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Moral Distress in Pediatric Healthcare Providers[1]

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Pediatric providers across professions and clinical settings experience moral distress. Higher moral distress correlates with intent to leave for all professionals. Physicians as professional group had the highest moral distress. Intensive care nurses had the highest moral distress for nurses. While all providers describe distressing scenarios as disturbing, physicians report situations as occurring more frequently. The most distressing situations include requests for aggressive treatments not in child's best interest, poor team communication and lack of provider continuity. Understanding moral distress as experienced by all pediatric providers is needed to create interventions with a goal of reducing provider turnover.

SAFE, HIGH QUALITY pediatric healthcare cannot exist without the retention of a prepared and experienced provider workforce. The growing problem of healthcare provider shortages, especially nurse shortages, is a national priority as identified in Institute of Medicine reports on the state of nursing (Finkelman & Kenner, 2012). The phenomenon of moral distress has been linked to job retention, a critical work force issue for healthcare organizations (Burston & Tuckett, 2012). The focus of this study is assessment of the degree of moral distress experienced by pediatric healthcare providers including nurses, physicians and other healthcare providers and the relationship of moral distress to healthcare provider job retention.

Moral distress, defined as distress that occurs when constraints make it nearly impossible to pursue the right course of action (Jameton, 1984), is identified as a significant factor affecting nurse satisfaction and retention (Allen et al., 2013; Houston et al., 2013; Pauley, Varcoe, & Storch, 2012). Wilkerson's (1987/88) Moral Distress Model (MDM) describes moral distress as a negative feeling state that results when an individual decides that an action is morally right but does not follow through with this action. In this model, the degree of distress experienced is significantly affected by the frequency of cases encountered and the ability of one to effectively cope with these encounters. Nursing turnover is a negative outcome of frequent encounters that are felt as very distressing.

Root causes of moral distress can be internal to the caregiver (perceived powerlessness, lack of knowledge of alternatives) or external factors (poor staffing, limited administrative support, provider incompetence). Constraints can be embedded in the clinical situations themselves, like requests for futile or

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Poster Presentations
1. 4th Annual Nursing Research Symposium, Children's Healthcare of Atlanta Atlanta, Georgia; May 8, 2013.
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Table 1 Respondents by position for each professional group.

Physician	*n* (%)	Nurse	*n* (%)	Other	*n* (%)
Attending	98 (73.7)	Novice (<1 year)	14 (2.4)	Respiratory therapist	43 (27)
Resident	21 (15.8)	Colleague (>1 year)	241 (41.8)	Social worker	23 (14.5)
Fellow	10 (7.5)	Resource	204 (35.4)	Physical therapist	21 (13.2)
Other	1 (0.8)	Leader (masters)	11 (1.9)	Speech pathologist	13 (8.2)
Missing	3 (2.3)	Asst. nurse manager	64 (11.1)	Child life specialist	12 (7.5)
		Clinical educator	3 (0.5)	Interpreter/Translator	9 (5.7)
		Nurse practitioner	23 (4)	Occupational therapist	5 (3.1)
		Other	4 (0.7)	Physician's assistant	5 (3.1)
		Missing	13 (2.3)	Chaplain	4 (2.5)
				School teacher	3 (1.9)
				Paramedic	1 (0.6)
				Other	14 (8.8)
				Missing	6 (3.8)

inappropriately aggressive treatment, inadequate informed consent, or witnessing false hope (Hamric, 2012). The impact of moral distress on providers includes emotional responses (anger, frustration, guilt) and physical disorders (headache, sleep dysfunctions). It can affect social relationships and contribute to avoidance behaviors in professional interactions (Gutierrez, 2005). An ongoing concern of healthcare organizations is the impact moral distress has on intent to leave one's clinical position. Moral distress contributes to nursing turnover and is directly correlated to nurses' intent to leave their clinical positions (Cavaliere, Daly, Dowling, & Montgomery, 2010; Corley, 1995; Hamric, Borchers, & Epstein, 2012).

Although largely studied in providers who care for adult patients, moral distress is described in some pediatric nurses. Grief and moral distress are identified in pediatric intensive care unit (PICU) nurses working with children at the end of life (Davies et al., 1996; Lee & Dupree, 2008) and in neonatal intensive care unit (NICU) nurses related to resuscitation and outcome of premature infants (Janvier, Nadeau, Deschênes, Couture, & Barrington, 2007). When compared, nurses from adult intensive care units (ICUs) report somewhat higher moral distress than nurses from PICUs (Lawrence, 2011). In one study of pediatric oncology/hematology nurses, over 50% of the nurses report thinking about leaving their current clinical setting due to psychological reasons and moral distress (Lazzarin, Biondi, & Di Mauro, 2012).

Recent reports identify moral distress in professionals other than nurses. Significant moral distress is identified in pediatric residents (Hilliard, Harrison, & Madden, 2007). Of physicians and nurses working in adult and pediatric ICUs, nurses are found to have higher moral distress compared to physicians (Hamric & Blackhall, 2007; Hamric et al., 2012). Two recent studies comparing moral distress in a variety of professionals working in differing clinical settings report moderate to high levels of moral distress in all disciplines with nurses reporting the highest overall level of distress (Allen et al., 2013; Houston et al., 2013).

Using Wilkerson's (1987/88) MDM as the conceptual framework, this study seeks to better understand moral distress experienced by all pediatric providers. The objectives of this study are: (1) to determine the degree of moral distress experienced by pediatric providers from different professional groups and working in different clinical settings; (2) to describe the relationship of moral distress to pediatric provider intent to leave; and (3) to identify specific situations more likely to be associated with pediatric provider moral distress.

Methods

A descriptive study on moral distress in pediatric providers was conducted in April and May 2012. The setting was a large pediatric health system in the southeast that includes three children's hospitals with 60 pediatric specialties. A convenience sample included all registered nurses providing direct patient care (n = 1765); attending physicians with admitting privileges, subspecialty fellows, and pediatric residents (n =650); and other healthcare professionals including respiratory therapists, social workers, physical therapist, and other healthcare providers (n = 626). (Table 1 shows a full list of other providers by profession) The survey was sent via e-mail and providers were invited to complete the survey through a direct link to SurveyMonkey®. Participants were given 6 weeks to complete the survey with reminders sent to non-respondents at 2 and 4 weeks.

The survey included demographic questions, two questions about intent to leave one's position, and the Moral Distress Scale-Revised (MDS-R©) (Hamric et al., 2012). This scale included 21 statements describing situations known to cause moral distress in clinical practice. Respondents rated each situation on two dimensions: (1) how frequently they experience it (0 = never to 4 = very frequently) and (2) how disturbing it is or would be for them (0 = none to 4 = great extent). Composite scores for each situation (range 0–16) were computed, and an overall moral distress score or MDS (range 0–336)) was calculated. An overall respondent MDS could be calculated only if greater than 90% of individual situation scores were completed.

The Moral Distress Scale originally developed and validated by Corley (1995) in critical care nurses included 38 morally distressing situations rated on a 7-point Likert