Moral Distress and Professional Autonomy Among Staff Nurses in Private Hospitals

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Abstract

To optimize nurses' roles, it is essential to minimize moral distress and maximize professional autonomy. However, limited local studies explore the correlation between moral distress and professional autonomy among nurses. This research in Midsayap, Cotabato for Q1 2023 utilized a quantitative approach, revealing that most nurses were young adults (19-35 years old), predominantly female, with a bachelor's degree, and employed in private hospitals. Moral distress was low, and professional autonomy varied. No significant relationships were found between demographic factors and moral distress or professional autonomy. Despite moral distress, high professional autonomy can be achieved, and the two are not significantly related. An autonomy enhancement plan was developed to address the study's findings.

Keywords: Descriptive, Correlational Design; Moral Distress; Nurses; and Professional Autonomy

INTRODUCTION

Moral distress in nursing refers to the suffering affecting one's intellect, body, and interpersonal connections at work, arising from a conflict between personal beliefs and actions. It occurs when a person knows the right course of action but is unable to carry it out due to institutional policies and professional autonomy. Studies indicate that 80 percent of nurses experience moderate to severe moral distress (Abdolmaleki et al., 2018). This distress is a significant factor leading nurses to leave their positions and, in some cases, the profession entirely. It can negatively impact a nurse's ability to care for patients and may require an extended period for resolution.

Nurses faced various challenges during the COVID-19 pandemic, including work-related stress, long hours due to a shortage of staff, limited resources, strained relationships with patients and families, and concerns about patient and nurse safety. Additionally, making decisions on care provision and other work-related pressures contribute to moral distress among nurses. This moral distress can lead to burnout, self-esteem loss, professional disappointment, reduced job satisfaction, and, in some cases, nurses leaving their careers (Godshall, 2021).

Professional autonomy involves the ability to make independent decisions and act in alignment with one's professional knowledge. It is crucial in rapidly evolving healthcare situations to define and elevate the nursing profession. Globally, there is concern about how fundamental nursing components are managed in the context of expanding specialized nursing roles (Skar, 2010).

Reducing nurses' autonomy can hinder their ability to apply personal and professional moral reasoning, leading to moral distress, especially during a pandemic. In Samar Island, Philippines, nurses with greater

autonomy show excellent performance, job satisfaction, and commitment. Organizational initiatives, such as sufficient assistance, policies, and training, are crucial for fostering autonomy (Labrague et al., 2018). This study focuses on exploring the relationship between autonomy and moral distress among nurses in private hospitals, aiming to enhance professional values and prevent vulnerabilities. Staff nurses often face moral distress and challenges in professional autonomy related to patient care and unit operation decisions. The research, conducted by a former staff nurse and current clinical instructor, hopes to contribute valuable insights for both academic and clinical settings, fostering positive outcomes and resolving workplace conflicts.

The study, conducted in the Municipality of Midsayap, Cotabato for the 2nd quarter of 2023, aimed to assess moral distress and professional autonomy among nurses in private hospitals. It addressed specific questions regarding the profile of nurses in terms of age, sex, highest educational attainment, and number of years in the nursing profession. The study also explored moral distress concerning time, resources, and relationships, as well as professional autonomy in patient care and unit operation decisions. Additionally, it investigated the significant relationships between profile factors and both moral distress and professional autonomy. The goal was to propose a nursing service enhancement plan based on the study's finding.

METHODOGOLY

Research Design

This quantitative research utilized a descriptive, correlational research design to provide a "snapshot" of the frequency and characteristics of the profile, moral distress, and professional autonomy of nurses in private hospitals in the Municipality of Midsayap, Cotabato during the 2nd quarter of 2023 (Ihudiebube-Splendor & Chikeme, 2020). The descriptive design was employed to analyze the respondents' age, sex, highest educational attainment, number of years in the nursing profession, and the type of institution. It was also used to assess moral distress and professional autonomy. The correlational design examined the interrelationship between the profile, moral distress, and professional autonomy of the nurses.

Environment

The study was conducted in Midsayap, a first-class municipality in the Province of Cotabato, situated in the northwest section of the province. Midsayap serves as a major commercial and trading center, experiencing recent industrial development. The municipality has one public and five private healthcare facilities with varying classifications, including secondary and tertiary hospitals, each with different bed capacities, managed by either the Provincial Government of Cotabato or private entities.

Respondents

This study involved staff nurses from three private hospitals in Midsayap Municipality. The estimated total population of respondents included 51 from Community Health Service Cooperative Hospital (a private Level II hospital), 29 from Midsayap Doctors Specialist Hospital Incorporated (a private Level II hospital), and 22 from Anecito P. Pesante Sr. Memorial Hospital Incorporated (a private Level II hospital). In total, 102 staff nurses participated in the study.

Sampling Design, Inclusion and Exclusion Criteria

Sampling for this study involved a complete enumeration, including all staff nurses from selected hospitals regardless of their area of assignment. Inclusion criteria required respondents to be of legal age, employed as staff nurses in a private hospital in Midsayap, North Cotabato, and willing to provide voluntary consent. Excluded from the study were Nurse Managers, Departmental head nurses, individuals with potential

COVID-19 exposure or symptoms, and staff nurses with less than six months in service who did not actively participate during the pandemic surge.

Instrument

The study employed a three-part questionnaire. Part one focused on the respondents' profile, covering age, sex, highest educational attainment, years of experience, and the type of institution. Part two consisted of a moral distress questionnaire adapted from Eizenberg et al. (2009). This 11-item questionnaire used a six-point Likert scale, assessing three factors: 'relationships,' 'resources,' and 'time.' Internal consistency for each factor exceeded 0.79. Mean scores categorized distress levels from extremely low to extremely high. Part three utilized the Blegen et al. (1993) scale, adopted from Mrayyan (2005), employing a five-point Likert scale for 42 self-reported items related to patient care and unit operations. The Cronbach's alpha values for each subscale were .88 and .94, respectively. Interpretation categorized scores as very low to very high.

Data Gathering Procedure

The research process began with the submission of three research titles for approval. Once a title was approved, an adviser was assigned, and further approvals were sought from the Dean of the College of Allied Health Sciences, the Chief Academic Officer, and the Chief of Hospitals. The study underwent a Design hearing for expert panel approval. Following this, approval was obtained from the University of the Visayas-Research Ethics Committee (UV-REC). The researcher awaited the release of the notice to proceed before recruiting the first respondent, ensuring adherence to Inter-agency Task Force (IATF) guidelines during in-person data collection for the safety of both respondents and the researcher. An enumerator was hired to assist in distributing and retrieving research questionnaires. In data collection, inclusion and exclusion criteria guided respondent selection, and the enumerator was briefed on these criteria for recruitment. Questionnaires were distributed and collected on the same day, checked for completeness, and any missing or unanswered items were addressed with the respondents. All completed questionnaires were collected, compiled, and subjected to descriptive and inferential statistical analysis. At the study's conclusion, the completed questionnaires were shredded, while a soft copy of tabulated responses was retained for reference and deleted after the study.

Statistical Treatment Data

The study employed the following statistical methods: Frequency Distribution and Simple Percentage for presenting the respondents' profile; Mean Score for assessing moral distress and professional autonomy; Chi-Square for evaluating the significant relationship between profile and moral distress, as well as profile and professional autonomy; Cramer's V for determining the strength of association in significant relationships identified by Chi-Square; and Pearson r for examining the significant relationship between moral distress and professional autonomy among nurses.

Ethical Considerations

The study strictly adhered to the ethical guidelines set forth by the University of the Visayas' research ethics committee, ensuring the integrity of this research.

RESULTS AND DISCUSSION

Profile of the Nurses

The majority of nurses in the study were young adults, aged 19 to 35, aligning with Erik Erikson's psychosocial development theory. Millennial nurses (under 35) comprised 65% of the workforce, while those over 60 were less than 5%. In terms of gender, nursing remains female-dominated, with over 75%

being women. Despite societal changes, nursing has retained its female majority. Regarding education, most nurses held a bachelor's degree, a requirement for licensure. Few had master's or doctorate degrees. The age of respondents in a related study averaged 30.62 years, with the majority holding degrees in nursing. In terms of experience, there was a roughly equal distribution among those with 1-5, 6-10, and 11-15 years of service. Very few had 16-20 years or more, indicating a potential turnover issue. This aligns with findings showing most nurses having served for more than 15 years in a related study.

Moral Distress among Nurses

Table 1 shows that in terms of time, nurses rated it low, expressing moderate belief that they lacked time for patient care. They admitted to keeping patients waiting and providing insufficient attention due to time constraints. This indicates a broader issue of nurses being overwhelmed by a higher patient load, causing rushed and compassion-lacking care, leading to moral distress.

Studies, like Bradley (2023), highlight that a shortage of nurses directly impacts patient care quality. Patient mortality increases with fewer nurses, emphasizing the importance of maintaining an appropriate nurse-patient ratio. Shortages lead to ER overcrowding, prolonged waiting times, and increased likelihood of medical errors, including medication mistakes.

The dimension of resources was also rated low. Nurses believed they were compelled to respond inadequately due to resource shortages. Lack of privacy and patient referrals to other wards due to overcrowding reflect the strain on resources. This scarcity is attributed to an insufficient allocation of funding, worsened by experiences like the COVID-19 pandemic.

Regarding relationships, nurses rated it low, feeling compelled to follow orders against their conscience, sometimes disregarding patient and family inquiries. Collaboration and teamwork with doctors were noted as essential, emphasizing the need for nurses to assert themselves as patient advocates, stay updated on healthcare trends, and maintain competence.

Overall, low ratings in time, resources, and relationships signify low moral distress. However, the nurses still experience moral distress, highlighting the need for hospital administrators to address root causes by ensuring adequate nurse-patient ratios, allocating financial resources, and promoting professional autonomy among nurses.

Table 1. Moral Distress among Staff Nurses

Statements		Mean score	SD	Interpretation
Time	Factor mean	3.31	2.11	Low
Resources	Factor mean	3.28	2.04	Low
Relationships	Factor mean	2.96	1.83	Low
Grand mean		3.18	1.81	Low

Note: *n=102.*

Legend: 1.00 – 1.83 is extremely low, 1.84 – 2.66 is very low, 2.67 – 3.49 is low, 3.50 – 4.32 is high, 4.33 - 5.15 is

very high, and 5.16 - 6.00 is extremely high.

Professional Autonomy among Nurses

Table 2 shows that in patient care decisions, nurses rated their autonomy as high. They perceived full independent authority and accountability in areas such as serving as patient advocates, preventing skin breakdown, teaching self-care activities, and preventing patient falls. They also felt empowered to refuse physician's orders, advance PRN orders, and inform patients of surgery risks. Additionally, they believed

in sharing authority and accountability when questioning physician orders, discussing alternatives, and deciding on the timing of care.

Consistent with this, Shohani et al. (2018) found high levels of professional autonomy among nurses, especially in patient care decisions. Similarly, Alruwaili and Abuadas (2023) reported moderate overall work autonomy, with more autonomy in patient care decisions compared to unit operation decisions.

Concerning unit operation decisions, nurses rated their autonomy as moderate. They expressed involvement in group decisions related to department committees, delivery of care methods, and unit goals. Nurses shared authority and accountability in tasks such as arranging trading hours, making patient assignments, and developing unit procedures. This autonomy extended to areas like developing and revising unit policies, initiating research activities, and planning yearly budgets.

Labrague et al. (2018) also highlighted a moderate degree of professional autonomy among Filipino nurses, emphasizing the positive impact on job outcomes. This suggests that while nurses have a high level of autonomy in patient care decisions, they operate within a collaborative and interdisciplinary healthcare setting, demonstrating both dependent and interdependent functions.

In summary, nurses possess high professional autonomy in patient care decisions, showcasing their independence within the nursing profession. However, their role is intricately connected to collaborative healthcare practices.

Table 2. Professional Autonomy among Staff Nurses

Statements		Mean score	SD	Interpretation
Patient Care Decisions	Factor mean	3.64	0.58	High
Unit Operation Decisions	Factor mean	3.20	0.81	Moderate
Grand mean		3.42	0.63	High

Note: *n=102.*

Legend: 1.00 – 1.80 is very low, 1.81 – 2.60 is low, 2,61 – 3.40 is moderate, 3.41 – 4.20 is high, and 4.21 - 5.00 is very

high.

Relationship between Profile and Moral Distress

The correlation between the profile variables (age, sex, highest educational attainment, and number of years in the profession) and the dimension of time, resources, relationships, and overall moral distress were examined. For time and resources, the p values were greater than .05, indicating a lack of significant correlation. Therefore, age, sex, educational attainment, and years in the profession were not significantly associated with time and resources of moral distress. This suggests that nurses, regardless of their profiles, face similar time and resource challenges but adapt to cope with the demands of patient care.

However, regarding relationships, the number of years in the profession showed a significant correlation, with a positive relationship indicating that longer tenure led to higher moral distress in relationships. This is consistent with findings suggesting that prolonged service exposes nurses to diverse cases and changes, potentially straining relationships, especially with new colleagues.

Conversely, age, sex, and highest educational attainment were not significantly correlated with relationships of moral distress. This implies that, irrespective of these profile factors, nurses may experience similar levels of distress in interpersonal relationships. Similarly, overall moral distress was not significantly correlated with age, sex, highest educational attainment, or number of years in the profession. This indicates that moral distress is not influenced by these profile factors. Nurses, regardless

of their profiles, encounter moral distress, but their knowledge and coping mechanisms, developed during education and exposure to real cases, contribute to their ability to manage and adapt to challenges in patient care.

Contrasting findings from other studies highlight the complexity of moral distress and its various influencing factors. While some studies associate moral distress with factors like work experience, team communication, powerlessness, staffing, and provision of care, the current study does not find significant correlations with the specified profile variables. Different contexts, settings, and methodologies might contribute to these discrepancies. In conclusion, despite the lack of direct correlation between certain profile factors and moral distress, it's crucial for healthcare management to address various contributing factors to alleviate moral distress among nurses.

Relationship between Profile and Professional Autonomy

The correlation analysis indicates that the p values between profile variables (age, sex, highest educational attainment, and number of years in the profession) and professional autonomy were not significant (greater than .05). Consequently, the null hypothesis was not rejected, suggesting no significant correlation between these profile factors and professional autonomy. This implies that professional autonomy is not influenced by age, sex, educational attainment, or years in the profession. Regardless of these profile aspects, nurses can achieve a high level of professional autonomy.

Professional autonomy is an integral part of the nursing profession, instilled in nurses during their education and carried throughout their careers. This understanding persists regardless of age, sex, educational attainment, or years in the profession. Nurses recognize the autonomous nature of their practice, as evidenced by their membership in accredited professional organizations, symbolizing the autonomy of the nursing profession. In contrast, Rababa et al. (2022) found that nurses, according to gender, experience, and nursing home type, had low perceived control over nursing practice. This study provides insights into how nurses' sociodemographic and professional characteristics may impact their perceived control over nursing practice.

Another study by Gharaaghahi et al. (2022) indicated that ICU nurses demonstrated moderate autonomy and job stress, with autonomy showing a positive correlation with work experience in the ICU. The findings suggest the need for strategies to enhance nurses' autonomy and address factors contributing to job stress in the ICU. In conclusion, fostering professional autonomy in nursing is essential, as it contributes significantly to patient care. Management should actively support and promote autonomy within the nursing profession, recognizing its vital role in patient care.

Relationship between Moral Distress and Professional Autonomy

Table 3 indicates that the p values for the correlation between moral distress dimensions, overall moral distress, and patient care decisions were greater than .05, suggesting a lack of significant correlation. Consequently, the null hypothesis was not rejected, indicating that patient care decisions are not significantly influenced by time, resources, relationships, or overall moral distress among nurses. High levels of these factors do not necessarily hinder achieving high patient care decisions. Similarly, the analysis for unit operation decisions showed p values greater than .05, leading to the conclusion that unit operation decisions are not significantly correlated with time, resources, relationships, or overall moral distress. Despite high levels of these variables, achieving high unit operation decisions is still possible.

Furthermore, the correlation between moral distress dimensions, overall moral distress, and overall professional autonomy had p values greater than .05. The null hypothesis was not rejected, signifying that professional autonomy is not significantly influenced by moral distress. Therefore, a high level of

professional autonomy can be attained despite high moral distress among nurses. Contrary to these findings, other studies have reported a positive relationship between professional autonomy and moral distress. However, this study suggests that moral distress is not a contributing factor to professional autonomy. Nurses' moral distress may be seen as part of the challenges and frustrations in nursing practice, common to the entire healthcare team.

Additional studies also reported an inverse relationship between professional autonomy and moral distress, emphasizing the importance of autonomy in reducing moral distress. However, the current study implies that improving these variables independently is crucial, as moral distress does not directly impact professional autonomy.

Table 3. Relationship between Moral Distress and Professional Autonomy

Variables	r value	*p* value	Decision	Interpretation
Patient Care Decision				
Time	-.116	.245	Failed to reject Ho	Not significant
Resources	-.125	.210	Failed to reject Ho	Not significant
Relationship	-.100	.317	Failed to reject Ho	Not significant
Overall Moral Distress	-.126	.207	Failed to reject Ho	Not significant
Unit Operation Decisions				
Time	-.140	.160	Failed to reject Ho	Not significant
Resources	-.151	.130	Failed to reject Ho	Not significant
Relationship	-.104	.299	Failed to reject Ho	Not significant
Overall Moral Distress	-.147	.142	Failed to reject Ho	Not significant
Overall Professional Autonomy				
Time	-.144	.149	Failed to reject Ho	Not significant
Resources	-.155	.120	Failed to reject Ho	Not significant
Relationship	-.114	.255	Failed to reject Ho	Not significant
Overall Moral Distress	-.153	.125	Failed to reject Ho	Not significant

Legend: Significant if *p* value is < .05. Pearson r value interpretation: -1 perfectly negative, -0.8 strongly negative, -0.5 moderately negative, -0.2 weakly negative, 0 – no association, 0.2 weakly positive, 0.5 moderately positive, 0.8 strongly positive, and 1 perfectly positive.

CONCLUSION AND RECOMMENDATION

In conclusion, the study finds that age, sex, highest educational attainment, and number of years in the profession do not significantly influence moral distress and professional autonomy among nurses. The results indicate that nurses can experience low moral distress and high professional autonomy irrespective of these demographic factors. Furthermore, professional autonomy is not significantly correlated with moral distress, suggesting that nurses can maintain a high level of professional autonomy even in the face of elevated moral distress. The study aligns with the Theory of Moral Reckoning, attributing nurses' moral

distress to challenges in time, resources, and relationships during patient care. Additionally, the Self-Determination Theory's emphasis on autonomy is reflected in the study's findings. A professional autonomy enhancement plan has been proposed based on the results. Recommendations include presenting the findings to hospitals for potential adoption, utilizing the study as a reference for policy development, incorporating the results into educational discussions, and disseminating the study through research congresses and publications. The study suggests potential research avenues such as comparative analyses on moral distress and professional autonomy among nurses in different settings and exploring the phenomenology behind professional autonomy.

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