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WHAT'S NEW IN INTENSIVE CARE

# Moral distress in ICU nurses

Meredith Mealer[1*] and Marc Moss[2]



The intensive care unit (ICU) is a stressful environment due to high patient mortality and morbidity, daily confrontations with ethical dilemmas, and a tension-charged atmosphere [1]. The ICU is an especially complex and difficult work environment for critical care nurses. Critical care nurses are repeatedly exposed to work-related stresses, including involvement in end-of-life discussions, prolongation of life with artificial support device, and the potential for delivering inappropriate care [2]. When confronted with these stressful situations, nurses may feel powerless, unable to provide care according to their own belief system, and therefore prone to develop moral distress. Moral distress is an increasingly recognized problem that has critical implications on the ability to deliver healthcare properly. In this commentary, we discuss the risk factors for moral distress, its consequences, and potential preventative and therapeutic interventions.

Moral distress occurs "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" [3]. More specifically, moral distress requires three situations: (1) a need for a morally responsible action occurs; (2) the individual determines the best strategy based on their own morality; (3) the individual is then prevented from implementing their plan of action due to internal and/or external constraints [4]. Moral distress is especially common in critical care healthcare professionals, occurring in up to 80 % of critical care nurses [5]. In general, nurses are more likely to develop moral distress than physicians due to the nurse's perceived inability to make decisions and their feeling of being "voiceless" during morally complex conversations [4, 6].

Over time, repetitive exposure to ethical dilemmas can cause more persistent feelings of powerlessness and render the nurse more likely to remove themselves from future discussions of morally charged situations. Repetitive exposure to morally stressful events can also result in an intensity of symptoms, as new situations may evoke stronger reactions due to the recall of earlier distressing situations [4, 7]. Long-term consequences of moral distress can include withdrawal, emotional exhaustion, depersonalization toward patients, and other symptoms of burnout syndrome [8]. Moral distress can also impair the ability of a critical care nurse to provide proper patient care, impact their ability to perform expected job responsibilities, and decrease the amount of time spent with patients and families. The development of moral distress may also increase the risk of a critical care nurse leaving the profession [4]. This downstream turnover of critical care nurses can increase healthcare costs, decrease productivity, lower staff morale, and reduce the overall quality of care as experienced nurses who leave the ICU must be replaced [9].

Several factors may increase the likelihood of developing moral distress, including specific aspects of patient care, internal constraints, and external constraints. During the care of patients, the perception of delivering inappropriate care can trigger moral distress [2]. Examples of what may be considered inappropriate care include—but are not limited to—providing unnecessary or "futile" treatment, inadequate pain relief, and false hope to patients or their families; hastening the dying process; disregarding patients' wishes; working with other caregivers who may not be competent to perform their job responsibilities. Internal constraints arise from the inability to maintain a healthy mental and emotional perspective when encountering difficult patient care experiences. Examples of internal constraints include lack of self-confidence, excessive fear, the inability to cope with perceived suffering, and conflicts with religious

*Correspondence: meredith.mealer@ucdenver.edu
[1] Division of Physical Medicine and Rehabilitation, Department of Medicine, University of Colorado Anschutz School of Medicine, 13001 E. 17th Place, F490, Aurora, CO 80045, USA
Full author information is available at the end of the article

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or spiritual beliefs. External constraints result from specific policies and aspects of the ICU work environment [10]. The most common external constraints are a lack of a collegiality, the perceived hierarchical structure of healthcare institutions, and inadequate communication [11]. Additional external constraints include hospital or unit policies that conflict with one's beliefs, inadequate staffing, and compromising care due to cost constraints and concerns (Fig. 1).

The moral distress scale (MDS) is the most common survey used to diagnoses moral distress [12]. Designed for critical care nurses, the MDS consists of 32 items in a 7-point Likert format that focus on clinical situations encountered in the ICU environment. Higher scores reflect a higher level of moral distress. The MDS has been adapted for non-ICU settings, and there have been attempts to create a shorter, less burdensome survey instrument. For example, the MDS-R includes 21 items and has six parallel versions to cover disciplines beyond nursing, including physicians and other healthcare professionals [13].

There are no large randomized controlled trials that have examined strategies to prevent or treat moral distress in critical care nurses. Therefore, future well-designed trials will be necessary to more definitively identify beneficial interventions. Potential strategies that may prevent and treat critical care-related moral distress may be categorized into three groups: (1) educational interventions, (2) interventions focused on enhancing the ICU environment, and (3) interventions focused on helping individuals cope with their work environment. It is unlikely that any single intervention will be effective in preventing and treating moral distress in critical care nurses; rather, multidimensional interventions that address the ICU environmental culture and individual practitioner level will be more likely to successfully prevent and treat moral distress [1, 6]. Ethics education provides nurses with the necessary tools for decision-making and developing individual coping skills. Ethics education may also improve self-confidence, reduce fear, and improve the ability to cope with complex ethical dilemmas [14]. Potential interventions that may enhance the ICU environment include implementing ethics committees, establishing multidisciplinary ethics rounds, establishing formal debriefings after morally charged events, and involvement with the development of end-of-life/futile care policies. Potential interventions that could help individuals cope with their environment include practices that promote resiliency, such as mindfulness-based stress reduction, self-reflection, cognitive flexibility,

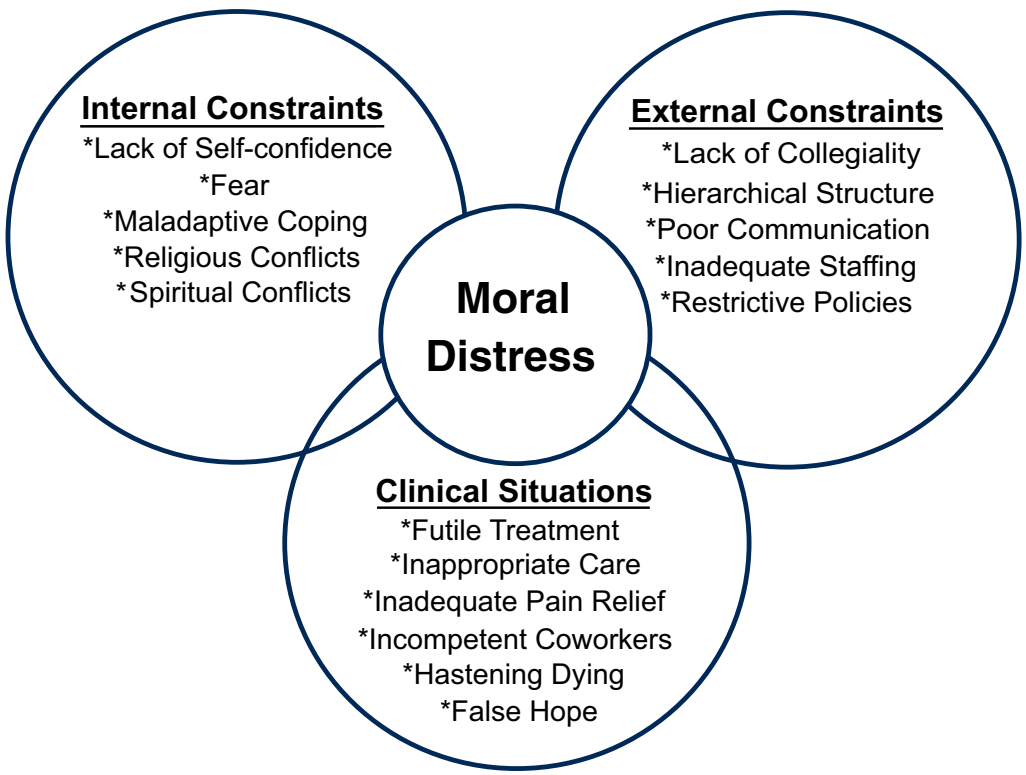


**Fig. 1** Factors that increase susceptibility to develop to moral distress

greater self-awareness, stronger communication, and professional networking and journaling [4]. Enhancing resilient coping mechanisms may reduce symptoms of burnout syndrome, compassion fatigue, secondary traumatic stress, and posttraumatic stress disorder [15].

In summary, we applaud the editors of *Intensive Care Medicine* for helping to raise awareness that moral distress occurs commonly, results in deleterious consequences among critical care nurses, and has downstream consequences for their patients. Critical care professional societies, hospitals, and other stakeholders all have a responsibility to acknowledge that moral distress occurs—and to develop strategies to identify moral distress among their members and employees [6]. In addition, these groups should encourage the conduct of clinical trials that examine interventions designed to reduce moral distress in critical care nurses.

**Author details**
[1] Division of Physical Medicine and Rehabilitation, Department of Medicine, University of Colorado Anschutz School of Medicine, 13001 E. 17th Place, F490, Aurora, CO 80045, USA. [2] Division of Pulmonary Sciences and Critical Care Medicine, Department of Medicine, University of Colorado Anschutz School of Medicine, Aurora, CO, USA.

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