**Relationship between Autonomy and Moral Distress in Emergency Nurses**

***Abstract***

***Background:*** *Decreased autonomy of nurses lead to limited ability to decide and intervention. Limited independence may restrict nurses' opportunity to use their own ethical reasoning and lead to moral distress. The relationship between independence and the occurrence of moral distress requires further studies.*

***Purpose:*** *To investigate the relationship between professional independence and moral distress in emergency nurses.*

***Methods:*** *This descriptive correlative study conducted on 173 emergency department nurses in Tabriz, Iran. Data were collected through a professional independence questionnaire and a moral distress questionnaire, then analyzed using SPSS 13 software with descriptive and inferential statistics.*

***Results:*** *The results showed that the level of professional independence of emergency nurses was in low level (83.20±16.90), and the moral distress was moderate (7.43±3.52). The results also indicated a significant negative relationship between professional independence and the frequency of moral distress (p=0.018). Bivariate analysis using the Pearson correlation showed the professional autonomy was significant with the frequency and the intensity of moral stress. Also three multiple regression moral showed age statistically significantly predicted frequency, intensity and overall moral distress.*

***Conclusion:*** *Lack of autonomy make it difficult for nurses to function effectively and efficiently, which leads to moral distress. Increasing the professional independence as well as, using elder nurses in emergency departments beside younger nurses reduce the exposure of nurses to moral distress.*

**1. Introduction**

Autonomy is an important element of professional identity and strength in clinical practice. Professional independence in nursing has been defined as the ability to make independent decisions based on comprehensive knowledge, clinical specialization and evidence-based practice ([1](#_ENREF_1)). Limiting the autonomy of nurses can limit their ability to make decisions which lead to moral distress ([2](#_ENREF_2)). Nurses face with many challenges that lead to work pressure, including invasive procedures, patients' conditions, resuscitation, working with incompetent personnel and polices that would be in conflict with patients' needs ([3](#_ENREF_3)).

Moral distress may perceived as a type of discomfort that affects mind, body, and interpersonal relationships in the workplace. This tension is a result of conflict between belief and action ([4](#_ENREF_4)). From Jampton's viewpoint, moral tension is a condition that when a person knows what is right to do, but is prevented from doing it and feels incapable of doing it ([5](#_ENREF_5)). Or in practical definition moral distress is a painful feeling that occurs when nurses are confronted with an action that morally is appropriate, but because of instructional polices cannot do it. Studies show that 80% of nurses experience moderate to high levels of moral distress in their working environments ([1](#_ENREF_1), [6](#_ENREF_6)). In a study by Corley 15% of the nurses left their profession because of moral tensions ([6](#_ENREF_6)).

Common causes of moral distress in nurses include: work pressure, high demands of patients and their families, unnecessary tests for patients and decision making in the last stages of life ([1](#_ENREF_1), [7](#_ENREF_7)). Moral tensions can have various adverse consequences both for nurses and patients, including loss of self-esteem, disappointment in professional life, reduced job satisfaction, burn-out, and even abandoning a nursing career ([8](#_ENREF_8), [9](#_ENREF_9)).

In this regard, Papathanassoglou et al. in 2012 showed an inverse relationship between the level of professional independence and the moral distress of nurses in intensive care wards [2]. Ando and Kawano (2016) found that the moral distress of psychiatric nurses was inversely related to their job satisfaction ([10](#_ENREF_10)). Also Jacobson et al. in a study around effects of moral emotional traits on workplace bullying in MBA students found that moral emotional traits may be useful to consider in personnel selection ([11](#_ENREF_11)). Besides above factors, other factors such as age ([3](#_ENREF_3)), work experience and etc. ([12](#_ENREF_12)) has been evaluated as effective factors on emotional distress.

There has to be a professional way of dealing with professional dilemmas ([13](#_ENREF_13)). Despite a few studies has paid on this subject in different countries and units, little is known about moral distress in nursing working in the Emergency Departments (ED).

Emergency nurses are exposed to more psychological and moral stresses due to the stressful atmosphere caused by direct exposure of patients and their relatives to staff and acute problems of the patients ([14](#_ENREF_14)). But there has been little evidences of the relationship between nurses' professional independence and moral distress in emergency nurses.

In this study, we hypothesized that professional independence has correlation with moral distress in emergency nurses. So, this study conducted to examine the relationship between professional independence and moral distress of nurses working in emergency departments.

**2. Methods**

*2.1. Participants & setting*

Astbury et al (2014) declare quantitative studies have sought to measure and analyses the causal relationship between moral distress and associated variables ([15](#_ENREF_15)). This descriptive-correlative study, was conducted in emergency departments at five educational governmental hospitals in Tabriz, Iran. Sample size was determined based on primary data of Papathanassoglou study ([2](#_ENREF_2)), based on the correlation between the professional independence and moral stress variables (-0.21), with 95% confidence, 80% power, in bilateral test using G power software version 3.0.10 obtained 178, considering 5% loss it increased to 187. A total of 187 people were selected by stratified sampling based on the percentage of emergency nurses in each hospital to the total emergency nurses of hospitals. Nine participants refused to continue the study, and five questionnaires were not totally completed and were set aside, so173 nurses were considered.

The inclusion criteria included to have Bachelor’s degree or higher qualifications in nursing and have at least one year experience in emergency room, age above 22 years. Any nurses who had changed his/her workplace were excluded.

*2.2. Measurement tools*

The demographic forms contained: age, sex, marital status, experiences in emergency room and income status.

Professional autonomy: The Professional autonomy Questionnaire developed by Shatzen Huffer (1987) ([16](#_ENREF_16)), to measure the nurses' professional independence contained 30 items which measures nurses professional independence on the four point Likert scale. Total scores range 60- 240. A range of 60- 120 indicates a low independence, 121- 180 moderate independence and above 180 indicates higher independence. Its reliability by Cronbach's alpha was 0.94.

Moral distress was measured by Moral Distress Scale- Revised (MDS-R) which was revised by Dr. Ann Hamric from Corley's original 38 item scale; the revised version has 21 items ranging from 0 to 5 Likert scale that measures the frequency and intensity of nurses' ethical tension ([17](#_ENREF_17)). The higher scores indicate increased frequency and intensity of moral distress, scores between 0- 42 indicate low frequency or intensity of moral tension, 43-84 the moderate, and 85-126 indicate the higher intensity or frequency of moral distress. The reliability of MDS-R by Cronbach's alpha was 0.88 ([14](#_ENREF_14)). In present study the internal consistency was 0.81.

The validity of questionnaires confirmed by ten expert academic members.

*2.3. Ethical considerations*

Prior to data collection, the study was explained and informed consent obtained from all participants following research consult and ethics committee of Tabriz Medical Science approval (code: 1036514, Date: 2017.1.31). The participation was optional and no identifying information was collected

*2.4. Data collection and Analysis*

From April 2017 to June 2017 the questionnaires were distributed among emergency nurses in different shifts and to be asked to fill in via self-report. Data analysis was performed using SPSS software. Demographic data, professional autonomy and moral distress were analyzed by descriptive statistics (frequency, percentage, mean and standard deviation). \*After evaluating and confirming the normality of variables, the correlation of professional autonomy and moral distress with demographic characters was analyzed by t test, ANOVA and Pearson correlation. The liner multivariate regression model was used for prediction of contextual factors effects.

**3. Results**

A total of 173 out of 187 distributed questionnaires were completed. Results are presentedas following in different subscales:

*3.1. Demographic information of subjects*

The number of male nurses in this study slightly exceeded the female nurses (52.6% and 47% respectively). Most of subjects were under 30 years of age, married, with an experience of 1 to 5 years in ED. The income status of nurses indicated that most of them considered their spending more than income (Table1).

*3.2. Professional autonomy*

The mean scores of professional autonomy of emergency nurses showed that it was 79.68 to 95.83, which indicates the low level of autonomy.

The professional autonomy based on demographic characters are shown in table 1. Data analysis using independent t test and ANOVA showed that there was not significant differences between autonomy scores based on demographic characters (Table 1).3.3. *Moral distress*

The frequency and intensity of the moral distress of emergency nurses showed those were in moderate level (Table1).

Also table 1 shows the moral distress of participants based on demographic characters. Data analysis using independent t test and ANOVA showed that there was significant differences between frequency and intensity of moral distress scores based on age and work experience.

*3.4. Professional autonomy and moral distress*

Bivariate analysis using the Pearson correlation coefficient between professional autonomy and moral distress are shown in Table 2. The professional autonomy was significant with the frequency and intensity of moral stress.

Three multiple regression was run to predict moral distress scores (frequency and intensity) from gender, age, work experience in emergency department and autonomy scores.

In first model for predict frequency of moral distress from above independent variables, autonomy and age statistically significantly predicted frequency of moral distress, F (4,168) = 13.525, P<.001, R2 = .244. The proportion of variance in the frequency of moral distress that can be explained by these two predictors is 24.4 percent. Unstandardized coefficients in table 3 for autonomy is -.226. This means that for each one score increase in autonomy score, there is a decrease in frequency of moral distress of .226 score when all other independent variables are held constant.

In second model for predict intensity of moral distress from above independent variables, age statistically significantly predicted intensity of moral distress, F (4,168) = 4.062, p =.004, R2=.08. The proportion of variance in the intensity of moral distress that can be explained by age of nurses is 8 percent. Unstandardized coefficients in table 4 for autonomy is equal -.112. This means that for each one score increase in autonomy scores, there is a decrease in intensity of moral distress of .112 score when all other independent variables are held constant.

In third model for predict overall moral distress from above independent variables, age and autonomy statistically significantly predicted overall moral distress scores, F (4,168) = 8.911, P<.001, R2 = .175. The proportion of variance in the overall moral distress scores that can be explained by these two predictors is equal 17.5 percent. Unstandardized coefficients in table 5 for autonomy is equal -.333. This means that for each one score increase in autonomy score, there is a decrease in overall moral distress scores of .333 score when all other independent variables are held constant. Therefore based on study hypothesis, professional autonomy of nurses had a significant negative correlation with moral distress.

**4. Discussion**

The findings of this study provide a primary view of emergency nurses' autonomy and their moral distress: the mean of professional autonomy scores were at a low level,

The findings of present study in accord with low autonomy was in line with sarkoohi ([19](#_ENREF_19)). All the nurses included in our study worked in emergency departments. But studies that reported on nurses working in intensive care settings and clinical nurses have documented a higher level of autonomy ([2](#_ENREF_2), [10](#_ENREF_10), [20-22](#_ENREF_20)).

The limited autonomy of nurses restricts their ability to reason, decide and act, in situations where quick and critical decision is needed. When hospitals have no specific policy for addressing incidents of moral tension and conflict, it becomes more difficult for a nurse to make her own decision, which increases her distress. According to the Mirsaidi et al., the low level of professional independence among nurses in Iran is routine and is related to obedience to doctors ([23](#_ENREF_23)). The three most important factors that were reported to decrease nurses’ autonomy were autocratic management, doctors and workload ([24](#_ENREF_24)).

Regarding the intensity and frequency of emotional distress among nurses in ED results indicated that these were in moderate level. These results are in line with the results of many studies ([25](#_ENREF_25)), [[14](#_ENREF_14)], ([3](#_ENREF_3)) on the moral distress in nurses. Alternatively, the results of Papathanassoglou et al. (2012) have shown a low level of moral distress in intensive care nurses ([2](#_ENREF_2)). This discrepancy in various researches can be attributed to different environments and working conditions or unequal situations.

It can be consider that nurses face with worries about professional errors. The more tension factors in an organizational environment, the higher tensions perceived by its members and, consequently more moral tensions.

Among demographic characters, nurses’ age showed a negative and significant correlation with frequency and intensity of moral distress. In this regard, some studies also have shown age and work experience ([4](#_ENREF_4)) had negative relation with moral distress.

Nurses in front of moral distress use their own bio-psycho capacities and capabilities to deal. When nurses experience undue stress, they are more likely to quit the job; some may even be pushed into giving up nursing altogether ([26](#_ENREF_26)).

Nurses will experience moral stress when they want to make ethical decisions about a specific topics. But organizational barriers, such as the lack of adequate time, lack of supportive authority, physician authority, policies and organizational rules, make it difficult for them to do the right thing which causes moral distress in nurses. Emergency nurses are exposed to more psychological and moral stresses due to the stressful atmosphere caused by direct exposure of patients and their relatives to staff and acute problems of the patients. In this regard, the feeling of psychological insecurity in the emergency nurses is higher.

With respect to results, there was a significant negative correlation between professional authorities with frequency of moral distress. In other words, the greater the professional independence of nurses, the less they face with moral tension in emergency nurses. These results are accord with those of Karanikola et al. study on intensive care nurses ([21](#_ENREF_21)). Also, Ameri et al. (2013) showed that professional independence of oncology nurses is one of the most important factors that prevents nurses' moral distress ([27](#_ENREF_27)) . But Sarkoohi et al. in a study on pediatric intensive units found a positive correlation between nurses’ professional autonomy and moral distress. She showed that increased professional autonomy without adequate support from physicians and relevant authorities, could have been responsible for the positive relation between professional autonomy and moral distress. In other words, increasing professional autonomy leads to experience more conflicts and thus higher moral distress ([19](#_ENREF_19)).

In this regard, studies have shown when nurses faced unnecessary care, and became the presenter of the doctor's orders, their professional independence is distorted, so that the weakness of nurses' authority may be leads to moral disturbances ([21](#_ENREF_21), [23](#_ENREF_23)).

**5. Limitations**

This study was conducted with Iranian emergency nurses in university hospitals. The level of nurses’ authority and moral distress may differ in other departments and other hospitals. Also This study included all parts of triage, resuscitation, outpatient care. Studying each of those parts separately could provide more details.

**6. Conclusion**

The results revealed that nurses experienced more emotional distress when their professional autonomy was compromised in ED.. In the other word, when nurses’ are allowed greater independence and are allowed to make choices themselves, the frequency and intensity of emotional distress would be reduced. So, it is recommended to increase the support and interpersonal cooperation by managers as well as using older experienced nurses beside the younger nurses to decrease their moral distress in emergency departments.

**Conflict of interest**

The authors declare that there is no possible conflict of interests and we have no financial interests related to the material in the manuscript.

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**Table1. Relationship of characteristics with autonomy and moral distress**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Moral distress\*** | | | | **p** | **Autonomy\*** | **n (%)** | **Characters** | |
| **p** | **intensity** | **p** | **frequency** |
| <0.001α | 52.17 (15.65) | 0.001 | 55.67(16.19)  45.77 (11.80) | 0.18 | 79.68 (19.15)  85.82 (14.55) | 74(42.8)  99(58.2) | ≤ 30  > 30 | Age (yrs.) |
| 0.407α | 47.80 (14.08) | 0.435 | 47.49 (14.01) | 0.134 | 85.06 (13.72) | 91(52.6) | Male | Sex |
| 48.09 (14.88) | 49.32 (16.80) | 81.13 (19.71) | 82(47.4) | Female |
| 0.129α | 48.51 (16.58) | 0.136 | 50.43 (15.70) | 0.626 | 82.45 (15.93) | 72(41.6) | Single | Marital status |
|  | 47.53 (12.73) | 46.89 (15.05) |  | 83.73 (17.61) | 101(58.4) | Married |
| 0.062β | 51.12 (15.96) | 0.001 | 54.31 (16.66) | 0.222 | 81.64 (18.02) | 107(61.8) | 1-5 | Work experience in ED (yrs.) |
| 46.87 (9.61) | 44.80 (10.42) |  | 84.27 (14.20) | 40(23.1) | 6-10 |
| 46.35 (12.33) | 41.65 (12.23) |  | 88.50 (11.01) | 12(6.9) | 11-15 |
| 43.27 (18.15) | 43.50 (16.82) |  | 81.25 (21.02) | 8(4.6) | 16-20 |
| 40.72 (13.48) | 42.09 (13.61) |  | 95.83 (12.20) | 6(3.5) | ≥ 20 |
| 0.184β | 45.71 (14.08) | 0.630 | 46.87 (12.28) | 0.196 | 80.80 (13.03) | 63(36.4) | Equal cost | Income status |
| 48.44 (13.92) | 49.19 (17.20) |  | 83.55 (20.63) | 84(48.6) | Spend more |
| 51.73 (16.36) | 46.30 (16.19) |  | 87.84 (9.58) | 26(15) | Income more |

\*Data presented as mean and standard deviation

\*\*Emergency Department

α independent t test, β: ANOVA test

**Table2.** Pearson Correlation significance between study variables (n=173)

|  |  |  |  |
| --- | --- | --- | --- |
| Variables | Frequency | Intensity | Autonomy |
| Frequency | 1 | .811\*\*(P<.001) | -.328\*\*(P<.001) |
| Intensity |  | 1 | -.180\* (p=.018) |
| Total moral distress |  |  | -. 269\*\* (P<.001) |
| Autonomy |  |  | 1 |

\*Correlation is significant at the 0.05 level, \*\*Correlation is significant at the 0.01 level.

Table 3: Predictors of the frequency of moral distress

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Predictors | Unstandardized Coefficients | | Standardized Coefficients | P | 95% CI\*\* for B | |
| B | Std. Error | Beta | Lower Bound | Upper Bound |
| Autonomy | -.226 | .063 | -.248 | <.001 | -.350 | -.102 |
| Age | -11.421 | 2.357 | -.368 | <.001 | -16.075 | -6.767 |
| Gender | 2.520 | 2.117 | .082 | .236 | -1.660 | 6.699 |
| Work experience in ED\* | -.380 | 1.110 | -.026 | .733 | -2.571 | 1.811 |

\*Emergency Department

\*\* Confidence Interval

Table 4: Predictors of the intensity of moral distress

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Predictors | Unstandardized Coefficients | | Standardized Coefficients | P | 95% CI\*\* for B | |
| B | Std. Error | Beta | Lower Bound | Upper Bound |
| Autonomy | -.112 | .065 | -.131 | .086 | -.240 | .016 |
| Age | -5.937 | 2.427 | -.204 | .015 | -10.728 | -1.145 |
| Gender | .599 | 2.180 | .021 | .784 | -3.705 | 4.902 |
| Work experience in ED\* | -.988 | 1.143 | -.071 | .388 | -3.245 | 1.268 |

\*Emergency Department

\*\* Confidence Interval

Table 5: Predictors of the overall moral distress scores

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Predictors | Unstandardized Coefficients | | Standardized Coefficients | t | P | 95% CI\*\* for B | |
| B | Std. Error | Beta | Lower Bound | Upper Bound |
| Autonomy | -.333 | .121 | -.199 | -2.746 | .007 | -.573 | -.094 |
| Age | -17.499 | 4.330 | -.306 | -4.042 | <.001 | -26.046 | -8.951 |
| Gender | 3.270 | 4.056 | .058 | .806 | .421 | -4.738 | 11.279 |
| Work experience in ED\* | -3.670 | 4.476 | -.061 | -.820 | .413 | -12.507 | 5.167 |

\*Emergency Department

\*\* Confidence Interval