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Communication

Causes of moral distress in the intensive care unit: A qualitative study☆

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ABSTRACT

Purpose: The purpose of the study is to examine the causes of moral distress in diverse members of the intensive care unit (ICU) team in both community and tertiary ICUs.
Materials and methods: We used focus groups and coding of transcripts into themes and subthemes in 2 tertiary care ICUs and 1 community ICU.
Results: Based on 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 causes of moral distress were concerns about the care provided by other health care workers, the amount of care provided (especially too much care at end of life), poor communication, inconsistent care plans, and issues around end of life decision making.
Conclusions: Causes of moral distress vary among ICU professional groups, but all are amenable to improvement.
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1. Introduction

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]. Empirical studies identify significant prevalence and high levels of moral distress in nursing practice [3,5] and have linked moral distress to burnout and attrition [6–8]. Recent research has explored moral distress in other health care disciplines, with 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 by both quantitative [5,11,15–17] and qualitative [10,12,13,18–33] means, there have been few qualitative studies of moral distress in intensive care unit (ICU) professionals [20,26,33–35], and none that have addressed moral distress in all ICU professionals in both community and tertiary ICUs. Therefore, the purpose of this study was to examine the causes and consequences of moral distress in diverse members of the ICU team in both community and tertiary ICUs. This article describes the causes of moral distress.

2. Materials and methods

A study on moral distress in ICUs was conducted in all 13 ICUs in the Vancouver area in 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 [36]. Then, all ICU clinical staff in 3 of the participating hospitals (see Supplementary Digital Content for selection criteria) were invited to participate in focus groups to address causes and consequences of moral distress. Focus groups were stratified by physicians, nurses, and other health professionals (physiotherapists, respiratory therapists, dieticians, social workers, and pastoral care). In 1 hospital, separate groups 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 groups lasted 1 hour and were led by an experienced qualitative health researcher 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 read numerous articles about moral distress. Throughout the planning and preparation phase of the study, the researcher was supported by other members of the team who had subject matter expertise.

In the focus groups, the concept of moral distress was explained to participants at the start of the discussion and included any negative emotions that the person experienced in response to a conflict between the care they think should be provided and the care that is provided.

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Telephone interviews were conducted with nurses and other health professionals who were unable to attend the focus groups and expressed an interest in participating (none of the physicians who were unable to attend the focus groups requested to participate). The transcripts from the interviews were appended to the transcripts from the corresponding focus group (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, Burlington, MA, USA). Theme codes were developed to reflect the topics discussed in the focus group sessions, and subtheme codes were created based on the content of the discussions. All coding was done by 1 research assistant (the coder) to ensure consistency. The researcher who conducted the focus groups 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 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 that each theme/topic was mentioned in the focus groups by provider type. The number of times a topic/theme 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. This type of analysis is called attribution or assertion analysis [37] or incidence density [38] and is used as an indication of the relative importance of a theme to participants [37–39]. We created the following criteria for inclusion of a cause of moral distress which ensured that a theme was relevant to multiple respondent types and/or multiple people within a respondent type: mentioned in at least 4 groups or at least once by each respondent type or at least twice by 1 respondent type and the topic was raised in discussion at least 10 times.

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

3. 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 one hospital. The interviews included 3 nurses and 1 other health professional. A total of 56 providers participated in the focus groups (Table 1). In the following description, quotations from participants are included verbatim except where clarifications are required or to maintain anonymity, as indicated by parentheses. Additional description of themes and exemplary quotations are provided in the Supplementary Digital Content.

The common causes of moral distress fell into 8 main categories (Table 2). An issue that was discussed at great length or brought up multiple times during a focus group was considered to be a more important issue to participants than one that was discussed very briefly and/or rarely [34,38,39]. Table 2 part B provides the number of times that participants discussed each of the causes of moral distress.

3.1. Quality of care

3.1.1. Concerns about other providers' care

Nurses experienced distress as a consequence of inadequate care provided by other nurses and physicians. Inadequate nursing care, as described by nurses, can primarily be characterized as resulting from lack of effort or commitment to the patient (see Supplementary Digital Content). The most common concern cited by nurses about physicians was that they do not respond fast enough to a patient's needs (see Supplementary Digital Content). Physicians, particularly at 1 tertiary hospital, expressed significant distress related to the quality of care provided by other physicians within and outside of the ICU (see Supplementary Digital Content). It was perceived that some ICU physicians may admit a patient into the ICU, although the patient does not really need to be there or they may keep the patient in the ICU longer than necessary: "Yeah, and similarly, like, sometimes we're uncomfortable sending people to the ward or some—under the care of certain people—you know, either here or at [our affiliated hospital]." (Physician).

Other health professionals expressed less distress associated with inappropriate or inadequate care provided by others.

3.1.2. Teaching vs optimal care

Physicians and other health professionals expressed concern that patients may not receive the best or most appropriate care when care was provided by residents, especially during high-risk technical procedures.

"I mean, I think, like, for myself, I understand that everybody has to learn and to me I have moral distress when I see the same person reattempting the same procedure, unsuccessfully, without guidance from a superior. And just continuing to perform that– and just not understanding that they need to stop and they need to have supervision. Or they need to have someone else come in and perform that procedure." (Other health professional).

Other health professionals also found that residents were giving information to families related to the work of the other health professionals but that they were providing incorrect information or inadequate explanations (see Supplementary Digital Content).

3.1.3. Lack of end-of-life conversations

In 2 ICUs, physicians were morally distressed by patients being denied the information that they were dying and the lack of discussion about end-of-life care, including "code" status. The primary source of distress was physicians in the community and other parts of the hospital failing to have these conversations with their patients, and consequently, the ICU physicians were left to break this news to the patients (see Supplementary Digital Content).

"And patients with end-stage lung disease that will come to us and it's, you know, a patient on home oxygen who's never had a conversation with their physician about end-of-life care. That's just outrageous, you know. Because that's a, you know, terminal diagnosis. So it's very, very frustrating to then be encountering those patients over and over

Table 1
Number of participants by hospital and provider type

	Tertiary hospital 1	Tertiary hospital 2	Community hospital	Total
Nurses: registered nurses	6/111[a]	8/192	5/50	19
Nurses: clinical nurse leaders	–	4	–	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] Number of participants/total number of each profession working in that ICU.

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