

Moral Distress in Critical Care Nurses: A Qualitative Study

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Abstract

Background

Health care professionals find themselves participating in insignificant events in human existence such as birth, pain, and death which is a privilege but also poses challenges as this participation involves decisions that can be life-changing and having an effect on everyone involved. The study aimed to explore moral distress within the context of Saudi Arabia.

Methodology

A simple qualitative design was used with a research paradigm of constructivism. Data collection included in-depth interviews with five critical care nurses who were purposively sampled. The setting for the study was the critical care units at King Abdul- Aziz Medical City- Jeddah. Data analysis included content analysis. Principles of academic rigor were followed.

Findings

Two themes emerged from this study with various subthemes. Theme 1: Turning away from nursing obligations: hands are tied, the burden of workload, no voice, not honoring oath; Theme 2: Bad practice: hierarchy in practice and feeling guilty.

Conclusions

This study highlights that moral distress within critical care units is a real problem that impacts on critical care nurses' physical and psychological stress. Health care institutions should mobilize resources to reduce these effects on critical care nurses and other health care professionals.

Keywords: critical care nurses' moral distress, moral distress, moral distress in critical nursing

1. Background

Moral distress amongst health care professionals occurs when they are unable to follow through with moral actions resulting in a compromise in professional integrity (Wilkinson, 1987). Also, the term “ moral distress has been deployed to describe the psychological, emotional and physiological suffering that nurses and other health professional experience when they act in ways that are inconsistent with deeply held ethical values principles or commitments” (McCarthy & Gastmans, 2015: p131). Health care professionals find themselves participating in insignificant events in human existence such as birth, pain, and death which is a privilege but also poses challenges as this participation involves decisions that can be life-changing and having an effect on everyone involved (Savel & Munro, 2015). More specifically nurses are constantly faced with challenges ethically in their practice, as nursing is a relational discipline that is traditionally considered a moral practice that involves caring and compassion. Since the intimate nature of caring involves caring for the patient's body and integrity can conflict with contemporary policies and practices and this can be deleterious for nurses leading to ethical dilemmas and moral distress (Kälvermark, Higlund, Hansson, 2004).

Meltzer and Huckabay (2004), highlighted that participating in care that is futile and watching a patient suffer is a catalyst for moral distress, fatigue and being burnout. Within the critical care context, patient's lives are saved as well as dying prolonged despite meaningful recovery (Huynh, Kleerup, Wiley, et al, 2013). In addition, Ferrell & Coyle (2008), highlights that there is a relationship between nurses own suffering and the suffering he/ she witnesses. Sometimes the very care that nurses provide may be the same source of continued suffering, more

pain, and prolonging death. Studies that have been conducted on moral distress report that the most common sources of moral distress for nurses are sustaining life support even though it is not in the best interest of the patient, staff shortage, staff not adequately trained, inadequate relief of pain relief and false hope given to patient and families, inadequate communication about end of life and inappropriate use of health resources (Corley 2002; Pavlish, Brown- Saltzman; Winters & Neville, 2012; Piers, Azoulay, Ricou et al 2014).

Within the critical care, context technology is used to provide highlight specialized care to critically ill patients who could be on the brink of death. Critical care nurses work closely with patients spending an extensive amount of time at the bedside of the patient which allows them to observe patients and symptoms such as pain and suffering of patients who are on life-sustaining treatment for long periods (Epstein & Hamaric, 2009). In some instances, aggressive treatments can sometimes increase the burden of suffering for the patient and prolong death (Gonzalez, 2016). This results in moral distress which produces physical and emotional stress which results in chronic stress and hypertension leading to job absenteeism (Caine & Ter-Bagdasarian, 2003).

The critical care unit (CCU) is an area where the patient has a life-threatening diagnosis. However, despite the advances in technology and treatment, the mortality rate of patients in these units remains high. According to the Center for Diseases, the mortality rate in critical care is more than 50% (2017). Hence, this leads to more difficult decisions centered around life-saving treatments such as renal dialysis, mechanical ventilation. This can lead to moral distress as this creates conflict for CCNs who have a conflict between maintaining a patient's life versus the quality of life (Gonzalez, 2016).

Also, end of life decisions and other treatment decisions are usually made by doctors within the CCU marginalizing the care from CCN even though the CCN is expected to provide care to the patient and the family. This often leads to an emotional climate where ethically decisions are made and contested or causing division within the multidisciplinary team (AACN, 2006). This results in a host of emotional feelings such as sadness, guilt, depression, anger, frustration, anxiety, hopelessness and helplessness leading to distress (Corley et al, 2002). The negatives of moral distress is also highlighted in the literature and ranges from headaches, gastrointestinal problems, nightmares and insomnia which can lead to limiting care for patients and families, leaving the CCN, absenteeism from work and even leaving nursing as profession (Coley et al, 2002; Elpern, Covert & Kleinpell, 2005; Gutierrez, 2005)

There is vast literature that focuses on nurses experience with moral distress (Austin et al., 2003; Mobley et al., 2007; Zuzelo, 2007; Calvin, Lindy, & Clingon, 2009; Piers et al., 2012; Shorideh, Ashktorab, & Yaghmaei, 2012; Wiegand & Funk, 2012; Choe et al., 2015), however there is limited literature that has explored how critical care nurses cope with this situation more especially within the context of Saudi Arabia. It is within this backdrop that the current study aims to add to the body of knowledge within an Arab context exploring this phenomenon within a qualitative lens.

2. Methodology

2.1 Research Design and Researcher Paradigm

The study followed a simple qualitative approach. This approach was chosen as the researcher aimed to achieve a thick description of the phenomenon of moral distress, which would allow for the researcher and participants to engage in rich conversations in which participants were allowed to describe experiences related to moral distress in an in-depth manner. The research paradigm for this study was constructivism which included an epistemology where the researcher viewed the world with multiple realities, ontology reality is viewed as being subjective of and axiology the researcher believed that the research is value-laden as the phenomenon of moral distress is ethically and morally intertwined (Creswell et al, 2007).

2.2 Research Setting

The setting of the study was the critical care units of King Abdul Aziz Medical City- Jeddah, Saudi Arabia. The hospital is a 566 bedded hospital with 10 critical care units, however, for this study, only the three acute general critical care units were included. The researcher chooses the acute areas within the general critical care specialty as the researcher aimed to focus only on acute medical-surgical critically ill patients. The medical city is a military hospital that caters to the military personnel, their family members, the staff and the dependents of staff.

2.3 Study Participant, Sampling and Sample Size

The participants included critical care nurses who were working with the acute general critical care areas. Only participants with six and more months of experience within a critical care context were included in the study. This inclusion criterion allowed only for participants with a relative amount of experience to be included as the researcher felt that participants with less than six months of experience could not have sufficient experience

within the phenomenon at hand. Sampling included a purposive sampling of five critical care nurses. After the fifth in-depth interview data saturation was met.

2.4 Data Collection Process and Data Collection Method

Before data collection, appointments were made with the nurse managers of the respective critical care units. A convenient time to meet possible participants was arranged before approaching participants. Thereafter participants were approached whilst on duty, during lunch breaks and interview appointments were made to commence conversations.

In-depth interviews were conducted, as this permitted an in-depth exploration of the participants to experience and allowed for conversation. The participants were interviewed in whatever location they preferred, was audio-recorded and transcribed verbatim. Interviews lasted between 35-45 minutes. The researcher started with a primary question of “*what is your experience with moral distress within the critical care unit?*” This was followed by probes such as *how did you feel in a morally distressing situation?*

2.5 Data Analysis

Data analysis included a simple content analysis where the researcher read and reread through the transcribed interviews. The researcher continued to examine and familiarise oneself with the data. The researcher thereafter identified coding units. Also, the researcher examined the previously determined meaning units for redundancies, clarification, or elaboration by relating meaning units to each other and a sense of the whole. Thereafter data emerged into subthemes and themes. Unit of analysis included classifying the content in themes using a word, phrase or a sentence. All data related to one theme was added under the unit. The researcher constantly used the objectives of the study as a constant guide during the data analysis (Erlingsson & Brysiewicz, 2017).

3. Ethical Considerations

Once the necessary permission was obtained from the Nursing Director of the Hospital, King Abdullah International Medical Research Center and the Institutional Research Board then only did data collection commence. The researcher assured all the participants that they are under no obligation to participate in the study and they could withdraw at any time and re-assurance was given of protection from harm (physical and psychological) and deception. Confidentiality, privacy, and anonymity were maintained by ensuring that the data was and will be able to be traced to any participants. Informed consent (written) was obtained from the participants.

4. Academic Rigor

Credibility, dependability, confirmability and transferability, the four criteria of trustworthiness were followed (Guba & Lincoln, 1985). The researcher ensured credibility by peer debriefing which included peers reviewing the inquiry. Dependability was ensured by providing a detailed account of the method to allow for replication of the study. Conformability was ensured by member checking. Transferability was ensured by providing thick descriptions of the setting, participants, and data collection methods.

5. Findings and Discussion

5.1 Sample Realization.

Five critical care nurses were included in the study with the average age being 32.5 years. The average years of experience of participants were 4.8 years. Participants included Saudi and expatriate nurses.

Data analysis revealed subthemes and themes as indicated in the table below:

Subthemes	Themes
Hands are tied	Turning away from nursing obligations
Burden of workload	
No voice	
Not honoring the nursing oath	
Hierarchy in practice	Bad practice
Guilty	

5.2 Turning Away From Nursing Obligations

Some respondents expressed that morally distressing situations often lead to them turning away from nursing obligations. Two respondents described that they felt as if their **hands are tied** in a situation that was often morally challenging and often leads to not providing an acceptable standard of care

“I cannot say no...even if I know that this is wrong I cannot do anything. My hands are tied and there is nothing I can say or do..this compromises standards”.

“I know the right action but I cannot do the right thing because my hands are tied...no proper care provided”.

According to Rushton (2015), when nurses are unable to translate their moral choices into actions, it results in nurses not practicing according to their values which negatively impacts the multidisciplinary team, organizations, patients and their families. According to Christodoulou-Fella et al (2017), work-related moral distress may be associated with inadequate safety of care, reduced productivity and compromised health status among health professionals.

Some participants described the situations as having **no voice** especially in times when decisions made as perceived as unfair.

“I felt that that was not was right...patient was supportive care...but because the son has power ...brought the patient to the ICU and the other patient was left to die because her family has no power...but I cannot say anything”.

One participant expressed that some decisions are unfair that sometimes lead to the death of a patient who could have survived:

“Sometimes I feel like the decisions are not right.....patient was supportive care but no CPR...they were in a hurry ...not our decision...The vital signs were fine...maybe the patient came back ...we let the patient die”.

“Nobody wants to listen to the nurses...we are expected not to question, just accept decisions”.

“You feel like you have no voice, you know but you cannot say anything...its just bad”.

According to Mealer and Moss (2016) repeated exposure to morally distressing situations cant lead to persistent feelings of powerlessness resulting in nurses avoiding future discussions and ultimately resigning from the workplace. Having no voice and feeling helpless as a result of moral distress can result in anger, guilt and debilitating frustration, anger, and guilt. This can lead to the deterioration of one's moral integrity and possibly one's moral agency (Rushton, Cadwell, & Kurtz, 2016).

Participants described their experiences resulting in them **not honoring the nursing oath**:

“We swore to do good and no harm...but we do not do right....and it happens again and again and ...will do bad things and not fulfill the obligations that we swore to”.

“The nursing oath becomes hard to maintain...I know I have to stick by this oath but sometimes I cannot as the situation is so difficult”.

According to Carneval (2013), there has been a growing recognition of the complexity of nursing practice and nurses' accountability for their practice and care provided. Nurses are guided by a code of ethics as nursing is a common ground for ethical and legal instruments and is obligated towards patients, families professional colleagues as well as nursing the profession as the nursing practice is increasingly recognized as a moral endeavor. Also, Porter (2010) found in their study that participant's values and professional ethics were challenged. In addition participants further described that while there were emotional/psychological component in the participants' descriptions of moral distress, "the decision to place the issues within the ethical domain of practice is an important decision since personal moral values and professional ethical obligations were compromised"(p 138)

A very common experience amongst most participants was the **burden of workload**. Participants expressed that have a large workload often resulted in them not being able to carry out nursing care effectively and safely:

“When I am busy with the patient sometimes ...for instance when I need to administer medication I know I should be using an alcohol swab to clean the port, but because I am busy I do not...I know that I should but I don't as there is no time”.

“When we are busy we take short cuts in what we need to do to save time and move on to the next patient...most times we have two heavy patients and cannot do the correct procedures are we taught.... I know that this is a central line and not doing the right thing can lead to infection”.

Poor working conditions such as the high workload of health care professionals have been closely related to moral distress. This type of overload can result in poor patient care and hindering the execution of professional activities leading to moral distress. In some cases, this can lead to burnout syndrome and dissatisfaction (Wolf et al, 2016).

5.3 Bad Practice

Participants were very vocal about the **hierarchy in practice** between doctors and nurses. Most often doctors would decide with no input from the nurse:

“We had a doctor who would give the patient only 24 hrs in the ICU...due to bed shortages he will then discharge the patient from ICU into the step-down...the nurse was not asked about any input into this decision...even though I knew it was not the right decision...he could not be questioned because he is the doctor”.

In addition, hierarchy in practice was most often related to the doctors not following certain procedures:

“They do not wear gloves or washing hands....like during the insertion of a central line...this often leads to infection in the ICU...the doctor does what he wants and this is wrong..it harms the patient.

Nurses are more likely to experience constraint-distress than physicians because of their position in decision-making hierarchies (Fourie, 2017). The emotional implications caused by moral distress is due to the nurses' lack of power in making decisions, which leads to interventions against their beliefs and values and denying their knowledge, resulting in feelings of frustration, powerlessness, and guilt, related to the organizational and ethical conflicts (Dalmolin et al 2010).

Maffoni et al (2019) reported that the relationship with colleagues and superiors, and organizational constraints often led to personal value conflicts a resulting in moral distress.

Some nurses described **feeling guilty** with morally challenging experiences. The feeling of guilt was often related to issues surrounding death and end of life care:

“I feel extremely guilty when I know I could have done more to save a patient life but I couldn't as the system would not allow it”.

“End of life decisions are difficult ...especially when it comes to CPR...sometimes patients need more time but we do not give it to them...I feel guilty”.

6. Conclusion

This study highlights that moral distress within critical care units is a real problem that impacts critical care nurses' physical and psychological stress. Health care institutions should mobilize resources to reduce these effects on critical care nurses and other health care professionals. As previously indicated, there are few studies completed within the context of Saudi Arabia. The effects of moral distress are challenging for staff and can be further complicated by a multicultural context of staff as in the case of Saudi Arabia.

7. Limitations

The study reflects the experiences of five participants and was limited to what participants were willing to share during the data collection. Also, data included a sensitive topic, which could have influenced the responses from participants.

Recommendations

A similar study in another setting within the context of Saudi Arabia could provide a more expanded view of the phenomenon at hand. Besides, this study only included females nurses and a future study including males and members of the other health care professionals are advisable.

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