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Newham, Roger; Hewison, Alistair; Neilson, Sue; Afoko, Vivian

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Moral distress experienced by neonatal intensive and paediatric care nurses in Northern Ghana: a qualitative study

Vivian Afoko
PhD Candidate, Nursing, University of Birmingham, Birmingham, UK

Alistair Hewison
Reader Nursing, Nursing, University of Birmingham, Birmingham, UK

Susan Neilson
Associate Professor Nursing, Nursing, University of Birmingham, Birmingham, UK

Roger Newham
Associate Professor, Nursing, University of Birmingham, Birmingham, UK

Abstract

Background: Moral distress has been studied widely in nursing but not in developing economies.
Aim: To investigate how moral distress is experienced by nurses working in neonatal intensive care and paediatric wards in Northern Ghana and to determine support measures offered by nurse managers.
Method: Qualitative descriptive method. Forty nurses and fourteen nurse managers working with children in four hospitals in Northern Ghana were interviewed. Thematic data analysis was carried out.
Results: Six themes were identified: nurses experience morally distressing situations due to a variety of causes; the impact of morally distressing situations on nurses; coping mechanisms of nurses who experienced morally distressing situations; recommendations made by the nurses to reduce the incidence of moral distress; inadequate support measures available to nurse managers and nurse managers experience moral distress too.
Conclusion: The causes of moral distress in developed and developing economies are similar. The frequency and intensity of moral distress is high in Northern Ghana. Consistent with other studies conducted in Africa, nurses and nurse managers relied on their religious faith as a form of resilience. No support measures are available to nurse managers to support nurses who experience moral distress.

Corresponding author:
Roger Newham, College of Medical and Dental Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT UK.
Email: r.newham@bham.ac.uk

Keywords
Africa, Ghana, moral difficulties, moral distress, nurse managers, nurses

Introduction

Moral distress is a term that has been added relatively recently to the lexicon of nursing to describe a type of distress nurses can and do experience. Originally characterised by Jameton (1984: 6) as 'when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action', the definition has since expanded to include not only constraint on action but uncertainty and dilemmas (Morley et al., 2017), highlighting the moral nature of nursing work and its sometimes-problematic relationship to organisational concerns (Fourie, 2015). Moral distress is known to affect patient care and nurses' wellbeing, and the effectiveness of the wider organisation (McCarthy and Deady, 2008). Nurses who experience moral distress avoid exposure to sick patients and so withhold care, which contributes to longer hospital stays for patients, increased complications and higher mortality rates (Lamiani et al., 2017), dilemma (Fourie, 2015), and some nurses leave the profession after experiencing prolonged moral distress (Prompahakul and Epstein, 2020). The experience and impact of moral distress on nurses in developed economies has been investigated in depth (Prompahakul and Epstein, 2020). This is not the case for developing economies (Maluwa, 2012). Although the classification 'developing economy' is somewhat contested (United Nations, 2020), Northern Ghana has been designated as a developing economy (International Monetary Code of Professional Conduct and Nursing and Midwifery Council of Ghana Fund, 2018). Further, it is not known whether nurses working in Neonatal Intensive Care Units (NICUs) and paediatric wards in Northern Ghana experience moral distress, requiring the need for this study.

Ghana is a middle-income economy in West Africa. Ghana gained independence from Great Britain 64 years ago. Nurses are a key group of healthcare professionals, playing a vital role in the healthcare delivery system in Ghana. The nature of the nursing profession in Ghana is ethical: to protect the patient from harm, to provide care that prevents complications and to maintain a healing environment for patients and families (Code of Professional Conduct and Nursing and Midwifery Council of Ghana, 2017). Because of the moral nature of their work, they encounter moral difficulties regarding patient care.

Hospitals in Ghana face challenges of inadequate material resources arising mainly from limited availability of funds to purchase equipment and daily consumables (Akortsu and Abor, 2011). Additionally, the shortage of nurses hampers achievement of the national health goals. For instance, in a typical NICU in Ghana, 2 nurses care for 15 neonates. Another challenge for nurses in Ghana is the interplay of cultural practices, beliefs of patient relatives and the need for the practice of evidence-based medicine. Parents and guardians of ill children sometimes withhold consent for recommended evidence-based hospital treatment of critically ill patients and seek discharge against medical advice for traditional home management.

Purpose

The purpose of this qualitative study was to gain an in-depth understanding of the experiences of moral distress in nurses in NICUs and paediatric wards in Northern Ghana and elucidate the support measures available to nurses by nurse managers in these wards.

Aim

The aim of this empirical study was to explore the experience of moral distress in nurses working in NICUs and paediatric wards in Northern Ghana and support measures offered by nurse managers working in NICU and paediatric wards. The focus on NICU and paediatric wards was pragmatic because of the author's experience of working in NICU and paediatric wards and evidence that nurses are likely to encounter moral distress working in such environments (Carnevale, 2013; Prentice et al., 2016).

Methodology

Design

The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines was used (Tong et al., 2007).

A qualitative descriptive method was used (Sandelowski, 2010) informed by the broad principles of phenomenology (Merriam and Tisdell, 2016). The intention was to focus on the detailed descriptive accounts of participants to explore their experiences of moral distress in depth (Sandelowski, 2010).

Sample participants

The research was undertaken in four hospitals: a tertiary hospital, a regional hospital, a district hospital and a faith-based mission hospital. These hospitals provide 24-hour services providing a range of primary to specialist care depending on the level of the facility. The faith-based mission hospital offers similar services as a district hospital. Nurses in these hospitals run three-shift systems daily and are directly managed by nurse managers in their day-to-day care of patients.

Sampling

A purposive sample of registered nurses and nurse managers with experience of working in NICU and paediatric wards was recruited (Devers and Frankel, 2000). An initial sample size of 38 participants was proposed (24 nurses and 14 nurse managers) (Kim et al., 2017); however, the sample size was guided by data saturation (Kerr et al., 2010). Data saturation was reached after we carried out 40 interviews with nurses and 14 interviews with nurse managers. All participants were full-time employees providing direct patient care. No participant withdrew from the study.

Inclusion criteria

Nurses aged 18–59 years, currently practising as a nurse for not less than 6 months, serving as a nurse or as a nurse manager within a NICU and/or paediatric wards and prepared to talk about their perceptions and experiences.

Exclusion criteria

Nurses working in wards other than NICU/paediatric wards, student nurses and nurses qualified less than 6 months, nurses on orientation and non-nursing staff of NICU/paediatric wards.

Data collection

All data were collected between November 2018 and April 2019 using semi-structured interview schedules. The individual interviews were conducted in a quiet room in the hospital or at the participant's home, audio recorded and transcribed verbatim. Each interview lasted an average of 60 minutes. The semi-structured interview was designed to explore how participants experience moral distress, identify the factors that contribute to the experience of moral distress, and examine the impact of the experience on participants and any coping mechanisms developed in response. Nurse managers were also asked about the support measures available to nurses who experience moral distress.

Data analysis

Thematic data analysis was undertaken following the six-step process developed by Clarke and Braun (2017). Data were managed using NVivo© software version 12 (QSR International Pty Ltd, 2018). All digital audio recordings were listened to several times before transcription. The first transcribed recording was reviewed by AH, RN, SN and once accuracy and formatting were established, VA continued to transcribe the interviews to immerse herself in the data as recommended by Clarke and Braun (2017). This process was to gain a contextual understanding of the accounts of participants' constructs of moral distress in Ghana.

Analysis of the transcribed interviews revealed six themes. Four themes emerged from the interviews with frontline nurses: (1) nurses experienced morally distressing situations due to a variety of causes; (2) impact of moral distress situations on nurses; (3) coping mechanisms of nurses who experienced moral distress situations; and (4) recommendations made by the nurses to reduce the incidence of moral distress. Two themes emerged from the nurse manager interviews: (1) inadequate support measures available to nurse managers to address morally distressing situations in nurses and (2) nurse managers experience moral distress too.

Results

The participants were aged between 21 and 40 years. The highest rank was a senior nursing officer. Most of the participants were of the Mole-Dagbon ethnic origin and most reported their religion as Christian followed by Muslims. Most participants had 1–5 years of work experience in NICU and paediatric wards.

Frontline nurses

Causes of morally distressing situations. Morally distressing situations were common on the wards and all participants had experienced them. The morally distressing situations were discussed among nurses on duty, and experiences were shared during patient hand over to the nurses on the next shift.

> it's often, it's often, let me say on the average I experience it three times in a week (Site 1. NICU. N. 10).

Lack of basic items led to improvising of items even though participants were aware of the risks of improvising certain items. Below is an example to illustrate the sort of morally distressing situations a participant encountered:

> We improvise a lot of times, we don't have basic items, especially tourniquets to use on the patients so, we tear the tip of the disposable glove then we use it for the neonate that is the improvised thing that we do (Site 2. NICU. N. 15).

Increased workload prevented them from adequately caring for their patients. The participants reported that lack of nurses (in terms of numbers) contributed to their experience of moral distress. A participant stated this:

> The nurse-to-patient ratio is high, 2 staff managing about 50 clients surely you would be distressed, and you may not be able to do your best in helping the patients. In nursing training, I assumed a particular perception about the nursing profession, when I came to the practical, it feels different (Site 4. Paed. N. 40).

Poverty of family members and guardians of patients was reported by participants as a major source of distress. In some cases, nurses and doctors contributed money to help. For example:

> For you to probably stay and watch a baby die slowly when you eventually have little you can do to help. . .there are instances where nurses or staff have come together to make contributions to buy medications (Site 1. NICU. N. 1).

Religious beliefs interfered with the care of patients. In the Muslim community, 'Suuna' is the naming ceremony for a new-born baby. The ceremony is carried out exactly on the seventh day after birth and requires that the baby be at home for the ceremony. A participant commented:

> . . .because the baby was not all that fine and a baby on oxygen is a very critical case so why should you allow the religion, because of naming ceremony you must discharge this baby that made me very upset (Site 2. NICU. N. 4).

Disagreement among nurses and between nurses and medical officers was felt by more than half (67.5%) of the participants to be a source of moral distress. Some participants felt that nurses should be aware of their duties and responsibilities and continuously seek the best and advocate for their patients. A participant recounted her experience:

> We don't work as a team regarding patient care, when you need colleagues to support you in advocating for patients it is difficult because some people are so reluctant to help (Site 3. Paed. N. 34).

Exposure to these morally distressing situations usually had an adverse effect on the staff. All participants acknowledged that the experience of morally distressing situations had a significant impact on them psychologically and physically.

Impact of morally distressing situations on nurses. The accounts of the participants reflected the impact of moral distress. Participants reported feelings of sadness and anger when experiencing moral distress. These emotions were also evident in their body language and facial expressions during the interviews. Participants shared this:

> It makes you feel so bad because you know this baby will not survive if it's discharged it might be a chance of 50/50. You have counselled them to stay but they still insist that they'll go, it is very sad clients have their rights you cannot force them but it's very sad (Site 2. NICU. N. 15).

> It keeps haunting us a lot (Site 1. NICU N. 6).

Several nurses reported the experience of moral distress affected them physically. Effects of stress induced by moral distress included loss of appetite, fatigue, headache and insomnia. The most common physical effects reported were headaches and loss of appetite.

> I have headaches in the night when I experience such difficulties. . .. (Site 4. Paed. N. 39).

All 40 nurse participants reported that care was neglected because of moral distress, and this affected the nurse–patient relationship on the wards. They all also felt this damaged the reputation of their hospital.

> . . .to some extent it will have an impact on the hospital because if nursing care is inadequate because of lack of staff the hospital will be labelled with a bad name and at the long run nobody will want to seek for care or want to have anything to do with the nurses and the hospital (Site 2. NICU. N. 5).

The respondents used various coping methods to ameliorate the impact of moral distress. These comprised talking to peers, and/or praying to God for strength, hope and direction.

Coping mechanisms. Participants described external support they had accessed with some seeking counsel from religious leaders and others resorting to prayer to seek strength and hope to enable them to deal with moral distress.

> it's only God who can always console us (Site 1. NICU. 7).

> Well sometimes I just give it up to God and say I hope for better things to come and then manage what I can, what I cannot do I just leave it . . . (Site 3. Paed. N. 36).

Most of the participants also reported speaking with their peers as a source of support

> . . .the only support is from colleagues because when it happens colleagues come in to talk to me, they come in to speak with us and encourage us. This gives me hope to keep on working, we talk to each other about the difficulty (Site 3. Paed. N 35).

Recommendations to reduce the incidence of morally distressing situations. During the interviews, respondents reflected on what could be done to reduce morally distressing situations. They recommended timely work planning and procurement of instruments and equipment. Participants suggested the hospital management establish a fund to pay for the treatment of under-privileged children.

> If we can ascertain that it's genuine that they can't afford [treatment costs]. Why don't we have some structures in place, those kinds of isolated cases, the hospital will take up that responsibility (Site 1. NICU. N. 1).

The need to provide basic items in NICU and paediatric wards was identified:

> I think they should make all the resources available for us to work with and that will reduce the moral distress in the nurses, because we the nurses are with the patients 24/7 and they expect a lot from us, so all the things we need to work with they should make it available (Site 1 Paed. N. 13).

Nurse managers

Inadequate support measures available to nurse managers to address morally distressing situations in nurses. All 14 nurse managers felt they did not have the skills needed to support nurses who experienced moral distress:

> Elsewhere you will have some in-service training as managers but here we don't always have it. There is no specific training for us or to equip you to address such morally disturbing situations, no we don't have such capacity (Site 4. Paed. NM. 2).

Insufficient support measures available to nurse managers. Participants stated that there were no structures, policies or practices in the hospitals to support on the wards. All 14 managers stated there were no formal structures in place to help the nurses manage morally distressing situations:

> There is no ethics committee that will help nurses go through some of these situations. There is no support group in the facility that we have, there is nothing of that sort (Site 4. Paed. NM. 14).

Nurse managers experience moral distress too. All 14 nurse managers found themselves working as nurses approximately three times in a week on the wards because of increased workload and shortage of nurses.

> Working as a nurse manager in NICU is challenging, we try to provide logistics and guide nurses to work. We also care for patients in addition to our managerial roles. The work is so demanding that one works alongside his/her managerial role. We have official things to do like documentation and writing of reports and we still must physically care for patients. For instance, this morning I am nursing 21 babies, alone (Site 1. NICU. NM. 2).

Discussion and implications

In this study, it was revealed that Ghanaian nurses experienced moral distress working in NICU and paediatric wards, even though participants were unfamiliar with the term 'moral distress'. The notion of moral distress was conceptualised in the United States by Jameton in 1984, and subsequently arguments, discussions and knowledge of the concept have significantly increased in the ethics literature in developed economies (Sanderson et al., 2019; Wilson, 2018). This has contributed to the increase in knowledge of the experience of moral distress in nurses. With the gradual increase in the number of studies carried out in developing economies it was surprising to note that nurses and nurse managers in Ghana were not familiar with the concept, even though they could have read articles on moral distress published elsewhere to enhance their knowledge of it. Over the years in Ghana, local nursing curricula have generally included little information about ethics (Donkor and Andrews, 2011). This may in part explain why some nurses are unaware of the term moral distress. This aligns with studies that reported that nurses were not familiar with the term before the actual research investigation (Nasrabadi et al., 2018; Prompahakul and Epstein, 2020).

This study highlighted the fact that the experience of moral distress was not only limited to nurses, but also nurse managers, consistent with studies by Ganz et al. (2015), Kortje (2016), Nasrabadi et al. (2018), Nikbakht et al. (2018). Nurse managers experienced moral distress in a unique fashion, they experienced moral distress first as nurses and second as managers. The two-fold experience lies in the fact that due to lack of nurses, nurse managers sometimes fall back to support their subordinates by carrying out duties on the ward. They therefore face the same issues as their subordinates. They experience at first-hand what their nurses experience daily.

This contrasts with Ganz et al's. (2015) study in which nurse managers were uninvolved with daily clinical care, because managers saw supervising nurses as their main responsibility.

The nurse manager's second experience of moral distress stems from the responsibility and role as a manager, in the provision of scarce material and human resources. However, provision of essential material resources and advocating for more nurses for the smooth running of the ward has become a challenge for nurse managers in Ghana. Many of the managers would have risen through the ranks to get to their current positions (Townsend et al., 2015). This may allow them to empathise easily and to appreciate the experience of distress in their subordinates (Kortje, 2016).

The results of this study suggest that the experience of moral distress in Ghana is like what prevails in other parts of the world (Oh and Gastmans, 2015; Prentice et al., 2016). The experience of moral distress therefore may have no geographical boundaries and nurses may experience it irrespective of the country in which they work. Nevertheless, there are some differences in the experience of moral distress in nurses that seem to resonate strongly with what has been observed in other developing economies (Prompahakul and Epstein, 2020). Resources influence the contributing factors differently. Lack of basic items, instruments and consumables seen in the healthcare delivery system in Ghana is largely due to less budgetary allocation to the health sector in general (Akortsu and Abor, 2011). Hospitals lack the funds necessary to purchase simple equipment and basic supplies for patient care (Akortsu and Abor, 2011). With lack of basic items, nurses are constrained and unable to act on their moral responsibilities and attain their professional goals. For instance, the need to check the fasting blood sugar for every child diagnosed with severe malaria remained only theoretical, because of lack of items. Lack of basic items meant that family members of patients were required to buy items out of their own pocket to care for patients. If a parent or family member cannot afford these, the nurse cannot proceed further, leading to the experience of moral distress. However, family members' inability to purchase medicines and consumables are directly attributed to widespread poverty in the Northern part of the country (Cooke et al., 2016), making it challenging for nurses to provide quality care. The findings of this study mirror what is generally seen in developing economies where the general populace has a low standard of living (United Nations, 2020). Although some similar findings have been reported regarding lack of material resources in some developed economies such as the United Kingdom, Canada and the United States (Morley et al., 2019), lack of basic instruments and care beds are more pronounced in developing economies, including Ghana.

Nurse managers in this study felt inadequately supported and empowered to support nurses. Participants' voices were not heard on issues regarding lack of basic instruments. The finding of this study support studies that have reported low organisational support among nurses in clinical care setting (Haghighinezhad et al., 2019; Robaee et al., 2018). However, this contrasts with Aitamaa et al. (2019) who found nurse managers in Finland used various mechanisms to support nurses experiencing moral distress, including specific institutional instructions and principles. Effective communication with all team members will go a long way in reducing disagreements regarding patient care that may lead to moral distress on the wards (Haghighinezhad et al., 2019). This is particularly important where nurses work with physicians who usually generate orders for nurses to carry out. It is imperative to have effective communication, including the need for physicians to listen to and empathise with nurses who carried out orders that generated moral distress of nurses (Vincent et al., 2020).

Participants in this study were impacted by their daily experience of moral distress consistent with the findings of studies in both developing and developed economies (LeBaron et al., 2014; Prentice et al., 2016). Nurses described a sense of sadness when faced with moral distress, others indicated that they felt guilty after the experience consistent with other studies

(Prompahakul and Epstein, 2020). Guilt and self-blame have been linked with moral injury, which is currently an emerging global issue linked to persistent exposure to moral distress (Papazoglou and Chopko, 2017). Čartolovni et al. (2021) in a scoping review of the literature on moral injury in healthcare professionals reported that nurses' experience of moral residue may end with moral injury over time.

Conclusion

Moral distress is a global and important concept for nursing practice although it has not been widely investigated in developing economies, particularly in Africa and especially Northern Ghana. The causes of moral distress in Northern Ghana are like those identified in the wider literature, but the profound nature of the causal factors such as lack of nurses and lack of basic instruments and consumables are greater.

Key points for policy, practice and/or research

- Moral distress is common in Northern Ghana even though nurses were not familiar with the term 'moral distress'.
- Nurses and nurse managers are impacted by the experience of morally distressing situations in Northern Ghana.
- Mitigating the impact of moral distress is critical if we are to maintain a healthy working environment.
- Interventional studies are needed to develop and test evidence-based and culturally appropriate coping mechanisms that support nurses to navigate the experience of moral distress.

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Ethical approval

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ORCID iDs

Vivian Afoko https://orcid.org/0000-0002-0578-8293

Alistair Hewison https://orcid.org/0000-0002-8508-1967

Roger Newham https://orcid.org/0000-0001-6159-244X

Supplemental material

Supplemental material for this article is available online.

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Vivian Afoko is a nurse whose professional interest is in understanding nursing ethics especially ethical and unethical care in paediatric nursing.

Alistair Hewison is lead for Clinical Leadership in the Centre for Health and Social Care Leadership at the University of Birmingham, UK and leads end-of-life care research.

Susan Neilson is a Lecturer in the School of Nursing at the University of Birmingham. She is a qualitative methodologist.

Roger Newham is a Registered Nurse (UK) and (USA) with a clinical background in HIV and in Infection Control and academic background in medical ethics.