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Moral distress among nursing and non-nursing students*

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Abstract
Their nursing experience and/or training may lead students preparing for the nursing profession to have less moral distress and more favorable attitudes towards a hastened death compared with those preparing for other fields of study. To ascertain if this was true, 66 undergraduates (54 women, 9 men, 3 not stated) in southeastern USA completed measures of moral distress and attitudes towards hastening death. Unexpectedly, the results from nursing and non-nursing majors were not significantly different. All the present students reported moderate moral distress and strong resistance to any efforts to hasten death but these factors were not significantly correlated. However, in the small sample of nurses in training, the results suggest that hastened death situations may not be a prime reason for moral distress.

Keywords
hastened death, moral distress, students

Introduction

Moral distress is the painful feelings and/or psychological disequilibrium that results from recognizing an ethically appropriate action, yet not taking it because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations.[1] A hastened death means taking or not taking an action, the result of which will be death occurring sooner than it would have done.[2] Inasmuch as hastened death situations involve life and death moral dilemmas, they may lead to concern, confusion, and moral distress for health professionals, even those with many years' experience, as they try to determine the basis of these statements and an appropriate response.[3] Obtaining a greater understanding of the foundation of moral distress would assist efforts to prevent or minimize its negative effects on the nursing profession and therefore on health care in general. Individual background as well as preparation for medical professions may influence moral distress and attitudes towards a hastened death, hence the present focus. The purpose of the study was to ascertain whether those preparing for the nursing profession have less moral distress and more favorable attitudes toward hastened death than those preparing for other professions.

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Background

Nurses face a wide variety of ethical problems ranging from those resulting from growth in scientific knowledge and technology, and the availability of new diagnostic equipment and treatment opportunities,[4] to those deeply human issues such as informed consent, treatment, and maintenance of life and/or resuscitation.[5] Furthermore, the stated goals of the nursing profession are ethical: to promote and/or restore health, prevent illness, and respect human rights, including rights to life and dignity in working with individuals, families, the community, and related groups.[6] Understanding what causes nurses to become distressed about their ethical problems could help them to accomplish these professional goals.

Death encounters are among the most problematic issues nurses face in clinical practice,[7] and include dilemmas that may be practical, psychosocial, spiritual, legal, existential, or medical in nature. Of these, medical end-of-life decisions for terminally ill people are often the most challenging issues for those who care about them.[8] Such encounters are common. American nurses increasingly report that terminally ill patients or their family members ask for assistance in dying. In one study, about one third of responding hospice nurses in Oregon reported that in the previous four years they had cared for a patient who deliberately hastened death by voluntary refusal of food and fluids.[9] About one third of the respondents in a survey of critical care nurses reported that they had been asked to assist in hastening a patient's death.[10] Thus, nurses are often at the vortex of complex ethical dilemmas such as deciding whether to hasten death for someone who is terminally ill or suffering.

There is a broad spectrum of patients' requests for hastening death: from a passive wish to have death occur but no active plans to hasten it, to requests for specific interventions to hasten death, to specific thoughts or plans for committing suicide.[11] Nurses bring values to their work and can identify ethical dilemmas in their work environment. Consequently, they may experience moral distress about any or all types of requests for hastening death. First used in Jameton's[12] book on nursing practices, moral distress is currently considered an umbrella term that captures the experiences of people who are morally constrained.[13] The theory of nurse moral distress explains that nurses experience such distress as a result of being unable to advocate for patients, and suggests that one avenue of further exploration would be to determine if there are antecedent factors that predict moral distress.[14]

To date, most studies have focused on nurses working in critical care or acute care situations.[13] In addition, however, most medical and nursing schools offer training on death and dying, in which most students participate. However, although end-of-life issues are covered, in-depth information is not provided.[15] This preparation can make a difference in moral distress, and is thus a reasonable avenue for exploration.

Training may enhance moral sensitivity and thereby reduce moral distress. For example, an experiential learning module that included role play and time spent at a hospice, a funeral home, and an anatomy laboratory, had a positive effect on undergraduate nursing students' attitudes toward care for dying persons, a positive transformation that increased slightly after a four-week period.[16] In another study, training was associated six months later with reduced anxiety about death, increased knowledge, and an improved attitude towards caring for dying people.[17] Training can thus have a positive effect on attitudes toward dying persons.

In addition, among three groups of nurses in training in one study, those with the most training in ethics were most aware of moral issues in nursing dilemmas, and senior nursing students in all three programs were more aware of moral issues than freshman nursing students.[5] In addition, the practicing nurses in another study were receptive to end-of-life education, and productive in the introduction of an education module involving end-of-life care.[18] An educational program designed to improve medical-surgical nurses' death awareness, ability to communicate with dying persons and their families, and care for caregivers, had no effect on these nurses' attitudes or behavioral intentions towards care for dying patients and their families, but caused them to improve in their understanding of how others might perceive their behavior towards dying patients and their relatives. However, this change disappeared over time.[19] In addition to having a positive

effect on attitudes toward dying persons, training can have at least a temporary positive effect on awareness of moral issues.

Taken together, these findings suggest that nursing education may help students to become comfortable with dealing with dying persons and sensitive to the multifaceted aspects of nursing practice. By implication, therefore, training such as that provided by an integrated ethics, legal and health policy course in the nursing curriculum[20] could prepare them to confidently analyze and successfully resolve ethical dilemmas, thereby diminishing their moral distress about aspects of end-of-life care such as requests for a hastened death.

Training and experience are not always beneficial, however, and may occasionally hinder moral sensitivity. Current clinical training, by focusing narrowly on biomedical aspects of medicine, may inhibit many medical students' growth as moral agents.[21] In one study, when presented with a hypothetical moral dilemma in the Nursing Dilemma Test, senior baccalaureate nursing students actually displayed a higher level of principled thinking than practicing, experienced nurses. Additionally, as registered nurses accrued more experience, they used principled thinking less often.[22] These findings suggest that training and experience interfered with using principled thinking about some of the ethical dilemmas frequently found in nursing. One implication is that nursing training and experience may cause students to become inured to ethical dilemmas, so that it increases their moral distress about aspects of end-of-life care and decreases their acceptance of requests to hasten death.

Thus, moral dilemmas happen to all, but the nursing profession involves unique experiences in which dying individuals request a hastened death. Although it may not help with principled thinking, most relevant education seems to improve attitudes toward dying individuals and enhance moral sensitivity, and thereby provide a mechanism with which to diminish moral distress. The present purpose, therefore, was to ascertain whether students who are early in their nursing training, compared with those commencing their training for other professions, have less moral distress and more accepting attitudes toward hastening death. Since research suggests that training may reduce moral distress,[20] we expected undergraduates preparing to be nurses to have lower moral distress and more accepting attitudes towards hastening death than undergraduates preparing for other fields of study.

Method

Participants

The convenience sample included students from a small, predominantly Catholic liberal arts college in an urban area in southeastern USA. The student body comprises about 75% women, 60% Catholic in religious affiliation, and 40% from minority ethnic backgrounds. Those who are nursing majors complete courses that include death and dying issues such as pain medication and hospice services, and some complete an entire course in death and dying. In addition, some will already have had practical experience with helping someone who was terminally ill or who has died. Those who are not nursing majors complete other courses relevant to their major field of study, but will not necessarily take any courses that cover death and dying issues. Non-nursing majors are not as likely to have had practical experience with helping someone who was terminally ill or who has died.

Materials

The student participants provided some demographic information and completed two questionnaires. The Moral Distress Scale[1] comprises 30 sentence fragments that describe moral dilemmas that nurses are likely to face in their current practice (e.g. 'provide better care for those who can afford to pay than those who cannot'), which are scored on a Likert scale so that 0 = no distress and 6 = very severe distress. The sum of the scores for all items is divided by 30, so that total moral distress is a continuous variable that could range from

0 (none) to 6 (very severe distress). For the present study, one item was slightly reworded to remove sexist language. When completed by practicing nurses, this scale was internally consistent, with Cronbach's alphas around the 0.90 range.[1,23,24] Evidence of its validity was a negative correlation with the Ethical Environment Questionnaire administered to a group of registered nurses,[23] so that moral distress increases as the ethical environment deteriorates, as would be expected. Among the non-nursing undergraduate student participants, this scale was highly internally consistent (Cronbach's alpha = 0.94).

The Schedule of Attitudes Toward Hastened Death[25] was originally 20 true–false statements about the desire for a hastened death, designed to be completed by respondents who were terminally ill. The modification asked for students to imagine that they were terminally ill (e.g. 'dying would seem like the best way to relieve the pain and discomfort of my illness'), and to answer on a Likert scale scored so that 0 = not true at all and 6 = very true. The total scores were divided by 20, so that attitudes towards hastening death was a continuous variable that could range from 0 (no tolerance for hastened death) to 6 (belief that hastened death is appropriate and right). Evidence of reliability was the high internal consistency of the true-false version when completed by terminally ill HIV/AIDS patients.[25] Evidence of validity was a unidimensional factor structure when completed by the same terminally ill HIV/AIDS patients.[25] Among the sampled students, this scale was internally consistent (Cronbach's alpha = 0.87).

Procedure

After obtaining approval by a human subjects institutional review board, the researchers distributed questionnaires on campus during class for some participants and after class for others. Students who were in class received a small amount of extra credit for participating; extra credit was given on a separate a form to preserve anonymity. Other opportunities for extra credit were available. Students who were outside class received no incentives for participating. Both in and out of class, the students completed the questionnaires anonymously while the researcher waited.

Results

The participants were 66 undergraduate students (54 women, 9 men, 3 not stated). Their average age was 24.89 years (SD = 8.76). Their most frequently listed college major was nursing (24, 38.1%); the other 42 majors included education, psychology or counseling, business, biology or radiation technology, and miscellaneous other fields. Their ethnic background was European-American (34, 57.6%), African-American (17, 28.8%), Hispanic-American (4, 6.8%), or other (4, 6.8%). Note that seven respondents did not answer this question. Their most frequently reported religion was Catholicism (41, 66.1%), but other religious backgrounds included Protestant (13, 20.6%), miscellaneous other backgrounds, and four people did not answer this question. Their average length of medical experience was 11.41 months (mode = 0, SD = 30.57).

A *t*-test indicated that, counter to expectations, there was no significant difference between nursing and non-nursing students on either moral distress, $t(41) = -1.24$, $P = 0.22$, or attitudes towards a hastened death, $t(49) = 0.05$, $P = 0.96$. However, two demographic differences occurred for moral distress. First, European-American students on average reported moderate moral distress ($M = 4.69$, SD = 0.99), whereas African-American students reported neutral levels of moral distress ($M = 3.46$, SD = 1.33), a difference that is statistically significant: $t(35) = 3.14$, $P = 0.003$ (2-tailed), $\eta^2 = 0.22$. Students who had a Catholic religious background ($n = 41$) reported significantly more moral distress than those who reported other religious backgrounds, $t(40) = 2.07$ (2-tailed), $P = 0.045$, $\eta^2 = 0.10$.

One demographic difference was shown for attitudes towards hastening death. On average, European-American students reported moderately strong attitudes against hastening death ($M = 2.14$, SD = 1.01),

whereas African-American students reported extremely strong attitudes against hastened death ($M = 1.15$, SD = 0.63), a difference that was statistically significant, $t(40) = 3.13$, $P = 0.003$ (2-tailed), $\eta^2 = 0.20$.

A Pearson correlation indicated that moral distress was not significantly correlated with attitudes towards hastening death r ($N = 45$) = 0.03, P =0.88. It must be noted that some students failed to answer all questions, and those with missing data were not included in the affected analyses, so that degrees of freedom in some cases are less than the total number possible.

The students' moral distress scores averaged 4.32 (SD = 1.17), which indicates slight to moderate moral distress. For a comparison of means from other research, Zuzelo's[24] study of registered nurses working with neonatal and newborn patients used a 29-item version of the Moral Distress Scale, and reported 23 means, ranging from 3.06 to 4.14, numbers that are somewhat lower (less morally distressed) than the present average. Research with medical and surgical nurses[23] and medical intensive care nurses [26]obtained averages of 3.64 and 3.66, respectively, which are also somewhat lower (less morally distressed) than the present average.

On attitudes towards hastening death, both nursing and non-nursing students who participated in this study averaged 1.77 (SD = 0.97), which indicates moderate disagreement with hastening death. The present version of the Schedule of Attitudes Toward Hastened Death used a 7-point Likert format, which allowed responses of: 0 = not true at all; 1 = mostly untrue; 2 = slightly untrue; 3 = neither true nor untrue; 4 = slightly true; 5 = mostly true; 6 = very true. Rosenfeld et al.[25] used a true-false version of this questionnaire with HIV/AIDS patients, which forced them to respond either not true or true. Thus, the present version allowed for more gradations of responses about hastened death than that used by Rosenfeld et al. However, Rosenfeld et al.[25] obtained an average score of 3.05 out of 20, which suggests few endorsements of positive attitudes towards a hastened death, and indicates a negative position similar to that shown by the present students.

Discussion

The present results indicate that, unexpectedly, preparation to work in nursing versus another profession made no difference to moral distress or attitudes towards hastening death. Apparently, a student's college major does not influence the level of distress caused by moral dilemmas, such as those caused by situations involving the possibility of hastening death, as those in the medical profession may face. These results are consistent with Corley et al.'s[1] finding that professional nurses' age and professional experience do not make a difference in moral distress. The additional information from the present results is that undergraduate training to be a nurse may be no different to undergraduate training in other fields in terms of sensitizing students to moral distress or changing their attitudes towards a hastened death.

The current results also suggest that ethnic background makes a difference in moral distress. The sampled European-American and Catholic students reported more moral distress than African-American students. In contrast, Corley et al.[1] found that professional nurses who were African-American reported more moral distress than other professional nurses. Students who are early in their training may respond differently to practicing professionals. Nursing experts[27] noted that a person's ethnicity, among other personal characteristics, has the capacity to influence moral sensitivity. Our results add that ethnic and religious background influence moral distress as well as moral sensitivity.

Ethnic background also made a difference in attitudes towards hastening death. All the student participants were, on average, against hastening death, but the African-American and non-Catholic students were even more so than European-American and Catholic students. This result is consistent with a review of 33 empirical studies, which indicated that non-white racial or ethnic groups generally lacked knowledge of advance directives to a greater degree than other racial or ethnic groups, consistently preferred the use of life support, and were less likely than white people to support advance directives.[28]

Hastening death is an extremely controversial subject, and the present results indicate that minority status and religious background (but not nursing college major) can make a difference to undergraduates' attitudes. Future research could examine whether having a living will would reduce the moral distress in family members and medical personnel. If so, European-American and Catholic individuals might especially benefit from having training in how to obtain a living will because of the reduced degree of moral distress it would convey.

Most of our student participants reported slight to moderate moral distress (average 4.32, about the midpoint of the scale). These results appear to be similar to those of Corley et al.,[1] who obtained a range of scores from 3.9 to 5.5 on a 32-item measure of moral distress, and Corley et al.,[23] who reported a mean of 3.64 on a similar 30-item measure. Apparently, students who are preparing to be nurses and those who are training for other professions are similar to practicing nurses in reporting slight to moderate levels of moral distress.

The current students also reported moderate disagreement about efforts to hasten death. In comparison, nearly three-quarters of patients with terminal AIDS/HIV agreed with only three or fewer of the 20 statements endorsing a hastened death on the true-false version of the Schedule of Attitudes Toward Hastened Death.[25] It must be noted that Rosenfeld et al.'s[25] participants were mostly African-American, and among the present students African-Americans were more likely than others to disagree with efforts to hasten death. Our results indicate that college students who are not ill are similar to patients who are facing imminent death in their strong resistance to efforts to hasten death.

Among the present students, there was no systematic relationship between moral distress and attitudes towards hastening death. It could be that situations involving a hastened death are not a concern for college students, regardless of whether they are preparing for medical or other professions. It could also be that the Catholic background of many of these students gave them moral certainty about what to do in a hastened death situation, and thus relieved them of moral distress. Corley[14] stated that factors predicting moral distress have not been identified. Additionally, the present results indicate that attitudes towards hastening death are not moral distress indicators.

A limitation of this study was the small, non-random sample, so conclusions cannot be generalized to other students, other adults, or samples comprised mostly of men. Another limitation was the current questionnaires. Students may respond to a hypothetical situation differently to if they were qualified nurses facing a situation of making a life or death decision for a terminally ill patient, or family members facing the same decision for a terminally ill loved one. In addition, the present tool for measuring moral distress was developed for practicing professionals, not students training to be professionals; and also the present tool for measuring attitudes to hastening death has been used with terminally ill hospice patients in the USA[25,29,30] and Greece,[31] but not with students. Both measures were internally consistent when completed by the present students, but validating them with students would be a reasonable direction for future research.

Although the current questions about moral distress seemed related to those about hastening death, the fact that these two variables were unrelated suggests that hastened death situations are not the prime reason for moral distress. It is possible that inadequate care or unequal care situations are relatively more morally distressful to those facing these decisions. Suggestions for enhancing ethical understanding and problem solving include ethics rounds, discussion groups, and debriefing sessions.[24] In the present study, inasmuch as culture made a difference in moral distress and attitudes towards hastening death, one implication is that these enhancements need to be implemented with a great deal of cultural sensitivity. A qualitative research design could be an appropriate way to investigate this topic. Future researchers will also need to consider how cultural factors enter into beliefs about hastening death and feelings about moral distress. In particular, medical professionals need to consider the cultural implications of moral dilemmas such as agreeing to hastening the death of a loved one.

Conflict of interest statement

The authors declare that there is no conflict of interest.

References

1. Corley M, Elswick R, Gorman M, Clor T. Development and evaluation of a moral distress scale. *J Adv Nurs* 2001; 33: 250–6.
2. Werth J. The relationship among clinical depression, suicide, and other actions that may hasten death. *Behav Sci Law* 2004; 22: 627–49.
3. Hudson PL, Schofield P, Kelly B, et al. Responding to desire to die statements from patients with advanced disease: recommendations for health professionals. *Palliat Med* 2006; 20: 703–10.
4. Torjuul K, Sorlie V. Nursing is different than medicine: ethical difficulties in the process of care in surgical units. *J Adv Nurs* 2006; 56: 404–13.
5. Krawczyk RM. Teaching ethics: effect on moral development. *Nurs Ethics* 1997; 4: 57–65.
6. International Council of Nurses. The ICN Code of Ethics for Nurses. *Nurs Ethics* 2001; 8: 375–9.
7. White KR, Coyne PJ, Patel UB. Are nurses adequately prepared for end-of-life care? *J Nurs Scholarsh* 2001; 33: 147–51.
8. Griffin S, Sawkins N. Managing end of life care using the Gold Standard Framework. *Primary Health Care* 2009; 19(9): 22–4.
9. Ganzini L, Goy ER, Miller LL, et al. Nurses' experiences with hospice patients who refuse food and fluids to hasten death. *N Engl J Med* 2003; 149: 359–5.
10. Puntillo KA, Benner P, Drought T, et al. End-of-life issues in intensive care units: a national random survey of nurses' knowledge and beliefs. *Am J Crit Care* 2001; 10: 216–29.
11. Hudson PL, Kristjanson LJ, Ashby M, et al. Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review. *Palliat Med* 2006; 20: 693–701.
12. Jameton A. *Nursing practices: the ethical issues*. London: Prentice-Hall, 1984.
13. McCarthy J, Deady R. Moral distress reconsidered. *Nurs Ethics* 2008; 15: 254–62.
14. Corley MC. Nurse moral distress: a proposed theory and research agenda. *Nurs Ethics* 2002; 9: 636–50.
15. Dickinson G. End-of-life and palliative care issues in medical and nursing schools in the United States. *Death Stud* 2007; 31: 713–26.
16. Mallory JL. The impact of a palliative care educational component on attitudes toward care of the dying in undergraduate nursing students. *J Prof Nurs* 2003; 19: 305–12.
17. Kurz JM, Hayes ER. End of life issues action: impact of education. *Int J Nurs Educ Scholarsh* 2006; 3(1): Article 18.
18. Ferrell BR, Virani R, Grant M, et al. Evaluation of the End-of-Life Nursing Education Consortium Undergraduate Faculty Training Program. *J Palliat Med* 2005; 8: 107–14.
19. Hainsworth DS. The effect of death education on attitudes of hospital nurses toward care of the dying. *Oncol Nurs Forum* 1996; 23: 963–7.
20. Garity J. Fostering nursing students' use of ethical theory and decision-making models: teaching strategies. *Learn Health Soc Care* 2009; 8: 114–22.
21. Branch WT. Supporting the moral development of medical students. *J Gen Intern Med* 2000; 15: 503–8.
22. Ham K. Principled thinking: a comparison of nursing students and experienced nurses. *J Contin Educ Nurs* 2004; 35(2): 66–73.
23. Corley MC, Minick P, Elswick RK, Jacobs M. Nurse moral distress and ethical work environment. *Nurs Ethics* 2005; 12: 381–90.
24. Zuzelo PR. Exploring the moral distress of registered nurses. *Nurs Ethics* 2007; 14: 344–59.

25. Rosenfeld B, Breitbart W, Stein K, et al. Measuring desire for death among patients with HIV/AIDS: the Schedule of Attitudes toward Hastened Death. *Am J Psychiatry* 1999; 156(1): 94–100.
26. Elpern E, Covert B, Klienpell R. Moral distress of staff nurses in a medical intensive care unit. *Am J Crit Care* 2005; 14: 523–30.
27. Schluter J, Winch S, Holzhauser K, Henderson A. Nurses' moral sensitivity and hospital ethical climate: a literature review. *Nurs Ethics* 2008; 15: 304–21.
28. Kwak J, Haley WE. Current research findings on end-of-life decision making among racially or ethnically diverse groups. *Gerontologist* 2005; 45: 634–41.
29. Olden M, Rosenfeld B, Pessin H, et al. Measuring depression at the end of life: is the Hamilton Depression Rating Scale a valid instrument? *Assessment* 2009; 16: 43–54.
30. Rosenfeld B, Breitbart W, Gibson C, et al. Desire for hastened death among patients with advanced AIDS. *Psychosomatics* 2006; 47: 504–12.
31. Mystakidou K, Rosenfeld B, Parpa E, et al. Desire for death near the end of life: the role of depression, anxiety and pain. *Gen Hosp Psychiatry* 2005; 27: 258–62.