Comparison of Moral Distress and Burnout Experienced by Mental Health Nurses in Japan and England : A Cross-sectional Questionnaire Survey

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[Original]

Comparison of Moral Distress and Burnout Experienced by Mental Health Nurses in Japan and England : A Cross-sectional Questionnaire Survey

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Aims : To compare moral distress and burnout experienced by mental health nurses in hospitals both in Japan and England.

Methods : This is a cross-national study, and a cross-sectional design was adopted. An anonymous questionnaire containing 43 moral distress items, a 16 item burnout scale, and demographic data was administered to convenient samples ; 391 nurses in Japan, and 460 nurses in England. Among the participants, 289 nurses (73.9%) in Japan, and 36 nurses (7.8%) in England responded.

Results : The moral distress items which were commonly felt by nurses in both countries dealt with a lack of staff. Several differences, however, existed between the two, which reflected poor conditions such as long term social hospitalization in Japan. The nurses in England felt moral distress in a wider variety of situations, though they confront them less frequently than the nurses in Japan. Only in England was it found that the older nurses became, and the more experience they had accumulated, the less intensely they felt moral distress. The nurses in both countries felt the same levels of exhaustion, and cynicism, but as far as professional efficacy, the scores of the nurses in England were much higher than those of the nurses in Japan.

Conclusions : If nurses feel no moral distress, there will be no improvements of care. Nurses should have moral sense, and do their best to improve the situations without being burned out.

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INTRODUCTION

Clinical practice is fraught with stress. Nurses do not feel stressed only when they are busy, or tired, but also when they confront ethical issues. Jameton[1] classified moral problems into three types ; moral uncertainty, moral dilemma, and moral distress. He referred to moral distress as a type of moral and ethical problem which "arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action." In a study[2] administered in a critical care environment, nurses spoke of moral distress in terms of "senselessness", which included treatments administered only to prolong life, and a decision-making process which did not involve the patient. Holly[3] pointed out that moral distress occurs when patients are treated without regard to their personhood.

Moral distress, however, does not automatically occur just because a certain type of case occurs[4]. She described an example of a Code Blue ; a medical emergency in which a team of medical personnel work to revive an individual in cardiopulmonary arrest. Some nurses would suffer moral distress if resuscitation was done, while others would suffer moral distress if resuscitation was not done[4]. A conflict arose when a moral issue opposed a nurse's value or belief resulting in moral distress.

Moral distress is said to produce a variety of strong, negative feelings such as anger, resentment, frustration, and guilt[5]. It also causes nurses to lose self-worth, affects personal relationships, and causes various psychological effects, behavioral manifestations, and physical symptoms[4], which could lead to job dissatisfaction. In a study[6], 15% of the nurses said that they had left a previous position because of moral distress.

Meanwhile in mental health settings, moral issues are different from those in other settings. As a matter of Japanese law (The Mental Health and Welfare Act, 1995), patients with mental health problems are not considered to be fully mentally competent, which legitimizes involuntary hospitalization, or treatment without informed consent. They are also considered to be harmful to themselves and/or others by mental health professionals when they are in psychomotor excitation, which legitimizes seclusion, restraint, or other restrictions. In addition, staffing levels in psychiatric wards are much lower than in other wards, and the mental health community services are very insufficient in Japan.

There are few studies concerning the moral distress of care givers in mental health settings. Austin, Bergum, and Goldberg[7] administered a hermeneutic phenomenological study in Canada, and described that nurses felt moral distress when they were unable to respond to the needs of their patients, or treated patients with an "absence of respect". Ohnishi, Asai and Akabayashi[8] administered a questionnaire to psychiatric nurses in a hospital in Japan, which revealed that many nurses felt intense levels of moral distress concerning long-term social hospitalization where patients without serious conditions were confined for prolonged period of time, little respect was shown for patient autonomy for fear of accidents, there was insufficient care because of low staffing, and a lack of time to take care of patients.

How do mental health nurses in hospitals feel moral distress in different situations? Mental health settings in Japan have low staffing and scarce resources, while mental health care in the UK has higher staffing levels and enriched services ; Japan spends 5% of the total health budget on mental health, while the UK spends 10%. The number of psychiatric beds per psychiatrist is 30.2 in Japan, while that in the UK is 5.3, and the number of psychiatric beds per nurse is 4.8 in Japan, while it is 0.6 in the UK[9]. In Japan, community care has not been well funded by the government, and the major share of psychiatric care is provided by mid-size private hospitals[9]. To compare moral distress between the

two countries will generate interesting results, as there are no cross-national studies concerning moral distress. The aim of this study was to compare moral distress and burnout experienced by mental health nurses both in Japan and England.

*(foot note) In this study, "mental health" is generally used, but "psychiatric" is adopted when it is related to services in hospital, not to community services. When these terms were cited from literature, the original terms were used in this study.

METHODS

A cross-sectional study using an anonymous questionnaire was utilized. The survey was administered in November 2007 to January 2008 in Japan, and in October 2008 to February 2009 in England.

The subjects

The institutions where the survey was administered had been conveniently selected, and all the nurses were subjects in this study. The subjects belonged to nine institutions. Among them, six were in three prefectures in Japan : Two were public, one of which was an educational university hospital, one consisted of the psychiatric wards of a general hospital, and four were private psychiatric hospitals. Among the nine, three were in one NHS trust in England.

The characteristics of Japanese institutions and English ones are shown in **Table 1**. As a result of Mann-Whitney U-test, there was a significant difference between the numbers of beds per doctor in Japan and England ($p<.05$), and the number in Japan was approximately 10 times as many as that in England. There also was a significant difference between the numbers of beds per nurse in Japan and in England ($p<.05$), and that in Japan was more than twice as many as the number in England. In addition, the number of patients who have multiple caretakers during the night shifts in Japan was more than three times as many as that in England, and those scores were significantly different ($p<.05$).

The number of subjects in Japan was 391 nurses from six hospitals. Among the subjects in Japan, 289 nurses responded (the return rate was 73.9%). The demographic data of the participants is shown in **Table 2.** The subjects in England were 460 qualified nurses working either in the wards or the communities of three centers for mental health, where nurses in both services are tightly connected, and community nurses often visit wards when the patients, who they are in charge of, are hospitalized. Among them, only 36 nurses responded (the return rate was 7.8%).

Instruments

The questionnaire consists of three parts : 43 items concerning moral distress, 16 items of the Maslach Burnout Inventory - General Survey (MBI-GS)[10], demographic profiles ; gender, age, years of nursing experience, and years of nursing experience in mental health settings.

The questions concerning moral distress contained 24 items from the moral distress scale (MDS), and 19 original items based on literature reviews. The MDS was developed and evaluated by Corley, Elswick, Gorman, and Clor[6]. It was administered to critical care nurses in the USA, is available for nurses in critical care settings, and consists of 38 items. Items common in nursing, such as prioritizing a family's

Table 1 Characteristics of the institutions of the participants

Characteristics	Japan			England		
	mini..	median	max.	mini.	median	max.
number of beds per doctor	3.3	33.3	48.0	2.3	2.4	6.0
number of beds per qualified nurse	2.5	2.9	3.8	1.3	1.3	1.4
number of patients per ward (number of patients whom two or three staff take care of at night)	33.0	52.9	72.5	14.5	14.9	15.8

Table 2 Demographic data of the participants

Characteristics	Japan n (%)	England n (%)
Gender		
Male	74 (25.6)	17 (47.2)
Female	209 (72.3)	17 (47.2)
Unknown	6 (2.1)	2 (5.6)
License type		
Registered Nurse	195 (67.5)	35 (97.2)
Practical Nurse	88 (30.4)	—
CNS/Nurse Practitioner	—	1 (2.8)
Unknown	6 (2.1)	—
	Japan M±SD	England M±SD
Age	39.8±11.7	40.9±8.6
Years of nursing experience	16.0±10.9	16.3±9.0
Years of psychiatric nursing experience	10.3± 9.2	12.9±8.7
Years of nursing experience in other fields	6.0± 8.1	3.5±4.1

wishes, treatments without informed consent, unnecessary tests and treatments, unsafe levels of staffing, incompetent caregivers, medication errors, and patient abuse, were adopted from the MDS to the questionnaire of this study. Items unique to critical care settings, and those not applicable to mental health care settings, were rejected. Such rejected items were the items concerning extensive life-saving actions, a decision to "pull the plug", inadequate pain medication, and organ donation.

The added items were developed based on literature review, selected pursuant to their applicability to mental health nursing, and were examined by the authors to ensure content validity. Many of the new items were derived from the questionnaire administered by Ohnishi *et al*[8]. This questionnaire included items relating to long term social hospitalization, unethical behaviors of care personnel such as inadequate care, secretly mixing medication into a patient's food, ridiculing patients, searching through patients' belongings, and handling patients' shopping and paperwork affairs instead of giving them the opportunities to do so. Items concerning having no time to build relationships with patients, and being unable to advocate on behalf of patients were derived from the studies of Austin, Bergum, and Goldberg[7].

MDS items are written in English, and some other items in Japanese. The back translation method was adopted to keep both of the questionnaires same : Two versions, English and Japanese, were translated into the other language, the translated version was then re-translated into the original language, and then the original one and the final one were examined. The participants were required to respond in a 7-point Likert format ; 0 (none or never) to 6 (great extent or very frequently) in both intensity and frequency. A higher score reflects either a higher level or frequency of moral distress.

The MBI-GS is a global measure, and consists of three subscales : Exhaustion (Ex, 5 items), Cynicism (Cy, 5 items), and Professional Efficacy (PE, 6 items). The English version of the MBI-GS was developed by Maslach *et al*[10], and evaluated validity and stability (stability coefficients for Ex was .65, for Cy .60, and for PE .67). The Japanese version was done by Kitaoka-Higashiguchi[11]. The Cronbach's alpha coefficient of the Japanese version was .91 in Ex, .86 in Cy, and .86 in PE, which shows internal consistency.

Those items were given in a 7-point Likert format :

Table 3 Moral distress items for which intensity scores were more than 3

rank	Item	n	M±SD
	[Japan]		
1	11. Work with levels of nurse staffing that I consider "unsafe."	275	4.07±1.78
2	29. Observe without taking action when a patient continues to be hospitalized even though his/her condition is stable and he/she is able to live daily life without required hospitalization.	267	3.82±1.83
3	31. Work at a facility where excessive responsibilities prevent me from taking time to build relationship with patients.	266	3.73±1.77
4	12. Work in an environment where the facilities and equipment are insufficient to the point where I consider conditions "unsafe".	275	3.64±1.80
5	32. Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing.	267	3.57±1.91
6	8. Carry out a work assignment in which I do not feel professionally competent.	278	3.18±1.66
	[England]		
1	11. Work with levels of nurse staffing that I consider "unsafe."	36	3.97±1.87
2	39. Work at a facility where nurses are treated like machines causing them to quit.	33	3.67±2.20
3	31. Work at a facility where excessive responsibilities prevent me from taking time to build relationship with patients.	36	3.53±2.25
4	12. Work in an environment where the facilities and equipment are insufficient to the point where I consider conditions "unsafe".	35	3.49±2.01
5	23. Work with nurses who are not as competent as the patient care requires.	33	3.30±2.16
5	35. Work with doctors who refuse to listen to the opinions of nurses when they attempt to confer about a patient.	33	3.30±2.19
7	41. Follow institutional regulations that do not seem to benefit patients.	35	3.20±2.32
8	24. Work with nursing assistants who are not as competent as patient care requires.	33	3.09±2.27
9	1. Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit.	35	3.06±2.06
10	37. Administer medication by injection when a patient refuses its oral administration.	32	3.00±2.24

0 (none), 1 (a few/year), 2 (once/month), 3 (a few/month), 4 (once/week), 5 (a few/week), and 6 (everyday). The subscale score was calculated as the total score divided by the number of items of each subscale. In Ex and Cy, a higher score reflects a higher degree of burnout, while a lower score reflects a higher degree of burnout in PE.

Data collection

The bundles of the questionnaire were sent to all the head nurse managers, and were distributed to the participants. In Japan, the participants were asked to put their replies first into envelopes, and then into

Table 4 Moral distress items for which frequency scores were more than 3

Rank	item	N	M±SD
	[Japan]		
1	11. Work with levels of nurse staffing that I consider "unsafe."	272	3.82±1.83
2	29. Observe without taking action when a patient continues to be hospitalized even though his/her condition is stable and he/she is able to live daily life without required hospitalization.	268	3.62±1.86
3	31. Work at a facility where excessive responsibilities prevent me from taking time to build relationship with patients.	268	3.58±1.92
4	32. Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing.	269	3.32±2.04
5	12. Work in an environment where the facilities and equipment are insufficient to the point where I consider conditions "unsafe".	271	3.28±1.86
	[England]		
1	11. Work with levels of nurse staffing that I consider "unsafe."	31	3.45±2.13
2	31. Work at a facility where excessive responsibilities prevent me from taking time to build relationship with patients.	31	3.19±2.34

the collection boxes set in the wards. In England, the participants were asked to put their replies into pre-stamped envelopes, and then post them to the researchers. This method was adopted only for the participants' convenience, as the nurses there were assigned to a wider variety of sections compared to those in Japan. This, however, might have reduced the return rate.

Ethical consideration

Before administering the surveys, ethical approval was obtained in both countries and was granted by The Institutional Review Board of Mie University Faculty of Medicine in Japan (#852), and Harrow Research Ethics Committee in England (#08/H0719/53). The participants were given information about the survey, and then asked to respond anonymously only after they consented to the survey. Use of, and revision of the MDS were permitted by the author, Corley.

Data analysis

In the case of moral distress a mean score and SD were calculated in each item for both intensity and frequency, as they has not configured a scale with validity and reliability, while for MBI-GS, a mean score and SD were calculated for each subscale. To compare responses between the two countries the Mann-Whitney U-test was used. In cases of missing data, casewise deletion was adopted for moral distress items, while the missing values of MBI-GS items were calculated by extrapolating existing data.

The correlations between age or years of nursing experience, and each item score of moral distress in intensity, or each subscale score of MBI-GS were examined using Spearmans' rank correlation coefficient.

For statistical analyses PASW Statistics 18 was used, and the level of significance was set at 5%.

RESULTS

The moral distress items for which the intensity scores were more than the midpoint of 3 are shown in **Table 3**; six items in Japan, and 10 items in England. The frequency scores of moral distress items which were more than 3 are shown in **Table 4.**

Significant differences of the median scores between the two countries in intensity were found in five items (**Table 5**). Comparing the median scores in frequency between the two countries, a significant

Table 5 Moral distress items which are significantly different in intensity between the two countries

item	Japan			England			U test
	25th	Median	75th	25th	Median	75th	P value
[Japan > the UK]							
4. unnecessary treatment	2.00	3.00	4.00	0.00	2.00	4.00	0.039
29. continued hospitalization	3.00	4.00	6.00	0.00	1.00	5.00	0.001
32. inadequate treatment	2.00	3.50	5.00	0.00	1.00	4.00	0.000
[Japan < the UK]							
1. follow the family's wishes	1.00	3.00	3.00	1.00	3.00	5.00	0.041
37. administer injection	0.00	2.00	3.00	1.00	3.00	5.00	0.048

25th : 25th percentiles
75th : 75th percentiles

full sentences of the items above

4. Carry out a doctor's order for unnecessary tests and treatment.
29. Observe without taking action when a patient continues to be hospitalized even though his/her condition is stable and he/she is able to live daily life without required hospitalization.
32. Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing
1. Follow the family's wishes for the patient's care when I do not agree with them but do so because hospital administration fears a lawsuit.
37. Administer medication by injection when a patient refuses its oral administration.

difference was found in 15 items (**Table 6**).

In England, there was a significant correlation between moral distress intensity, and the age of nurses in four items. There was also a correlation between moral distress intensity and years of nursing experience in seven items (**Table 7**).

As for the subscale scores of MBI-GS, the mean± SD scores of Ex were 3.46±1.54 in Japan, and 3.44± 1.59 in England, while those of Cy were 2.54±1.61 in Japan, and 2.52±1.86 in England. The scores of PE, however, were not as close between the two countries as those of Ex or Cy. The nurses in England had a significantly higher level of efficacy, 4.68±1.22, than those in Japan, which was 1.61±1.11.

Correlations between each moral distress item in intensity and frequency, and each subscale of burnout were examined, and the correlation coefficients which are significant ($p<.05$) and more than 0.2 were examined. In England, there were significant correlations found between the subscale scores of MBI-GS and 13 moral distress items in intensity, and 11 items in frequency. In Japan, there were significant correlations found between the subscale scores of MBI-GS and 23 moral distress items in intensity, and 27 items in frequency (**Table 8**).

DISCUSSION

This study was limited by the small sample and the low return rate in England. As the return rate in England for surveys of this type is usually at most 20%, 7.8% is not extremely low. There are some possible reasons for the small sample and the low return rate. First, it was very difficult for foreign researchers to access nurses in a wider variety of institutions in order to enlarge the sample size. Second, the geographical distance and the limited budget prevented the researchers from offering any form of compensation to the subjects and from using reminders. Last, the topic of moral distress might be less interesting for the subjects, or it may cause uncomfortable feelings in those who were morally distressed as Pauly[12] pointed out. Both cases would lead the subjects to not respond to the questionnaire.

In this study, however, several interesting results

Table 6 Moral distress items which are significantly different in frequency between the two countries

item	Japan			England			U test
	25th	Median	75th	25th	Median	75th	P value
[Japan > the UK]							
2. follow the instructions	2.00	3.00	4.00	1.00	2.00	3.00	0.018
3. follow the family's wishes	0.00	1.00	3.00	0.00	0.00	2.75	0.007
4. unnecessary treatment	1.00	3.00	4.00	0.00	1.00	3.00	0.001
5. tests without consent	1.00	3.00	3.00	0.00	0.00	2.00	0.000
7. given no information	1.00	2.00	3.00	0.00	0.00	2.00	0.000
8. a work assignment	2.00	3.00	4.00	0.00	1.00	3.00	0.000
9. a medication error	0.00	2.00	3.00	0.00	1.00	2.00	0.028
13. discontinue treatment	0.00	1.00	3.00	0.00	0.00	1.00	0.001
15. ridicule a patient	1.00	2.00	3.00	0.00	1.00	3.25	0.025
16. not to tell the truth	1.00	2.00	3.00	0.00	0.00	3.00	0.009
17. incompetent doctor	0.00	2.00	3.00	0.00	0.00	2.00	0.002
28. I am not competent	1.00	2.00	3.00	0.00	1.00	2.00	0.000
29. continued hospitalization	3.00	3.00	5.00	0.00	1.00	3.00	0.000
32. inadequate treatment	2.00	3.00	5.00	0.00	0.00	2.00	0.000
36. secretly mix medication	0.00	2.00	3.00	0.00	0.00	0.50	0.000

full sentences of the items above

2. Follow the instructions of the doctor, who prioritizes the wishes of the family over the patient.
3. Follow the family's wishes to continue life support even though it is not in the best interest of the patient.
4. Carry out a doctor's order for unnecessary tests and treatment.
5. Assist a doctor who performs a test or treatment without informed consent.
7. Ignore situations in which patients have not been given adequate information to insure informed consent.
8. Carry out a work assignment in which I do not feel professionally competent.
9. Avoid taking action when I learn that a nurse colleague has made a medication error and does not report it.
13. Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay.
15. Observe without taking action when health care personnel ridicule a patient.
16. Follow the doctor's order not to tell the patient the truth when he/she asks for it.
17. Assist a doctor who in your opinion is providing incompetent care.
28. Be required to care for patients I am not competent to care for.
29. Observe without taking action when a patient continues to be hospitalized even though his/her condition is stable and he/she is able to live daily life without required hospitalization.
32. Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing
36. Secretly mix medication into a patient's food or drink when he/she refuses it.

were obtained, given that little had been known about moral distress in mental health settings, and that there have been no cross-cultural studies for the theme. Much remains unknown, but this study presents a base for further studies.

Moral distress experienced by the psychiatric nurses

With regard to intensity, item 11 (Work with levels of nurse staffing that I consider "unsafe") had the highest scores in both countries. Three items were common in both countries ; item 11, 31 (Work at a

Table 7 Moral distress items correlated to age, or nursing experience in England (p<.05)

moral distress item	correlation coefficient
[Japan : age]	
32. Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing.	−.139
2. Follow the instructions of the doctor, who prioritizes the wishes of the family over the patient.	.125
[Japan : nursing experience]	
2. Follow the instructions of the doctor, who prioritizes the wishes of the family over the patient.	.128
[England : age]	
12. Work in an environment where the facilities and equipment are insufficient to the point I consider "unsafe".	−.456
24. Work with nursing assistants who are not as competent as patient care requires.	−.428
26. Work with doctors who are not as competent as patient care requires.	−.382
25. Work with non-licensed personnel who are not as competent as patient care requires.	−.363
[England : nursing experience]	
28. Be required to care for patients I am not competent to care for.	−.460
24. Work with nursing assistants who are not as competent as patient care requires.	−.391
12. Work in an environment where the facilities and equipment are insufficient to the point I consider "unsafe".	−.381
8. Carry out a work assignment in which I do not feel professionally competent.	−.359
21. Provide better care for those who complain than those who are quiet.	−.352
5. Assist a doctor who performs a test or treatment without informed consent.	−.350
32. Treat patients inadequately (i.e. restrain patients who wander, or diaper incontinent patients) because of understaffing.	−.341

facility where excessive responsibilities prevent me from taking time to build relationship with patients), and 12 (Work in an environment where the facilities and equipment are insufficient to the point where I consider conditions "unsafe"). These findings mean that the nurses in both countries were intensely distressed by a lack of staff, though the levels of staffing are totally different between the two countries.

It can be speculated that one of the reasons for this result is that the patient conditions are different ; Almost all of patients in England are in the acute stage, while most patients in Japan are in the chronic stage, and stable. It can be assumed that another reason is that nurses have a tendency to complain about staffing in order to pursue better care. Or that all human beings, including nurses, may easily become accustomed to their environments, and/or cannot compare their environments with those they don't know.

Several significant differences did, however, exist between the two countries. The two items whose median scores in intensity in England were significantly higher than those in Japan were following the family's wishes, and medication by injection. As following a family's wishes is very common in settings other than mental health care in Japan, it

Table 8 Correlation coefficients between the scores of moral distress items and subscale of MBI-GS (p<.05 and r>0.2)

Moral distress item	1	2	5	6	7	8	11	12	15	16	21	22	23	24	26	27	28	29	30	31	32	33	34	35	37	38	39	40	41	42
J1																														
Ex		.25	.22			.32	.23	.26							.23			.27		.33			.29	.23			.36	.20		
Cy	.22	.23	.23		.23	.36		.25					.22		.28	.25	.22	.27	.24	.34	.29	.24	.31	.29		.26	.45	.29	.23	
PE													.29	.21	.20								.21							
J2																														
Ex		.27	.20			.28	.29	.27	.21				.23		.25	.21	.20	.29	.24	.28	.26		.34	.32		.24	.38	.24	.27	.22
Cy	.21	.25	.24	.25	.26	.33	.20	.26	.27	.21		.22	.24		.29	.26	.23	.29	.22	.28	.31	.28	.32	.37		.31	.44	.31	.27	.21
PE												.22																		
E1																														
Ex			.42																						.42	.41	.37			.38
Cy				.37									.38					.36		.50			.36	.43			.54	.35	.50	.36
PE																														
E2																														
Ex							.50	.45					.49											.37		.35				
Cy								.47			.40		.39					.37		.44			.38				.45		.40	
PE							.43						.39																	

E1 : correlation between moral distress intensity and the subscale of MBI-GS in England
E2 : correlation between moral distress frequency and the subscale of MBI-GS in England
J1 : correlation between moral distress intensity and the subscale of MBI-GS in Japan
J2 : correlation between moral distress frequency and the subscale of MBI-GS in Japan

seems to cause less distress when done in the mental health care environment. Forcing medication, orally or by injection, is also common in Japan, but nurses believe in administering medication even against patients' wishes. These situations conform to their values and never cause moral distress.

In contrast, the three items, whose median scores in Japan were higher than those in England, were rarely experienced by the nurses in England. Long stays in hospital being one of the big and unique problems of Japanese psychiatry[13], it was expected that the item score would be higher in Japan than in England. As for inadequate care caused by low staffing, nurses in Japan recognize that understaffing results in inadequate care treatment, though the nurses in both countries complain of a lack of staff. This seems to reflect the actual poor conditions in Japan. The item, carrying out an order for unnecessary tests and treatment, may reflect that it is difficult for all Japanese, including nurses, to say "No".

As for frequency, the number of items which exceeded 3 was different ; five items in Japan, and two items in England. The frequency scores were significantly different in 15 items, where the problems expressed were various, but the scores in Japan exceeded those in England in all 15 items. It should be noted that nurses in England felt moral distress in wider variety of situations, though they confronted them less frequently compared to nurses in Japan.

The relationship between moral distress and age or experience

In England, significant correlations were not only found between moral distress intensity, and the age of nurses, but were also found between moral distress intensity and years of nursing experience. These correlation coefficients were all negative, which means that the older nurses became and the more experience they had accumulated, the less in-

tensely they felt moral distress. This, however, does not hold true for Japan. The fact that the number of the items which significantly correlated was only three, and the correlation coefficients were small, and not always negative, indicates that neither age nor experience diminish moral distress among Japanese nurses.

As for the relationship between moral distress and experience, results in literature indicate the opposite. Wilkinson[4] interviewed 24 nurses, and analyzed the data qualitatively. She found that "more experienced and knowledgeable nurses were more able to manipulate the system, and were, therefore, more likely to implement their moral decisions and suffer fewer instances of moral distress." On the other hand, Elpern, Covert, and Kleinpell[14] administered a questionnaire survey to 39 staff nurses in a medical intensive care unit, and found that there was a positive correlation between years of nursing experience and moral distress. They speculate that "most likely with increasing years in the nursing profession, the cumulative weight of distressing experience also increases."

In this study, the three moral distress items which correlated to age in England were regarding insufficient facilities and incompetency of other medical staff. Nurses with advancing age seem to be able to better manage with insufficient facilities, and cover the deficiency of others. The items which correlated to years of nursing experience in England, item 28 (Be required to care for patients I am not competent to care for.) and 8 (Carry out a work assignment in which I do not feel professionally competent.), seem to be unique to nurses with less experience.

In the items correlated to age and nursing experience in Japan, it should be noted that there is a positive correlation coefficient in item 2 (Follow the instruction of the doctor, who prioritizes the wishes of the family over the patient), even though the correlation is very weak. Those who perceived the physician as "decision-maker" and the nurse as "order-follower" are said to experience less guilt than those with strong feelings of nursing autonomy[4]. Aged nurses in Japan, who therefore have more experience, seem to follow an older value system which dictates that nurses should be obedient to doctors.

Moral distress and burnout

The participants in both countries felt almost same level of exhaustion and cynicism. The mean scores of Ex in this study were relatively high, even though the scores are known to be different among nations and/or vocations. The Ex score of nurses in Canada was 2.98, and psychiatric workers 2.54. The mean scores of Cy in this study were also higher than the scores shown by Canadian nurses (1.80), and psychiatric workers (1.88)[15]. The reasons for lower levels of exhaustion and cynicism compared to the results of this study are not known, but these were administered in '90. One possibility is that the mental health care environment has changed with the passing of time.

As for PE, the mean scores were extremely different between Japan and England. In the study by Schaufeli et al[15], the PE mean scores of Dutch (civil servants, and rural workers), Finnish (computer jobs), and Canadians (military, clerical, technologists, nursing, management, and psychiatric workers) ranged from 4.14 to 4.86. The mean score of the nurses in Japan, 1.61, is considered to be extremely low, while the mean score of the nurses in England, 4.68, is normal. One reason why the professional efficacy of Japanese mental health nurses is so low is that it is speculated that mental health nursing is considered to be such an easy job that any nurse can do it, even though he/she is not competent in other settings in Japan. This is because many patients can live their daily lives with little care. Some nurses are aware of their incompetency, which leads them recognize patients as those who should obey their orders[16]. The extremely low score of PE shows that the nurses consider themselves incompetent, or they struggle to successfully improve patients' conditions. Lack of resources such as rehabilitation facilities may affect the nurses' recognition of incompetency caused by failing to reintegrate patients into society.

The number of items indicating correlation between moral distress item and burnout subscale differ between the two countries, which is reasoned by the fact that the number of participants differ. But the fact that all the correlation coefficients are

positive means that nurses who are morally distressed more feel a greater degree of burnout.

Limitations of the study

This study has several limitations. First, this research adopted cross-sectional method through self-administered questionnaire, which has several limitations ; the respondents do not always answer honestly, and causal connections cannot be proved. Second, the participants were not selected at random, so the responses might not be a perfectly accurate representation of nurses in both countries. Last, the response rate in England was very low, and it is possible that the responses were biased ; possibly only the nurses who were suffering from moral distress responded.

CONCLUSION

Several differences were found between the moral distress experienced by mental health nurses in Japan and England as expected. Some of the differences, such as long term social hospitalization, reflected the uniqueness of the mental health systems and poor resources in Japan, while the same ethical problems, such as following a family's wishes, existed in both countries caused different levels of moral distress. In addition, nurses in both countries felt intense moral distress concerning a lack of staff, even though the levels of staffing were totally different. The frequency of moral distress affects the intensity of moral distress differently between the two countries. The age or years of nursing experience also affects moral distress differently.

In this study only moral distress and burnout were examined. The levels of moral distress which nurses feel are thought to be affected by many factors. Moral distress correlates burnout. But there will be no improvements of care if nurses feel no moral distress. Nurses should have moral sense, and do their best to improve the situations without burning out. More studies concerning values, views, goals of nursing, and sensitivity, as well as professional efficacy are needed.

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精神科看護師が経験した倫理的悩み：質問紙調査による日本とイングランドの比較

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倫理的悩みは，看護師が倫理的価値や原則に基づいて正しい意思決定をしたが，現実的な制約により実行できなくなったときに生じる。研究目的は，精神科医療において資源の豊富さに差があるイングランド（以下，英）と日本の精神科看護師が経験する倫理的悩みとバーンアウトを比較することである。

方法は，倫理的悩みに関する質問，バーンアウト尺度，それに属性に関する項目から成る無記名自記式質問紙を用いた横断的研究である。対象者は便宜的に抽出された看護師・准看護師で，日本では6病院で働く391人，英では3病院の460人であった。

日本の289人（回収率73.9%），英の36人（回収率7.8%）から回答があり，両国で共通して強い悩みとなっていたのは，「人員配置の不足」であった。一方でいくつかの相違もあり，長期の社会的入院のように不十分な状況を反映した項目の得点は日本で高かった。また，英の看護師は日本に比べ，倫理的悩みに遭遇する頻度は少ないにも関わらず，より多くの項目で悩みを示していた。属性との関連では，英でのみ，年齢が高くなるほど，すなわちより多くの経験を積んでいるほど，悩みの程度が低くなっていた。バーンアウトについては，両国の看護師は同程度の疲弊感とシニシズムを示していたが，職務効力感は英の看護師のほうがはるかに高かった。

倫理的悩みを感じ，バーンアウトすることなく状況を改善する努力をしていくことが重要である。

キーワード：倫理的悩み，バーンアウト，精神科看護師，質問紙，横断的研究

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