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Ethical concerns in maternal and child healthcare in Malawi.

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Ethical concerns in maternal and child healthcare in Malawi

Abstract

Background: Caring is a core function of nurses and it confers upon them ethical obligations as ethical agents. Failure to carry out such ethical obligations raises ethical concerns. This study was not intended to explore ethical concerns, but the reported findings reveal problems which have ethical implications. This paper aims to elucidate the ethical issues inherent in the findings and propose strategies to mitigate them.

Research design and methods: An exploratory-descriptive qualitative design was used within a larger Action Research Study. Data were collected through focus group discussions (FGDs) with nurse/midwives, and through exit interviews which were conducted with the women who participated in the study on their day of discharge. Six FGDs and thirty exit interviews were conducted, and data were analysed through thematic analysis.

Participants and research context: The study took place at selected maternal and child healthcare settings in Lilongwe, Malawi. The participants were nurse/midwives and women who were admitted in maternal and child healthcare settings and were purposively sampled.

Ethical Considerations: Ethical approval was obtained from the relevant ethics committee and all ethical guidelines were followed in the conduct of the study.

Findings: The findings are presented under three themes which emerged from the data. The findings reveal effects of staff shortages on patient outcomes, problems experienced in low resource clinical settings and disrespectful nurse/patient communication.

Conclusion: The findings reveal that institutional factors constrain moral agency and patient safety is severely compromised in some of the clinical settings in Malawi which raises serious ethical concerns.

Keywords

Ethical concerns; Ethical practice; Ethical agency; Nursing ethics; Caring; Moral communities

Introduction

Nursing and midwifery are moral enterprises¹ and this implies that morality should be the guiding principle in the provision of nursing and midwifery care. Furthermore, health care organizations are believed to be moral communities.² Morality refers to traditions or beliefs about right and wrong conduct,³ while professional morality refers to standards of conduct which are acknowledged and encouraged by those in the profession who are serious about their moral responsibilities.⁴ The professional code of ethics prescribes the standards of conduct for nurses and midwives. These are ethical obligations and duties, and it is expected that nurses and midwives should comply with them in order to conduct themselves in a professional and ethical manner. However, there is evidence that care is compromised in some of the healthcare facilities in Malawi either because of factors in healthcare settings where nurses practise or nurses' attitudes and behaviour.⁵

The nurses' work environment⁶ is a prerequisite for the provision of quality and safe patient care. Persistent gaps in human resource exist across all cadres, districts and health care levels within Malawi's public sector⁷. The nurses' work environment is characterised by a severe nursing shortage and the nursing and midwifery personnel vacancy rate is at 63%.⁷ This translates to a nurse/midwife population ratio of 1:2300 and nurse-patient ratio of 1:80 against a 1:6 nurse-patient ratio recommended by the International Council of Nurses (ICN).⁸ Another challenge confronting the health sector in Malawi is the gross lack of material resources and supplies. There is evidence that the quantity and quality of equipment in public health facilities is low and 20-25% is out of service,⁷ and there are also regular shortages of essential medical products and technologies. Additionally, most of the public health facility infrastructure is dilapidated due to long periods of lack of maintenance and there is congestion of patients due to the high disease burden. The foregoing discussion reflects the nature of the work environment, and consistent with Moisoglou et al.⁶ the environment could be described as non-favourable, and may not only negatively impact patient outcomes, but also the wellbeing and performance of healthcare workers. Such work environments create an ethical environment which is described in the literature as morally uninhabitable.⁹

Liaschenko and Peter² argued that the most challenging moral problem of the twenty-first century is the relationship between an individual moral agent and the practices and institutions in which the moral agent is embedded. They argued that institutions can constrain the moral agency of those who work in them and the authors of this paper support this view. Furthermore, this view is also supported by Boakye et al. who also revealed in a study that

morally uninhabitable work environments constrain moral agency and provoke suffering and distress⁹. However, the findings of their study revealed that the nurse/midwives negotiated their practice and navigated through the morally uninhabitable work environment by holding onto their moral values and commitments. Whilst these midwives seemed to have developed resilience and responded positively to a negative work environment, arguably, others may respond negatively. It is argued that such work environments can sometimes cause nurses to be accustomed to them leading to a numbing of emotions and failure to demonstrate compassion towards patients. In this case, moral agency would be constrained not directly by institutional factors, but by the nurses themselves and ethical practice would be compromised.

Moral agency is defined as a person's capacity to engage in deliberate actions that are morally relevant; touching on matters of right and wrong, good and bad, or just and unjust.¹ Pask¹⁰ draws our attention to a type of moral agency where nurses should see the value in what they do and believe that what they do can make a positive difference. It is argued that for nurses to function in such a capacity and to make a difference in the lives of patients that are entrusted under their care, the environment must be enabling. It is further argued that a vicious circle can be observed in clinical settings which are non-favourable where initially, the non-favourable work environment will constrain moral agency and consequently the distress which the nurses will experience will cause them to harden and to have no concern over patients, which will further constrain moral agency. This bears resonance with what Hochschild,¹¹ an American Sociologist termed emotional deadness or emotional numbness and claimed that it provides an exit from overwhelming distress whilst the individual remains physically present on the job. These are not unique problems for nurses in Malawi, but rather, for all health care workers who work under similar conditions in Africa and beyond. When ethical agency is constrained, moral failure occurs, and such practice raises moral concerns. This study did not set out to explore ethical concerns; but it was conducted in response to concerns of negative patient experiences in Malawian clinical settings. The ethical concerns discussed emerged from participants' narratives and the aim of this paper is to elucidate these concerns and propose strategies to mitigate them. This resonates with the goal of a study which was conducted in Canada to describe the moral climate of the nurses' work environment and to improve it.¹² This is essential because there is evidence that most studies have described the nursing and midwifery work environments in resource-constrained settings but have not identified the ethical implications for those working in such environments.⁹

Research Methodology

The study employed a qualitative methodology, and an exploratory-descriptive qualitative design was utilised. This research design was appropriate because it can be used to explore and describe aspects of clinical nursing practice including patient perspectives which was the remit of this study.¹³ However, this was part of a larger Participatory Action Research (PAR) Study.

Study setting, population and sample

The study was conducted at a tertiary and a secondary or district healthcare facility. The two facilities are public hospitals in Lilongwe, Malawi, and the study was implemented in maternal and child healthcare settings which included two maternity settings and one paediatric department. The study participants were nurse/midwives working in these clinical settings and women who were admitted at Maternity units and the women whose children were admitted at the Paediatric department. Purposive sampling was used, a sampling method which selects individuals for study participation based on their particular knowledge of a phenomenon for the purpose of sharing that knowledge.¹⁴

Data Collection

Data were collected through six focus group discussions (FGDs) with 48 nurse/midwives and 30 exit interviews with the women who were discharged from the selected clinical settings and semi-structured interview guides were used.

Data analysis

Data were analysed using the six steps of thematic analysis by Braun and Clarke.¹¹ Initially, the transcripts were read several times to familiarise with the data, and then the transcripts were manually coded. Finally, all the related codes were grouped into potential themes. Manual analysis of qualitative data has a limitation in that it is a tedious and time-consuming process.^{15, 16} However, it allowed visualisation of the codes and themes together, and immersion into the data which is essential for qualitative data analysis.

Trustworthiness

Lincoln and Guba¹⁷ identified credibility, dependability, confirmability and transferability as the criteria for promoting trustworthiness of study findings in qualitative research. Peer-debriefing, member checking and triangulation were used to enhance credibility of findings in this study. As Corden and Sainsbury¹⁸ assert, excerpts from participants' narratives have been included to enable readers make judgements about the fairness and accuracy of the analysis. Data sources and site triangulation also enhanced credibility of the findings. Multiple sources of data ensured that different perspectives were taken into consideration and hence enriched the data.¹⁹

Ethical consideration

Ethical approval for the study was obtained from the College of Medicine Research and Ethics Committee (COMREC) of the University of Malawi, and the reference number is P.03/16/1909. Verbal and written consent was obtained from all the individual participants before data collection.

Study Findings

The study findings reveal that severe nursing shortage, gross lack of material resources and disrespectful nurse/patient communication are some of the problems and challenges which confront the healthcare facilities where the study was conducted. Study participants narrated these issues as factors which hindered the delivery of compassionate care or factors which generally affected the quality of care. The findings are initially presented as verbatim accounts of the way participants narrated the issues without portraying the inherent ethical issues. The findings are presented under the following themes: effects of severe staff shortages on patient outcomes in maternal and child healthcare settings; problems experienced in low resource clinical settings and disrespectful nurse/patient communication in maternal and child healthcare settings.

Effects of severe staff shortages on patient outcomes in maternal and child healthcare settings

The study participants discussed their observations on staffing levels in the various clinical settings and their narratives confirm that nursing shortage is one of the problems confronting the health sector in Malawi.

The nurse-to-patient ratio is high because the ideal one is 1 to 10, but you find that it is 1 to 100, how can one give quality care in that case? (FGD-5-Nurse/Midwife Participant #6)

The study findings reveal the effects of severe staff shortages on patient outcomes. One participant gave an account of a woman who delivered without the assistance of a midwife because of staff shortages.

My colleague was conducting another delivery and I was in theatre where we had four Caesarean sections [...] when I came back, the other woman had already delivered on her own and she had a big tear. (FGD-3-Nurse/Midwife Participant #2)

While hospital delivery is encouraged as a safe motherhood initiative, an account was also given of a situation where a woman nearly missed death, and another woman died after being assisted to deliver by a midwife because there was no midwife to monitor their conditions after delivery due to staff shortages.

when you are working just the two of you in the labour ward, you conduct a delivery you are supposed to be monitoring that woman frequently [...] sometimes you just assist her to deliver and you just cover her up, you go to the next patient, or you have a patient in theatre [...] We had an incident where the patient could have died because she had PPH (Postpartum haemorrhage). (FGD-3-Nurse/Midwife Participant #4)

Likewise, another participant said:

One night we had a client who had PPH and was attended to in theatre, the operation was done, and the patient was supposed to go to the ward, but then there was no nurse at the recovery room [...] then we went back to theatre with another emergency case, [...] we later found that the patient who was left at the recovery room had died. (FGD-3- Nurse/Midwife Participant #6)

The study, however, also reveals that sometimes women deliver without the assistance of a midwife because of outright negligence. One of the participants gave the following account:

What disappointed me is that since I arrived on 8th up to 30th when I delivered my baby, most nurses [...] who were on night shift were not doing the right things so that

most mothers were delivering their babies in the examination room, some even in the bathrooms. (Client Participant # 29)

Problems experienced in low resource clinical settings

Narratives from the nurses/midwives who participated in this study reveal that lack of material resources and supplies is one of the problems in the public healthcare facilities in Malawi.

Some drugs are not available in the pharmacy, and patients are told to buy, but some patients cannot manage, so they just stay without treatment. (FGD- 4 –Participant#3)

Another participant said:

Sometimes we run short of aprons, gloves, BP (Blood pressure) machines. As of now, we do not have BP machines, and sometimes we are struggling in the antenatal with only one BP machine. (FGD-2-Nurse/Midwife Participant #7)

Sometimes care is not rendered due to lack of material resources, and the excerpt below illustrates this:

There are many mothers with anaemia and during ward rounds, we need to check the HB [haemoglobin] using a hemocue machine, which we do not have. So, I have to go look for it from another ward, in the end, you spend a lot of time looking for resources without providing care. (FGD-4-Nurse/Midwife Participant #1)

One participant commented on the problem of congestion of patients in the wards and lack of bed space.

The room was very full; there were no beds, not even for the sick babies. Sick babies were made to sleep on the floor with no proper beddings and the floor was cold (Client Participant # 01)

Another participant said:

In the serious ward (Acute Ward); the beds are too small to accommodate six babies. [...]. It sometimes happens that the baby would recover from the sickness that brought them to the hospital but would start suffering from a new disease which would be contracted from the shared bed. (Client Participant # 12)

Disrespectful nurse/patient communication in maternal and child healthcare settings

Narratives from the women who participated in this study revealed that disrespectful communication is a common problem, and the following excerpts illustrate this:

There are other nurses who would start shouting at patients even before they finish asking what they want to know. (Client Participant # 01)

There are other doctors or nurses who shout at patients [...] others would even beat the patients (Client Participant# 04)

At the health centre, they sometimes leave you by yourself to suffer on your bed without any help and even shouting at you. (Client # Participant 02)

The study findings revealed that disrespectful nurse/patient communication is perceived by some of the women as a lack of love.

Whenever a baby is sick, the mother becomes confused and sometimes the mother may not respond rightly to the questions which a nurse may ask. If they meet the nurse who has no love, the nurse would start shouting at such a mother. (Client Participant # 12)

The study findings reveal the consequences of disrespectful nurse/patient communication and the excerpts illustrate this.

Sometimes they (patients) could even tell you openly saying that friend of yours, (fellow nurse) we are always afraid of her. Sometimes when they are late to get the medication, they can stay without medication for fear of being shouted at. (FGD-6-Participant#3)

The problem is that guardians (patient's relatives) are always afraid of nurses [...] they are not free to tell us the patient's problems; they just stay quiet for fear of being shouted at. (FGD-5- Nurse/Midwife Participant # 1)

Discussion

The reported findings are derived from narratives of study participants on the state of the care at the maternal and child healthcare settings where the study was conducted. The findings reveal severe staff shortages and lack of material resources and supplies which negatively impact patient outcomes. Malawi is one of the countries with a high maternal mortality rate

(MMR). The MMR is at 439 deaths per 100,000 live births²⁰ and women are encouraged to deliver at healthcare facilities where they can be assisted by skilled birth attendants. This is a safe-motherhood initiative which is being implemented to curb the high mortality. However, the study findings reveal negative patient outcomes occurring more commonly as a consequence of the severe staff shortages. It is argued that these longstanding infrastructural or resource-related constraints have ethical implications. Inherent in these reported findings are problems that raise ethical concerns. From an ethical standpoint, these findings reveal harm occurring to women, the worst scenario being the loss of life. This is a violation of the principle of non-maleficence. There is also evidence of missed care as a consequence of lack of material resources and supplies which according to Boakye et al.⁹ reveal the nurses' inability to fulfil their moral responsibilities. The findings reflect compromised patient safety, and it is argued that this is an ethical concern in nursing and midwifery practice in Malawi. In addition, the findings reveal disrespectful communication, more commonly, towards patients, which reflect the prevailing ethical climate. The ethical climate has been defined as the "implicit and explicit values that drive healthcare delivery and shape the workplaces in which care is delivered" (p.24).¹² The disrespectful nurse/patient communication reflects unethical practice and failure of moral agency. These observed ethical issues are extended into a discussion.

Patient safety: An ethical concern for resource-poor clinical settings

Patient safety is a fundamental principle of health care,²¹ and Kangasniemi et al.²² argued that it is an ethical imperative. It is defined as "the absence of preventable harm to a patient during the process of health care and reduction of risk of unnecessary harm associated with health care to an acceptable minimum."²³ Nurses are constantly present with the patient at the bedside and therefore they have a critical role in ensuring patient safety.²⁴ However, this can only be guaranteed subject to the availability of adequate staffing levels and the quality of healthcare services. World Health Organization²¹ observed that in many countries health services are of poor quality which endangers the safety of patients and compromises health outcomes. As discussed earlier, most health care facilities in Malawi are characterised by a lack of both human and material resources and supplies which negatively impacts the provision of patient care. Patient safety at the healthcare facilities where this study was implemented was significantly compromised. The study findings reveal that the main problem responsible for compromised patient safety was severe staff shortages and the resultant high nurse/patient ratio. PSNet and AHRQ²⁴ maintain that increasing numbers of

patients eventually compromises nurses' ability to provide safe care, and the findings in this study support this view.

The ethical principle of non-maleficence confers upon healthcare personnel a moral obligation not to cause harm to anyone.^{25, 26} However, the findings of this study reveal that the principle was grossly violated. Harm can be physical or psychological, and physical harm includes pain, disability, discomfort, and death, while psychological harm includes mental distress, humiliation, exploitation and annoyance.²⁶ Harm occurring to patients due to shortage of nurse/midwives as this study reveal involved sustaining a severe perineal tear and death. The harm inflicted on patients was physical, but psychological harm cannot be ruled out. World Health Organization²¹ asserts that the psychological cost to the patient and their family associated with the loss of a loved one is significant though more difficult to measure. Congestion of patients was also one of the problems which were mentioned as a cause of concern by some of the study participants and arguably, it is also a potential cause of harm. This is a common problem in most clinical settings in Malawi, but seems to be more prevalent in the paediatric ward. Some of the participants reported that several ill children were placed on one cot or on the floor bed such that they can easily contract nosocomial infections. Considering that we are now in the era of the COVID-19 pandemic, this is contrary to the WHO recommendation of maintaining social distance of at least one metre apart. Congestion of patients increases the risk of transmission of other infections as well as the COVID-19 virus to both patients and even staff.

Hendrick²⁶ indicates that harm can be intentional or unintentional. Some of the harm inflicted on patients according to the findings in this study was unintentional but caused by institutional factors. As already discussed, understaffing was a significant cause of injury and avoidable harm, and it is an institutional factor. It is extremely disheartening that lives can be lost due to a shortage of health care personnel. These findings support the argument by Liaschenko and Peter² that healthcare organizations can constrain the moral agency of those who work in them. The severe staff shortages hindered the nurses from effectively fulfilling their moral responsibilities as ethical agents. Lützen et al.²⁷ describe such a situation as a blocked moral agency, and they attribute it to contexts which are prohibitive. Resource-poor clinical settings as is the case in Malawi are prohibitive and are a major deterrent to the fulfilment of ethical or moral agency. The nurses working in these clinical settings were without any doubt aware of their duties and obligations as ethical agents to save the lives of the women who were entrusted under their care, but they were let down by the staff shortages.

The lack of material resources and supplies reported in this study also hindered nurses from providing the necessary care. This is consistent with what is termed in literature as missed care. Jones et al.²⁸ defined it as unfinished care, implicitly rationed care and care left undone. There is evidence that staffing and resource adequacy are some of the nursing practice environment elements that are significantly related to missed nursing care.^{29,30} In this study, missed care was evidenced by statements such as “*you spend a lot of time looking for resources without providing care.*” These findings support the notion which was expressed by Aiken et al.³¹ that missed care is associated with the omission of nursing tasks. It is argued that incidents like the self-delivery which led to a severe perineal tear, the reported case where a woman nearly died due to postpartum haemorrhage and the reported death of a woman occurred as a consequence of missed care. Rodney et al. argued that the safety of patients depend on a safe moral climate in which the organizational, material and interpersonal resources are available and the values for safe, competent, ethical care are in place.¹² Arguably, the cause of all these patient safety issues confronting the health sector in Malawi and other countries with similar challenges is the lack of a safe moral climate.

Disrespectful nurse/patient communication: A type of moral failure and an ethical concern

The study provides evidence that disrespectful nurse/patient communication is one of the problems confronting the health sector in Malawi. It may seem this is common in Malawi, and existing literature also reflects the same problem.^{32–34} These findings portray a lack of ethical sensitivity, which Milliken³⁵ asserts to be a foundational component of ethical action and that where this is lacking, the result is ethically incongruent care. Lützen et al.²⁷ defined ethical/moral sensitivity as “an understanding of patients’ vulnerable situation as well as an awareness of the moral implications of decisions that are made on their behalf” (p. 216). Furthermore, these findings portray a lack of awareness of the vulnerability which illness imposes on patients. Gastmans³⁶ argues that persons who require nursing care are vulnerable, and an awareness of this should compel any prudent nurse to comport themselves in a manner which will not increase the patient’s vulnerability. What these findings reveal is a scenario where ethical practice is at stake. The ethical essence of nursing is to provide care in response to the vulnerability of a human being to maintain, protect, and promote his or her dignity as much as possible.³⁶ These findings reveal gross violation of the principle of respect of persons and human dignity, which are essential ethical values in healthcare and are ethical imperatives. The promotion of human dignity requires that all humans should be treated with

equal respect regardless of sex, age, ethnicity, sexuality and function.³⁷ Nurses therefore have an obligation as ethical agents to uphold patient's dignity as they provide care. Arguably, the disrespectful nurse/patient communication and the resultant violation of the principle of respect of persons and human dignity portray moral failure by the nurses themselves, and not as a result of institutional constraints.

Malawi is particularly known as the warm heart of Africa because of the warmth which people who visit the country experience. However, strangely enough, the ethical climate in the hospital does not seem to reflect such warmth. This could be attributed to several factors, but one possible explanation could be the prevalence of moral distress and burnout among Malawian nurses. Moral distress refers to an experience when a person knows what is right to do but does not do it because of external or internal impediments to the person's actions.¹ A study by Maluwa et al.³⁸ revealed moral distress among Malawian nurses and the causes among many factors included lack of resources. The following verbatim quote from a study by Msiska et al.³³ reflect how the lack of resources can lead to moral distress and it states, *"So if you don't have the resources, it's so stressful, and when you stand there with your knowledge, your skills, everything but you can't do anything and it's so stressful"* (p. 101). The situation within the Malawian clinical settings has not improved over the years, but has worsened, and the behaviour of the nurses depicted in this current study shows that it is likely that moral distress is still prevalent and hence the disrespectful nurse/patient communication. Burnout is defined as a process in which a professionals' attitudes and behaviour change in negative ways in response to job strain.³⁹ The staff shortages and the congestion of patients which have been reported in this paper are factors which can lead to job strain and indeed burnout. Besides, there is also evidence of burnout among healthcare personnel in Malawi. Thorsen et al.⁴⁰ revealed significant burnout among maternal health staff in Malawi who participated in their study. It is therefore argued that burnout could also be the likely cause of the disrespectful nurse/patient communication and the dismissive attitudes which Malawian nurse/midwives demonstrate towards patients.

Implications for practice

The study reveals serious ethical concerns regarding patient safety as a consequence of a severe shortage of nurses and missed care due to lack of resources. The principle of non-maleficence is grossly violated and therefore these institutional factors need to be urgently addressed. World Health Organization²¹ recommends that treating and caring for people in a safe environment and protecting them from health-care-related avoidable harm should be a

national and international priority. Tackling the human resource shortage should be a priority if patient safety will be ascertained in Malawi. The government is making efforts to address the staff shortages through the Ministry of Health; however, it is argued that the pace at which the deployment of newly qualified nurses is taking place does not match with the magnitude of the problem. A report by Jerving⁴¹ indicates that despite efforts in the country by healthcare educational institutions to train more health professionals, the government has been slow to absorb new graduates because of budgetary restrictions which were recommended by the International Monetary Fund. In view of this, the problem of staff shortages is likely to persist. However, such decisions are made without considering the impact of such staff shortages on patient safety. It is argued that this is a challenge which nursing and midwifery as professions should address to effectively resolve the problem of shortage of nurses and its impact on patient outcomes. Liaschenko and Peter² argued that nurses must exercise power and be able to speak to policy issues such as staffing and resources. They recommended that this moral dialogue can be most effective when conducted at the level of professional unions or other professional organizations. In Malawi, this can be ably accomplished by the Nurses and Midwives Council of Malawi as a regulatory body, the National organization of nurses and midwives of Malawi (NONM), and the Association of Malawian Midwives (AMAMI) just to mention a few. Gallagher and Tschudin⁴² posited that nurses should function at the macro level as ethical leaders where they can engage politically, lobbying politicians, and ensuring that their voice is heard in national and international forums. This is what is required to lobby for more healthcare personnel and resources. Whether such leaders exist is an issue worth considering, however, there is evidence that such leadership skills can be attained through practically designed training programmes⁴³ and role modelling.⁴² The staffing and resource constraints are a consequence of low healthcare financing and these needs compete with other healthcare needs in the country and the nurse leaders' ability to effectively lobby could enable these healthcare needs to be considered as a priority. There is evidence that priority setting in healthcare presents distinctive ethical challenges, and it is recommended that decision-makers should utilise theories of distributive justice in priority setting.⁴⁴

Kangasniemi et al.²² assert that nurse managers play a strategic role in patient safety and that their role is to incorporate ethical values of patient safety into decision-making at all levels in an organization. Accordingly, safe staffing should be the goal in the recruitment and deployment of nurses and other healthcare personnel. The International Council of Nurses⁴⁵ defined safe nurse staffing in its position statement as an appropriate number of nurses

available at all times across the continuum of care, with a suitable mix of education, skills and experience to ensure that patient care needs are met and that the working environment and conditions support staff to deliver quality care (p.1). There is a need to develop policy briefs on safe staffing. Policy briefs are short documents that present research findings and their recommendations to a non-specialist readership such as policymakers.⁴⁶ They are recommended as a key tool for engaging with policy actors⁴⁷ and it is argued that this is another strategy which the nurse leaders in Malawi can use to lobby for more staffing and adequate resources. Policy briefs should therefore be developed for this purpose, to initiate dialogue with the relevant policymakers and stakeholders. This is an approach which can help policy actors to be aware of the magnitude of the problems confronting the healthcare facilities and can prompt them to intervene and improve the nurses work environment. There is evidence that improving staffing levels and resources would help to create morally habitable work environments.⁹

Tackling the human resource crisis prevalent in the clinical settings in Malawi is a long-term goal, and the staff shortages will likely persist. This implies that there will still be a potential risk that nurses will continue to develop moral distress. What is required is to support them so that while they continue to practice in such environments, they should not develop moral distress or burnout. There is evidence in literature of nurses who work in environments which are likely to cause moral distress but have demonstrated resilience. For example, Traudt et al.⁴⁸ revealed in a study that intensive care unit nurses who despite the frequent and intense end-of-life situations they experienced, they did not manifest moral distress. They demonstrated a strong sense of moral agency that was facilitated by the moral community and moral dialogue in their units. These strategies promoted critical reflection of moral agents on their moral practices. It is therefore recommended that moral communities should be created within Malawian clinical settings and moral discourse should be encouraged to curb the occurrence of moral distress. It is argued that strategies to resolve moral distress and burnout will also help to improve nurse/patient communication and promote greater ambience in the hospital environment consistent with the warmth which Malawians are known to possess. However, the disrespectful nurse-patient communication portrays a dehumanizing of care and what is critical to these findings is the need for re-humanizing nursing and midwifery practice. It is argued that this is also a function of ethical leadership. Ethical leaders are role models for implementing change and caring and appropriate ethical behaviour.⁴⁹ Furthermore, compassionate, committed and emotionally sensitive ethical leadership is also required to have compassionate and smiling nurses as this

is a gesture of care for those who care.⁵⁰ There is also evidence that humanizing healthcare⁵¹ can also take place through qualitative research, and accordingly, the primary aim of this study was to embed compassionate care in nursing and midwifery practice at the selected healthcare facilities where the study was conducted.

Conclusion

The paper reports ethical concerns in selected Maternal and Child Healthcare settings in Malawi. These concerns are mainly a consequence of institutional problems which constrain moral agency among nurses. The study findings reveal that patient safety was grossly compromised due to severe staff shortages and gross lack of resources with fatal consequences on patient outcomes. The findings reveal a violation of the principle of non-maleficence leading to both physical and psychological harm, and dishearteningly, even loss of life. In addition, the study findings provide evidence that disrespectful nurse/patient communication is also one of the problems confronting the health sector in Malawi leading to violation of the principle of respect of persons and human dignity. This demonstrates a lack of ethical sensitivity, unethical practice and more importantly, moral failure. It is recommended that the nursing and midwifery professions should embrace the role of ethical leaders and lobby for the recruitment of more nurses to ensure safe staffing and procurement of more resources. Furthermore, the creation of moral communities is also proposed, and that moral dialogue should be encouraged to prevent the occurrence of moral distress and burnout and to build resilience among nurse/midwives. It is also recommended that re-humanizing of healthcare should also be promoted through ethical leaders who should model appropriate caring and ethical behaviours.

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Conflict of interest

The authors declare that there is no conflict of interest.

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