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EMPIRICAL STUDIES

Moral distress experienced by care leaders' in older adult care: A qualitative study

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Abstract

Background: Many healthcare professionals have left their professions recently because of increased moral distress, and the COVID-19 pandemic has had a further major impact on the ever-changing healthcare environment.

Aim: The purpose of the study was to examine care leaders' experiences of moral distress in their daily work in older adult care.

Methodology: A qualitative design was used. The data consisted of texts from interviews with care leaders ($N = 8$) in an older adult care context. Content analysis was used to analyse the data.

Findings: Five themes emerged: (1) moral distress arises from a lack of time, (2) moral distress contributes to a sense of inadequacy but also a sense of responsibility, (3) moral distress arises from an imbalance in values, (4) increased knowledge and open discussion help reduce moral distress and (5) reflection, increased support and increased resources can reduce moral distress.

Conclusion: Moral distress is something that care leaders, according to this study, experience daily in an older adult care context and it is considered to have increased. Care leaders can experience moral distress from a lack of time; patient-related, relative-related or other ethically difficult situations or an imbalance between own values and an organisation's, other caregivers', patients' and/or patients' relatives values. Increased staffing resources, more knowledge (training and lectures) and time for reflection individually, in groups or with an outside expert could increase care leaders' insights into and ability to reduce moral distress. Although situations that are characterised by moral distress are burdensome, care leaders have the opportunity to learn from such situations through reflection and discussion and can develop strategies for future ethical challenges. Future research could focus on exploring caregivers' experiences of moral distress.

KEYWORDS

experiences, interviews, moral distress, nurse leaders, older adult care

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INTRODUCTION

An increased emphasis on efficiency in healthcare today has led to ethical conflicts becoming highly common in care environments [1,2]. Ethical conflicts can arise, for example, when top management introduces changes or issues directives that conflict with care leaders' ethical values [2]. This in turn can result in care leaders experiencing moral dilemmas or stress [2]. The ever-changing healthcare environment [3,4]. Deschenes et al. [4] has also been further majorly impacted by the COVID-19 pandemic [5,6]. More attention has been placed on the "moral distress" that caregivers may experience [7] when they are unable to act in the way they wish because of an external obstacle, such as the COVID-19 pandemic [8]. Moral distress has been identified as the reason underlying why many caregivers have chosen to leave their professions in recent years and given its major impact on care, the topic should be further researched [9].

Background

Used alongside the terms "ethical problems" and "ethical stress," moral distress is defined as a psychological imbalance that occurs when people are aware of the ethically appropriate action that a situation would require but cannot perform this action due to external obstacles [4,10,11]. Moral distress is thus linked to moral judgment: when a person understands what the "right thing" to do is but is unable to act in a manner in accordance with such understanding due to, for example, external obstacles [1,9,10,12,13]. The concept of moral distress, therefore, can be broadened to include not only the awareness of the right action or measure but also that the action or measure cannot be realised or implemented in a satisfactory manner due to factors beyond a person's control [12-14]. Such factors can include, for example, power structures, legal constraints or lack of time [10].

Moral distress can lead to work-related stress, reduced self-esteem or negative emotions such as frustration, anxiety, sadness or fear [4,9,10,11]. It can also lead to professional growth or positive emotions such as improved self-reflection [4]. While it can be considered an ethical phenomenon, where ethical and moral obligations come into conflict, caregivers nonetheless also can experience moral distress without experiencing a sense of conflict [12,13].

Some of the factors leading to greater complexity in the daily care environment include reduced staffing, the increased number of patients with greater and more challenging needs, the need to simultaneously maintain high-quality care while minimising care costs [4,15], that

populations are getting older and patients are more unwell, and that care throughout the world is being restructured [16]. Improved methods for ethical problem-solving are required [3,4]. Caregivers commonly experience moral distress in their daily work [4]. Ethical problems arise when caregivers are required to act in a way they perceive is not in the patient's best interests [17-19]. Being required to defend patients' best interests and right to self-determination can give rise to a great deal of stress in caregivers' everyday work life [16].

Caregivers can be required to prioritise, especially if limited resources or a limited budget conflict with meeting patients' basic needs [19]. In such cases, a tension arises between the organisation's values and needs and/or caregivers', patients' and patients' relatives needs and values [2]. Care leaders act as an intermediary between these values and thereby have considerable influence on the caring atmosphere [1,2]. As previously noted, when the primary emphasis in an organisation is placed on costs and productivity, conflict can arise between such organisational values and care values, where patient care is the most important [1,2,19]. Some of the most common ethical problems that caregivers experience are a lack of resources, patients who are more and more unwell, and not being able to develop and produce high-quality care [1,2,11,19,20]. Common ethical problems in care can be related to an organisation, staff, patients or other factors [1,3,20]. For example, care leaders can experience ethical problems linked to a lack of appreciation or interprofessional conflicts in different practical situations [20], and increased work stress can be linked to situations where patients or relatives are uncooperative or behave inappropriately [17].

Care leaders can experience moral distress as contributing to emotional and/or mental harm [21]. When caregivers are required to take "incorrect" measures, even though they have knowledge of and are aware of the measures that should be taken, they can experience feelings of shame, guilt or remorse [10,21]. When caregivers are obliged to take measures that go against their ethical principles, their emotional integrity is damaged, which can lead to burnout [21]. Moral distress does not dissipate once a situation has passed; care leaders and other caregivers continue to experience moral distress even after the actual care situation is over [10]. Some caregivers even perceive that moral distress can lead to a disinclination to work [18]. Moral distress can contribute to mental suffering as well as reduced self-esteem, which in turn can lead to a change of profession [10,18,21,22]. Researchers have shown that care leaders prioritise organisational responsibilities over their human and ethical responsibilities [10,21]. The experience of consciously doing what one perceives to

TABLE 1 Example of the data analysis

Meaning unit	Condensed meaning unit	Code	Category	Main theme
"... the budget really steers us more than ethical values... unfortunately... money steers... we're here for our patients and I don't think the organization should forget, that it's about the city's residents and their well-being. More and more there is talk about money rather than about people"	Economic values steer the organisation's ethical values. Money is more important than people. Imbalance in values	The budget steers rather than ethical values. Economic factors were paramount. Increased moral distress since participants did not always have the opportunity to emanate from their ethical values	Economic values that steer the organisation's ethical values, create moral distress	Moral distress arises from an imbalance in values

be incorrect also contributes to psycho-emotional damage and damage to professionalism [18,21]. This can be considered hidden suffering caused by being forced to betray one's ethical principles [21]. Perceived moral distress even leads to more medical errors, which can result in increased costs and reduced patient satisfaction [22].

Several new ethical dilemmas have emerged in conjunction with the COVID-19 pandemic that contributes to caregivers' moral distress, and many of these are linked to a lack of resources, both medical and human [8]. Patients' moral distress has even increased, which in turn affects caregivers [7]. Care leaders' and other caregivers' work pace has increased and their workload has grown, and they do not have the same time as before to reflect on ethical problems and/or prioritise work tasks [8,23]. Care leaders are experiencing great stress because of the constant stream of new information from national health authorities, which often requires rapid change [5]. Care leaders and other caregivers are experiencing increased moral distress linked to patients' unalleviated moral suffering [7,24]. Care leaders and other caregivers are even experiencing increased moral distress caused by uncertainty about the future, uncertainty linked to decision making and the fear of failure [7]. Care leaders face a significant task in seeking to meet the challenges part of the ongoing COVID-19 pandemic [23].

As seen above, there is an urgent need for new and better strategies for dealing with moral distress in healthcare [16]. The development of high-level ethical leadership is needed, which will improve the quality of patient care, improve caregivers' welfare and streamline care organisations [19,20].

AIMS

The purpose of the study was to examine care leaders' experiences of moral distress in their daily work in older adult care.

METHODOLOGICAL ASPECTS

The research question was: How do care leaders experience moral distress in their daily work in older adult care?

Data material and data collection

A qualitative design was used in this study. The data material consisted of texts from interviews with eight ($N = 8$) care leaders (aged 28–62 years) in Finland regarding their experiences of moral distress in their daily work

in older adult care. The participants worked within different older adult care settings: home care, care wards for older adults, older adults daycare centers and service housing. The participants were selected in collaboration with the head nurse of the organisation. The selected participants first received a written invitation to participate in the study by email and secondly a telephone call was made to orally inform them about the study. The information letter detailing the study and participation in an interview on the topic of moral distress was sent by email. The participants' experience varied from 4 to 43 years in different nursing contexts and from one to 21 years of experience as a care leader in older adult care.

Analysis

Semi-structured interviews were conducted digitally (online) during February and March 2021, because of the COVID-19 pandemic. The interviews lasted between 40 and 60 min and were recorded and transcribed. The data material was analysed using qualitative content analysis [25]. Both researchers analysed the material by reading it several times to open up the subject. Sentence units were found, condensed, coded and categorised. The analysis generated five main themes. Through qualitative content analysis, similarities, variations and differences were revealed. Both researchers discussed and agreed on the choice of final themes. For an example of the data analysis conducted see Table 1.

Ethical considerations

The research has been conducted in accordance with the guidelines for the Finnish National Board on Research Integrity TENK [26]. One researcher contacted care leaders working at the care organisations included in the study and invited them to participate in the study by email. Those indicating that they wished to participate received oral and written information about the study purpose, confidentiality and the intention to publish the research results. Permission to conduct the interviews was given by the included care organisations and written informed consent was obtained from the study participants. The ethical permit to conduct the study was approved by a research ethics committee at the university where the researchers are based. If the interview caused unpleasant feelings in participants and they felt they needed to discuss these, they were encouraged to contact the interviewer afterward.

FINDINGS

Five themes were generated (see Table 2). These five themes are described in more detail below.

Moral distress arises from a lack of time

The participants revealed that they wanted to spend more time with their patients but could not. They experienced that only having the time for the most necessary care measures was difficult.

... you would need to have sufficient time for your patients, that's the biggest [problem linked to moral distress] ... It's reflected onto the patients ... even if the caregivers are as nice and capable as you like they don't have time to perform the work properly. The physical [work] but the mental [work] becomes probably left half-done.

(P2)

The participants also noted that they needed to prioritise between patients, that is, due to a lack of time they were required to choose which patient received more of their time. "[Caregivers] don't know how much extra time they can give to this patient so that other patients don't suffer too much... we are struggling to be sure with time pressure and staff shortages that it's crazy right now [during the pandemic]" (P5).

The participants stated that the COVID-19 pandemic had led to an even greater time pressure, which consequently increased their moral distress. Not only were the care leaders affected by such a lack of time; caregivers' lack of sufficient time for work tasks impacted patient care, regardless of how good the caregivers were. The participants revealed that increased sick leaves and quarantine periods during the COVID-19 pandemic had resulted in the need to employ underqualified temporary staff and that as a result competency was sometimes lacking. Also, the participants noted that the inability to perform certain tasks that are delineated but for which resources do not exist could cause moral distress, for example, the inability to take patients out for individual walks. The participants perceived that more staffing resources would lead to the reduction of moral distress.

The participants also experienced that their moral distress increased when they as care leaders were required to assist caregivers or provide direct-patient care because of a lack of staffing resources, which resulted in their administrative work being left uncompleted.

TABLE 2 Study findings

Main themes	Core findings within the themes
Moral distress arises from a lack of time	<p>Only having time for the most necessary care measures was experienced as difficult.</p> <p>Being forced to prioritise between patients and having to choose which patient should receive more of their time caused moral distress.</p> <p>The COVID–19 pandemic had led to an even greater time pressure, which consequently increased their moral distress and impacted patient care</p>
Moral distress contributes to a sense of inadequacy but also a sense of responsibility	<p>Inadequacy was linked to staffing resources, with the participants revealing that there was nothing further they could do to acquire more staffing resources, even if more resources were needed.</p> <p>More fully qualified staff would result in a “calmer” work tempo, which thereby would facilitate the sharing of responsibility and reduce moral distress.</p> <p>Moral distress could arise when caregivers who are not really interested in older adult care were employed.</p> <p>Moral distress could lead to the development of a stronger sense of responsibility for patients and could awaken a desire and vision for the future</p>
Moral distress arises from an imbalance in values	<p>Economic values were used to steer the organisation’s ethical values, which created moral distress since participants did not always have the opportunity to emanate from their ethical values because economic factors were paramount.</p> <p>The patients’ relatives could sometimes have a different opinion on a matter than caregivers or even the patients themselves, which created an imbalance in values. The participants perceived that they were often “caught in the middle” when seeking to reconcile differing opinions</p>
Increased knowledge and open discussion help reduce moral distress	<p>Several caregivers lacked knowledge about moral distress and greater knowledge on the topic was needed.</p> <p>Newly graduated caregivers were more aware of ethics than previous generations.</p> <p>It was seen as important to discuss moral distress during meetings and make one’s organisation more aware of the topic.</p> <p>The participants emphasised the importance of openness in the workplace to reduce moral distress</p>
Reflection, increased support and increased resources can reduce moral distress	<p>Reflecting on the day’s events or engaging in therapeutic writing could help reduce moral distress. Thinking positively about the future and/or realising that opportunities to influence matters and act differently in the future do exist could be helpful.</p> <p>A request for support from upper management regarding how to reduce moral distress was expressed.</p> <p>Regular work supervision was seen as important and speaking to an outside expert or therapist who is familiar with what one has been through or with a work colleague was a good way to relieve moral distress.</p> <p>An open atmosphere where caregivers could “dare” talk about moral distress was an essential key to reducing moral distress</p>

Most participants stated that they prioritised the work that was most urgent, thus they could assist in direct-patient care despite other important work being left uncompleted. “If I’m at work in the field with the patients and do a good job there but then you know that e-mails and other [administrative] tasks are tumbling in that you should do... and my boss asks when will you send in that and that report...” (P8).

Moral distress contributes to a sense of inadequacy but also a sense of responsibility

The participants experienced that it was difficult to accept that although one had done one’s best, it could still feel as if one had done too little. A sense of inadequacy was also linked to staffing resources, with the participants

revealing that there was nothing further they could do to acquire more staffing resources, even if more resources were needed. The participants perceived that more fully qualified staff would result in a “calmer” work tempo, which thereby would facilitate the sharing of responsibility and reduce moral distress. The participants noted that not only their work was affected by moral distress but also their leisure time. Bearing the responsibility as care leader for all of the various care tasks that should be performed as well as the immense task of supporting staff could quickly lead to a sense of inadequacy and thus moral distress. “The sense of inadequacy that you go home from work and think you have a thousand things that you think that you should have done and done a little better...” (P8). This same participant emphasised that her way of allaying moral distress was to make staff feel seen and that she typically sought to “boost” staff so that they felt important. Moral distress even could arise from the sense that one is unable to maintain a sense of responsibility for patients to the extent one would like.

The most important is probably that you should have insight into that no matter how much you work, the work will never be finished. ... sometimes you have to be tough and prioritize. ... even if a lot feels like routine ... so you must plan your work to be able to manage.

(P8)

The participants experienced that moral distress could arise when caregivers who are not really interested in older adult care were employed. Nonetheless, the participants revealed that such caregivers must be tolerated, because of the shortage of fully-qualified staff. This could cause care leaders moral distress. “We do not have enough qualified staff here in healthcare... so it is to be sure a great moral distress... some are not as interested in older adult care who nonetheless work... so it is to be sure stressful...that they maybe don't do their job with all of their heart” (P2).

A positive aspect of moral distress was that it could lead to the development of a stronger sense of responsibility for patients and could awaken a desire and vision for the future. The participants revealed that a stronger sense of responsibility for patients could lead them to seek more staffing resources and staff who would be “available” for patients, all to ensure patients' well-being and sense of security. “So that you don't have to think that ‘Oh, now we should do so and so!’. Or: ‘This we should do differently [because of too few staff]’ without having the situation under control so that all parties are satisfied” (P1).

The participants furthermore experienced that their moral distress had grown concurrent with the COVID-19

pandemic and ever-stricter pandemic-related guidance. They revealed that caregivers who did not follow pandemic-related guidance could cause them moral distress.

... you become stressed by colleagues who haven't followed restrictions and now are in quarantine ... and that not even you as a caregiver follow these restrictions we to be sure even have people from the contact tracing team who don't follow the restrictions ... it has probably to do with trust ...that you have missed sound judgment...

(P3)

Moral distress arises from an imbalance in values

Some participants experienced that the ethical values delineated at the organisation they worked at and their own values were comparable, while others experienced that other, for example, economic values were used to steer the organisation's ethical values, which created moral distress in their daily work.

... the budget really steers us more than ethical values ... unfortunately ... money steers. ... we're here for our patients and I don't think the organization should forget, that it's about the city's residents and their well-being. More and more there is talk about money rather than about people.

(P5)

Many participants perceived the organisation's budget as being strict and that they did not always have the opportunity to emanate from their ethical values, because economic factors were paramount. The participants experienced this as being morally distressing; they knew what they should and would like to do but were required to act in a different way. Organisations in the private sector were perceived as having unbalanced ethical values because there was a focus on money and profit. “Yeah, and it's to be sure about money and profit. And I believe you shouldn't make a profit off healthcare. It's simply unethical” (P2). The participants maintained that some moral distress was acceptable, but that when there were several simultaneous, active stress factors over a longer period of time that moral distress became unsustainable and negatively impacted their well-being.

The participants even experienced that they as care leaders could have different ethical values than other caregivers. They furthermore noted that situations could

sometimes occur where it was difficult to “satisfy” all parties and that in such situations they were required to prioritise the tasks to be performed in accordance with their own values. “It’s probably both and...enough stress is perfectly okay, but it will probably become burdensome when you have to take care of both the patient’s situation and then also the staff’s situation. And sometimes then perhaps the staff’s situation may in such cases have to wait” (P1).

Some participants also experienced that moral distress could arise if official organisational “views” differed from the views held by themselves and other caregivers:

... then with age so comes more illnesses ... which get worse; such that make that [patients] can no longer live in their apartments. And ... to make decision-makers understand that [patients] can’t forever live in an apartment ... but instead they need to move to a unit where they have staff around the clock... this is a difficult chapter.

(P5)

The participants experienced that patients’ relatives could sometimes have a different opinion on a matter than caregivers or even the patients themselves, which can be considered an imbalance in values. The participants perceived that they were often “caught in the middle” when seeking to reconcile differing opinions and that they often were required to compromise their own values because of a patient’s right to self-determination.

That you in some way make both [the patient and his/her relatives] satisfied, even if they have very different opinions about what the patient needs due to, e.g., his/her illness. It can be difficult... you must either step on [someone] or back up your own cause ... that we do like this then... despite everything...

(P1)

The participants even mentioned that when a care relationship ends and relatives not only are unappreciative but also express dissatisfaction they could experience moral distress.

And finally the patient dies and relatives leave us by slamming the door shut... It to be sure passes with time. But it’s no doubt really quite hard if they just say how wretched we are ... and it becomes a resignation in that I

have tried but that they still think I am completely useless, both as a boss and as a person ... you think about it and sometimes it feels as if you could do nothing more, but sometimes it feels as if you did not do your best.

(P4)

Increased knowledge and open discussion help reduce moral distress

Many participants experienced that several caregivers did not know what moral distress is and that greater knowledge on the topic was needed. One participant said that caregivers could be aware of ethics but not moral distress nor how it was linked to work processes. They advocated increased discussion and knowledge and also more training and lectures on the topic. The participants experienced that newly graduated caregivers were more aware of ethics than previous generations. Nonetheless, the general perception was that only one or two caregivers being more aware of both ethics and moral distress was insufficient; both topics should be highlighted so that everyone was aware of them. The participants emphasised that these topics should not only be discussed in workplace settings but also generally in society. “... maybe it would be useful if you would be given lectures on ethics and moral distress... so you would dare to talk about things to get rid of the shame” (P7). Another participant stated: “Thanks to training you have aha experiences... how you should think and do. It awakens thoughts and discussion among the staff... reading a book is also good but it is different to listen to someone who lectures and [who] really burns for this” (P5).

While some participants perhaps considered an imbalance in values to be natural, one participant stated that it was important to discuss moral distress during meetings and make one’s organisation more aware of the topic. Some participants perceived that they had a relatively good relationship with their managers and noted that they met with their managers every week to discuss and jointly find solutions to eventual problems. The participants emphasised the importance of openness in the workplace, arguing that moral distress would not “disappear” but instead increase. They maintained that ever greater financial constraints (stricter budgets) and a growing older population would result in more instances of moral distress, related to the need to prioritise tasks and/or other ethical concerns.

I also think that in the future ...then we will have increasingly unwell people and fewer resources that [will] lead to many challenges ... economic ... that will come as well. But to

support the staff now in their endeavor to remember that bit ... and that you cannot simply forget the patient. But instead emanate from that the patient should have it good.

(P7)

Reflection, increased support and increased resources can reduce moral distress

The participants experienced that despite urging their staff not to ruminate over work matters when not at work they themselves had difficulty following their own advice. The participants described occasionally sleepless nights, which they attributed to moral distress linked to various work-related matters. They revealed that while hobbies or activities such as handicrafts or going for a walk could help them compose their thoughts for a while, they often were still “bothered” by disconcerting thoughts. They noted that giving both themselves and other caregivers time to reflect on current and future work could possibly reduce moral distress. “... you should have more time for reflection and simply to be able to think in your work. To think both as a care leader about your own work and plan how you would like it in the unit. But above all to get the staff to sit down and just discuss” (P7). The participants stated that soliloquising (engaging in self-talk) or generally reflecting on the day's events were other approaches that could help reduce moral distress. They also noted that thinking positively about the future and/or realising that opportunities to influence matters and act differently in the future do exist could be helpful. Another approach mentioned was taking a moment at the beginning of or during the day to gather and write down one's thoughts and reread these thoughts at the end of the day, that is, therapeutic writing.

... I write emails that I never send. That you get to write out [your feelings] during the day and write things that are negative and weighty. The whole then becomes a little less of a problem... You read it at the end of the day and see what you thought... and come to the conclusion that there are probably other more important things.

(P4)

The participants also expressed a desire for support from upper management regarding how to reduce moral distress among staff. “That you should receive help with how to discuss advice on how to talk with staff or how they should feel that they more easily can come and talk if they feel stressed.

And it is perhaps very fixed in oneself too... how one is as a boss...how the staff then feel that ‘[him/her] I can talk to’...” (P1). The participants even expressed that they would like upper management to listen to them more because they wanted to be respected for their vast knowledge, noting that they believed this could reduce moral distress. They moreover experienced that upper management seldom initiated discussions about moral distress and observed that they as care leaders could not discuss their work or feelings about their work outside of the workplace, because of their duty of confidentiality. However, they mentioned that regular work supervision was possible and perceived that speaking to an outside expert or therapist who is familiar with what one has been through or with a work colleague was a good way to relieve moral distress. They stated that the COVID-19 pandemic had reduced their opportunities for work supervision, with the result that they found it more difficult to manage their moral distress. The participants experienced that the key to reducing moral distress was an open atmosphere where caregivers could “dare” talk about moral distress. “... that you deal with things as soon as you see them and that you don't try to sweep it under the rug” (P6). Despite perceiving situations characterised by moral distress as being burdensome, the participants still felt that they could learn from such situations and apply this knowledge in future situations.

DISCUSSION

The purpose of this study was to examine care leaders' experiences of moral distress in their daily work in older adult care. Moral distress was seen to arise from a lack of time. The participants revealed that they only had time for the most necessary care measures, but that they would like to spend more time with patients because doing so would contribute to better-quality and more comprehensive patient care. This is in line with previous research, where the greatest and most common ethical problems are linked to a lack of resources and the need to realise and further develop high-quality care [1,2,19,20,27]. The participants noted that a lack of time contributed to an inability to provide sufficient mental care for patients and led to the need to prioritise physical work, which negatively affected patients. The COVID-19 pandemic, resulting in among other things increased sick leaves and quarantines, also exacerbated this problem [7]. For example, certain tasks such as taking patients for outdoor walks had to be deprioritised because of scarce resources [19]. Catania, Zanini, Hayter, Timmins, Dasso et al. [5] also found that the COVID-19 pandemic had resulted in a lack of resources, linked to sick leave and relocations, while in this study we saw an increased lack of time linked to increased sick leave,

quarantine periods and the need to employ underqualified temporary staff. The participants in this study perceived that more staffing resources could reduce moral distress. They furthermore noted that their moral distress increased when their administrative work was left uncompleted, linked to a lack of staffing resources and the need to assist caregivers by engaging in direct patient care [28].

Moral distress was seen to contribute to a sense of inadequacy – but also responsibility. The participants experienced that they were unable to maintain a sense of responsibility for patients to the extent they would like. This can be compared with previous research, in which moral distress is found to contribute to negative emotions, work-related stress and even reduced self-esteem [4,10,11]. The participants in this study noted that not only were more staffing resources needed but also highlighted that the “type” of caregiver was important. Moral distress was experienced when caregivers who are not really interested in older adult care were employed. Other researchers have also shown the challenges that care leaders face in finding sufficient staffing resources for the large workloads experienced [28]. Researchers have found that patient numbers are increasing but budget allocations for staff are being minimised and staffing resources are scarce [4,15]. Caregivers’ fatigue affects the quality of care, and a larger workforce would ensure quality [28]. The participants here also highlighted that moral distress could lead to the development of a stronger sense of responsibility for patients and a desire and vision for the future. This in turn could lead them to seek more staffing resources and staff who would be “available” for patients, with the aim to ensure patients’ well-being and sense of security. In previous research, improved self-reflection and professional growth have been found to be positive consequences of moral distress,⁴ but not increased sense of responsibility. The participants in this study experienced that their moral distress increased because of the COVID-19 pandemic and ever-stricter pandemic-related guidance [5], revealing that caregivers who do not follow pandemic-related guidance could cause them moral distress. This result differs from findings in other studies, where caregivers were instead found to prefer isolating during the COVID-19 pandemic because of their significant fear of becoming infected [5].

Moral distress was found to arise from an imbalance in values. Some participants experienced that organisational values linked to patient issues could differ from the values held by those who worked with patients on a daily basis. Researchers have shown that care leaders have perceived that organisational responsibilities have priority over their human and ethical responsibilities [10,21]. The experience of consciously doing what one perceives to be incorrect contributes to psycho-emotional damage and damages professionalism [18,21]. We found that not only was there

an imbalance in values between the organisation and the care leaders, but also between the care leaders and their staff. The participants furthermore experienced that it was burdensome when patients’ relatives had a different opinion on a matter than caregivers or the patient. This was linked to the sense that participants were often “caught in the middle,” that they needed to “step on someone’s toes” or that they were required to compromise their own values because of the patient’s right to self-determination. These experiences are in line with previous research, in which common ethical problems are found to arise when caregivers are forced to act in a way they perceive is not in the patient’s best interests [17,18]. Feeling required to “fight” on a daily basis to protect patients’ rights and right to self-determination contributes to caregivers experiencing a great deal of stress in their everyday work life [15]. The participants in this study also experienced moral distress when patients’ relatives expressed dissatisfaction or were seen to be unappreciative [17].

Increased knowledge and open discussion were found to help reduce moral distress. Many participants experienced that a greater awareness of moral distress was needed because not all caregivers are aware of what it means. The participants emphasised the importance of open discussions about moral distress within an organisation [2]. As seen in previous research, participants often use discussion to solve ethical problems [3,17], not only with other caregivers but also doctors [17]. Caregivers who encounter ethical issues related to themselves more often use the support of external experts [3]. Greater variation in the methods used to solve ethical problems and the use of external experts would facilitate ethical problem-solving, and ethics literature, codes of ethics, ethical reasoning and decision-making should be combined to create new dimensions and gain external knowledge [3]. Researchers have also found that open dialogue, an understanding of caregivers’ vulnerability [23] and a more varied range of methods would be helpful in ethical problem-solving [3]. We found that the participants in this study wanted more training and lectures on moral distress because it would increase knowledge on the topic [1,17,20] and could lead to personal growth [18]. The participants experienced that there was a clear difference between newly graduated caregivers and previous generations regarding their knowledge of ethics, which can be attributed to ethics being more prominent in current nursing education programs. Moreover, in line with previous research [4,15], the participants maintained that moral distress would increase over time, in step with increased financial constraints (stricter budgets) and a growing older population, which they linked to an increased need to prioritise tasks and/or other ethical concerns.

Reflection, increased support and increased resources can reduce moral distress. We saw that despite

encouraging their staff not to do so, the participants ruminated over work matters when not at work. The participants revealed that they sought to compose their thoughts by engaging in hobbies or activities. Other researchers have found that leisure activities, a focus on good food and a good night's sleep can help caregivers relax [28] and that reflection can be used to reduce caregivers' moral distress [15]. The participants in this study also noted that being given the time to reflect on current and future work could reduce moral distress; engaging in open discussion and reflection, in which different points of view are included, could increase both own and others' insights. The participants in this study revealed that they even used different strategies to reduce their experiences of moral distress, for example, soliloquising (engaging in self-talk), generally reflecting on the day's events or therapeutic writing. This is in line with other studies, where care leaders have been shown to use self-management strategies to relax from difficult thoughts linked to a large workload [28].

The participants expressed a desire for support from upper management regarding how to discuss moral distress with their staff. They also wanted upper management to listen to them more and respect their vast knowledge, perceiving that this could lead to reduced moral distress. The importance of care leaders receiving support from management has been highlighted in other studies, with researchers finding that care leaders cannot support their own staff unless they themselves are supported by upper management [23]. The participants in this study stated that discussing moral distress outside of the workplace was not possible because of their duty of confidentiality and noted that work supervision was possible, perceiving speaking to an outside expert or therapist to be an important support function. However, the COVID-19 pandemic had reduced opportunities for work supervision and consequently, the participants found it more difficult to manage their moral distress. Other researchers have seen that open dialogue can help identify caregivers' need for support [23]. The participants experienced that the key to reducing moral distress was an open atmosphere, where people could talk about difficult things. Despite perceiving situations characterised by moral distress as being burdensome, the participants still felt that through reflection and discussion they could learn something from such situations and gain new insights and approaches.

Strengths and limitations

One limitation may be that there were only female participants; the results could have been different if male

participants had been included. To strengthen the study's credibility, the focus was placed on ensuring reliability and transferability. In terms of credibility in the selection of participants, all those included had experienced moral distress in their work as care leaders. The number of participants in the study was considered sufficient because the data were considered to have reached saturation. Most of the participants had significant work experience. Credibility was sought during analysis through the certification of each step of the analysis. To inhibit the researchers' own pre-understanding from guiding the interpretation, the data analysis was carried out in close collaboration between the researchers, one of whom is also an experienced researcher in qualitative methods. Descriptive quotes have been used to answer the requirements of reliability in the results. To strengthen the reliability, a clear and comprehensive description of the methodological procedure has been given.

CONCLUSION

Moral distress is something that care leaders, according to this study, experience daily in an older adult care context, and it is considered to have increased. Care leaders can experience moral distress from a lack of time; patient-related, relative-related or other ethically difficult situations; or an imbalance between own values and an organisation's, other caregivers', patients' and/or patients' relatives values. Increased staffing resources, more knowledge (training and lectures) and time for reflection individually, in groups or with an outside expert could increase care leaders' insights into and ability to reduce moral distress. Although situations that are characterised by moral distress are burdensome, care leaders have the opportunity to learn from such situations through reflection and discussion and can develop strategies for future ethical challenges. Future research could focus on exploring caregivers' experiences of moral distress.

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CONFLICTS OF INTEREST

The author state that there are no sources of conflicts.

AUTHOR CONTRIBUTIONS

Fanny Ahokas contributed to the study conception and design, data analysis, discussion, and drafted the manuscript. Jessica Hemberg contributed to the study conception, design, data analysis, discussion and provided critical reflections.

ETHICAL APPROVAL

The research has been conducted in accordance with the guidelines for the Finnish National Board on Research Integrity TENK (2012). One researcher contacted care leaders working at the care organisations included in the study and invited them to participate in the study by email. Those indicating that they wished to participate received oral and written information about the study purpose, confidentiality and the intention to publish the research results. Permission to conduct the interviews was given by the included care organisations and written informed consent was obtained from the study participants. The ethical permit to conduct the study was approved by a research ethics committee at the university where the researchers are based. If the interview caused unpleasant feelings in participants and they felt they needed to discuss these, they were encouraged to contact the interviewer afterward.

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REFERENCES

- Aitamaa E, Leino-Kilpi H, Puukka P, Suohonen R. Ethical problems in nursing management: the role of codes of ethics. *Nurs Ethics*. 2010;17:469–82.
- Ganz F, Wagner N, Toren O. Nurse middle manager ethical dilemmas and moral distress. *Nurs Ethics*. 2015;22:43–51.
- Aitamaa E, Suhonen R, Puukka P, Leino-Kilpi H. Ethical problems in nursing management—a cross-sectional survey about solving problems. *BMC Health Serv Res*. 2019;19:1–11.
- Deschenes S, Gagnon M, Park T, Kunyk D. Moral distress: a concept clarification. *Nurs Ethics*. 2020;27:1127–46.
- Catania G, Zanini M, Hayter M, Timmins F, Dasso N, Ottonello G, et al. Lessons from Italian front-line nurses' experiences during the COVID-19 pandemic: a qualitative descriptive study. *J Nurs Manag*. 2020;29:404–11.
- Sethi B, Sethi A, Ali S, Aamir H. Impact of Coronavirus disease (COVID-19) pandemic on health professionals. *Pak J Med Sci*. 2020;36:6–11.
- Vittone S, Sotomayor C. Moral distress entangled: patients and providers in the cOVID-19 era. *HEC Forum*. 2021;33:415–23.
- Miljeteig I, Forthun I, Hufthammer K, Engelund I, Schanche E, Schaufel M, et al. Priority-setting dilemmas, moral distress and support experienced by nurses and physicians in the early phase of the COVID-19 pandemic in Norway. *Nurs Ethics*. 2021;28:66–81.
- Morley G, Bradbury-Jones C, Ives J. What is 'moral distress' in nursing? A feminist empirical bioethics study. *Nurs Ethics*. 2020;27:1297–314.
- Corley MC, Minick P, Elswick R, Jacobs M. Nurse moral distress and ethical work environment. *Nurs Ethics*. 2005;12:381–90.
- Savel RH, Munro CL. Moral distress, moral courage. *Am J Crit Care*. 2015;24:276–9.
- Fourie C. Moral distress and moral conflict in clinical ethics. *Bioethics*. 2015;29:91–7.
- Morley G, Ives J, Bradbury-Jones C, Irvine F. What is 'moral distress'? A narrative synthesis of the literature. *Nurs Ethics*. 2019;26:646–62.
- Sandman L, Kjellström S. The ethics book - Ethics for caring professions. In Swedish: Etikboken - Etik för vårdande yrken. Lund: Studentlitteratur; 2018.
- Ulrich C, Taylor C, Soeken K, O'Donnell P, Farrar A, Danis M, et al. Everyday ethics: ethical issues and stress in nursing practice. *J Adv Nurs*. 2010;66:2510–9.
- Andreassen Devik S, Munkeby H, Finnanger M, Moe A. Nurse managers' perspectives on working with everyday ethics in long-term care. *Nurs Ethics*. 2020;27:1669–80.
- Musa M, Harun-Or-Rashid M, Sakamoto J. Nurse managers' experience with ethical issues in six government hospitals in Malaysia: a cross-sectional study. *BMC Medical Ethics*. 2011;12:1–7.
- Oh Y, Gastmans C. Moral distress experienced by nurses: a quantitative literature review. *Nurs Ethics*. 2015;22:15–31.
- Slettebø Å, Skaar R, Brodtkorb K, Skisland A. Conflicting rationales: leader's experienced ethical challenges in community health care for older people. *Scand J Caring Sci*. 2018;32:645–53.
- Aitamaa E, Leino-Kilpi H, Iltanen S, Suhonen R. Ethical problems in nursing management: the views of nurse managers. *Nurs Ethics*. 2016;23:646–58.
- Nasrabadi A, Khoob M, Cheragh M, Joolaei S, Hedaya M. The lived experiences of clinical nurse managers regarding moral distress. *J Med Ethics History Med*. 2018;11:1–10.
- Davis M, Batcheller J. Managing moral distress in the workplace: creating a resiliency bundle. *Nurse Leader*. 2020;18:604–8.
- Markey K, Ventura C, O'Donnell C, Doody O. Cultivating ethical leadership in the recovery of COVID-19. *J Nurs Manag*. 2021;29:351–5.
- Jia Y, Chen O, Xiao Z, Xiao J, Bian J, Jia H. Nurses' ethical challenges caring for people with COVID-19: a qualitative study. *Nurs Ethics*. 2021;28:33–45.
- Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24:105–12.
- Finnish Advisory Board on Research Integrity. Guidelines for responsible conduct of research and procedures for handling allegations of misconduct in Finland. [cited 2021 Jan 25]. Available from: http://www.tenk.fi/sites/tenk.fi/files/HTK_ohje_2012.pdf; 2012.
- Hopia H, Lottes I, Kanne M. Ethical concerns and dilemmas of Finnish and Dutch health professionals. *Nurs Ethics*. 2016;23:659–73.
- Liu Q, Luo D, Haase J, Guo Q, Wang X, Liu S, et al. The experiences of health-care providers during the COVID-19 crisis in China: a qualitative study. *Lancet Glob Health*. 2020;8:790–8.

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