, dignity, and moral judgment by healthcare workers. The full effects of moral distress in relation to nursing students are not fully understood, but it has been said that it may lead to a loss of caring and avoidance of patients when morality is tested (Theobald, 2013).

If moral distress is not resolved, it leads to moral residue (Epstein & Delgado, 2010). Nurses who are affected by moral distress and do not address it end up feeling as if they lack importance and are not valued by their superiors. These nurses are left feeling defenseless and

overlooked despite their education or experience in the field. "Moral residue, which is the continuing belief that one's moral concerns have not been acknowledged, and that no correct and meaningful action was taken to mitigate those concerns causes a continuous and spiraling negative feeling of depression and despondence" (Epstein & Delgado, 2010, p 1).

Moral residue can be assessed by the crescendo effect model (Epstein & Hamric, 2009). Moral residue increases as more situations of moral distress occur. Eventually, a breaking point will be reached by the nurse. According to Epstein & Delgado (2010), moral residue can lead to the nurse becoming unresponsive to morally distressing situations and burn out. Some nurses have left the healthcare profession due to the burden of moral distress (Epstein & Delgado, 2010).

Nursing Specialty Areas and Moral Distress

There are particular nursing specialty areas in which nurses are at most risk for moral distress; the one most documented is the Intensive Care Unit (ICU). This aggregate of nurses actually carries the highest level of situational complaints related to moral distress (Deepika, Parsins, & Rodriquez, 2014). The reason for this is that critical care nurses are most often put in situations that could lead to moral suffering. Critical care nurses work with patients near death so tensions often are very high. One example of moral distress ICU nurses may experience is if a physician discharges a patient before the nurse sees fit. Another example of moral distress in critical care nursing is when a patient has a DNR order, but the family is insistent that the healthcare professionals resuscitate the patient. Also, a family might be insistent on keeping the patient on life support, but the nurse knows that discontinuing the life support would be best for the patient.

Another nursing aggregate that experiences high levels of moral distress is homecare nurses (Brazil, Kassalainen, Ploeg, & Marshall, 2010). These nurses also are faced with the stress of end of life care. There are many moral conflicts that can arise when caring for someone who is dying. This experience is especially difficult for nurses, because it often is hard to remain unattached to patients. Patients in the homecare setting must sometimes undergo aggressive healthcare treatments, which often can lead to the nurses feeling as if they are suffering with the patient. These nurses lack support from other nurses and resources, because they are usually alone with their patient. Being isolated can lead to moral distress based on nurses' feelings of inadequacy. A challenging clinical situation, such as an unexpected death, can leave the nurse feeling as if she made no impact on the patient's life, which can lead to moral distress.

Other contributing factors affecting home care nurses' moral distress involve the role of the informal caregivers, challenging clinical situations, and service delivery issues (Brazil et al., 2010). For instance, if the primary informal caregiver of a patient is her husband, and he suffers from poor vision, how can the nurse comfortably entrust in him the task of giving his wife her medications as ordered? Factors leading to moral distress in home care settings, which are not risk factors in hospital settings, include things that can only be assessed when the nurse goes to the patient's home. The nurse may witness the informal caregivers' burdens and the emotional and physical stress that caregivers experience having to take care of a family member. A nurse in a hospital setting may miss a patient that is being abused or neglected at home, but a home care nurse is more likely to catch these negligent and abusive acts since the nurse is actually in the home setting. A home care nurse could go to a patient's home and find heavily soiled bed linens unchanged since the nurse was there for her last visit. Finally, a home care nurse may find that the informal caregiver is not competent or trustworthy when caring for the patient. Incompetent

care by the informal caregiver might involve compromising patient safety by giving too much

pain medicine to the patient so the caregiver does not have to hear the patient complain.

Prevention of moral distress in hospital situations leads back to the nurse manager, yet

nurse leaders' moral distress is overlooked and untouched by researchers (Edmonson, 2010).

Nurse leaders should not just focus on policies and procedures for their facility, but also on what

applies to the individual patient, their staff and coworkers, and patients' moral standing. A nurse

leader/ manager stressor may occur if the nurse leader feels as if the patient load is too much on

her staff nurses. It is important for nurse leaders to create an environment that facilitates moral

courage so that their nurses will not be intimidated to come to them about their moral distress

issues. A nurse leader can create this kind of environment by allowing open, honest, and

professional communication and providing a vehicle for their nurses and co-workers to openly

evaluate their moral distress. As cited in Edmonson (2010), it is the nurse manager's

responsibility to act if moral distress is occurring; because according to the American Nurses

Association, the nurse manager should address all situations involving moral distress in the

workplace.

Measuring Moral Distress

There are a number of different tools to assess the level of nurses' moral distress. One

method is the "4 A's of Eliminating Moral Distress" (AACN, 2008). This approach includes the

4 A's of Ask, Assess, Affirm, and Act to help promote a healthy work environment.

In the Ask phase, nurses must become aware of moral issues affecting themselves or their

colleagues. The Ask phase is the reflection stage in which the nurse needs to ask herself, "Am I a

victim of moral distress or do I know someone who is?" "Has anyone in my family or friend

circle noticed that I am suffering" (AACN, 2008, p.3)?   Signs that nurses could look for when

assessing themselves in the reflection stage are lethargy, hyperactivity, weight gain/ loss, impaired sleep, physical ailments, resentment, sorrow, depression, anxiousness, emotional outbursts, and shutdown. Some behavioral or spiritual signs and symptoms of moral distress in nursing might be addictive behavior, erosion of a relationship, apathy, crying due to workload, inappropriate engagement with patients or their families, loss of meaning, crisis of faith, and avoidance (AACN, 2008, p.3).

The next phase is to Assess. In the assessment phase nurses need to decide how pressing the matter is at hand. On a scale of 0-5, the nurse must rate the level of distress being experienced. Five is extremely distressed and ready to act, 3 is distressed but not ready to act, and 0 is not feeling distressed at all. When in the assessment phase, the nurse may use the 4 R method to help lower the nurse's ranking on the scale. The 4 R's include Relevance, Risk, Rewards, and Roadblocks. When assessing Relevance, the nurse may ask, "What kind of impact is this going to have?" When assessing Risk, the nurse may ask, "What will happen if I do not act?" When assessing Reward, the nurse must ask, "How is it going to make me feel after?" Finally, when assessing Roadblocks, the nurse must ask, "What may get in my way as I pursue this" (AACN, 2008, p. 4)?

The next step is to Affirm (AACN, 2008, p. 5). This step happens when nurses realize they are in fact a victim of moral distress. Moral distress is not physically or emotionally healthy; therefore, once the nurses discover it is present in their work, then they must take steps to change it or it will negatively affect them in their workplace and personally. It is the nurse's responsibility as a professional to act.

The final phase of the 4 A's test is to Act. When nurses begin to act on their moral distress, they must be careful to ensure they are taking care of themselves and, most importantly,

addressing their barriers to reduce risk, identify an appropriate support group, and seek guidance when they feel they need it (AACN, 2008, p.6).

A scale available to assess the level of moral distress is Corley's Moral Distress Scale (Corley, Elswick, Gorman, & Clor, 2001). This scale tests for frequency and intensity of moral distress in a healthcare setting. Corley's Moral Distress Scale is specific for the ICU. It helps examine moral dilemmas and issues within an ICU. Some of the main issues in ICU, which this scale helps evaluate, are performing futile treatments, discharging patients too early, and working in unsafe or understaffed conditions.

Another moral distress scale is The Moral Thermometer (Weaver & Wocial, 2012). This thermometer goes from none too worst possible and also provides a 0-10 scale. Having a two- in- one type scale is good because all people think differently. Although the visual analogue scale may be helpful for some people to rate their moral distress, the verbal numeric test may be better for others. This scale was designed and developed as a cross-sectional survey in order to provide a tool to use for nurses in all healthcare settings.

Strategies to Alleviate Moral Distress

Strategies are important in nursing so that nurses are aware of how to handle situations involving moral distress. An example of a strategy is CODE developed by Lachman (2010). The acronym stands for Courage to be moral requires, Obligation to honor, Danger management, and Expression and action. It takes courage for a nurse to stand up for patients' needs or the nurse's own morals. The obligation to honor patient's rights is inherent to *The Code of Ethics for Nurses* published by the American Nursing Association (2015) and in hospitals' codes of ethics. Danger management includes cognitive strategies for emotional control. The nurse has to be able to overcome risk aversions. Expression and action means the nurse proactively takes the problem

and addresses it with his or her leadership rather than overlooking the situation. Policies supporting open and honest communication among the healthcare professional staff is paramount in ensuring an environment where everyone feels safe to express their feelings, thoughts and beliefs without retribution (Lachman, 2010).

Summary

The healthcare system is often paternalistic in nature leading to ethical dilemmas experienced by the health-care providers during their career. Nurses may feel as if they must compromise what is best for the patient in order to appease the outside forces involved in the patient's care (Theobald, 2013, p.5). Jameton (1984) was the first to notice and document this occurring among nursing students in the clinical setting as well as practicing registered nurses (RNs) (p6).

Moral distress is significant to nursing because studies have demonstrated that moral distress is a major contributor to nurses leaving the work setting and profession (AACN, 2015). Research regarding nursing students rather than practicing RN's is limited, but necessary to ensure moral distress is not causing nursing students to leave the profession before they even receive their degree and licensure.

Moral distress can occur from multiple internal and external factors that may affect all nurses differently due to their personalities, character traits, world views, experiences, and relationships (McCarthy and Gastmans, 2015). Nursing students often experience moral distress due to breeches in safety, moral dignity, and moral judgements involving themselves and/or the patient (Theobald, 2013). If moral distress is not addressed, it leads to moral residue which can cause the nurse to become unresponsive to morally distressing situations and burn out.

The two main fields that experience moral distress are ICU and home health care. A nurse's level of moral distress can be assessed with many different tools including, The 4a's of Moral Distress (AACN, 2015), Corley's Moral Distress Scale (Corley, Elswick, Gorman, & Clor, 2001), and the Moral Distress Thermometer (Weaver & Wocial, 2012).

Once nurses are aware that they are experiencing moral distress, they must find strategies to alleviate moral distress. One strategy is the CODE strategy developed by Lachman (2010). The CODE strategy stands for Courage to be moral requires, Obligation to honor, Danger management, and Expression/action.

Chapter III

Methodology

Design

   Quantitative methodology was used for this senior honors thesis. The approach was a descriptive survey, with the survey being developed by the researcher. The researcher's survey was used as a measurement tool that tested the occurrence of moral distress among nursing students in the clinical setting. The nursing students' perspectives were evaluated by asking questions about the student's experiences in the clinical setting with faculty, health care providers within the hospital, and fellow students.

   The survey contained 25 questions. Twenty-four students signed consents to complete the survey in the graduating classes of Fall 2016 and Spring 2016. Twenty-two students responded and completed the survey. The researcher divided the survey into 5 sub-groups to evaluate the students' responses. Questions 2, 6, 19, 20, 21, 22, 23, and 25 involve non-specific questions that do not ask who caused the student to experience moral distress, but evaluated the students on whether they experienced moral distress in general and their feelings regarding the moral distress experienced. The second subgroup included questions that evaluated the student themselves. These questions evaluated whether the student themselves did something unethical in the clinical setting. The self-subgroup included questions 1,7,11, and 15. The third subgroup evaluated the nursing students' fellow colleagues and whether students witnessed them committing an unethical action in the clinical setting. The questions included in the fellow nursing student subgroup were 3,8,12, and 16. The fourth subgroup focused on the actual nursing staff employed by the organization. The questions that evaluated the nursing staff were 5,9,13, and 17. The fifth

and final subgroup focused on the actual University faculty who worked with the students within the clinical setting. The questions that evaluated this subgroup were 4,10,14, and 18.

Setting

The setting was clinical facilities in which students were placed for lab experiences.

Population

The research included the graduating nursing classes of Spring 2016 and Fall 2016 at the University of Southern Mississippi Gulf Park campus. All students in these graduating classes were present for the oral presentation of the research during the Spring 2016 semester. Twenty-four students signed the informed consent to participate in the survey. The researcher had a small population because some classes lacked clinical experience.

Procedure

After the survey and informed consent form was developed, approval for the study was sought from the University of Southern Mississippi (USM) Institutional Review Board (IRB). When IRB approval was obtained, the researcher visited nursing classes, including all USM-Gulf Coast (GC) nursing students except first year students, to introduce the study. The visits took place during the Spring 2016 semester.

The informed consent form and research process was thoroughly explained by the researcher to the prospective student participants. The students were informed that there is no penalty whatsoever for participating or not participating in the study. They also were told that they are free to withdraw from the study at any point without a penalty. Students who volunteered for the study signed consent forms, which were collected by the researcher during the introductory session. A list serve was created containing the email addresses of students who agreed to participate in the study.

During the introductory sessions, moral distress, as defined by Jameton (1984), was explained to the volunteers who already should have been exposed to this subject during their first semester of nursing school. Student volunteers were asked to stay aware of any feelings of moral distress they experience during their Spring 2016 clinical rotations as well as reflecting on these feelings and experiences during previous semesters. Participants were encouraged to jot down moral distress experiences the same day they were experienced and to write notes about previous experiences that relate to the study. During the semester, students were reminded via email about the study and the suggested process for remembering their moral distress experiences.

At the end of the semester, the researcher's survey was distributed via email to the list serve of student participants. Students were given a link to complete the survey using the Survey Monkey format. Students were told the survey took less than five minutes to complete, so they were aware of how much time needed to allocated to complete the survey. Data collection was anonymous. Data was analyzed and descriptive statistics were compiled.

Assumptions

It is assumed that students were honest in completing the survey. It is assumed that the participants understood the concept of moral distress as it has been described in nursing literature and by the researcher. It is assumed that the students had adequate time to reflect on their past experiences in order to complete the survey.

Limitations

One limitation was the inexperience of the researcher. A second limitation was that the participants may not make notes of their moral distress the same day they experience it. This may lead to incomplete or slightly inaccurate data. A third limitation was the small sample size

the researcher used. The fourth limitation was the education level and experience of participants.

The fifth limitation was being unsure if the participants have a full understanding of moral

distress.

Chapter IV

Analysis

Twenty-four students signed consent forms to participate in the Moral Distress Among Nursing Students questionnaire. Twenty-two students responded to the questionnaire. All students who responded to the survey had previously viewed the short oral presentation on moral distress and signed the consent form to participate. The questionnaire asked specific questions regarding moral distress experienced within the clinical setting. The questionnaire consisted of 25 questions. All students who participated answered 25 of 25 questions.

Table I: Students' responses by specific question

The question column lists the question number being evaluated. The yes, no, and not sure column include how the students answered the specific question. The first number in the yes, no and not sure column include the percentage of students who chose that answer choice. The second number in the yes, no, and not sure column is the actual number of students who responded with that answer choice. See Appendix A for the entire questionnaire.

Question	Yes		No		Not Sure	
1	13.64%	3	72.73%	16	13.64%	3
2	54.55%	12	40.91%	9	4.55%	1
3	40.91%	9	54.55%	12	4.55%	1
4	22.73%	5	72.73%	16	4.55%	1
5	72.73%	16	27.27%	6	0.00%	
6	72.73%	16	22.73%	5	4.55%	1
7	0.00%		81.82%	18	18.18%	4
8	9.09%	2	72.73%	16	18.18%	4

9	68.18%	15	31.82%	7	0.00%
10	22.73%	5	68.18%	15	9.09%	2
11	4.55%	1	81.82%	18	13.64%	3
12	40.91%	9	54.55%	12	4.55%	1
13	72.73%	16	22.73%	5	4.55%	1
14	27.27%	6	63.64%	14	9.09%	2
15	13.64%	3	81.82%	18	4.55%	1
16	9.09%	2	81.82%	18	9.09%	2
17	31.82%	3	54.55%	12	13.64%	3
18	22.73%	5	72.73%	16	4.55%	1
19	50.00%	11	50.00%	11	0.00%
20	63.64%	14	34.36%	8	0.00%
21	27.27%	6	72.73%	16	0.00%
22	36.36%	8	54.55%	12	9.09%	2
23	18.18%	4	81.82%	18	0.00%
24	40.91%	9	50.00%	11	9.09%	2
25	40.91%	9	59.09%	13	0.00%

Question 24 in the survey specifically focuses on the overall moral distress experienced by the students. Nine students said they had experienced moral distress in the clinical setting, 11 students said they did not experience moral distress in the clinical setting, and 2 students were unsure whether they had or had not experienced moral distress in the clinical setting. Even

though only nine students responded "yes" to experiencing moral distress in the clinical setting, 16 students indicated on question 6 that they had, in fact, felt powerless to advocate for their assigned patient due to the lack of control they had as a student nurse. Question 6 evaluated a situation that is usually described as moral distress.

An analysis of the subgroups revealed that most nursing students' unethical experiences involved a nurse employed at one of the organizations in which they had their clinical rotations. Two of the nonspecific questions, questions 19 and 20, showed that symptoms felt when moral distress was experienced had a greater number of students answer yes than that of question 24 that asked in general if the students felt they experienced moral distress at all. Eleven students answered question 19 with the yes answer choice evaluating their unpleasant physical signs and symptoms felt with moral distress. Fourteen students answered yes to question 20 that evaluated unpleasant emotional signs and symptoms felt with moral distress. Only nine participants answered "yes" to question 24 that states "I believe I experienced moral distress in one or more clinical rotations." This shows a discrepancy in participant understanding of moral distress because more participants reported that they experienced symptoms that occur as a result of moral distress and a smaller number of participants said they actually experienced moral distress.

Chapter V

Discussion

The intent of this senior honors thesis was to obtain descriptive data about the moral distress experienced by nursing students during their clinical rotations in nursing school and then to analyze the data to determine if moral distress is prevalent within one nursing school setting. The participants who signed an informed consent were emailed the questionnaire at the end of the Fall 2016 semester. Once the researcher received 22 of the 24 responses after three attempts of emailing the survey, the researcher began the analysis of data.

More than 50% of participants answered 3 questions out of the non-specific subgroup with "yes," which indicated they experienced moral distress, but did not specify who caused the moral distress. These questions were numbers 2, 6, and 20. The researcher also found that questions 5, 9, and 13 were all answered with "yes," by more than 50% of the students which evaluated the staff employed with the actual facilities the clinical rotations were held. It was found that only 9 out of 22 students reported that they experienced moral distress. Although this number is less than half of the students who participated in the survey, 14 students indicated they experienced unpleasant emotional symptoms related to an experience within the clinical setting regarding an ethical issue. The researcher also found several other question that indicated moral distress was experienced by the students. 12 students on question 2 reported witnessing patient care they felt was futile. 16 students indicated they felt disrespected by someone employed by the facility during a clinical rotation. Fifteen students indicated they witnessed a RN employed by the facility do something unethical. Sixteen students indicated they witnessed a person employed by the facility say something unethical during a clinical rotation. Also 16 students responded yes to question 6 that indicated they had felt powerless to advocate for their assigned

patient due to the lack of control they had as a nursing student. Jameton (1984) indicated a similar problem regarding his nursing students' morals being tested within the clinical setting due to lack of control, which resulted in moral distress. The researcher came to the conclusion that there must be a disconnect between the students witnessing unethical actions, feeling symptoms indicating moral distress, and identifying these feelings as moral distress. If a future study is developed by the researcher, the researcher would attempt to develop the participants understanding of moral distress to a higher degree.

Conclusion

Nursing students answered a 25 question survey evaluating ethics- related experiences the students were exposed to within the clinical setting involving the students themselves, nursing staff at the various organizations, nursing student colleagues, and nursing faculty employed by the University of Southern Mississippi. It was found that although only 9 of 22 students answered that they had experienced moral distress, more than half of the students answered yes to questions that focused on ethics-related experiences they had encountered. Also, more than half indicated unpleasant symptoms experienced after witnessing an unethical action, which typically might be described as moral distress. It was found that the nurses employed by the organizations were the main group that was perceived to be practicing unethically. Since the nurses within the organization were perceived to exhibit unethical behavior, this could lead to a loss of caring and avoidance of patients due to the nursing students' morality being tested (Theobald, 2013). Physical and emotional symptoms felt by the nursing student due to unethical situations may decrease the nursing students' desire to be a part of the profession (AACN, 2015).

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Appendix A

Moral Distress Questionnaire

Moral distress arises "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p. 6).

The American Association of Critical Care Nurses' (AACN, 2008) definition of moral distress is, "when you know the appropriate action to take, but the nurse is unable to act upon it, or you act in a manner contrary to your personal or professional values which undermines your integrity and authenticity" (AACN, 2008, p.1).

Patient advocate: means that the nurse takes action to meet patients' needs when they are unable to act on their own behalf (personal communication, Rich, 2016).

This questionnaire is based on the premise that there are a number of situations experienced by nursing students during clinical rotations that may generate feelings of moral distress or cause them to experience unpleasant physical, emotional, behavioral, or spiritual signs and symptoms.

American Association of Critical Care Nurses. (2015). *Moral distress*. Retrieved from

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Jameton, A. (1984). *Nursing practice: The ethical issues*. Englewood Cliff, NJ.: Prentice Hall.

IMPORTANT NOTE: YOUR ANSWERS TO THIS QUESTIONNAIRE WILL BE COLLECTED ANONYMOUSLY. THERE WILL BE NO IDENTIFYING CONNECTION BETWEEN YOU INDIVIDUALLY AND YOUR ANSWERS TO THE QUESTIONNAIRE, I.E. THE DATA COLLECTION TOOL DOES NOT IDENTIFY PARTICIPANTS.

Please choose one answer that best describes your experiences related to the questions below.

During one or more clinical rotations during nursing school:

1. I have provided patient care that I felt was unnecessary or not desired by the patient or his/her family member/significant other.

Yes

No

Not sure

2. I have witnessed patient care being provided that I felt was unnecessary or not desired by the patient or his/her family member/significant other.

Yes

No

Not sure

3. I have felt disrespected by my student colleagues in the clinical setting.

Yes

No

Not sure

4. I have felt disrespected by my clinical instructor in the clinical setting.

Yes

No

Not sure

5. I have felt disrespected by someone employed by the facility during a clinical rotation.

Yes

No

Not sure

6. I have felt powerless to advocate for my assigned patient due to the lack of control that I, as a nursing student, have in the clinical setting.

Yes

No

Not sure

7. I have done something unethical during a clinical rotation.

Yes

No

Not sure

8. I have witnessed a nursing student colleague do something unethical during a clinical rotation.

Yes

No

Not sure

9. I have witnessed a registered nurse employed by the facility do something unethical during my clinical rotations.

Yes

No

Not sure

10. I have witnessed my clinical instructor do something unethical during my clinical
   rotations.

Yes

No

Not sure

11. I have said something unethical during my clinical rotations.

Yes

No

Not sure

12. I have witnessed a nursing student colleague say something unethical during my clinical
   rotations.

Yes

No

Not sure

13. I have witnessed a person employed by the facility say something unethical during my
   clinical rotations.

Yes

No

Not sure

14. I have witnessed my clinical instructor say something unethical during my clinical rotations.

Yes

No

Not sure

15. I have felt that patient safety was in jeopardy while I was completing something I was expected to do in the clinical setting.

Yes

No

Not sure

16. I have witnessed a nursing student colleague do something that jeopardized patient safety during my clinical rotations.

Yes

No

Not sure

17. I have witnessed a person employed by the facility do something that jeopardized patient safety during my clinical rotations.

Yes

No

Not sure

18. I have witnessed my clinical instructor do something that jeopardized patient safety during my clinical rotations.

Yes

No

Not sure

19. I have experienced unpleasant physical signs or symptoms during a clinical experience or shortly after being in the clinical setting. Examples may include: headache, GI upset, overeating or loss of appetite, hyperactivity or lethargy

Yes

No

Not sure

20. I have experienced unpleasant emotional signs or symptoms during a clinical experience or shortly after being in the clinical setting. Examples may include: guilt, resentment, fear, depression, anger, confusion, or frustration

Yes

No

Not sure

21. I have experienced unpleasant behavioral signs or symptoms during a clinical experience or shortly after being in the clinical setting. Examples may include: feeling unable to act according to my conscience, crying due to issues related to a clinical situation, treating patients as non-persons, over involvement with a patient or family, or apathy.

Yes

No

Not sure

22. I have experienced unpleasant spiritual signs or symptoms during a clinical experience or shortly after being in a clinical setting. Examples may include: feeling a loss of life meaning, feeling helpless, feeling a loss of self-worth, feeling a disconnection with people at a clinical facility or in my nursing class, questioning my religious beliefs.

Yes

No

Not sure

23. I have had thoughts of withdrawing from nursing school due to my uncomfortable feelings related to clinical rotations.

Yes

No

Not sure

24. I believe that I experienced moral distress during one or more clinical rotations.

Yes

No

Not Sure

25. I felt unable or reluctant to report to my instructor the moral distress I experienced during

my clinical rotations.

Yes

No

Not applicable

**THE UNIVERSITY OF
SOUTHERN MISSISSIPPI.**

INSTITUTIONAL REVIEW BOARD
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Phone: 601.266.5997 | Fax: 601.266.4377 | www.usm.edu/research/institutional.review.board

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
  Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 16012903

PROJECT TITLE: An Analysis of Moral Distress Experienced by Nursing Students

PROJECT TYPE: New Project

RESEARCHER(S): Katherine Merchant Johnson

COLLEGE/DIVISION: College of Nursing

DEPARTMENT: Collaborative Nursing Care

FUNDING AGENCY/SPONSOR: N/A

IRB COMMITTEE ACTION: Expedited Review Approval PERIOD OF
APPROVAL: 03/17/2016 to 03/16/2017

Lawrence A. Hosman, Ph.D.
Institutional Review Board

THE UNIVERSITY OF SOUTHERN MISSISSIPPI AUTHORIZATION TO

PARTICIPATE IN RESEARCH PROJECT

Participant's Name _____

Consent is hereby given to participate in the research project entitled Moral Distress Experienced by Nursing Students _____. All procedures and/or investigations to be followed and their purpose, including any experimental procedures, were explained by
<u>Katherine Merchent Johnson</u>. Information was given about all benefits, risks, inconveniences, or discomforts that might be expected.

The opportunity to ask questions regarding the research and procedures was given. Participation in the project is completely voluntary, and participants may withdraw at any time without penalty, prejudice, or loss of benefits. All personal information is strictly confidential, and no names will be disclosed. Any new information that develops during the project will be provided if that information may affect the willingness to continue participation in the project.

Questions concerning the research, at any time during or after the project, should be directed to <u>researcher(s) name(s)</u> at <u>telephone number(s)</u>. This project and this consent form have been reviewed by the Institutional Review Board, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board, The University of Southern Mississippi, 118 College Drive
#5147, Hattiesburg, MS 39406-0001, (601) 266-5997.

Use the following only if applicable: The University of Southern Mississippi has no mechanism to provide compensation for participants who may incur injuries as a result of participation in research projects. However, efforts will be made to make available the facilities and professional skills at the University. Information regarding treatment or the absence of treatment has been given. In the event of injury in this project, contact treatment provider's name(s) at telephone number(s).

A copy of this form will be given to the participant.

_____   _____
Signature of participant   Date

Katherine Merchent Johnson   1/17/2016

_____   _____
Signature of person explaining the study   Date