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

***Abstract***

***Background:*** *Reducing the 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 room nurses was in low level (83.20±16.90), and the level of moral distress of subjects was moderate (7.43±3.52). The results also indicated a significant negative relationship between professional independence and the severity (p<o.oo1) and frequency of moral distress (p=0.018) in emergency nurses.*

***Conclusion:*** *Lack of autonomy and decision-making power make it difficult for nurses to function effectively and efficiently, which leads to moral distress. Increasing the professional independence of emergency room nurses can reduce 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)]. Studies show that 80% of nurses experience moderate to high levels of moral stress in their working environments [[1](#_ENREF_1), [6](#_ENREF_6)]. In a study by Corley 15% of the nurses left the profession because of moral tension [[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 stress of nurses in intensive care wards [2]. Ando and Kawano in 2016 found that the moral stress 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)]. Nevertheless, 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*

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 each hospital's emergency nurses. Nine participants refused to continue the study, so 178 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 nurse who had changed his/her workplace was 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) [[12](#_ENREF_12)], 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 4 Likert scale that measure the frequency and severity of nurses' ethical tension. To obtain an overall moral distress score the frequency is multiplied by the intensity score, which providing overall distress score 0 to 16, that higher score indicates increased frequency and intensity of moral distress, a score of 0-5 indicates low frequency or intensity of moral tension, 6-10 the moderate, and 11-16 means the high intensity or frequency of moral distress. The reliability of MDS-R by Cronbach's alpha was 0.88 overall [[13](#_ENREF_13)]. In this study the internal consistency was 0.81.

The validity of questioners was 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 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). The correlation of professional autonomy and moral distress was analyzed by inferential statistics (Pearson correlation).

**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 professional autonomy scores showed the low independence of nurses. Also the mean scores of professional autonomy of emergency nurses based on gender are shown in table2. The results show that male nurses' professional independence scores were higher than those of female nurses.

3.3. *Moral distress*

The frequency and intensity of the moral distress of emergency nurses by gender are shown in table3. The mean scores of severity, frequency and total moral distress indicate that all the subjects have a moderate moral distress. The mean score of female nurses was higher in the intensity and frequency of moral distress.

*3.4. Professional autonomy and moral distress*

The relationship between professional autonomy and moral distress using the Pearson correlation coefficient are shown in Table 4. The professional autonomy was significant with the frequency of moral distress and the intensity of moral stress. Also it was significant with a total score of moral distress. 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, though male nurses reported a greater degree of autonomy than did their female peers. In this regard, Mirsaidi et al. in a study on clinical decision making in Iranian nurses indicated that men have been preceded in participation in clinical decision making than women [[14](#_ENREF_14)].

The findings of present study are in accord with those of Sarkoohi [[15](#_ENREF_15)]. 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 moral autonomy. [[2](#_ENREF_2), [10](#_ENREF_10), [16-18](#_ENREF_16)]

The limited autonomy of nurses restricts their ability to reason, decide and act, in situations where quick and critical decisions are often necessary. When hospitals have no specific policy for addressing incidents of moral tension and conflict, it becomes more difficult a nurse to make her own decision and 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 [[19](#_ENREF_19)]. The three most important factors that were reported to decrease nurses’ autonomy were autocratic management, doctors and workload [[20](#_ENREF_20)].

Regarding the severity and frequency of emotional distress among nurses in emergency room, the statistical analysis indicated that the severity and frequency of emotional stress were in moderate level. Also, the results showed that female nurses were more likely to have a higher moral tension compared to male nurses. These results are in line with the results of many studies [[21](#_ENREF_21)], [[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 stress 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 are faced 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.

Nurses in front of moral stress 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 [[22](#_ENREF_22)].

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 authority with intensity and frequency of moral stress. 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 [[17](#_ENREF_17)]. Also, Ameri et al. (2013) showed that professional independence of oncology nurses is one of the most important factors that prevents nurses' moral distress [[23](#_ENREF_23)] . 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 [[15](#_ENREF_15)].

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 leads to moral disturbances [[17](#_ENREF_17), [19](#_ENREF_19)].

**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**

We found that when nurses’ professional autonomy was compromised, they experienced more emotional distress. One can expect from this finding that when nurses’ are allowed greater independence and are allowed to make choices themselves, their emotional distress will be reduced. The male nurses in our study were able to maintain greater professional independence than female counterparts. That might suggest that it is more reasonable to employ more male nurses for Iranian 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.

**Acknowledgment**

This article is results of the master's thesis in nursing which has sponsored by the Tabriz University of Medical Sciences. We acknowledge all the nurses participated in this study. Also we appreciate and deeply thank Mrs. Nancy Mehler for participation in English edition.

**References**

[1. Varjus, S.-L., T. Suominen, and H. Leino-Kilpi, *Autonomy among intensive care nurses in Finland.* Intensive and Critical Care Nursing, 2003. **19**(1): p. 31-40.

2. Papathanassoglou, E.D., et al., *Professional autonomy, collaboration with physicians, and moral distress among European intensive care nurses.* American Journal of Critical Care, 2012. **21**(2): p. e41-e52.

3. Borhani, F., et al., *Moral sensitivity and moral distress in Iranian critical care nurses.* Nursing ethics, 2017. **24**(4): p. 474-482.

4. Borhani, F., S. Mohammadi, and M. Roshanzadeh, *Moral distress and its relationship with professional stress in nurses.* Iranian Journal of Medical Ethics and History of Medicine, 2014. **6**(6): p. 10-19.

5. Jameton, A., *Dilemmas of moral distress: moral responsibility and nursing practice.* AWHONN's clinical issues in perinatal and women's health nursing, 1992. **4**(4): p. 542-551.

6. Corley, M.C., *Nurse moral distress: a proposed theory and research agenda.* Nursing ethics, 2002. **9**(6): p. 636-650.

7. Corley, M.C., et al., *Development and evaluation of a moral distress scale.* Journal of advanced nursing, 2001. **33**(2): p. 250-256.

8. Hart, T.J., *Moral distress in a non-acute continuing care setting: The experience of Registered Nurses.* 2009.

9. Bell, J. and J.M. Breslin, *Healthcare provider moral distress as a leadership challenge.* JONA'S healthcare law, ethics and regulation, 2008. **10**(4): p. 94-97.

10. Ando, M, Kawano M., *Association between moral distress and job satisfaction of Japanese psychiatric nurses.* Asian/Pacific Island Nursing Journal, 2016. **1**(2): p. 55-60.

11. Jacobson, R.P., Hood J.N, and Jacobson K. J. *The Effects of Moral Emotional Traits on Workplace Bullying Perpetration.* Ethics & Behavior, 2017. **27**(7): p. 527-546.

12. Schutzenhofer, K.K., *The measurement of professional autonomy.* Journal of Professional Nursing, 1987. **3**(5): p. 278-283.

13. Fernandez-Parsons, R., L. Rodriguez, and D. Goyal, *Moral distress in emergency nurses.* Journal of Emergency Nursing, 2013. **39**(6): p. 547-552.

14. Mirsaidi, G., Lakdizaji S, and Ghojazadeh M. *Individual-social effective factors on clinical decision making in nurses.* Asian J. Med. Pharm. Res, 2012. **2**(2): p. 38.

15. Sarkoohijabalbarezi, Z., Ghodousi A, and E. Davaridolatabadi, *The relationship between professional autonomy and moral distress among nurses working in children's units and pediatric intensive care wards.* International Journal of Nursing Sciences, 2017. **4**(2): p. 117-121.

16. Amini, K., et al., *Nurses’ autonomy level in teaching hospitals and its relationship with the underlying factors.* International journal of nursing practice, 2015. **21**(1): p. 52-59.

17. Karanikola, M.N., et al., *Moral distress, autonomy and nurse–physician collaboration among intensive care unit nurses in Italy.* Journal of nursing management, 2014. **22**(4): p. 472-484.

18. Lee, H.K. and Yang H.J. *Influence of Professional Self-Concept and Professional Autonomy on Nursing Performance of Clinic Nurses.* International Journal of Bio-Science and Bio-Technology, 2015. **7**(5): p. 297-310.

19. Mirsaidi, G., Lakdizaji S, and Ghojazadeh M. *How nurses participate in clinical decision‑making process.* J App Environ Biol Sci, 2012. **2**: p. 620-4.

20. Mrayyan, M.T., *Nurses’ autonomy: influence of nurse managers’ actions.* Journal of advanced nursing, 2004. **45**(3): p. 326-336.

21. Azizi, A., Sepahvani M.A, and J. Mohamadi, *Relationship between Moral Distress and Mental Health among Female Nurses.* Iran Journal of Nursing, 2015. **27**(92): p. 57-64.

22. Abou Hashish, E.A., *Relationship between ethical work climate and nurses’ perception of organizational support, commitment, job satisfaction and turnover intent.* Nursing ethics, 2017. **24**(2): p. 151-166.

23. Ameri, M., Safavibayat Z, and A. Kavousi, *Evaluation of clinical situations leading to moral distress in nurses working in oncology wards of Tehran-based educational hospitals in 2012.* Modern Care Journal (Scientific Quarterly of Birjand Nursing & Midwifery Faculty), 2014. **11**(2): p. 153-160.

**Table1. Demographic characters of participants (n= 173)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Percent (%)** | **Frequency** | | **Characters** | |
| 42.8  49.1  8.1 | 74  85  14 | ≤ 30  31-45  ≥ 45 | | Age (yrs.) |
| 52.6  47.4 | 91  82 | male  female | | Sex |
| 41.6  58.4 | 72  101 | Single  married | | Marital status |
| 61.8  23.1  6.9  4.6  3.5 | 107  40  12  8  6 | 1-5  6-10  11-15  16-20  ≥ 20 | | Work experience in emergency room (yrs.) |
| 36.4  48.6  15 | 63  84  26 | Equal cost  Spend more  Income more | | Income status |

**Table 2. Distribution of professional autonomy mean scores based sex (n= 173)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **sex** | **N** | **Mean** | **Median** | **Std. Deviation** | **Minimum** | **Maximum** |
| **Professional autonomy** | Male | 91 | 85.07 | 85 | 13.73 | 52 | 106 |
| Female | 82 | 81.13 | 86.50 | 19.72 | 41 | 103 |
| Total | 173 | 83.20 | 86 | 16.90 | 41 | 106 |

**Table 3. Distribution of moral distress mean scores based sex (n=173)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **maximum** | **minimum** | **SD** | **median** | **mean** | **n** | **sex** | **variables** | |
| 4.19 | 0.81 | 0.66 | 2.28 | 2.26 | 91 | male | Intensity | Moral distress |
| 4.05 | 0.90 | 0.80 | 2.23 | 2.34 | 82 | female |
| 19.90 | 0.57 | 0.73 | 7.61 | 2.34 | 173 | total |
| 7.37 | 0.50 | 1.17 | 4.16 | 3.98 | 91 | male | Frequency |
| 7.33 | 1.50 | 1.24 | 3.87 | 4.00 | 82 | female |
| 7.33 | 0.50 | 1.20 | 4.00 | 3.99 | 173 | total |
| 19.90 | 0.57 | 3.41 | 8.00 | 7.35 | 91 | male | Total |
| 18.69 | 1.19 | 3.70 | 7.33 | 7.63 | 82 | female |
| 8.24 | 1.81 | 3.52 | 4.58 | 7.43 | 173 | total |

**Table4.** Pearson Correlation significance between study variables (n=173)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Variables** | | **autonomy** | **intensity** | **Frequency** | **total** |
| Autonomy | Pearson Correlation | 1 | -.33\*\* | -.18\* | -0.27\*\* |
| Sig. (2-tailed) |  | .0001 | .018 | .0001 |
| Intensity  Moral distress | Pearson Correlation | -.33\*\* | 1 | .81\*\* | .95\*\* |
| Sig. (2-tailed) | .0001 |  | .0001 | .0001 |
| Frequency  Moral distress | Pearson Correlation | -.18\* | .811\*\* | 1 | .95\*\* |
| Sig. (2-tailed) | .018 | .0001 |  | .0001 |
| Total | Pearson Correlation | -0.27\*\* | .95\*\* | .95\*\* | 1 |
|  | Sig. (2-tailed) | .0001 | .0001 | .0001 |  |

\*\*. Correlation is significant at the 0.01 level (2-tailed).

\*. Correlation is significant at the 0.05 level (2-tailed).