Consequences of Moral Distress in the Intensive Care Unit: A Qualitative Study

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Background Moral distress is common among personnel in the intensive care unit, but the consequences of this distress are not well characterized.

Objective To examine the consequences of moral distress in personnel in community and tertiary intensive care units in Vancouver, Canada.

Methods Data for this study were obtained from focus groups and analysis of transcripts by themes and subthemes in 2 tertiary care intensive care units and 1 community intensive care unit.

Results According to input from 19 staff nurses (3 focus groups), 4 clinical nurse leaders (1 focus group), 13 physicians (3 focus groups), and 20 other health professionals (3 focus groups), the most commonly reported emotion associated with moral distress was frustration. Negative impact on patient care due to moral distress was reported 26 times, whereas positive impact on patient care was reported 11 times and no impact on patient care was reported 10 times. Having thoughts about quitting working in the ICU was reported 16 times, and having no thoughts about quitting was reported 14 times.

Conclusion In response to moral distress, health care providers experience negative emotional consequences, patient care is perceived to be negatively affected, and nurses and other health care professionals are prone to consider quitting working in the intensive care unit. (*American Journal of Critical Care.* 2017;26:e48-e57)

Moral distress is the anger, frustration, guilt, and powerlessness that health care professionals experience when they are unable to practice according to their ethical standards.[1-4] Data from empirical studies have indicated significant prevalence and high levels of moral distress in nursing practice,[3,5] and have linked moral distress to burnout and attrition.[6-8] Other studies of moral distress in other health care disciplines have yielded similar findings.[1,9-13] Quantitative and qualitative studies show that moral distress has a profound effect on nurses and other health care professionals, as well as on the quality of interdisciplinary team workplaces and the safety of patients.[14,15]

Although moral distress can be evaluated quantitatively[5,11,15-17] and qualitatively,[10,12,13,18-33] few qualitative studies have addressed moral distress in professionals working in intensive care units (ICUs).[20,26,33-35] In a recently published qualitative study[36] of diverse members of the ICU team in both community and tertiary ICUs, the dominant causes of moral distress were concerns about the care provided by other health care workers, the amount of care provided, poor communication, inconsistent care plans, and issues around end-of-life decision making. This article describes consequences of moral distress from the perspective of these ICU professionals.

Methods

A study[37] on moral distress in ICUs was conducted in all 13 ICUs in the Vancouver area of British Columbia, Canada, in 2011 and 2012. First, a quantitative survey was completed by nurses, physicians, and other health professionals in all of the participating units.[37] Then, all ICU clinical staff in 3 of the participating hospitals (see Table 1 for selection criteria) were invited to participate in focus groups to address causes and consequences of moral distress. Focus groups were organized by profession: physicians, nurses, and other health professionals (ie, physiotherapists, respiratory therapists, dietitians, social workers, and pastoral care). In 1 hospital, separate group meetings were held for registered nurses and clinical nurse leaders because of internal issues that may have hindered open discussion had the participants been in the same group. Focus group meetings lasted 1 hour and were led by an experienced qualitative health researcher (N.J.H.) who has a decade of experience conducting focus groups on a diverse range of health delivery and systems issues. To ensure that the researcher had adequate knowledge about moral distress, she met several times with members of the moral distress research team to discuss the topic and she read numerous articles about moral distress. Throughout the preparation phase of the study, the researcher was supported by other members of the team who had subject matter expertise.

In the focus groups, at the start of the discussion, the concept of moral distress was described to participants as any negative emotions they experienced in response to a conflict between the care that they think should be provided to patients in the ICU and the care that is provided. We chose to use the broad concept of negative emotions because a goal of the focus groups was to identify the emotions that people experienced during moral distress and, consequently, we did not want to suggest emotions to participants, which could bias their responses. Telephone interviews were conducted with staff who were unable to attend the focus group meetings and expressed an interest in participating. Transcripts from the interviews were appended to the transcripts

> Moral distress has a profound effect on nurses and other health care professionals.

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Table 1
Criteria for selection of intensive care units for participation in focus groups

1. To capture moral distress experiences in different intensive care units (ICUs), the sample included ICUs from 1 community hospital and 2 tertiary hospitals.

2. From among the tertiary and community ICUs, units were included that had relatively high moral distress scores (ie, more moral distress) on the moral distress survey. We selected units with relatively high moral distress so that we would be able to discuss the issue with providers who were more likely to have experienced this distress.

Table 2
Number of participants by hospital and provider type[a]

Participant	Tertiary hospital 1	Tertiary hospital 2	Community hospital	Total
Staff nurses	6/111	8/192	5/50	19
Clinical nurse leaders	0	4	0	4
Other health professionals	9/27	7/124	4/33	20
Physicians	5/8	3/12	5/5	13
Total	20	22	14	56

[a] Numbers with slashes are No. of participants/total number of each profession working in that intensive care unit.

from the corresponding focus group (ie, same ICU and provider type) and were included as part of the focus group for analyses.

Discussions were audio recorded and transcribed for coding and analysis in NVivo 9 (QSR International). Theme codes were developed to reflect the topics discussed in the focus group sessions and subtheme codes were created on the basis of the content of the discussions. All coding was done by 1 research assistant (the coder) to ensure consistency. The researcher who conducted the focus group sessions trained the coder on the concept of moral distress and the coding scheme. At the beginning of the coding process, the researcher reviewed the coding of each transcript as it was completed to ensure that codes were being used as intended. After enough transcripts were reviewed to ensure that codes were being used appropriately, the coder coded the remainder of the transcripts and these were reviewed by the researcher after all coding was completed. Any coding disagreements between the coder and the researcher were discussed and the researcher made the final decision about the appropriate code to apply.

The content of the focus groups' discussions was described quantitatively by determining the number of focus group sessions (by provider type) in which each theme and subtheme was mentioned and the total number of times each theme or topic was mentioned in the focus groups by provider type.

The number of times a theme or topic was mentioned does not indicate the number of individuals who expressed an opinion on that topic, because a unit of discussion may have included multiple respondents who contributed to the conversation and the same individuals may have mentioned a topic multiple times during the focus group meeting. This type of analysis is called attribution or assertion analysis,[38] or incidence density,[39] and is used as an indication of the relative importance of a theme to participants.[38-40]

Approval to conduct this study was received from the Providence Health Care/University of British Columbia Research Ethics Board.

Results

A total of 10 focus groups and 4 interviews were conducted. At each of the 3 hospitals, 1 focus group was conducted with each provider type and a fourth group was conducted with clinical nurse leaders at 1 hospital. The interviews included 3 nurses and 1 other health professional. A total of 56 providers participated in the focus groups (Table 2). Quotations from participants are included verbatim except where clarifications are required or to maintain anonymity, as indicated by brackets. Additional descriptions of themes and exemplary quotations also are provided.

According to the comments made during the focus group meetings, consequences of experiencing moral distress in the ICU include an emotional response to the situation (Table 3) and mechanisms for coping with these emotions, an impact on care, and an impact on considering quitting working in the unit.

Emotional Response and Coping With Emotions

Emotional Response. Across all provider types, frustration was the emotion most frequently described in association with morally distressing situations (Table 3). Nurses and other health professionals said that there were times when they felt embarrassed about the level of care being provided. They also felt worthless or discouraged when their concerns were ignored.

> "So it's very, very frustrating to then be encountering those patients over and over at a time of crisis where it's impossible to give good care, good end-of-life care. And that's the—I guess, I mean, the frustration is kind of a, you know, it's a frustration. But the moral part of it comes in these patients being denied adequate end-of-life care. And that's very sad." (Physician)

"I feel very frustrated when I have to tell a family it's—I don't have time for you, or I can't—I feel embarrassed when I'm sitting in a family meeting and I'm having this disastrous outcome with this physician … And I feel sometimes, really, I don't want to say depressed, but very disillusioned and discouraged at the health care system and how we treat some of our families and the patients. And how we don't attend to what they need." (Other health professional)

Coping With Emotions. Participants often mentioned that venting, discussing the situation with compassionate colleagues, or debriefing with their team were effective ways to cope with or manage negative emotional responses to moral distress. Some physicians and other health professionals explained that, over time, they have learned ways to manage or cope with morally distressing situations. With experience, participants also learned to compartmentalize their emotions and were able to leave their concerns at work to prevent them from seeping into their personal lives.

> "It's changed a lot for me over time, to be honest. Early on in my career, I'd say I would internalize it a lot. I would see it almost as a failure of my medical care. Was I not communicating adequately enough? And there's the one good thing about experience and time and having more and more body of knowledge and also being able to understand.… I'm able to have more separation but with compassion. So it's not that I have such a vested interest." (Physician)

Some participants said that to cope with moral distress, they have become less invested in their work and attempt to distance themselves from causes of moral distress. At the tertiary hospitals, some nurses and other health professionals felt that there was a culture within their ICUs that staff should hide or repress their emotions to avoid appearing weak.

> "You have to carry a certain amount of denial with you all the time.… Denial that you were hurt by something that somebody said, or that a family member said something that made your eyes well up or something like that. Like, if you're going to let yourself be moved around by that all the time, you can't function in a therapeutic way with it." (Nurse)

Table 3
Emotions associated with morally distressing situations

Provider type	Emotion[a]
Physicians	**Frustrated/irritated** Annoyed Sad Guilty Stressed
Nurses	**Frustrated** **Angry** Worn down/disheartened Fatigued Distressed Stressed Embarrassed Hurt (that cannot do more for the patient) Increased compassion Dishonest (with family/patients)
Other health professionals	**Frustrated** Guilty Embarrassed Disillusioned/discouraged Angry Worthless/useless/devalued Helpless Sad

[a] The most frequently mentioned emotions are indicated in bold.

Nurses and other health professionals frequently mentioned that when they felt moral distress, it was best to try to do something to address the cause. Other coping strategies used by ICU staff included requesting to change their patient assignment, taking a break from the ICU and working in a general care area, and drinking alcohol after work.

Alleviation of Emotions. Nurses and other health professionals suggested that debriefing with the health care team about morally distressing situations helped alleviate negative emotions. Nurses also suggested that having a physician tell them the situation was not their fault would alleviate some feelings of moral distress.

> "I remember one time I was involved in a really terrible code blue. It was my patient, and the guy didn't survive. And I felt like maybe it was my fault in some way 'cause I didn't recognize the changes soon enough. And then the physician, the attending, said to me afterwards, 'No, it's not your fault.' It wasn't like— the guy wasn't going to ever make it in—like, he just kind of reassured me and—that did make me feel better, even though I still felt bad. But either/or, I think sometimes it would be nice to

Table 4
Perceived impact of moral distress on patient care

Impact	No. of times a discussion about impact on care occurred during the focus groups			
	Nurses	Other health professionals	Physicians	Total
Negative	10	11	5	26
Positive	6	1	4	11
None	4	3	3	10

hear it from the physicians more. But I think they sort of look after each other and then the nurses sort of look after each other. Not all the time, but you see that kind of be the way it goes." (Nurse)

In contrast to getting support within the ICU, physicians were more likely to alleviate moral distress by spending time with their children, exercising, and drinking beer. One physician mentioned that the weeklong call schedules help to alleviate moral distress because at the end of the week, he is able to walk away from the problem.

Lack of Moral Distress. Some physicians and other health professionals reported that they did not feel moral distress at all. A few physicians thought that some situations were unpleasant but they would not go so far as to categorize them as morally distressing. Physicians who did not feel distress often said that they were doing the best they could and that was all that could be expected. These physicians explained that they experienced moral distress earlier in their careers but had come to this realization over time.

> "You know, you've got to make so many decisions in life, not just in here but in everything. And some people, I think, do take that home with them and have a hard time with it. But when you've got to do all this decision making—pretty high stakes sometimes. I think you just learn to make your best call and move on." (Physician)

Among the other health professionals who did not feel moral distress, reasons for lack of distress included not doing things that made them uncomfortable and gaining understanding over time that physicians' decisions that differ from their own were often done with good reason.

> "Because if I think back on my practice when I was a very junior RT [respiratory therapist], I felt a lot of distress when I perceived us to be taking futile steps. And I would get very frustrated when

we would—we're going to go from this to the oscillator. And then we're going to add PRISMA [a system for continuous renal replacement therapy]. We're going to do this and this. I would get so frustrated because I would be viewing the situation as futile. I didn't understand the big picture. And so that was very distressing for me. But the more skilled I became, the more experience I had, the easier it was for me to view these additions to therapy as being potentially lifesaving.…" (Other health professional)

Exacerbation of Emotions. Nurses and other health professionals mentioned that unsupportive comments from coworkers could make feelings of moral distress worse.

> "Or honoring the value of each other's struggles. Like, I'm giving a report when it's—there's been something in that day that's caused me a great deal of distress—And I'm conveying that and I said, 'This is really something that needs to be passed on.' And the nurse who was [getting the] report just kind of went, 'Why?' Like, are you frigging kidding me? This has been a whole day with this issue and you're, like, 'Why?' So, like, you know, feign interest if nothing else. Just pretend that you care enough about what this day's meant to carry it forward." (Nurse)

> "… in the coffee room, lunchroom, and stuff that everybody just talks amongst themselves. Mind you, sometimes I think that builds up to more frustration 'cause they realize everybody's in the same boat, that they're all frustrated." (Nurse)

Impact on Care

Based on the number of references to how care is affected by moral distress, participants were most likely to think that moral distress has a negative impact on care (Table 4).

Negative Impact. All 3 provider groups stated that managing morally distressing situations places excessive demands on their time and attention. For example, physicians reported that as a consequence of spending extended periods of time in family conferences, they have to rush when managing patient care. Nurses expressed that basic care needs are sometimes compromised when they are required to spend their time advocating for their patients, and other health professionals said when they have to devote much

of their efforts to dealing with a patient who is in a morally distressing situation, their other patients get neglected. Therefore, they avoid these situations to save time, but this practice of avoidance may translate into a lack of support for families and patients or poor quality care.

"I think in the area where it's not beneficial, in my experience, is when I'm in sort of the—in conflict with the family or where the family who I feel are unreasonable or, you know, whose—particularly that direction of care isn't [inaudible]. And then I—I hope that my care of the patient is the same, but I certainly avoid that family, you know, or, you know, avoid ongoing meetings with them." (Physician)

"Even on rounds you experience this moral distress or these feelings of frustration, worthlessness, that then you're not in the right mind frame to do your job effectively when you move on. So you may just be forgetting something, not noticing something that is a danger to that patient, just based on that stress you're holding." (Other health professionals)

"That you overcompensate for one particular person and maybe you—or one team, and you spend more time with this one patient. But you're neglecting your others, right." (Other health professionals)

Participants also thought that feeling moral distress could cause them to be distracted or unfocused.

"So it takes emotional energy. It takes time away. You can lose focus. Yeah, so it can have negative impacts." (Physician)

According to a few physicians, experiencing moral distress may jade future patient and family interactions because the providers come to expect that future experiences will mirror negative past experiences; consequently, they enter into patient/family relationships with apprehension or minimize interactions.

"I can think it can affect future interactions. So I talked about the ones you're interacting with the family and it—you may have put in hours of many meetings and committed yourself quite a bit. And complaints that come back or more aggressive behavior that comes your way, despite having sort of committed to a lot of time, effort, energy, and trying to help

them, can, I think, have adverse consequences for future patients, approaches to other interactions. I think there are those—there is some crossover from previous experiences that can be negative and distressing." (Physician)

Similarly, other health professionals explained that having their opinions ignored in the past may diminish their willingness to assert their opinions in the future, which could adversely affect patient care.

"I think that if you have a repeated interaction with a certain director where you've—you have a history of bringing concerns or ideas forward and they're not being listened to or they're being dismissed … And the next time that you see a similar situation, you're more reluctant to bring your ideas forward because you're anticipating a repeated outcome." (Other health professional)

Positive Impact. Some nurses and physicians suggested that feeling morally distressed caused them to become hypervigilant when they were caring for patients in morally distressing circumstances. Many thought that this helped them to become more focused and attentive, and they even suggested that it may have led to a decrease in errors or an increase in quality of care. To avoid blame or guilt, some nurses became more vigilant to ensure that they were not doing anything to contribute to the problem.

Many physicians felt that experiencing moral distress is essential to being good doctors and some fear becoming doctors who no longer feel distress. They rationalized that a lack of these emotions could lead to carelessness or cause them to become disconnected from the effects of their decisions.

"Everything that we do has had such an incredible impact on people's lives that, unless you feel something about it, unless you feel distressed about it or anxious about it or second guessing, you know, I think it's time to leave … I am most distressed about the people that you see that just don't care." (Physician)

Nurses described that when they feel moral distress, they can be more compassionate toward patients.

"Just because you feel so badly, like [another nurse] was saying, you feel badly for what the patient's going through. So I'd probably say I'm probably more compassionate.…" (Nurse)

Table 5
Perceived impact of moral distress on desire to quit working in the intensive care unit

Have thought about quitting	No. of times a discussion about thoughts of quitting occurred during the focus groups			
	Nurses	Other health professionals	Physicians	Total
No	6	3	5	14
Yes	9	6	1	16

No Impact. Some physicians, nurses, and other health professionals felt that experiencing moral distress did not affect patient care or lead to patient safety errors.

Quitting

Have Thought About Quitting Working in the ICU. Nurses and other health professionals mentioned that feeling burned out had influenced their desire to quit working in the ICU (Table 5). Burnout was described as feeling demoralized, defeated, or overwhelmed by morally distressing issues.

> "I wonder if I'm cut out for it … Like, it crosses your mind of how long can I do this? Can I do this for really 10 or 15 years? Or is it—am I going to burn out in 2?" (Other health professional)

> "I love my profession. I've always been a huge advocate for nursing and especially ICU nurses. But you do burn out every now and again. You do get tired, and you get demoralized, is the other thing. You get demoralized on many, many levels." (Nurse)

Nurses explained that feeling like they were responsible for, or contributing to, morally distressing situations created a desire to quit working in the ICU.

> "Certainly when I first started working in critical care and I would take a lot of stuff that happened personally and take it home with me, I would think that maybe I needed to leave. Not because of discomfort of the direction of care. But because I felt like, in my own failings, I wasn't doing as good a job as maybe somebody else would. And that had a pretty big impact on me as far as, you know, maybe I shouldn't be here. So I had to wrestle with that for a few years before I could feel comfortable where I am." (Nurse)

While working outside of the ICU, participants were sometimes reminded of how much they enjoyed their work in the ICU compared with other units that were less interesting and equally morally distressing. Some other health professionals considered going to a different hospital with a lower workload, but others felt that feelings of fatigue, burnout, and dissatisfaction were intrinsic to the nature of the ICU.

> "I think if I've ever gotten to that point of feeling really frustrated, I've sort of taken a step back to think, is this going to be different anywhere else? And what I keep coming back to is, no. I know that there will be that other doctor at another hospital. I know there will be that other family at another facility. I know there will be that situation." (Other health professional)

Participants described their desire to quit as varying from day to day; certain situations might spark feelings of frustration or distress and a desire to quit, but the situation would pass and the desire to quit would dissipate. Some experienced nurses and other health professionals who worked in the ICU for many years found that feelings of moral distress accumulated over time and it became increasingly difficult to work in the ICU. However, others reported that they were able to develop coping strategies that reduced their moral distress.

Have Not Thought About Quitting Working in the ICU. Although many physicians expressed frustrations at work that made them think about quitting, none said that they would leave their jobs. This sentiment was echoed by many nurses and other health professionals who described the challenging and engaging nature of their work that motivates many of them to remain in the ICU.

> Physician 1: "It is physically tiring. But overall, I still like it. I mean, I can't imagine-- okay, I'll put it this way to you now. Can you imagine yourself sitting in an office?"
> Physician 2: "That's more distressing, sitting in an office."
> Physician 1: "Oh, way more. No, I can't imagine—in a world of medicine, I can't imagine a more interesting or challenging job. And as much as all of these things are frustrating, they're also part of what makes it interesting and challenging."

> "I like my job. I love the equipment in the ICU. I'm a very hands-on kind of person. I like dealing with people, and I like working with the equipment. And there's not too many other departments out

there that you can play with all the stuff that we have in here. Keeps me unbored." (Nurse)

"But, I mean, looking after these patients, it's like trying to solve a puzzle a lot of the times and the pieces don't always fit together, and you're trying to make them fit and trying to sort it out. And it's kind of fun. And so—and it's fun having intelligent interaction with your team. And it's pretty darn enjoyable, right. And so that's addicting, right." (Nurse)

Physicians found that learning to cope with and address morally distressing issues was a practical alternative to quitting.

"So it's about—for me maybe not as—not internalizing it. Not taking it as a personal failure, but being able to take that further step back and more laidback approach for me and say, you know what, this isn't—it's not about me." (Physician)

Discussion

Focus groups with health care providers in 3 ICUs revealed that staff who experience moral distress predominantly feel frustrated. Nurses and other health professionals cope with their distress by talking to supportive colleagues from whom they get emotional support and feel an alleviation of their emotions by venting. These care providers, including physicians, also find, with experience, that they are better able to deal with moral distress by learning to not internalize the situations and to separate their work and home lives such that the emotions they experience at work get left there. Nurses and other health professionals expressed that they would be better able to cope with moral distress if there were debriefings immediately after a morally distressing experience. Physicians, on the other hand, were much more likely to mention reducing their moral distress by using coping mechanisms external to the workplace, such as by spending time with family or exercising.

Many of the focus group participants felt that moral distress reduced the quality of patient care. All types of health care providers indicated that morally distressing situations were distracting and left them with less time for other patients. However, some participants expressed that moral distress improved patient care by increasing vigilance and effort. Performance improving with low levels of stress has been found in other settings.[41]

In addition to the impact on quality of care, moral distress affects workplace satisfaction and longevity.[14] Addressing the impact on staff turnover is important not only to improve the work experience of ICU staff but also to ensure stability within ICUs.

One limitation of this study is that the use of focus groups, in general, provides insights into participants' experiences and perspectives, but the findings are not necessarily generalizable. Generalizability may be further limited because the groups were conducted within only 1 Canadian province. However, the cross-regional differences may be mitigated by the similarities in technologies, values, and goals of ICU care in most developed countries. Another limitation is that the low participation rate by profession, except for physicians, may limit the generalizability of these findings. However, the numbers of participants in our focus groups are similar to those in other qualitative studies. Strengths of this study include the variety of sites and of professional groups included and the open-ended approach to the focus group sessions.

Based on the comments and suggestions of nurses and other health professionals, team-wide debriefings immediately after a morally distressing situation might help workers cope with these experiences. These debriefings should have the support of ICU administrators, with dedicated time made available for the event. Critical-incident stress debriefing prolongs distress if the debriefing is not handled appropriately.[42-44] In situations where nurses and other health professionals were not responsible for a morally distressing situation, it would be beneficial for the physicians to talk to these providers and let them know that they were not responsible for the events that took place.

Some participants mentioned that the culture of their unit inhibited talking to peers, because they feared that they would be perceived as weak. Changing culture is a difficult and slow process, but it can be facilitated when new attitudes or behaviors are modeled by prestigious members of the group.[45-47] If physicians can make comments that let the ICU teams know it is normal to feel upset as a result of a morally distressing situation, and that openly discussing the situation and the consequent emotions is valuable and accepted, then attitudes may begin to change. It may also give others permission to

> Team-wide debriefings just after a morally distressing situation might help workers cope with these experiences.

share their emotions with colleagues and, hence, alleviate the intensity of their emotions. However, physicians may not feel comfortable exposing their emotions and vulnerabilities, given the current culture in which such openness may be perceived as weakness. Physicians may feel less moral distress than other ICU team members because the physicians have more autonomy and control—factors that are inversely related to moral distress[48,49]—and more-experienced physicians may feel less moral distress than newer physicians feel. Consequently, it could be difficult to find more-experienced physicians to serve as role models in these situations. Physicians who express moral distress may be perceived by nurses and other health professionals as the cause of their own moral distress. However, understanding the physician's emotional response to a situation could help nurses and other health professionals understand the challenge all clinicians struggle with when providing care in these circumstances.

When nurses and other health care professionals feel overwhelmed or burned out from moral distress, sometimes a break from the ICU gives them time to recover and rejuvenate. Instituting a process by which nurses and other health professionals can either perform nonclinical duties in the ICU or work outside the ICU for a short time and then return to the ICU could help to reduce burnout and improve job satisfaction and workplace longevity. It would be important that these options are understood to be voluntary and they are presented in a way that made it clear that choosing to take a break from ICU clinical work is neither a punishment nor a weakness, to avoid stigmatizing those who choose these strategies.

Conclusions

In response to moral distress, health care providers experience negative emotional consequences, patient care is perceived to be negatively affected, and nurses and other health care professionals are prone to consider quitting working in the ICU. Nurses and other health professionals find that moral distress can be reduced with the support of colleagues and with the opportunity to talk about the morally distressing situations in a supportive environment.

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