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Responses and Results to Ethical Problems by Psychiatric Nurses in Japan

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A B S T R A C T

The aim of this study was to investigate the responses of Japanese psychiatric nurses to ethical problems, and the results of those issues. The participants were 130 nurses who worked in psychiatry wards in a hospital. The nurses answered the question "how did you respond when you faced an ethical problem and what results did you get?" in free description. Seven categories were selected qualitatively from their responses: "Lack of action and no change," "Experiencing problems and feeling gloomy," "Pointing out misconduct and being hurt," "Consultation among staff and resolution or not," "Consultation with physicians and getting positive or negative responses," and "Searching for and providing evidence-based care," and "Thinking for themselves." The facts that some nurses do not cope with ethical problems and some face moral distress without knowing what to do suggest that "improvement of moral efficacy to cope with ethical problems", "proposing resolution methods", and "organizational ethics support" may be useful.

Nurses confront ethical problems in clinical settings. Jameton (1993) describes three types of experiences related to ethical problems which nurses confront: 1) moral uncertainty: nurses feel moral uncertainty when they are unsure about the right thing to do; 2) moral dilemmas: when two or more clearly moral principles apply but support mutually inconsistent courses of action; 3) moral distress: when nurses are sure about what to do, but are unable to do it. Jameton (1984) defined moral distress as when one knows the right things to do, but institutional constraints make it nearly impossible to pursue the right course of action. In many medical settings, nurses feel moral distress (Hamric & Blackhall, 2007; Pauly, Varcoe, Storche, et al., 2009). This moral distress affects quality of care (Haggstrom, Mbusa, & Wadensten, 2008), job satisfaction, physical and psychological symptoms (Schluter, Winch, Holzhauser, & Henderson, 2008), or burnout (Ohnishi et al., 2010; Wagner, 2015).

As moral distress varies according to the work situation, mental health nurses may feel a different kind of moral distress from nurses in other settings because of restrictions to patients' freedom (e.g. involuntary hospitalization or seclusion) (Hamaideh, 2014). Magnusson and Lutzen (1999) examined moral distress in decision-making in the home care of people with long-term mental illness. They showed that nurses experienced feeling distressed, were confronted with intrusions into patients' privacy, felt alone when making decisions, and were not welcome in patients' homes.

Austin, Bergum, and Goldberg (2003) showed that nurses felt moral distress when they were unable to respond to the needs of their patients or treated patients with an "absence of respect." Deady and McCarthy (2010) demonstrated three themes in moral distress of Irish psychiatric nurses: professional and legal conflict, professional autonomy and score of practice, and standard of care and client autonomy.

In Japan, a previous study found that many nurses had high moral distress concerning long-term social hospitalization, whereby patients without serious conditions were confined for prolonged periods, when little respect was shown for patient autonomy for fear of accidents, and there was insufficient care because of "low staffing" and "a lack of time to take care of patients." Nurses also have ethical concerns about hospital discharge (Tanaka, Hamada, Arashi, Koyama, & Yanagai, 2010) and low staffing (Ohnishi et al., 2010).

Although nurses face moral distress, there are few studies on the responses of nurses when they face moral distress. Varcoe, Pauly, Storch, et al. (2012) showed nurses' perceptions of and responses to morally distressing situations in various wards. They showed 4 categories as among the responses: 1) "Inaction and being blown off" which shows that nurses' requests were ignored, dismissed, and nurses did not do anything. 2) "Demeaning and blowing up" means that nurses received a range of demeaning and devaluing responses to their concerns and request for action. 3) "Resisting and deflecting concerns" means that nurses received resistance from physicians against their desire to act or deflecting from their managers. 4) "Responsive actions" means that all kinds of staff acted responsively. Tanaka et al. (2010) investigated the actions of psychiatric nurses using a scale which consisted of 11 items about actions facing ethical issues, and showed that the most significant coping response was "consulting with colleagues or supervisors."

Since the participants of Varcoe et al. (2012) were nurses in various wards, the responses of psychiatric nurses were not clear. And since Tanaka et al. (2010) used a scale which they made, though participants were psychiatric nurses, factors without the scale were not clear. Moreover, both studies examined only responses to ethical problems, and

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results after responses were not examined. Both responses and results may be important because results promote motivation for subsequent behavior. Since these responses and results will be related to protecting psychiatric patients' human rights, autonomy, privacy, or quality of life, it is very important to examine psychiatric nurses' behavior and results.

PURPOSE

The purpose of this study was to examine the responses of psychiatric nurses to ethical problems and the results after the response, comparing responses in this study with previous study.

METHODS

Participants

The participants were 200 nurses at a national hospital in Japan. This hospital is located in the middle of Japan. At 2010, there were about 300 beds in use, of which 250 are in the psychiatric wards and 50 in the internal medicine ward. It is a very famous hospital in Japan for alcoholism treatment.

Instruments

Questionnaires were completed on moral distress, sense of coherence, mental health, and job satisfaction as quantitative scales. They also answered the questions, "How did you respond when you faced an ethical issue?" and "What results did you get after your response?" in free answer form as qualitative data. In this study, we analyzed only qualitative data.

Data Collection

Following institutional review board approval, questionnaires were distributed to nurses working in the hospital, with the help of the head nurse. Nurses participated voluntarily. They answered the questions in free answer form, sealed the envelope including the questionnaire, and submitted their responses in a locked box. The researcher collected the questionnaires from the box. Informed consent was implied by participants completing and returning the surveys.

Data Analysis

We used qualitative analysis by Funashima (2001) based on Berelson, B. The sentences in the free description were analyzed line by line and the content was extracted. This content was classified into codes and those with a common meaning were grouped together. Categories and sub-categories were then formed. The sentences were separated into minimum sentences. The similar minimum sentence was classified into a code. The similar codes were integrated into subcategories, and finally into categories. To keep reliability of categorization, two researchers talked until agreement.

Ethical Consideration

Ethical permission for the study was obtained from the institutional review board of St. Mary's College.

RESULTS

We distributed 200 questionnaires and collected 136, the response rate was 68%. The effective questionnaires was 136 (male; 28, Female: 102). The background of the participants is shown in Table 1.The nurses were mainly female (78.5%) and the common age range was 40 to 49 years old. We selected seven categories by qualitative analysis. A category is enclosed in "" and a subcategory in [] in the following text. Some subcategories and categories are shown in Table 2.

Table 1
Background of the Participants.

Item		Number (n = 130)	Rate (%)
Gender	Male	28	21.5
	Female	102	78.5
Age (years)	20–29	8	6.2
	30–39	30	23.1
	40–49	46	35.4
	50–59	40	30.8
	60–69	6	4.6
Nursing experience (years)		18.7	
Nursing experience in current ward (years)		3.4	
Position:	Staff	115	88.5
	Others (chief, head nurse)	15	11.5

Category 1 was "Lack of action and no change." It means that some psychiatric nurses did not do anything when they confronted ethical problems, thus there was no change.

Category 2, "Experiencing problems and feeling gloomy," included [Experiencing patients' leaving after troubles and feeling gloomy] and [Administering unrequested medication and feeling gloomy]. It means that nurses could not perform any suitable behavior when they wanted to stop patients leaving the hospitals after troubles or stop administering unrequested medication.

Category 3, "Pointing out misconduct and being hurt," included [Pointing out misconduct directly] and [Receiving anger and being hurt]. It means that when a nurse confronted ethical problems in a clinical situation and she pointed out the misconduct to another nurse, the nurse became angry. The nurse who pointed out the misconduct was very hurt.

Table 2
Categories and Subcategories for Responses to Ethical Issues.

Category	Subcategory
1. Lack of action and no change	・Doing nothing and changing nothing
2. Experiencing problems and feeling gloomy	・Experiencing patients' leaving after trouble and feeling gloomy
	・Administering unrequesting medication and feeling gloomy
	・Receiving violent language from a patient and feeling gloomy
	・Checking patients' belongings and feeling gloomy
	・Not having enough power to give care and feeling gloomy
3. Pointing out misconduct and being hurt	・Pointing out misconduct directly
	・The nurse becoming angry and offended
	・Receiving anger and being hurt
4. Consulting among staff and resolution or lack thereof	・Consulting among staff and understanding each other
	・Consulting each other and having a positive change of mind
	・Consulting with a supervisor and getting organizational change
	・Consulting with a supervisor and receiving no change because of hospital systems
5. Consulting with a physician and getting positive or negative responses	・Consulting with a physician and getting positive responses
	・Consulting with a physician and getting negative responses
6. Searching for and providing evidence-based care	・Searching for evidence and giving convincing care
	・Searching for evidence and providing evidence-based care
7. Thinking for themselves	・Thinking for themselves and behaving

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