

Prevalence of Moral Distress in Medical Officers at National Cancer Institute Sri Lanka

Amjed DMMLA, Perera KYD, Amadoru SDS, Kandamby HGIT, Chaminda JLP

Ministry of Health, Sri Lanka

Amjedduwegoda@gmail.com

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Abstract- Moral distress occurs when the doctor's perception of ethically suitable action cannot be implemented due to situational constraints at health care settings (Ferrell, 2006). Moral distress can also be defined as emotional stress of the health care worker due to ethically conflicting situations (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004). The study was conducted in the National Cancer Institute Maharagama (NCIM), in Sri Lanka. The NCIM is the premium centre for cancer care in Sri Lanka. The grade medical officers working at NCIM were included in the study as the grade medical officers play a key role in treating cancer patients. The purpose of the study was to assess the prevalence of moral distress. A descriptive cross sectional study was conducted among all grade medical officers working in clinical areas of the NCIM. A structured self-administered questionnaire was used to collect data. A total of 160 grade medical officers were included in the study and 132 questionnaires were returned after completion of the questionnaire. The response rate was 82.5%. The prevalence of moral distress among the study population was 91.2% while 3.8% had severe moral distress and 9.8% had no moral distress. The majority of the grade medical officers had very mild moral distress (48.5%). Mild moral distress was seen among 33.3% of the grade medical officers and 4.5% of the grade medical officers had moderate moral distress. The study revealed a prevalence of 91.2% moral distress among grade medical officers at NCIM. However the majority of the grade medical officers had only very mild moral distress.

Index Terms- Moral distress, moral distress scale, factors contributing to moral distress.

Introduction

Providing health care is filled with value conflicts. Legal regulations and scarce resources may contribute to difficult ethical dilemmas and cause moral distress to health care providers. Moral distress is defined as emotional stress of the health care worker due to ethically conflicting situations (Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004). Good quality health care cannot be provided only with scientific and technical proficiency. But also it includes professional's ability and attitude towards value conflicts. The traditional work environment of doctors such as increased work load, lack of time and increased work related stress can limit the doctors to work according to ethical and professional ideals (Hospital & Psychology, 1997). The term moral distress was initially explained in nurses in 1980s by the researcher Andrew Jameton. He used the term moral distress as a feeling of nurses which resulting from a situation where the nurse knowing of right thing to do and the constraints makes it impossible to carry out the desired action (Jameton, 1984). Later the same researcher identified moral distress in other health care professionals such as doctors (Jameton, 1993).

Studies have been conducted in many countries about moral distress in last three decades. Most of the studies were limited to nurses as it was initially described in nurses and nurses were leading a middle care role in health services (Corley, Elswick, Gorman, & Clor, 2001). Later it has been identified that doctors also suffer with the same situations specially doctors in middle management level with the rise of patient rights and improvements in technology and knowledge in medical field (Jameton, 1993).

A study on moral distress of doctors was conducted among Norwegian doctors revealed 51% of doctors experiencing moral distress (Førde & Aasland, 2007). Moral distress of doctors in university hospitals in Iran was conducted in 2014 and identified moral distress among doctors in moderate amount (Abbasi et al., 2014).

Cancer is the second leading cause of death in Sri Lanka according to Annual health bulleting of Sri Lanka 2015. National Cancer Institute, Sri Lanka, is the premium Institute for cancer care in Sri Lanka. It consists of eight hundred beds and on average one

thousand out patients are treated daily. The moral distress of the health care workers is a researchable area in health care management. Medical Officers are one of the main components of health care providers in Sri Lanka.

Aim of the study

The aim of the study was to determine the prevalence of moral distress among the medical officers dealing with cancer patients at National Cancer Institute Sri Lanka.

Methods

A descriptive cross sectional study was conducted among the population of doctors working directly with cancer patients at National Cancer Institute Sri Lanka. The whole population of doctors working in the Institute was included to the study. Doctors working in Blood bank, Pathology, Haematology and all the consultants were excluded from the study.

The study instrument was a structured self-administered questionnaire. The questionnaire was developed by adopting the moral distress scale for physicians (Hamric, Borchers, & Epstein, 2012). A total of 21 items were categorized lik-ert scale from zero (never) to 4 (very frequent) for the frequency and zero (none) to 4 (great extend) for the disturbance of moral distress. Item number 1 and 16 were modified to the local setting with by experts in the field using modified Delphi technique. The data obtained for each item was computed to a composite score by multiplying frequency score by the disturbance score and for each item in the scale the score ranged from 0 to 16. The total composite score (for the 21 items in the scale) ranged from 0 to 336 by aggregating all 21 items. The cut off points for the moral distress levels from the composite score was determined by experts since there was no literature on cut off points for the moral distress levels in the scale. The experts included three consultant psychiatrists who were requested to suggest cut-off points for moral distress scale and after discussing with all 3 experts final decision was arrived to divide the score in the following manner.

Table: 3.1 Composite score for different levels of moral distress

MORAL DISTRESS COMPOSITE SCORE	MORAL DISTRESS LEVEL
0-42	No moral distress
43-84	Very mild moral distress
85-168	Mild moral distress
169-252	Moderate moral distress
253-336	Severe moral distress

The principal investigator collected data by visiting National Cancer Institute, Maharagama. The contact person for all the activities related to the conduct of the study was the principle investigator. The contact details and the phone numbers of the principle investigator were given in the information sheet.

Since all the grade medical officers were fluent in English the questionnaires, consent forms and the information sheets were prepared in English language.

Participants of the study were informed of the nature and the purpose of the study by providing the information sheet. All the participants were given a consent form prior to distribution of the questionnaire. Consent was obtained by an informed written consent form. The participants were informed of the option to withdraw from the study at any given point of the study. The questionnaires were distributed among the subjects following the collection of filled and signed voluntary informed written consent form by the principle investigator.

The respondents were given 10 days to fill and hand over the questionnaires to the principle investigator and allowed to contact the principle investigator for any clarifications. An identical envelop was given to all the respondents along with the questionnaire to place the questionnaire and seal it with glue after completing to ensure the anonymity. The respondents were asked not to write names and any identification letters or numbers on the given envelop.

Principle investigator collected the questionnaires by physically meeting the respondents after ten days of distributing. The respondents delayed to submit the questionnaires were given two reminders in two weeks apart and the respondents who failed to submit were considered as non-respondents.

All the collected questionnaires were kept under lock and key by the principle investigator and only the principal investigator and the supervisor had access to the filled questionnaire sheets.

A total of 160 medical officers were included in the study and out of them four medical officers refused to take part in the study. Questionnaires were distributed among 156 grade medical officers and 132 questionnaires were returned and 24 respondents failed to return the filled questionnaire after two reminders sent two weeks apart.

Each question of the questionnaire was pre-coded. The questionnaires were corroborated prior to data entry for completeness. The data entering and analysing was carried out using the computerized statistical software SPSS version 20.0. The results were described

according to the study objective. Approval to conduct the study at National Cancer Institute Maharagama, was obtained from the Director Cancer Institute. Consent was taken from Prof Anne B Hamric to use the moral distress scale after adaptation to local setting.

RESULTS

The study included 132 (n=132) participants and the response rate was 82.5%. The prevalence of moral distress was 91.2%. The mean moral distress score value was 91.79 with a standard deviation of 58.80. The minimum MDS score was 17 while the maximum was 316 while the highest item scored in the MDS was “Witness diminished patient care due to poor team communication” and the lowest item scored in MDS was for “Let medical students perform painful procedures on patients solely to increase their skills”. Severity of moral distress was analysed by defining four categories. The majority of the study population (58.3%) was classified as having very mild moral distress whereas severe moral distress was seen among 3.8%.

Table 4.7: Distribution of moral distress according to severity

Severity of moral distress	Frequency	Percentage (%)
No moral distress (0-42)	13	9.8
Very mild moral distress (43-84)	64	48.5
Mild moral distress (85-168)	44	33.3
Moderate moral distress (169-252)	6	4.5
Severe moral distress (253-336)	5	3.8
Total	132	100.0

DISCUSSION

The study of moral distress amongst health care workers has been limited to western countries and initial studies with regard to moral distress were conducted amongst nurses. However with time it has been seen that moral distress is not limited to nurses but encompasses all other health care professionals including doctors (Jameton, 1993). International studies on moral distress have been conducted for the past three decades whereas in Sri Lanka no studies have been conducted with regard to moral distress among health care professionals. According to a study conducted by Jameton in 1993 it was revealed that middle level health care workers including doctors suffer with moral distress (Jameton, 1993).

A prominent qualitative study conducted amongst Norwegian doctors in 2008 including all the categories of doctors working in the health care system in Norway revealed occurrence of moral distress amongst doctors (Førde& Aasland, 2008). However this was a qualitative study and there was no scale used to measure the level of moral distress. Another study conducted in Iran used a scale to measure the moral distress but was limited to university doctors(Abbasi et al., 2014).

This study used a validated scale to measure the moral distress of grade medical officers and the contributing factors were determined by a questionnaire. This study was limited to grade medical officers and the study setting was limited to one large institution where the doctors are more prone to moral distress. Since the middle level health care workers are more susceptible to moral distress study included all the grade medical officers involved in clinical care whereas the other studies were conducted amongst all the categories doctors.

The prevalence of moral distress of grade medical officers at National Cancer Institute Maharagama, was 92.5% which varied from no or very mild moral distress to severe moral distress. However most of the participants had only very mild moral distress which is a negligible amount of moral distress compared to mild, moderate and severe moral distress. Severe moral distress was found among 3.8% of the participants while 33.3% had mild and 4.5% had moderate moral distress.

The item with the highest moral distress score was “witness diminished patient care quality due to poor team communication” and the item with the lowest moral distress score was “let medical students perform painful procedures on patients solely to increase their skill”.

A study conducted among Iranian university doctors revealed the highest scoring item for moral distress was ‘diminished patient care due to poor team communication’ (Abbasi et al., 2014). The same finding was obtained in the study conducted among grade medical officers working in the NCIM as well. Sri Lankan doctors also reported that the biggest cause for moral distress was due to poor team communication. However, a study conducted among Norwegian doctors revealed that most of the doctors were morally distressed due

to long waiting times (Førde & Aasland, 2008). The working environment and the culture of the patients in different countries would have contributed to these different findings.

The situation which cause least moral distress among Iranian university doctors was “increasing the dose of sedatives which would hasten the death of the patient”(Abbasi et al., 2014). However the Sri Lankan Cancer Institute grade medical officers had the lowest score as a cause leading to moral distress for “medical students performing painful procedures”. This may be due to the fact that the university attached doctors are more exposed to medical students and teaching, and therefore the score for the medical students performing painful procedures wasn’t the lowest in Iranian university doctors whereas in cancer care medical students have very minimal role and the low frequency of the situations would have contributed to the difference.

The study conducted among Iranian university doctors did not identify the prevalence or the extent of moral distress but it described the frequency and disturbance of the situations causing moral distress (Abbasi et al., 2014). The study conducted among the Norwegian doctors revealed the percentages of morally distressing situation by a qualitative study and was unable to describe the extent of the problem (Førde & Aasland, 2008). Identifying the prevalence and the severity of the moral distress among the study population was achieved in this study will help to compare and carry out further studies to identify the problem among other health care professionals in different populations.

Limitations

The unavoidable limitations should be taken in to consideration while making inferences from the study findings.

The underreporting of moral distressing situations, due to the nature of information could have taken place. The sensitive nature of information can incriminate the respondents to underreport.

The data was collected retrospectively and the recall bias would have been inevitable.

As the study was conducted only for grade medical officers and from a specific institute, the results of the study cannot be generalized to the population of medical officers.

In the validation of the questionnaire, only face, content and consensual validity could be assessed due to time constraints.

A major limitation of the study was inadequate literature on moral distress of doctors as it is identified in recent past and most of the researches were on nurses.

There was no literature on cut-off points for different levels of moral distress and these levels were decided by obtaining expert opinion. This was a limitation of the study as due to time constraints a wider expert circle could not be used.

Despite all the limitations discussed above this was the first study conducted in Sri Lanka on moral distress of grade medical officers in National Cancer Institute Maharagama. The findings of this study can invariably aid the future researchers to explore the depth of moral distress of health care workers at different settings and for different categories of health care workers

CONCLUSIONS AND RECOMMENDATIONS

The prevalence of moral distress among the grade medical officers at NCIM was 91.2 %. The majority (48.5%) of the grade medical officers at NCIM had very mild moral distress while 9.8% had no moral distress. Severe moral distress was found among 3.8% of the population of grade medical officers. Mild moral distress was seen among 33.3% of the grade medical officers and 4.5% of the population had moderate moral distress.

Further studies which will go beyond the population of this study will be needed to understand the contributing factors of moral distress among health care professionals. The nurses, consultants and other health care staff can be included for further studies in different settings in Sri Lanka.

Further studies are needed to understand the effects and consequences of moral distress by which the grievance of moral distress can be better understood.

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Authors

First Author – Amjed DMMLA, MBBS,MSc (medical administration),Ministry of health, amjedduwegoda@gmail.com.

Second Author – Author name, qualifications, associated institute (if any) and email address.

Third Author – Author name, qualifications, associated institute (if any) and email address.

Correspondence Author – Amjed DMMLA, amjedduwegoda@gmail.com, lakariya1234@hotmail.com , 0094773867273.

