



Moral distress in nursing practice in Malawi

Nursing Ethics
19(2) 196–207

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10.1177/0969733011414968

nej.sagepub.com



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Abstract

The aim of this study was to explore the existence of moral distress among nurses in Lilongwe District of Malawi. Qualitative research was conducted in selected health institutions of Lilongwe District in Malawi to assess knowledge and causes of moral distress among nurses and coping mechanisms and sources of support that are used by morally distressed nurses. Data were collected from a purposive sample of 20 nurses through in-depth interviews using a semi-structured interview guide. Thematic analysis of qualitative data was used. The results show that nurses, irrespective of age, work experience and tribe, experienced moral distress related to patient/nursing care. The major distressing factors were inadequate resources and lack of respect from patients, guardians, peers and bosses. Nurses desire teamwork and ethics committees in their health institutions as a means of controlling and preventing moral distress. There is a need for creation of awareness for nurses to recognize and manage moral distress, thus optimizing their ability to provide quality and uncompromised nursing care.

Keywords

Malawi, moral distress, nursing ethics, nursing practice, practicing nurses

Introduction

Nurses in Malawi, as in many other developing countries, face great challenges when performing their duties. These challenges result from inadequate staffing, limited resources, lack of incentives and staff attrition. Inadequate staffing is mainly due to early retirement, brain drain in search for greener pastures and deaths.¹ The nation is also losing many nurses due to the HIV/AIDS pandemic.² Malawi, with 3000 nurses in the public sector, has the lowest number of nurses in the Southern African Development Community.³ Most hospitals in Malawi experience inadequate material resources which mainly result from limited

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availability of funds to purchase equipment and supplies for patients. In addition, the hospital infrastructure is outdated and provides work conditions that are not conducive to delivery of quality patient care. The HIV/AIDS pandemic, on the other hand, has increased the bed occupancy rate in hospitals. Consequently, nursing care is compromised because there is increased workload, which in turn raises constant ethical issues.

Efficient nursing care requires that nurses be able to handle ethical issues. Malawian nurses generally lack ethical skills and knowledge because of the way ethics is taught in nursing colleges. The curriculum focuses on the principles of ethics, and the course content emphasizes managing patients' stress without considering how to prevent or deal with nurses' moral distress.^{4,5} The problem is compounded by the fact that the standards for practical experience during training prescribed by the Nurses and Midwives Council of Malawi (NMC) do not spell out the required ethical skills for nurses.⁵ In addition, nurses face conflicting responsibilities towards regulatory bodies, other health workers, patients and their families⁶ and are prone to suffer from moral distress.

Nathaniel,⁷ defined moral distress as pain or anguish from confronting a situation in which the person is aware of a moral problem, acknowledges moral responsibility and makes a moral judgment about the correct action, but due to perceived constraints, acts in a manner that is perceived to be morally wrong. The situation affects the mind, the body, or one's relationships and includes despair, disequilibrium, hostility and rejection, hence compromising nurses' work.⁸

A number of studies on nurses' moral distress have been conducted in the developed countries.⁸⁻¹¹ In the developing world, a study that explored nurses' workplace distress and ethical dilemmas was conducted in Tanzania.¹² In Malawi, such studies were lacking. Moral distress threatens the quality of patient care and therefore needs attention.¹¹ This study was therefore initiated to explore the existence of moral distress among practicing nurses in Lilongwe District of Malawi. The objectives of the study were to: assess nurses' knowledge of moral distress; identify its causes; identify the sources of support for nurses when morally distressed; and identify coping mechanisms for distressed nurses.

Methodology

Study design

The study adopted a qualitative approach and a descriptive research design. A descriptive study was used to present a picture of types of people and their activities.^{13,14} The study used in-depth interviews to explore moral distress experiences among practicing nurses. Qualitative research was employed because it is 'holistic', i.e. concerned with humans and their environment in all their complexities, and is also 'naturalistic', i.e. without researcher-imposed constraints or control. Furthermore, the qualitative approach was deemed optimal in a study of this nature because of its flexibility, as such there was no rigid questionnaire before the inquiry. Instead, an interview guide that allows modifying the guide in the course of data collection was used. This open approach allowed exploration of meanings and gaining of insight into the little known situation of moral distress.¹⁵ In-depth interviews were conducted face to face to elicit a vivid picture of participants' perspective.¹⁶

Moral distress has not been studied in Malawi and is a sensitive issue. Hence, there was a need for gradual and careful probing. An open-ended data collection instrument was therefore appropriate to grasp the potential complexity, ambivalence and contradictions in responses. The qualitative method allowed participants to express themselves freely without interruption.

Participants

Twenty female Malawian nurses from various health-care settings participated in the study. All were qualified; six were registered nurses, nine were enrolled nurses, and five were nurse technicians. This

distribution is consistent with statistics reported by the Ministry of Health.¹² All had work experience of 18 months or more and minimum age of 25 years.

Ethical considerations

The research proposal was approved by the College of Medicine Research and Ethics Committee in Malawi and the Institutional Review Board of Michigan State University in the USA. Written permission to conduct the research in the selected health institutions was sought in advance from the responsible managers. General ethical principles of research were observed in that participation was voluntary, participants were informed of the nature of the study and signed consent forms. In addition participants gave explicit consent to having the interviews audio taped, had the right to withdraw at any time and confidentiality was guaranteed.

Data collection

Data collection was collected using the semi-structured interview guide. The responses of participants were tape recorded and written on note pads. The interview guide was developed in English because the prospective participants were well conversant with the language. Data was collected in November 2007.

Data analysis

Data analysis was done simultaneously with data collection. Individual interviews were transcribed from a digital voice recorder at the end of each day, as recommended by Polit et al.¹⁶ Audiotapes were transcribed verbatim and each typed transcript was checked against the audiotape as soon as each interview had taken place. The written transcripts from each interview were read later during the analysis and key words and significant statements were highlighted throughout the script. The identified themes that emerged from each interview were reviewed and similar themes that emerged were grouped together and reported as results.

Participants were assigned code numbers from 001 to 020. Responses were directly quoted in the participants' own words. Sentences were not grammatically corrected or improved, in order to capture the participants' meaning.

Results

Participants' descriptions of moral distress were placed into five main themes; knowledge and experience, causes, effects, coping mechanisms and desire for support services.

(1) Knowledge about and experience of moral distress

None of the participants was initially familiar with the meaning of the word moral distress, but when they were asked if they had come across a situation where they knew what to do but failed due to factors beyond their control and how they felt after the failure, all except one reported having experienced moral distress. Some nurses had even the vernacular name for moral distress. The nurses experienced moral distress regardless of their tribe or health facility. Their experiences concerned patient care and also the way they themselves were treated. The anecdotes also involved moral dilemmas, frustration, and burnout, all of which commonly accompany moral distress.

(2) Causes of moral distress

Participants' experiences were classified into six subthemes namely; shortage of staff, violating regulations in order to protect patients, being forced to accept disrespect, lack of resources, behavior of colleagues and mismanagement by superiors and bosses. All these resulted in inadequate provision of patient care by the nurses.

2.1. Shortage of staff. Participants described situations where they knew what to do but failed because of shortage of staff. Few available staff was overloaded and could not perform duties accordingly. One instance was narrated by participant # 019 as follows:

... a woman who had a normal delivery ... on discharge was supposed to be offered education on care of her new baby. I was alone on duty and I was busy with other patients, this patient could not wait for me. She went home without any information ... I felt I did not do anything ... I felt very bad ... I had guilty conscience ...

Another participant (# 008) had this to say:

... there are many patients who need attention and you are all alone. There are a lot of activities to be carried out urgently but you find yourself not able to do them. As a result your patient suffers.

A nurse complained that she was at times forced to delegate her work to a patient's guardian due to shortage of staff. It is worth noting that most guardians complain that nurses neglect their patients and leave their work to the guardians. Ironically such situations caused moral distress to nurses, as narrated by participant # 017:

Sometimes in high postnatal ward where you are expected to give nursing care to patients. I have asked the guardians to drain catheter, bed bath the patient and to bring bed pan. This is done because of shortage of staff ...

2.2. Violating regulations in order to protect patients. Most (12 out of 20) participants reported situations in which they failed to follow hospital rules, regulations or policies in order to protect their patients as well as their own interests. Regarding patients' welfare, one of the participants (# 007) narrated that:

... I was working at a Health Centre. I was alone on this day. The clinician was not there. The rule is that I am not supposed to prescribe drugs to patients. A patient came I knew what was wrong with him so I prescribed medication for the patient. I could not refer the patient to another hospital because the patient said he had no transport money ... I feel my patient felt better because I helped him but I had guilty conscience that I broke the rules.

Professional conflicts especially between junior doctors and experienced nurses were also found to cause moral distress among nurses. The nurses knew the right prescription for a patient and when a junior medical doctor prescribed inappropriate treatment, the nurse did not administer the treatment unto the patient. Such experience was shared by participant # 008 as follows:

Sometimes a junior student doctor prescribes wrong drugs. The regulation is I follow doctor's order but when I evaluated what the doctor has prescribed, I don't give the drug until someone senior has verified or changed. For example, a patient gasping ... ordered morphine ... I refused to give. I feel my patient is safe ...

Ten of the 20 respondents described regulations that were in conflict with their responsibilities as nurses. Examples included requirements that patients be seen by a clinician other than a nurse, when the clinician

was not available the patients were made to wait for a long time before being treated. This situation was shared by participant # 002 as follows:

Patients are supposed to be seen by a clinician who may not be available at certain times. Consequently the patients waited for a long period before they are attended to. I feel bad to see patients waiting when I could have assisted.

The study came across situations in which hospital regulations were in conflict with their duties. Participant # 003 had the following experience:

The hospital does not allow use of condoms being a Catholic institution it is difficult for me to assist patients who are on ARV when it comes to advice on protected sex.

2.3 Being forced to accept disrespect. Nurses expressed situations in which they felt a sense of being unappreciated or mistreated by patients, colleagues and supervisors. There were situations in which doctors shouted at nurses in the presence of other staff and guardians as narrated by participant # 008:

Sometimes you work hard to help patients . . . but you are shouted at by a doctor or a guardian in the presence of the patients, yet they expect that you work normally under such situations . . .

Nurses felt that they had a right to be respected and treated with dignity at all times as they in turn respected their patients' rights and treated them with dignity. Quite often supervisors tended to defend patients' rights at the expense of the nurses' rights as narrated by participant # 017:

I was on night duty in labor ward. It was a busy night. A lady who was HIV positive came in second stage and delivered a macerated still birth. To my surprise the lady refused that she gave birth to a MSB after her friend in LW delivered a live baby. Later she complained to the matron's office that I told her that she had MSB because she took niverapine. I was called at the matron's office and narrated my side of the story, but the matron shouted at me. I was confused and felt very bad . . . When issues happen in LW, you are accused, yet they expect that I accept the mistake and work normally. [The participant was angry and was sobbing when she was telling her story.]

2.4 Lack of resources. In some instances timely services could not be provided to patients due to shortage of supplies such as blood and unavailability of transport to collect blood from the bank. The experience from participant # 017 was as follows:

It was at night. There was a patient with PPH, I did all what I could do including calling for help . . . The patient needed blood. There was a need to collect blood from a blood bank of another institution but there was no transport. Patient's condition deteriorated. I felt very bad . . .

Lack of basic equipment also included thermometers for checking body temperature. Although the thermometers are cheap and affordable, they were not available in some facilities and hence caused moral distress. A good example of this was explained by participant # 014:

sometimes I fail to check patients' vital signs such as temperature because there are no thermometers or when they are there they are not working. I feel sorry and bad because sometimes you can miss someone who needs attention . . .

Lack of supplies including essential drugs and medicines often caused moral distress among practicing nurses. Situations arose in which a nurse on duty knew what service to render but there were no drugs and supplies. Participant # 016 narrated her experience as follows:

I had a patient who had eclampsia and needed hydralazine but there was no hydralazine available in the hospital. It was very difficult to control blood pressure. Watching the patient suffering gave me no job satisfaction . . .

Health facilities sometimes lacked basic equipment and participant # 015 shared the following experience:

there was a patient about 65 years old who was unable to eat. He had NGT inserted. He needed suctioning because he had secretions. There was no suction machine . . . Patient choked . . . I felt very bad because I failed to provide necessary nursing care because of lack of suction machine.

In all these situations participants reported that they felt angry, bad, dissatisfied, frustrated, sad, and guilty when they did not do what they were supposed to do.

2.5 Behavior of colleagues. Participants reported that other health care workers contributed to moral distress by reporting late for duties; in addition to shouting at nurses in the presence of guardians and patients; and a general lack of understanding. These experiences were reported by participant # 015:

I was on night duty in pediatric ward. When morning came I continued working until late because a colleague who was supposed to be on morning shift came late despite spending the night at home. I could not leave the ward without handing over to my fellow nurse.

Participant # 019 shared her experience as follows:

I was alone on night duty at a health center. A clinician was at large and a patient came who needed to be reviewed by a clinician. I could not do anything and therefore decided to refer the patient to another hospital. The patient refused because he had no transport money. I felt bad because if the clinician was there, the patient could have been treated.

2.6 Mismanagement by superiors and bosses. Hospital management contributed to nurses' moral distress. Matrons and ward in-charges favored some nurses and not others. The favoritism was with regard to duty roster, nominations to attend workshops, provision of transport when some nurses are bereaved and issues of promotion. Participant # 017 explained that:

I am always on duty during weekends but other nurses in the same ward do not work during weekends.

Participant # 004 added that:

Matrons and ward in charges have their own favorable nurses that they always send for workshops and training and are given the best assistance when they are bereaved.

Favoritism was also noted in terms of promotion as narrated by participant # 010:

When I first qualified I thought I would be promoted . . . but I was not yet other nurses with the same grade as mine were promoted . . .

Supervisors often frustrated hardworking nurses through creation of unfavorable working conditions as shared by participant # 002:

Working conditions . . . I am not chosen by the in-charge to go for workshops. Professionally I am not growing because of lack of training.

Poor supervision caused moral distress as narrated by participant # 015:

The attitudes that the seniors have towards juniors is very distressing. Instead of supervising, they are like policemen, instead of helping they are fault finders.

Management was also blamed for insufficient resources and for staffing shortages, which made it impossible for those working to get further training. The other issue that was raised by two of the participants regarding superiors was that when the nurses did well, everybody kept quiet; however, superiors capitalized on simple mistakes and amplified them. This was worsened by the fact that when nurses raise these issues during staff meetings they were labeled as trouble makers, hence preventing them from expressing themselves.

(3) Effects of the experience of moral distress

The majority (15 out of 20) of participants reported lack of sleep, physical pain (in the form of headache), lack of appetite, sadness, irritation and anger toward innocent family members over small issues. Participant # 017, after being shouted at by the matron due to a false report by a patient, narrated the following experience:

I felt headache, sad and became very emotional even towards my family members at home.

(4) Coping mechanisms

There were diverse coping mechanisms such as discussion with those involved; transferring duties to someone else; reporting the matter to higher authorities; sharing with a colleague; ignoring the situation; trying to forget it; crying and feeling guilty; prayer and seeking forgiveness. Years of work experience had a direct bearing on the participants' ability to develop coping mechanisms. Nurses with more experience were more resilient to moral distress and applied the coping mechanisms more effectively. Participant #003 narrated her experience as follows:

I try as much as possible to discuss the situation with concerned people and higher authorities until the problem is solved.

The study found that religion played a major role as a coping mechanism for most participants. Some prayed for help from God in dealing with distressing situations; some asked for help to forgive rather than hold a grudge, and some prayed to be forgiven. Prayer gave solace and allowed them to continue their normal lives.

(5) Desire for support systems

Nurses desired support systems but were dormant. They expected professional nursing bodies to offer them support by enforcing guidelines that promote fairness on nominations for training and promotion. In addition, nurses expected that the professional bodies understood what nurses went through and should offer support to improve their welfare and rights. Nurses expected that the professional bodies would restore the nursing care to its past, now lost, glory. The NMCM in particular was viewed as a body that would consider the merit of patient complaints in relation to the nurse working environment as narrated by participant #009:

they should sometimes visit us so that they appreciate how we work with limited resources . . .

Participant # 012 made the following suggestion:

they should stand with us because we work under very tough situations . . .

Participants expressed desire for their peers (colleagues and other health workers) to cultivate a team work spirit by focusing on patient care; sharing information; avoiding gossip and backbiting; and supporting each other during personal hardship like sickness and bereavement.

Nurses expected that their managers would ensure availability of resources for quality patient care; support nurses when problems arise; conduct supervision; arrange regular staff meetings; send nurses for trainings and workshops; avoid favoritism; conduct staff appraisals regularly, and avoid giving false promises. Participants were of the view that their institutions should have ethics committees that would remind and resolve ethical issues. Furthermore the committee would update nurses' ethical knowledge; prevent misconduct; and in general improve patient care.

Discussion

Knowledge about and experience of moral distress

The study results show that Malawian nurses frequently experienced moral distress regardless of the fact that the term was not familiar to them. It is thus interesting to note that although the moral distress concept was initially not well known and understood, the reality is that it was encountered by nurses during their day-to-day work. Participants in this study described their situation of moral distress and each experience was soul touching, confirming their commitment to patients. The sense of commitment to do what is right is an important part of the complete package ascribed to nursing care.¹⁸ Coley¹³ reported that moral distress is common world-wide in the nursing profession but has not received the attention it deserves. The AACN¹⁹ reported that moral distress is a critical, frequently ignored problem in the health care environment. Benoit,²⁰ as cited in Jameton,²⁰ indicated that moral distress was the common experience for nurses. The hands on care that nurses provide establishes intimate connection between nurses and their patients. Therefore, when patients suffer, nurses have firsthand information on the pain and suffering. Hence, it is distressing when nurses are unable to provide care that is perceived morally necessary for their patients.

Knowledge of moral distress would be enhanced if the phenomenon was well taught during pre-service at all levels of training from nurse technician to the university colleges of nursing. An effective way of teaching moral distress is through the use of problem-based learning. There is a need for an in service education for the serving nurses. On the other hand, workshops would be an effective way of sensitizing the nurse managers, supervisors and administrators.

Causes or sources of moral distress

In this study moral distress was mainly caused by problems associated with patient care, colleagues and administration, especially higher authorities. Results further show that working with inadequate resources in terms of drugs, time, staff and equipment was the major problem with regard to patient care and caused more distress among the participants. Nurses in resource poor countries, including Malawi, struggle daily with inadequate supplies of drugs, safe water, medical equipment and essential supplies. Shortages of these resources mean that nurses cannot provide quality care thereby leading to frustration and demoralization. These results are supported by other reports from Malawi^{21,22} that reiterate the pain these shortages cause on nurses.

Understaffing forces nurses to abandon opportunities to sit with patients, listen to their fears and provide all required nursing care. Inadequate staffing leads to work stress, burnout, job dissatisfaction, decreased

morale and staff sickness, which lead to increased absenteeism, turnover and poor patient care.²³ In addition, heavy workload often robbed nurses of time to reflect on their own distress. Nurses continue to care for too many patients and stifle their own negative feelings. The greatest losers are patients, both directly from the lack of resources and indirectly from the nurses' unhappiness.

Disrespect by peers, matrons, office in-charges, doctors, patients and guardians was another major source of distress. Nurses knew that they needed to be respected at the place of work; however, these expectations were not met. Nurses cannot treat patients and clients with respect and dignity when they themselves are not well treated. The Code of Nursing Ethics for Malawi stipulates that nurses should sustain cooperative relationships with co-workers.³ Frowning, shouting, intimidating and threatening others in the workplace are unprofessional and unacceptable behaviors. Nurse Managers and hospital administrators have the obligation to treat their subordinates with respect and dignity in order to provide a healthy work environment. A survey of London nurses found that respect at work, i.e. being valued and respected by patients, doctors, colleagues, hospital and the society, increased nurses' morale, job satisfaction and decreased nurses' intentions to leave the profession.²⁴

Effects of moral distress

The study results show that distressing experiences led to lack of sleep, physical pain, anger, frustration, sadness, hopelessness, and powerlessness. These results are consistent with those of Wilkinson⁷ and Fry et al.²⁵ It is important to note that although the problems occurred at work, they adversely affected most participants' personal and family lives with innocent spouses and children being the most affected. Amazingly no participant reported that their patients were affected. The nurses indicated that they managed to provide effective care anyway. This indicates that the nurses were unaware that their negative feelings affected patient care. It is highly unlikely that nurses' feelings could affect their families but not their patients.

Wilkinson⁷ argues that the quality of patient care can be affected more than nurses recognize. Because it threatens their self-image as nurses, they may not want to believe that they have failed to give good care. Participants in this study might have defined quality of care in terms of physical rather than total patient care. In addition they might have measured quality of care by the amount of effort they exerted, or on the strength of their feelings rather than patient outcome or how much self they had left to give after the energy depleting experience of moral distress.

There is substantial evidence^{26,27} that moral distress has a negative effect on patient care. Patients and guardians have complained about the conduct of some nurses in Malawi and the results in this study suggest that nurses may not meet the clients' expectations because most of them work under distressed conditions. Nurses suffer physical and psychological problems, then lose their capacity for caring, avoid patient contact and fail even to give good physical care. Some withdraw from bedside nursing and some leave the profession altogether.

Coping mechanisms for moral distress

The results that all nurses were morally distressed regardless of tribe and type of health facility show the extent of the problem among Malawian nurses. The results imply that moral distress is a multi-cultural and multi-health care institutional problem in Malawi. In view of its negative consequences on quality patient care, every health facility should establish mechanisms to control it.

The results show both effective and non-effective coping behaviors by distressed nurses. Behaviors like crying, suppressing one's feelings, ignoring or simply accepting the situation, trying to forget and keeping quiet, do not deal effectively with moral distress. In these situations nurses acted as if there was no problem.

Literature indicates that nurses who behave this way have damaged self-wholeness; some remain in nursing but provide poor quality patient care or leave the profession.⁸ Discussing distressing issues with colleagues, administrators, office in-charges and others is more helpful. Colleagues and administrators who allow nurses to vent their frustrations provide a therapeutic environment that relieves stress in the short term.⁷ Through discussions, nurses learn that their experiences are not unique, and also appreciate how others dealt with similar problems. Individuals with effective coping behaviors tend to gain control over troubling situations, to stay in the profession, and to provide quality patient care.¹⁰ However, it is worth noting that the more the nurses experience moral distress, the less likely are any coping behaviors to be effective.²⁷

In this study, nurses of all ages experienced moral distress; however, the coping mechanisms used by older and younger nurses were different. The older nurses were more resilient because they had more life experiences to draw lessons from than the younger ones. The relationship between work experience and development of coping mechanisms for moral distress was also reported by a number of studies: Schoen, as cited in Jameton;²⁰ Benner, as cited in Corley et al.;⁸ and West et al.²³ The major conclusion in these studies was that a person who cares for the sick before 25 years of age develops psychological trauma because coping mechanisms are not yet fully developed.

The results that the level of education is negatively correlated to the ability to cope with moral distress imply that in a Malawian setting where there were few registered nurses, there was a high probability for occurrence of moral distress. Furthermore, the few numbers of registered nurses imply that the skill mix between registered and technicians is poor.¹ Consequently most wards and departments are managed by low cadre of nursing staff and thereby compromising quality of nursing care in the country.

Interestingly, religion in this study has been found to influence positive outcomes during moral distress. Religion gave solace for nurses' souls in order to continue with normal life. These results are consistent with those reported by Jameton.²² In addition to divine intervention, this study has found that spouses played a positive role in assisting morally distressed nurses.

Sources of support

Peers. The results that teamwork and unity at a workplace provided an opportunity for sharing solutions to morally distressed nurses show the importance of fostering and maintaining this important source of support in the Malawian health facilities. Kalvemmark et al.²⁴ and Austin et al.²⁶ also reported similar results. Peers should therefore be encouraged to create a favorable work environment where ethical issues are freely discussed and good interpersonal relationships are promoted.

Hospital management. The results in this study show that managers could play major roles to prevent moral distress. Hospital management could offer valuable support by facilitating dialogue, getting accurate information about the distressing event and addressing barriers for its resolution. Nurse leaders should therefore involve nurses when making decisions regarding the development and revision of policies, especially those involving resource allocation. Furthermore, the managers should act as role models for the nurses in all issues pertaining to nursing profession. Ethics committees should be established to advocate for quality patient care.²⁶ However, not all situations may be completely resolved, but when nurses have been heard and their side of the story understood there may be a sense of satisfaction and healing.

Professional bodies. The results show that professional bodies have a role to play in assisting distressed nurses and preventing the occurrence of moral distress through advocacy with stakeholders for better working conditions, more respect, and opportunities for professional growth. Nursing standards of care stipulated by the NCMCM are difficult to achieve given inadequate human and material resources in Malawi; hence there is a need for adequate budgetary support for patient care. Another setback for nurses is the fact that patients'

rights are stressed more than health workers' rights; as a result the patients do not know their responsibilities towards health-care workers. There is a need for professional bodies such as the National Organization of Nurses and Midwives of Malawi to raise awareness so that nurses' rights are also respected by patients and the general public.

The participants in this study were well conversant with all professional bodies in the country except the Association of Malawian Midwives (AMAMI). Ironically in North America and Europe professional bodies like AMAMI play a major role in assisting nurses to recognize, discuss and resolve moral distress.¹⁹ These results may imply that Malawian nurses were missing the services of an important organization where they could get help when distressed.

Areas for further studies

This study has identified the following areas for further study:

- What type of moral distress do nurse managers experience?
- What is the perception of nurse managers on the issues that trouble nurses?
- What kind of support systems helps professional organizations, colleagues and nurse managers?

Conclusion

Nurses in Malawi experienced moral distress regardless of the type of facility, age or work experience, due to inadequate resources, conflicting policies and disrespect from peers, managers, guardians and patients. There are a number of coping mechanisms. The more experienced nurses were more resilient towards moral distress than younger ones. Religion and spouses were important sources of support for distressed nurses. There is a need for awareness creation among all stakeholders in Malawi in order to prevent and control moral distress among the practicing nurses and hence improve the quality of care.

Funding

The study was funded by Fogarty International Centre Grant number R25-TW7087 through Michigan State University and University of Malawi, College of Medicine.

Conflict of interest statement

The authors declare that there is no conflict of interest.

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