European Online Journal of Natural and Social Sciences 2023;
Vol.12, No 1 pp. 84-97
ISSN 1805-3602

Moral Distress among Nurses in Selected Hospitals in Nueva Ecija, Philippines

John Jason M. Villaroman [1,2*], Wireen Leila T. Dator[3,2]
[1] College of Nursing, Wesleyan University- Philippines; [2] College of Nursing, St. Paul University Manila, Philippines; [3] College of Nursing, Princess Nourah Bint Abdulrahman University, Riyadh, KSA
[*]Email: jasonmvillaroman@yahoo.com , Mobile #: +63916-642-4798

Received for publication: 03 September 2022.
Accepted for publication: 28 November 2022.

Abstract

The study focused on determining the level of moral distress among nurses in selected hospitals in Nueva Ecija, Philippines. Since moral distress is a wide-ranged phenomenon, its magnitude has affected health providers, especially nurses, who are working in a diverse and complex clinical environment. A quantitative correlational design was applied determining socio-demographic profile of the nurse respondents in terms of *sex, area of assignment and year of experience and its correlation to their moral distress levels.* Their moral distress levels were measured using the moral distress thermometer scale (MDTS).

The findings of this research indicated that nurses experience low to moderate level of moral distress and that female nurses are more prone to experience higher levels of moral distress than males. There is also a significant correlation between years of experience, inadequate working condition and the moral distress levels. Further, it has been concluded that this study supports evidences from relevant empirical findings that moral distress is indeed a serious phenomenon affecting nurses and can affect their working condition. Also, moral distress is more common to female nurses and may vary according to the complexity and diversity of their health environment.

Keywords: correlation, level of moral distress, moral distress, moral distress thermometer scale, nurses, profile

Introduction

Nursing, is one of the most physically, psychologically, and ethically demanding profession locally and globally. Because of the diverse culture in the clinical setting, there are challenges the nurses are facing in their day-by-day lives. Some of these are the various situations or conditions that serve as moral distress affecting their ethical values, integrity and mental health. This moral distress may also result in poor quality of care. Laskowski-Jones (2015) described moral distress as instinctive response induced by experiencing a situation or antecedents that are against the principles and moral values of a health provider which he or she believes may violate the delivery of health care. The moral distress may be worsened if the nurse lacks the ability and authority to do corrective intervention.

Further, Hamric (2010) explained that there are two significant issues that are typically present in situations involving moral distress. These issues are imbalance of power in the relationship between nurses and physicians in the healthcare setting, and issue within the healthcare system that complicates individual patient's situations. Furthermore, Karakachian & Colbert (2017) attributed several sources of moral distress in nursing which include the conditions in the clinical set-

tings and the internal and external limitations. These factors have been a major challenge not only in this or any particular country but worldwide. In addition to the constant exposure to disturbing and stressful situation in the clinical setting, the health care professionals, as well as the patients, have diverse culture, religion, social and economic status, and education levels that may compromise the interaction, quality and delivery of care, which eventually may lead to moral distress among the health care providers including the nurses.

Dalmolin, Lunardi, Barlem and Silveria (2012) described the tough consequences of moral distress on the personal and professional dimensions of nurses. These may influence their work satisfaction and quality patient care that eventually cause them to leave their profession. The study of Kousar Perveen, Muhammad Afzal , Sunil Abid , Iram Majeed , Muhammad Hussain (2017) found that moral distress decreases the performance level of nurses in the hospital setting. The impact of moral distress and its consequences to nurses are both immediate and long –term. It will not only move their wellbeing and decisions, but will also have significant bearing in the delivery of care to patients, considering that nurses comprise the largest number in the health care team and are the constant figure with the patient at the bedside, and coordinating among the health care team. It is therefore crucial to address the issue of moral distress among nurses to mitigate its impact; hence this study was done to explore the moral distress levels of the nurses and its correlation to their years of work experience, area of assignment, and sex.

Methodology

A quantitative correlational design was used in this research study. A total enumeration of 400 nurses from selected hospitals in the province of Nueva Ecija, Philippines were asked to answer the moral distress thermometer scale (MDTS). Developed by Corley (2002), the MDTS is a two-part questionnaire with the first part that determines the profile and the second part the determines the moral distress levels with the following five categories of *moral distress associated with clinical events: Lack of competence in work team with six items, Disregard for the patient's autonomy with four items, Inadequate working conditions with five items,* Denial of the nursing role as an advocate for the terminally ill patient*, and Denial of the nursing role as an advocate for the terminally patient with four items each.* The scale was answerable by a 5-point likert scale from 1 (never) to 5 (always). Reported Chronbach's alpha value from the pilot test is .90, which means that the internal consistency is very high.

Results

Demographic Profile of Nurse Respondents

Table 1. Distribution of respondents according to year of experience and gender

Years of Experience	**f**	**%**
16 - above	4	1.00
11 - 15	6	1.50
6 - 10	74	18.50
1 - 5	316	79.00
Total	**400**	**100.00**
Gender		

Years of Experience	f	%
Male	152	38
Female	248	62
Total	**400**	**100.00**

Table 1 shows that from the 400 nurse participants, 248 were females and 152 were males. The profile of the respondents in terms of gender is reflective and consistent with the global profile where females dominate the nursing profession. Most of the nurse respondents have a work experience within the range of 1 – 5 years.

Table 2 Distribution of respondents in terms of area of assignment

Area of Assignment	f	%
General ward	145	36.25
OR/DR Complex	65	16.25
Emergency Room	40	10.00
Pediatric ward	14	3.50
OB Ward	28	7.00
NICU	31	7.75
Hemodialysis	23	5.75
OPD	8	2.00
ICU	41	10.25
Cath. Lab	5	1.25
Total	**400**	**100.00**

Table 2 shows that majority which is 47 or 11.75% of the nurses were assigned at the general wards, followed by 41 or 10.25 percent at the Intensive Care Units, and 40 or 10.00 percent at the Emergency Room.

Moral Distress Level of Nurse Respondents

The following tables represent the moral distress level of the nurse respondents using the Moral Distress Thermometer Scale (MDTS).

Table 3. Lack of competence in work team

	Moral Distress Scale	Private Hospital			Public Hospital		
	Lack of competence in a work team	**M**	**SD**	**VD**	**M**	**SD**	**VD**
1	Providing assistance to a physician who, in your opinion, is acting incompetently as regards to patient.	2.74	1.222	MLMD	2.33	1.004	LLMD
2	Working with nursing technicians/assistants who do not possess the necessary competence that the patient's condition requires.	2.68	1.082	MLMD	2.65	1.171	MLMD
3	Working with nurses who do not have the competency to perform.	2.68	1.154	MLMD	2.36	0.936	LLMD

	Moral Distress Scale	Private Hospital			Public Hospital		
	Lack of competence in a work team	**M**	**SD**	**VD**	**M**	**SD**	**VD**
4	Working with physicians who do not have the competency to perform.	2.38	1.199	LLMD	2.01	0.881	LLMD
5	Working with support services who do not have the competency to perform.	2.50	1.206	LLMD	2.26	0.962	LLMD
6	Working with medical or nursing students who do not have the competency to perform.	2.38	1.240	LLMD	2.18	0.918	LLMD
	OWM	**2.55**	**1.041**	**LLMD**	**2.30**	**0.804**	**LLMD**

Table 4. Moral distress of respondents in terms of Lack of competence in a work team

Legend: Mean scores (M)	**Verbal Description (VD)**
4.20 - 5.00	Very High level of moral distress (VHLMD)
3.40 - 4.19	High level of moral distress (HLMD)
2.60 - 3.39	Moderate level of moral distress (MLMD)
1.80 - 2.59	Low level of moral distress (LLMD)
1.00 - 1.79	Very low level of moral distress (VLLMD)

The private hospital nurse-respondents obtained an overall weighted mean of 2.55 indicating low level of moral distress while the public hospital nurse-respondents yielded an overall weighted mean of 2.30 which is also low level of moral distress. This indicates that both private and public nurses had low level of moral distress resulting from lack of competence in the work team. Moreover, the highest mean for private hospital nurse-respondents was "Providing assistance to a physician who, in their opinion, is acting incompetently as regards to patient" with a mean of 2.74 indicating moderate level of moral distress. Meanwhile, the lowest mean was "Working with physicians who do not have the competency to perform" and "Working with medical or nursing students who do not have the competency to perform," both got a mean of 2.38 which indicates low level of moral distress.

Disregard for the patients' autonomy

Private hospital nurse-respondents got an overall weighted mean of 1.82 indicating low level of moral distress while the public hospital nurse-respondents obtained an overall weighted mean of 1.49 that indicates a very low level of moral distress. Meanwhile, the highest mean for private hospital nurse-respondents was "Complying with the request of the physician not to talk about death with a dying patient who asks about dying," with a mean of 1.96 indicating low level of moral distress. Likewise, the lowest mean was "Providing assistance to a physician who is performing a procedure on the patient, without informed consent, even from the family," and "Complying with the request of the physician not to discuss resuscitation with the family of the patient, in case of cardiac arrest, when the patient is devoid of discernment," both got a mean of 1.68 interpreted as very low level of moral distress. For public hospital nurse-respondents the highest mean was "Complying with the request of the physician not to talk about death with a dying patient who asks about dying," with a mean of 1.58 indicating very low level of moral distress. Further, the lowest mean was "Providing assistance to a physician who is performing a procedure on the patient, without informed

consent, even from the family," with a mean of 1.34 which indicates to have a very low level of moral distress.

Result reveals that both sets of respondents experiences minimal moral distress in this indicator.

Table 5. Moral distress of respondents in terms of disregard for patients' autonomy

	Moral Distress Scale	**Private Hospital**			**Public Hospital**		
	Disregard for the patient's autonomy	**M**	**SD**	**VD**	**M**	**SD**	**VD**
1	Providing assistance to a physician who is performing a procedure on the patient, without informed consent, even from the family.	1.68	1.049	VLLMD	1.34	0.635	VLLMD
2	Complying with the request of the physician not to discuss with the patient regarding the resuscitation, in the case of cardiac arrest.	1.79	1.054	VLLMD	1.51	0.769	VLLMD
3	Complying with the request of the physician not to discuss resuscitation with the family of the patient, in case of cardiac arrest, when the patient is devoid of discernment.	1.68	1.121	VLLMD	1.53	0.780	VLLMD
4	Complying with the request of the physician not to talk about death with a dying patient who asks about dying.	1.96	1.082	LLMD	1.58	0.754	VLLMD
	OWM	**1.82**	**0.972**	**LLMD**	**1.49**	**0.627**	**VLLMD**

Inadequate working condition

Table 6. Moral distress of respondents in terms of inadequate working condition

	Moral Distress Scale	**Private Hospital**			**Public Hospital**		
	Inadequate working condition	**M**	**SD**	**VD**	**M**	**SD**	**VD**
1	Not having the materials necessary to provide patient care.	2.34	1.049	LLMD	2.88	1.059	LLMD
2	Not having the equipment necessary to meet the urgent needs of a patient.	2.37	1.033	LLMD	2.93	1.058	MLMD
3	Needing to prioritize patients to be cared for due to the lack of human resources.	2.91	1.184	MLMD	3.01	1.056	MLMD
4	Needing to delegate nursing care to family members of patient due to insufficient human resources.	2.62	1.093	MLMD	2.90	0.876	MLMD
	OWM	**2.56**	**0.905**	**LLMD**	**2.93**	**0.911**	**MLMD**

In table 6, the private hospital nurse-respondents obtained an overall weighted mean of 2.56 indicating low level of moral distress while the public hospital nurse-respondents got an overall weighted mean of 2.93 indicates a moderate level of moral distress. The result indicates that private hospital nurse-respondents experience very low level of moral distress while the public hospital

nurse-respondents experience moderate level of moral distress. Meanwhile, the highest mean for private hospital nurse-respondents was "Needing to prioritize patients to be cared for due to the lack of human resources," with a mean of 2.91 indicating moderate level of moral distress. Likewise, "Not having the materials necessary to provide patient care," got the lowest mean of 2.34 which indicates low level of moral distress. For public hospital nurse-respondents, the highest mean was "Needing to prioritize patients to be cared for due to the lack of human resources," with a mean of 3.01 interpreted as having a moderate level of moral distress. Further, "Not having the materials necessary to provide patient care," obtained a lowest mean of 2.88 interpreted as having a low level of moral distress. Meanwhile, the highest mean for private hospital nurse-respondents was "Needing to prioritize patients to be cared for due to the lack of human resources," with a mean of 2.91 indicating moderate level of moral distress. Likewise, "Not having the materials necessary to provide patient care," got the lowest mean of 2.34 which indicates low level of moral distress.

The highest mean for private hospital nurse-respondents was "Needing to prioritize patients to be cared for due to the lack of human resources," with a mean of 2.91 indicating moderate level of moral distress. Likewise, "Not having the materials necessary to provide patient care," got the lowest mean of 2.34 which indicates low level of moral distress.

Denial of the nursing role as an advocate for the terminally ill patient

Table 7. Moral distress of respondents in terms of denial of the nursing role as an advocate for the terminally ill patient

	Moral Distress Scale	**Private Hospital**			**Public Hospital**		
	Denial of the nursing role as an advocate for the terminally ill patient	**M**	**SD**	**VD**	**M**	**SD**	**VD**
1	Avoiding taking action in situations of patient death associated with mal practice.	1.83	1.093	LLMD	1.58	0.664	VLLMD
2	Performing with professionals who do not explain to the patient their health status and disease.	1.85	1.022	LLMD	1.64	0.642	VLLMD
3	Initiating intensive procedures to save a life when the terminally patient has expressed the wish to die.	2.05	1.124	LLMD	1.73	0.824	VLLMD
4	Avoiding taking measures when the abandonment of the dying patient can be seen by the family.	1.90	1.085	LLMD	1.48	0.696	VLLMD
	OWM	1.91	0.950	LLLMD	1.61	0.552	VLLMD

Table 7 shows the moral distress of the respondents as to denial of the nursing role as an advocate for the terminally ill patient. Private hospital nurse-respondents obtained an overall weighted mean of 1.91 indicating low level of moral distress while the public hospital nurse-respondents garnered an overall weighted mean of 1.61 which indicates to have a very low level of moral distress. Meanwhile, the highest mean for private hospital nurse-respondents was "Initiating intensive procedures to save a life when the terminally patient has expressed the wish to die," with a mean of 2.05 indicating low level of moral distress. Similarly, "Avoiding taking action in situations of patient

death associated with malpractice," garnered the lowest mean of 1.83 which also indicates low level of moral distress. As to public hospital nurse-respondents, the highest mean was "Initiating intensive procedures to save a life when the terminally patient has expressed the wish to die," with a mean of 1.73 indicating very low level of moral distress. Meanwhile, "Avoiding taking measures when the abandonment of the dying patient can be seen by the family," got a mean of 1.48 which also indicates very low level of moral distress.

Result shows that the respondents experienced low level of moral distress when initiating procedures to save life of the terminally ill patients.

Denial of the nursing role as an advocate for the patient

Table 8. Moral Distress of the respondents in terms of denial of the nursing role as an advocate for the patient

Moral Distress Scale	**Private Hospital**			**Public Hospital**		
Denial of the nursing role as an advocate for the patient	**M**	**SD**	**VD**	**M**	**SD**	**VD**
Allowing nursing students to perform painful procedures on patient just to hone the skills.	1.85	1.091	LLMD	1.25	0.543	VLLMD
Providing assistance to physicians who are performing procedures on patients after cardio-respiratory recovery was not satisfactory.	2.16	1.147	LLMD	1.61	0.674	VLLMD
Observing, without taking action, when the nursing staff does not respect patient's privacy.	1.78	1.010	VLLMD	1.54	0.720	VLLMD
Obeying physician's orders not to tell the patient the truth, even when the patient asks you the truth.	1.96	1.077	LLMD	1.72	0.891	VLLMD
OWM	**1.94**	**0.917**	**LLMD**	**1.53**	**0.535**	**VLLMD**

Table 8 shows the overall weighted mean for private hospital nurse-respondents was 1.94 indicating low level of moral distress while the public hospital nurse-respondents got a 1.53 which indicates a very low level of moral distress. Result shows that the private hospital nurse-respondents and public hospital nurse-respondents have experienced different levels of moral distress.

The highest mean for private hospital nurse-respondents was "Providing assistance to physicians who are performing procedures on patients after cardio-respiratory recovery was not satisfactory," obtained a mean of 2.16 indicating low level of moral distress. Moreover, "Observing, without taking action, when the nursing staff does not respect patient's privacy," got the lowest mean of 1.78 which indicates a very low level of moral distress. For the public hospital nurse-respondents the highest mean was "Obeying physician's orders not to tell the patient the truth, even when the patient asks the truth," with a mean of 1.72 indicating very low level of moral distress. Further, "Allowing nursing students to perform painful procedures on patient just to hone the skills," got the lowest mean of 1.25 which indicates a very low level of moral distress.

Result shows that both respondents experience minimal level of distress to different situations. The private hospital nurses experience these kinds of moral distress when the physician was unable to deliver satisfactory procedures to patients suffering cardio-respiratory diseases.

Table 9. Correlation Analysis between the Nurse Participants' Demographic Profile and Moral Distress Level

		MD1	MD2	MD3	MD4	MD5	MDL
Sex	Correlation Coefficient	r= -0.037 p= .456	r= -0.066 p= .187	r= 0.013 p= .802	r= -0.081 p= .106	r= 0.002 p= .974	r=0.019 p=0.712
	N	400	400	400	400	400	400
		Negligible correlation	Negligible correlation	Negligible correlation	Negligible correlation	Negligible correlation	Negligible correlation
Years of Experience	Correlation Coefficient	r= 0.071 p= .155	r= -0.056 p= .267	r= .118* p= .018	r= 0.026 p= .61	r= 0.039 p= .441	r=0.011 p=
	N	400	400	400	400	400	400
		Negligible correlation	Negligible correlation	Negligible correlation	Negligible correlation	Negligible correlation	Negligible correlation
Area of Assignment	Correlation Coefficient	r= -0.015 p= .768	r= -0.015 p= .768	r= -.125* p= .012	r= 0.018 p= .726	r= 0.019 p= .712	r=-0.212 p=
	N	400	400	400	400	400	400

MD 1 = Lack of competence in a work team
MD 2 = Disregard for the patient's autonomy
MD 3 = Inadequate working condition
MD 4 = Denial of the nursing role as an advocate for terminally ill patient
MD 5 = Denial of the nursing role as an advocate for the patient

The years of experience is significantly correlated with inadequate working condition with a p value of 0.018, meaning the longer the period of time in the workplace the nurses have the higher the moral distress they experienced. This result indicates that nurses working under difficult condition such as workloads and numerous nursing tasks most likely experience moral distress.

Discussion

The sources of moral distress are found on several research studies together with its magnitude among healthcare providers especially nurses. Morley (2016) explained that the link between moral distress and work environment is documented since working environment in health care system is complex and diverse. Moreover, Oh & Gastmans (2017) have concluded that moral distress is common when someone perceive a more negative ethical climate in their clinical setting, also when these providers are bound to act in ways they perceived were not in the patient's best interest in the aspect of care and /or when the patient's family demonstrated inappropriate behavior against them. Moreover, exposure to a negative climate, incompetent colleagues, uncooperative behavior of patients and their family, futile care, and nursing shortage are also the causes of moral distress. Similarly, the public hospital nurse-respondents highest mean was "Working with nursing technicians/assistants who do not possess the necessary competence that the patient's condition requires,"

with a mean of 2.56 which accounts for a moderate level of moral distress. Likewise, the lowest mean was "Working with physicians who do not have the competency to perform with a mean of 2.01 interpreted as low level of moral distress. Moreover, private and public hospital nurses have experience moderate level of moral distress when they are working with physicians who act that they were incompetent, nor do not have the capacity to perform and also nursing and medical students and nursing technicians/assistants who do not possess the necessary competence.

Demographic Profile of the Nurse Respondents and Moral Distress Area of Assignment

Supporting pieces of evidence have shown that nurses affiliating in general ward have higher circumstances leading to moral distress. Generally known, charge nurses are responsible for all patients care under general care, critical care and post-operative units. These units require number of nurses to observe patients under their care; they are expected to contribute to the overall health care and well-being of their patients. Aside from the workloads of the general ward nurses they are also provide counseling, emotional aid to the patient's families and edify patients on their medication and medical conditions. Contreras and Dela Vega (2014) found out that there were more nurses assigned in the general wards. General wards are commonly the initial areas of assignment given to the new staff nurses. These areas do not require special skills like the special areas where competent and proficient nurses work. Dopek et. al (2016) explained that moral distress in intensive care unit is associated with profession, age and years of experience. This is based from their quantitative analysis and concluded that the phenomenon is higher among the critical care nurses and other non-physician professionals and is lower with older age on non-physician professionals and greater with years of experience in nurses. These conditions also contribute to a higher tendency to leave their job.

This result highlights the critical roles of years in service of the participants in their commitment to render quality nursing care to the patients. Kelerijani, Heidarian, Jamshidi and Khorshidi (2014) explained that nurses had shorter period of service to hospital due high turnover of manpower because of greater opportunities to work abroad with high salaries and other economic benefits.

Level of Moral Distress of the Nurse Respondents

The sources of moral distress are found on several research studies together with its magnitude among healthcare providers especially nurses. Morley (2016) explained that the link between moral distress and work environment is documented sine working environment in health care system is complex and diverse. Further, Oh & Gastmans (2017) have concluded that moral distress is common when someone is perceiving unhealthy working environment ethically in their clinical setting, also when these providers are obligated to do actions that they believe is not the best for their patient's interest in the aspect of care and /or when the patient's family demonstrated inappropriate behavior against them. Results came from the 15 quantitative studies they reviewed. Furthermore, exposing to a negative climate, incompetent colleagues, uncooperative behavior of patients and their family, futile care, and nursing shortage are also the causes of moral distress. From the result of this study in the theme *lack of competence in work team,* the public hospital nurse-respondents highest mean was "Working with nursing technicians/assistants who do not possess the necessary competence that the patient's condition requires," with a mean of 2.56 was verbally taken as "sometimes," which accounts for a moderate level of moral distress. Likewise, the lowest mean was "Working with physicians who do not have the competency to perform with a mean of 2.01 interpreted as low level of moral distress. Moreover, private and public hospital nurses have experience moderate level of moral distress when they are working with physicians, medical students, technicians/assistants and nursing students who act that they were incompetent, nor do not have the capacity to perform. Tigard and Howe (2017) stated that moral distress may be a natural consequence of the messiness of

moral life but when one experiences moral distress everyday due to their occupation, which seems to be the case for nurses and other healthcare professionals and then it may instead be regarded as an occupational threat that employers have a responsibility to address.

Though the result of the theme *disregard for patient's autonomy* indicates low level of moral distress among respondents, it is important to consider the effect of these parameters to patients. Nurses' are advocates of their clients. This philosophy is embedded in the theoretical principles of nursing which is also vital in the decision-making process maintaining quality health care. According to Carnevale (2013), nurses should be recognized in their promotion of moral values because the morality issues due complexity and diversity in nursing have been prevalent for quiet sometime. It is important to discuss issues about nurse-physician working conditions, work environment and to reevaluate policies and guidelines of health institutions in order to provide strategies on how to address moral distress, its impact on health care delivery system and empowerment. The principle for respect for autonomy usually associated with allowing or enabling patients to make their own decisions about which health care intervention they will or will receive. Nurses experience moral distress when medical doctors perform procedure on patients without informed consent. This seems to be a clear violation on ethical procedures on patient's autonomy. Negative social relationship will develop that cause psychological disturbance resulting to moral distress. Beauchamp and Childress (2009) stated that considerations of respect for autonomy in health care contexts tend to focus on situations in which decisions need to be made about health care interventions. A principle of respect for autonomy is also invoked in discussions about confidentiality, fidelity, privacy and truth-telling. The idea that patients should be offered options and allowed to make voluntary choices about potentially life-changing health care interventions is important. It undoubtedly discourages some inappropriate paternalism and protects some patients from unwanted intervention, for example, by permitting individuals to decline surgery that they consider more burdensome than beneficial. The idea that patients should be enabled to make informed decisions also helpfully encourages attention to individuals' understandings of health care interventions, and supports the development and use of potentially autonomy-enhancing patient decision aids (O'Connor, Bennett, Stacy, Barry, Col, Eden, Entwistle, Fiset, Holmes-Rovner, Khangura, Tomas and Rovner, 2009).

Adequacy and favorable working condition are needed to maintain a healthy and positive working environment. Meaning, this will contribute to address the effects of moral distress. Unfortunately, unfavorable working environment was strongly associated with levels of fatigue. Fatigue can come directly from bad working condition. Stress and fatigue are among the negative manifestations of moral distress. Found on several studies, these manifestations affect nurses and other health providers worldwide. During interview, the researcher also found that nurses manifested stress and fatigue because of morally distressing events. According to Ahmed, Sleem and Kassem (2015), nurses have many critical responsibilities in regard to patients, when these responsibilities are carried out in condition of limited resources whether in staffing or supplies and equipment, inflexibility in working hours and shifts, potential conflicts and bad relationships between staff, management and patients, and insufficient recovery time, all of these make nurses exposed to a variety of stressors resulting in relatively high level of fatigue.

Though the results from the theme *denial of the nursing role as an advocate for the terminally ill patient* have shown a low level of moral distress, recognition of this circumstances are necessary because nurses experiencing moral distress are high in caring for terminally ill patients who are suffering from both physical and emotional pain and end of life. Further, moral distress experiences

should not be ignored but recognized and be offered support constructively. (Corrado and Molinaro, 2017)

Results from the theme *denial of the nursing role as an advocate for the patient* revealed that the nurse respondents also experience moral distress when physicians are unable to deliver satisfactory procedures to their patients. Nurse's expectations to them are high because they believe that they practice medicine to attend to the needs of patients. They are expected to set higher standard of professional service to cure the patient's disease and illness. Likewise, public hospital nurses experience very low moral distress when doctor order them not disclose to the patients their condition.

Though this condition is prevalently low in this study, it is important to take in consideration that this situation heartens the nurse because they were unable to tell the truth to their patients. The social relationship between the patient and the nurse will develop but the feeling of guilt was still in them that can cause negative effect resulting to moral distress. On the other hand, nurses were able to cope with this situation through proper communication to patients and families to develop trusting relationship. Also, Hebert, Moore and Rooney (2011) stated that physicians are the key person of their patient's information especially confidential clinical results such as clinical diagnosis and prognosis of the terminally ill. They may tend to be insensitive and not focusing more on how their patients and patient's relatives might feel after delivering information and this is because their relationship is more technical with limited rapport. On the other hand, nurses are advocates of patients' feelings and information. They further explain and discuss relevant and clinical information more so that their patient can understand clearly. It is also important that decisions involving patient care must be discussed by other health disciplines who are involved in the patient's clinical management. According to Puttman-Casdorph, Drenning and Messenger (2009), the role of nurses as advocates of their patients in delivering accurate clinical and other vital information must be clearly understood. For a terminally ill patient and their family, the main objective is to work efficiently with transparency and integrity. Currently, there are no ethical guidelines or policies regarding nurse-patient advocacy.

Moral Distress and Years of Experience

The empirical findings of this study that more years of experience correlate with moral distress are explained by several research findings. Dodek (2016) found that moral distress is greater with nurses who have more years of experience and is associated with tendency to leave their profession. He also found out that the antecedents and consequences of moral distress are higher in nurses who work in the intensive care unit and other non-physician professionals than physicians. From another study, Schaefer et al. (2018) found that the average years of experience in nursing who experience moral distress is 10 years. Meaning, the longer these health professionals work in the hospital setting, the more chances they will experience antecedents that will lead to moral distress and its consequences. On the other hand, despite experiencing the negative impact of this phenomenon, nurses opted to stay in their profession because of the shortage in terms of nursing population that affect the health delivery system worldwide. Hence, it is vital to accept, understand and manage the magnitude of moral distress by creating a debriefing method that will enable nurses to reflect, discuss their experiences of morally distressing incidences and provide possible remedies to counter the negative manifestations and empower them to be able to provide quality nursing care.

Similarly, area of assignment was negatively correlated but significant with inadequate working condition with a p value of 0.012, meaning those respondents assigned in the medical ward were most likely experience moral distress. Nurses working in this particular area experience moral distress because aside from the patients care, they are responsible to maintain patient's record sys-

tematically, administering medications, checking dosages and taking patient history. This workload contributed to the work performance of the nurses in this area. According to Corley, Minick, Elswick and Jacob (2002), moral distress is created when the conditions contradict an individual's beliefs and inner moral values, and he or she has to act against those values as a result of those conditions and real limitations. The occurrence of moral distress can entail different repercussions for nurses, patients, and healthcare organizations (Corley, 2005). In facing these conditions, nurses may experience sadness, contradiction, futility, and affliction. Prolonging these conditions can lead to exhaustion of their resistance resources and cause dissatisfaction with the workplace (Cumming, 2009).

Conclusion

This research study was undertaken to understand moral distress, its antecedents, moral distress levels and its magnitude among nurses. By understanding and acknowledging this phenomenon as a common and complex issue in nursing, the delivering health institutions may formulate a more tangible solution in addressing its negative effects on both personal and professional lives of our unsung heroes of today. Moreover, the results of these solutions may lead to empowerment and strengthen the delivery of health care system. The study has also concluded that the empirical findings from several literatures about the relationship of gender and moral distress are valid. Meaning, female nurses are more predisposed to experience moral distress and that a gender sensitivity program can be formulated that includes involving female nurses in the aspect of patient's care planning, policy and decision making for them to be empowered. Also, seminars that recognize the ability of women to lead the nursing profession without restrictions related to gender can be done on a regular basis.

As a result of the moral distress level using the Moral Distress Thermometer Scale (MDTS), seven major solutions can be recommended; (1) *strengthening management, leadership and governance structures* that will ensure that procurement and maintenance plans for hospital equipment are developed and implemented, (2) *providing activities that will build and strengthen resiliency among nurses* because due to lack of equipment to meet urgent needs, building and strengthening resiliency will be able to escalate adaptation to clinical and critical environment thus reducing consequences of moral distress. (3) *Conducting different seminar-workshops about latest trends and issues on nursing intervention* are very helpful since nursing is a technical skill requiring practice to achieve precision in order to maintain standards. This will also boost their confidence to blend in a very distressful environment. In the aspect of a need to prioritize patient to be cared for, (4) *conducting seminars on nursing prioritization of the patient need of care, providing team building exercises* and (5) *ensure to maintain correct nurse- patient ratio distribution* are vital because these strategies can improve nursing management given limited human resources and be able to teach nurses providing strategies to cope with stress and moral distress consequences. More so, maintaining the ideal nurse-patient ratio distribution will reduce antecedents to moral distress like clinical and documentation errors.

In the aspect of a need to delegate nursing care to family because of insufficient resources, (6) *providing a regular check and balance on delegation of tasks and responsibilities, auditing of resources and strategies for better outcome in terms of human and physical resources* will lessen the incidence of delegating nursing care to patient's family members especially in the medical ward. Clinical interventions should be provided by health practitioners to maintain its standards then (7)

conducting seminars on planning, leadership and management can support bedside nurses to perform their responsibilities in a complex health environment.

The level of moral distress may also vary depending on the quality of these clinical settings since these are diverse and complex. Further, moral distress is a wide ranged phenomenon that is inevitably happening and affecting nurses and as a result, it may alter them to provide quality care.

References

Ahmeed, M.F., Sleem, W.F. and Kassem, A.H. (2015). Effects of Working Condition and Fatigue on Performance of Staff Nurses at Mansoura University Hospital. *IOSR Journal of Nursing and Health Science*. Retrieved from: www.iosrjournals.org

Barlem E.L.D., Lunardi, V.L., Lunardi, G.L., Dalmolin, G.L, Tomaschewski JG.(2012) Experience of moral distress in nursing: nurses' perception Revista da Escola de Enfermagem da USP, vol. 46, no. June 3, 2012, pp. 681-688 University of Sao Paulo Sao Paulo, Brazil. Retrieved from: https://scholar.google.com/scholar

Bhaga, T., (2010): The impact of working condition on the productivity of nursing staff in the midwife obstetrical unit of Pretoria West hospital. *IOSR Journal of Nursing and Health Scienc*e. Retrieved from: www.iosrjournals.org

Carnevale, F. (2013). *Confronting moral distress in Nursing: recognizing nurses as moral agents. McGill University, Ingram School of Nursing: Montreal Children's Hospital*. Montreal Canada. Retrieved from https://www.scielo.br

Contreras, N.H., and Dela Vega, A. V. (2013). *Nursing Competencies and Job Satisfaction of Staff Nurses in the Millennial Generation.* Retrieved from: lpulaguna.edu.ph › wp-content

Corley M. (2002). Nurse moral distress: a proposed theory and research agenda. *Nurse Ethics.;9*(6):636–50. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/12450000

Corley M, Minick P, Elswick RK, Jacobs M (2005). Nurse moral distress and ethical work environment. *Nurse Ethics, 12*(4):381–90. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/16045246

Corrado, A. & Molinaro, M. (2017). Moral distress in health care professionals. *UWOMJ 86.2*. Retrieved from https://www.uwomj.com

Cummings C.L (2009). *The effect of moral distress on nursing retention in the acute care setting* [dissertation] Florida (USA): University of North Florida. Retrieved from:https://scholar.google.com/scholar_lookup?title=The+effect+of+moral+distress+on+nursing+retention+in+the+acute+care+setting+[dissertation]&author=CL+Cummings&publication_year=2009&#d=gs_cit&u=%2Fscholar%3Fq%3Dinfo%3AX4UaTv4ChrQJ%3Ascholar.google.com%2F%26output%3Dcite%26scirp%3D0%26hl%3Den

Dalmolin, G., Lunardi, V., Barlem, E. & Silveira, R. (2012). Implications of Moral Distress on Nurses and Its Similarities with Burnout, Enferm vol. 21 no. 1 Florianopolis, retrieved from www.scielo.br

Dodek, P.M., Wong, H., Norena, M., Ayas, N., Reynolds,S.C., Keenan,S.P., Hamric, A, Rodney,P., Stewart, M. and Alden, L. (2016).*Moral Distress in Intensive Care Unit Professionals is Associated with Profession, Age and Years of Experience*. Retrieved from: https://www.ncbi.nlm.gov/PMID26596697

Hamric, A.B. (2017). A Health System- wide Moral Distress Consulation Service: Development and Evaluation. *HEC Forum, 29*(2):127-143. doi:10.1007/s10730-016-9315-y.

Herbert, K., Moore, H. and Rooney, J. (2011). *The Nurse Advocate in End-of-Life Care*. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3241064/

James, S., M., (2010): Working conditions at magnet hospitals, *American Journal of Nursing, 110* (11) 16-17. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/20661060

Karakachian, A. and Colbert, A. (2017). *Moral Distress: A Case Study*, retrieved from https://journals.Iww.com

Kelarijani, S.E.J., Heidarian, A.R., Jamshidi, R. and Khorshidi, M. (2014). *Length of service and commitment of nurses in hospitals of Social Security Organization (SSO) in Tehran*. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3992235/

Laskowski-Jones, L. (2015). Dealing with Moral Distress, *Nursing, 45*(3), 6, retrieved from https://journals.Iww.com

Morley, G., (2018). What is Moral Distress in Nursing? How, Can and Should We Respond to It. J Clin Nurs. 2018 Oct; 27(19-20):3443-3445.doi: 10.111/jocn.14332. Retrieved from https://www.ncbi.nlc.nih.gov

O' Connell, C.B., (2015). *Gender and Experience of Moral Distress in Critical Care Nurses*. Retrieved from: https://www.ncbi.nlm.gov/Epub/201430

Pendry, P.S. (2007), *Moral Distress: Recognizing it to Retain Nurses.* Surgical Intensive Care Unit, Lakeland Regional Medical Center, Lakeland, FL, USA. Retrieved from https://www.ncbi.nlm.nih.gov

Philippines is Nursing A Crisis (2017). *Mata Press Service*. Published by Asingh, Asian Pacific Post. Retrieved from: https://www.asianpasificpost.com

Puttman-Casdorph, H., Drenning, C. and Messenger, K. (2009). *Advance directives: Evaluation of Nurses' Knowledge, Attitude, Confidence and Experience*. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/19525766/

Schaefer, R., Zoboli, E. & Vieria, M. (2018). Moral Distress in Nurses: A Description of the Risks for Professionals, *enferm. 27*(4) Florianpolis 2018 Epub Nov 01, 2018. Retreieved at http://dx.doi.org/10.1590/0104-07072018004020017

Silén M, Tang PF, Wadensten B, Ahlström G. (2008). Workplace distress and ethical dilemmas in neuroscience nursing. *J Neurosci Nurs., 40*(4):222–231. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/18727338

Tigard D. W. (2017). Rethinking moral distress: conceptual demands for a troubling phenomenon affecting health care professionals. *Medicine, Health Care and Philosophy*. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/29247313