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Consequences of clinical situations that cause critical care nurses to experience moral distress

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Abstract

Little is known about the consequences of moral distress. The purpose of this study was to identify clinical situations that caused nurses to experience moral distress, to understand the consequences of those situations, and to determine whether nurses would change their practice based on their experiences. The investigation used a descriptive approach. Open-ended surveys were distributed to a convenience sample of 204 critical care nurses employed at a university medical center. The analysis of participants' responses used an inductive approach and a thematic analysis. Each line of the data was reviewed and coded, and the codes were collapsed into themes. Methodological rigor was established. Forty-nine nurses responded to the survey. The majority of nurses had experienced moral distress, and the majority of situations that caused nurses to experience moral distress were related to end of life. The nurses described negative consequences for themselves, patients, and families.

Keywords

Advocacy, critical care, end of life, ethical dilemmas, moral distress

Introduction

Moral distress is experienced by nurses as a result of challenges faced in clinical practice. Nurses have reported experiencing moral distress once a week[1] to one to two times a year.[1,2] Jameton[3] initially described moral distress as arising "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p.6). Nurses are often caught in the vortex of profound moral problems.[4]

A variety of situations can cause a nurse to experience moral distress. Corley[5] reported that nurses experienced moral distress when they felt that staffing was unsafe. Gutierrez[1] reported one cause of moral distress as overly aggressive treatment of patients and another when patients' wishes are disregarded. Moral distress also occurs when nurses observe patients suffering.[6]

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Moral distress has been reported as occurring frequently when nurses care for the dying.[5–13] Corley[5] found that moral distress occurred due to a variety of situations, including providing life-sustaining treatments that prolonged the dying process and following the directives of family members to continue life-sustaining treatments that were not in the best interest of the patient. Thus, the moral distress experienced by nurses is inextricably bonded to the distress experienced by patients.

Interestingly, heightened moral sensitivity may be a source of moral distress.[14] Nurses more attuned to the ethical dimensions of care may be more at risk for moral distress since these nurses see the moral dimensions of nursing being neither respected, discussed, nor managed.[14]

Responses to moral distress

Nurses have reported an array of emotions and feelings that they have experienced as a result of moral distress. These emotions include anger,[1,2,4,7,8,12,15,16] anxiety,[4,7] depression,[4,7,12] disgust,[8,16] guilt,[1,2,4,12] sadness,[1,4,16] and worry.[15] After experiencing moral distress, nurses have also reported feeling frustrated,[1,2,8,12,15–17] helpless,[15] hopeless,[16] and powerless.[4,8,16] They also experienced a loss of confidence,[15] self-blame,[18] self-doubt,[18] self-disappointment,[18] and a loss of self-worth.[7,12,15,18] As a result of moral distress, nurses have reported crying,[1,4,15] losing their appetite,[15] being unable to sleep well,[1,4,7,15] and experiencing nightmares.[12,15] Physical symptoms that nurses have reported include diarrhea,[12] headaches,[1,12,15] heart palpitations,[12,15] and vomiting.[4]

Nurses have reported that moral distress has affected their personal relationships.[7,12] Some nurses turn to family members and friends by sharing their feelings and concerns, whereas other nurses withdraw from family members and friends.[1] Nurses have also reported turning to alcohol.[4]

After experiencing moral distress, nurses have reported discussing advance directives with their families and encouraging their own personal family members to complete advance directives.[1,7] Experiencing moral distress also influenced future donation wishes for nurses: some nurses have made personal decisions not to donate their organs[1,7] or not to allow their family members to donate organs.[1] Not encouraging or recommending donation occurred as a result of nurses seeing that valuable resources were not being used wisely. Nurses perceived that blood products and organs were ''wasted'' on patients who were not expected to benefit from them.[7] Obviously, such decisions negatively affect future patients and families.

Moral distress affects nurses professionally. Nurses have reported that they have requested not to care further for a patient whose situation led to moral distress.[1,7,12] Nurses have also reported having decreased interactions with patients' families.[1] After nurses experienced moral distress, they are reluctant to go to work[1] and some nurses have reported working fewer hours to avoid the situation.[18]

Moral distress has affected some nurses' ability to continue working on the same unit, at the same hospital, and even in the nursing profession. Nurses have considered leaving[7] or have left[18] the specific unit where the situation that caused the moral distress occurred in search of better working conditions. Several researchers have found that nurses have left a nursing position as a result of moral distress.[4,5,12,16,19,20] Sundin-Haurd and Fahy[16] reported that some nurses left clinical nursing after experiencing moral distress. Elpern et al.[7] reported that nurses have considered leaving and Wilkinson[12] reported that nurses have left the nursing profession because of moral distress.

While previous research has demonstrated that there are multiple causes and responses to moral distress for nurses, the consequences of the situations for patients and families remain unexplored. The purpose of this study was to identify clinical situations that caused nurses to experience moral distress and to determine the consequences of the situations. The researchers sought to identify specific clinical situations that caused nurses to experience moral distress, to understand the consequences of those situations, and to determine if nurses would change their practice based on the experience of moral distress.

Research design

The purpose of this study was to determine clinical situations that caused critical care nurses to experience moral distress. The investigators specifically sought to answer three questions: (a) What situations caused moral distress for critical care nurses? (b) What were the consequences of each of the situations? and (c) What would the critical care nurses do differently if faced with a similar situation in the future?

The investigation used a descriptive approach. Surveys were distributed to a convenience sample of critical care nurses from six adult critical care units of a university medical center. The potential sample included all registered nurses working in the six units.

Participants were asked to complete an open-ended survey, four pages in length. Moral distress was defined on the first page of the instrument as "a type of moral conflict that occurs when one knows the right thing to do, but can't pursue the right action." If participants never experienced moral distress, they checked the line stating this, completed the demographic information, and returned the instrument. If participants experienced moral distress, they checked the line stating this, completed the demographic information, described a situation that contributed to the experience of moral distress, what if anything they did to address the situation, and what effect the situation had on the patient, family, and health-care providers. The critical care nurse was also asked what, if anything, he or she might do if faced with a similar situation in the future. The investigation was approved by the institutional review board.

Informational posters explaining the study were posted in each of the six critical care units. Surveys, along with addressed and self-addressed, prestamped envelopes were placed in each of the critical care nurses' unit mailboxes. Participants had the option of completing the survey, placing it into a sealed envelope, and placing it into a data collection folder in the unit or sending it by US mail to one of the researchers (D.W.).

Data analysis

All hand-written survey responses were typed. Descriptive statistics of the demographic data were compiled. Analysis of each participant's responses to questions and comments used an inductive approach and thematic analysis. ATLAS.ti was used to manage the data. Each line of the data was carefully reviewed and coded. Codes were collapsed into themes and operational definitions written for each. A random sample of surveys (10) was selected and analyzed by the other researcher (M.F.) to assure consistency in the themes.

Results

Surveys were distributed to 204 critical care nurses, and 47 surveys were returned, a return rate of 23%. Seventy-nine percent ($n = 37$) of the critical care nurses who completed a survey reported that they had experienced moral distress, whereas 21% ($n = 10$) of the critical care nurses who completed a survey reported that they had not experienced moral distress. Refer to Table 1 for demographic data of the critical care nurse sample. The critical care nurses who responded that they had not experienced moral distress were younger and had less experience in nursing and in critical care nursing.

Situations that created moral distress for critical care nurses

The majority of clinical situations that resulted in moral distress were related to end of life (73%; 27/37 responses). The end-of-life situations that created moral distress included medical futility (59%; 16/27 responses), organ donation (11%: 3/27 responses), over- or underadministration of analgesic medications (8%; 2/27 responses), and other end-of-life issues (22%; 6/27 responses). Refer to Figure 1 for an example of a clinical situation that caused a nurse to experience moral distress.

Table 1. Critical care nurse demographic data (n = 47, based on all participants completing the survey)

Gender	
Female	70%
Male	30%
Race	
White	93%
Black	2%
Asian	2%
Other	2%
Age	25–60 years (mean = 41 years)
Nursing experience	0.2–33 years (mean = 15 years)
Critical care nursing experience	0.2–32 years (mean = 13 years)

Additional clinical situations that resulted in moral distress included situations involving disclosure or nondisclosure of patient information (11%; 4/37 responses), a lack of patient respect (8%; 3/37 responses), maintaining safe patient care and the safety of the nurse (5%; 2/37 responses), and a lack of work ethic (3%; 1/37 responses).

Mrs. Woolen was hospitalized with ovarian cancer and metastases to her lungs, liver and kidney. She was a DNR (her physician ordered a DNR based on her living will and verbalized wishes). She became hypotensive on the floor and when the physician called her daughter, the daughter made her a full code (the physician canceled the DNR based on the daughter's wishes) and she was transferred to the ICU. I picked her up at 0700 at which time she was on some drips but stated she was ready to die because her cancer was so bad. She developed trouble breathing around 0900. After calling the doctor and arguing with him about her code status she was intubated because he refused to change the code status despite her wishes . . . I had a real problem with the doctor going against the patient's wishes and the daughter. I didn't think it was ethical or moral.

Figure 1. Exemplar of a clinical situation described by a study participant.

Consequences of the clinical situations that gave rise to moral distress in nurses

The critical care nurses described not only actual consequences for patients and their families but also potential consequences for future patients. Participants described consequences for patients involved with the situation that caused the nurse to experience moral distress. Negative patient consequences included (a) suffering, (b) prolonged dying, (c) undignified dying, (d) quantity versus quality of life, (e) inappropriate care, (f) delayed treatment, (g) prolonged hospitalization, (h) disrespect, (i) the inability to be with family, and (j) false hope. One positive patient consequence was identified: comfortable dying. The patient was comfortable, but the nurse had to handle a difficult situation. The patient's family members were

> screaming and yelling at me to give the Dilaudid because the doctor promised them she could get something (either Dilaudid or Ativan) every hour. I tried to educate them about her condition and level of response, assuring them if she appeared to need anything I would give it. I was certain another dose of Dilaudid would actually kill her.

Participants also described many consequences for patients' family members who were involved in the situation that caused the nurse to experience moral distress. The majority of these consequences were negative and included (a) suffering, (b) not being prepared, (c) being overwhelmed, (d) grief, (e) guilt, (f) financial burden, (g) fatigue, (h) stress, (i) anger, (j) being unable to spend time at the patient's bedside, and (k) organ donation. Having the time to process was the only positive consequence that occurred. This positive consequence was identified by one of the study participants who experienced moral distress because a patient's family was not supportive of a patient's desire to avoid aggressive interventions at the end of life. The nurse stated that the patient suffered and had a prolonged dying process, but that the patient's family did have time to process and begin the grief process.

Three of the nurses who participated in the study also identified consequences for future patients: two negative and one positive. All three of the situations involved patients who were possible organ donors. The first negative consequence involved donation of organs from a patient who might have been positive for HIV. The nurse was distressed as the donated organs had the possibility of causing serious future problems for recipients. The second negative consequence involved a physician who blocked an organ procurement organization representative from approaching a family to discuss organ donation. This action denied the family the opportunity to donate and denied possible organs to future recipients. The positive consequence involved a nurse arguing with a physician to treat hypotension in a patient who was a potential organ donor. The nurse commented, "ultimately, after some argument the resident agreed to treat the patient until the family's wishes were known. The family did wish to donate and the patient's liver was transplanted."

For nurses, consequences of the situation that created moral distress included frustration, anger, sadness, psychological exhaustion, helplessness, suffering, distress, disappointment, depression, and physical exhaustion. Nurses repeatedly noted that their voices were not heard and some described having to provide a lower standard of care. Nurses described experiencing conflict with patients' families, other nurses, and physicians. Some nurses described feelings of decreased morale and job satisfaction, and some nurses said they considered leaving their positions. Some nurses described feeling supported by administration, and others reported not being supported.

Changes in nursing practice based on experiencing moral distress

Fourteen nurses (38%) stated that they would change their practices if faced with similar clinical situations in the future (refer to Table 2). Two nurses who had tried to intervene stated that they would not do so in the future. Twelve nurses who did not intervene said that they would change their practice to intervene positively to influence a future situation that might cause moral distress.

The majority of the critical care nurses (62%; n = 23) noted that they would not change their practice based on the situation that created moral distress. Thirteen of these nurses had not intervened to try to minimize or resolve the situation that created moral distress and would not change their behavior in future situations. Ten nurses had intervened to try to minimize the situation that created moral distress and would do so in the future.

Table 2. Would critical care nurses change their practice if faced with a similar clinical situation in the future (to the one that caused the nurse to experience moral distress)? (n = 37, based on the critical care nurses who responded to the survey that they did experience moral distress)

Would not change practice	13/37 (35.1%)	Did not intervene and would not intervene in the future
	10/37 (27.0%)	Did intervene and would intervene again in the future
Would change practice	12/37 (32.4%)	Did not intervene but would intervene in the future
	2/37 (5.4%)	Tried to intervene and would not intervene in the future

To summarize, if the critical care nurses were faced with a similar clinical situation in the future (like the one that caused the nurse to experience moral distress), 22 (60%) nurses would intervene and 15 (40%) nurses would not intervene.

The nurses identified several changes that they would make in an effort to positively influence a future situation that might cause moral distress. These changes in practice included intervening earlier, providing more information, improving communication, not giving false hope, supporting family, facilitating family/physician communication, intervening with the physician about goals of care, being more assertive, being a patient advocate, calling administration, rallying nursing staff support, and consulting the ethics committee sooner.

Discussion

This study supports Wilkinson's[12] finding that moral distress occurs frequently in an individual nurse's practice. Several of the participants in this study noted that they had many situations from which to choose. One participant mentioned to the researcher (D.W.), ''Well which one should I tell you about?'' Moral distress is clearly not an event that critical care nurses experience only once.

Clinical situations

This study highlighted a variety of clinical situations that resulted in critical care nurses experiencing moral distress. The majority of situations that caused this sample of critical care nurses to experience moral distress were related to end of life, which supports the findings of other researchers that moral distress is experienced by nurses caring for the dying.[5–13] Most of the end-of-life situations in this study were related to overly aggressive and futile treatments; this has been demonstrated in previous research.[1]

None of the nurses in this study suggested consulting the palliative care team. As a palliative care service did not have a visible presence in the critical care units of the study facility, the omission is not surprising. Integration of palliative care services into critical care units can assist with early discussions regarding patient goals of care, ease the transition between life-saving and comfort care, and provide essential support services to patients, families, nurses, physicians, and other members of the critical care team.

Responses of the critical care nurses to the situations that caused moral distress

This study reinforced findings from previous studies that moral distress has detrimental effects on nurses. This study supports the findings from those studies that moral distress results in anger,[1,2,4,7,8,12,15,16] depression,[4,7,12] sadness,[1,4,16] frustration,[1,2,8,12,15–17] and helplessness.[15] In addition to the previous research, this study demonstrated that the moral distress experienced by critical care nurses resulted in the nurses feeling disappointed, distressed, and experiencing psychological and physical exhaustion.

This study supports previous research about the impact on the profession since some nurses described considering leaving their positions because of experiencing moral distress.[7] Nurses in this study also described feelings of decreased morale and decreased job satisfaction.

Critical care nurses' perceptions of the consequences of the clinical situation on patients and families

The situations identified in this study resulted in challenges for the nurses as they tried to provide ethical care to patients and families. Previous research has addressed the causes and the consequences of moral distress, primarily focusing on consequences for nurses. This study contributes to understanding the effect of moral distress on nursing practice and demonstrates that situations causing nurses to experience moral distress have detrimental effects not only on nurses but also on patients and families.

The majority of consequences for the patient were negative (e.g. suffering, prolonged undignified dying, delayed treatment). The majority of consequences for the family were also negative (e.g. suffering, not being prepared, financial burden, and guilt).

Interestingly, this study demonstrated that the clinical situations that caused critical care nurses to experience moral distress also may affect future patients. All of these involved organ donation. Two of the situations negatively affected future patients (e.g. placed future patients at high risk for illness and denied availability of donated organs), whereas one had a positive effect where a nurse was able to intervene successfully to influence the organ donation process.

Advocating: choosing action

Cox[21] aptly explained that the environment in which nurses work may create a "perfect storm" of events that prevent nurses from exercising professional autonomy (p.199). Nurses are faced with competing obligations and play an important role as patient advocates. Nurses are obligated to the hospital or institution that employs them and to the physicians and advance practice nurses who prescribe medications, interventions, and treatments. Yet, when faced with ethical dilemmas, nurses are more drawn to decisions that honor their commitment to society as a whole and their patients in particular.[17]

Advocating for patients can be frustrating, time-consuming, and exhausting. Nurses may find their efforts toward patient advocacy blocked and their concerns not taken seriously. While some of the nurses in this study stated that they tried to intervene on behalf of patients but their voices were not heard, others took action and were successful, thus influencing the situation. This experience of moral distress can negatively or positively affect future nursing practice. On the negative side, many of the nurses participating in this study did not take action when faced with an ethically challenging situation and stated that they would not take action if faced with a similar situation in the future. Also negative, some of the nurses who did take action stated that they would not do so in the future.

More positively, of those who did not take action, many would take action again in the future. Additionally, some nurses who did not intervene when faced with an ethically challenging situation stated that they would intervene if faced with a similar situation in the future. Thus, the experience of moral distress for these nurses served as a catalyst for positive change.

Learning from and moving on after moral distress

It is important that nurses take care of themselves so that they can effectively care for seriously ill patients and their families. A system needs to be in place so that nurses know who and where to turn to for help. This person or his or her designee can help each nurse to process the specific situation and cope with the distress that he or she may be experiencing or has experienced.

Debriefing is an important initial strategy to help nurses. Having a safe venue available where nurses can review the situation and circumstances that caused the moral distress is essential. The session can end by developing a strategy for how similar distressing situations can be prevented in the future. Questions can be asked such as the following: What went well? What did not go well? If the nurse was faced with a similar situation in the future what would he or she do differently? What help does the nurse need? Learning from difficult situations can help to improve care to future patients and families and contribute to the nurse feeling that he or she made a positive difference.

Moral distress can have a lasting effect on the nurse.[4] Nurses should be guided and encouraged to do things to promote their personal self-care and to rejuvenate themselves especially after experiencing moral distress. Taking personal time to promote mental and physical health is important. Individual counseling may also help nurses who faced distressing clinical situations.

Learning to move on after experiencing moral distress may not be easy, but it is necessary. Good can come out of bad situations. The experience of moral distress can strengthen a nurse's resolve to do better the next time.[22]

Study limitations

Data were collected from a convenience sample of nurses from one university medical center, thus limiting generalizability. This study is limited by a low rate (23%) of nurses responding to the survey. Wilkinson[12] also had a low response rate (7%) when she studied nursing and moral distress. The sample may be biased as nurses may have been more motivated to complete the survey if they had experienced moral distress. Completing a written questionnaire may also have limited the response rate. Nurses may not have wanted to take the time needed to answer the questions.

It is important to note that moral distress was defined on each survey as, "A type of moral conflict that occurs when one knows the right thing to do, but can't pursue the right action." It is possible that the nurses not responding to the survey had different experiences related to moral distress, ones that did not fit this particular definition.

Implications for research

Additional research is needed related to the experience of moral distress. Face-to-face interviews with critical care nurses may be beneficial. In an interview, the researcher can probe the participant and may be able to add depth to the data obtained. Future studies need to address strategies to reduce the incidence of moral distress and to identify effective strategies to manage moral distress. Understanding the experience of nurses is important in determining how nurses cope with ethically distressing situations and how they intervene or do not intervene to influence the situations. Future investigations need to examine closely the effects of morally distressing situations on patients and their families.

Conclusion

The majority of critical care nurses who participated in this study had experienced moral distress, and the majority of situations that created moral distress were related to end of life. The experience of moral distress can be reduced but not eliminated. Efforts need to focus on reducing the frequency of moral distress and helping nurses to move on after moral distress occurs.

Nurses will always face ethical challenges. It is essential that the effects of morally challenging situations on nurses, and on patients and families be acknowledged and examined.

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Conflict of interest

The authors declare that there is no conflict of interest.

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