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"Like Firemen Going into a Fire": Moral Distress in the Intensive Care Unit

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The definition, causes, and impact of healthcare professionals' moral distress in the intensive care unit (ICU) are reviewed. Individual and system strategies are proposed to mitigate the effects of moral distress.

Introduction

After dealing with a long, protracted death of a patient, a critical care nurse remarks:

"Critical care physicians and nurses are like firemen going into a fire. We know we're going to get burned, yet we do it over and over again until the burns no longer hurt."

This is a classic expression of moral distress. Moral distress occurs when a healthcare professional perceives an ethically preferable or morally right course of action to take, but they cannot take this course of action because internal or external constraints make it difficult (if not impossible) (Jameton 1984). Moral distress is often mistakenly equated with burnout, exhaustion, or an ethical dilemma, but it is distinct. For instance, in a

classic ethical dilemma, there are two mutually opposing courses of action, and the clinician just does not know which course to take. With moral distress, the healthcare professional has identified the preferable course of action, but cannot act on it (Wilkinson 1987). When clinicians experience moral distress, they likely also experience burnout or psychological distress. Conversely, moral distress is not necessarily present when an individual suffers from burnout or stress. Distinguishing moral distress from other phenomena is important in order to recognise its impact on ICU team members and implement interventions to reduce its detrimental effects (Hamric 2012).

Causes of Moral Distress

Moral distress has been studied over the past twenty years, particularly in the critical care context, but our understanding of this condition is still evolving (Hamric 2012; Lützén et al. 2006). Broadly, moral distress usually results from misalignment in goals and expectations between various stakeholders regarding treatment plans. This discordance can occur between patients/surrogate decision makers and healthcare professionals, between different healthcare professionals involved in a patient's care, or between patients and surrogates (or surrogates and other surrogates). Critical care physicians and nurses experience moral distress in a range of situations, but the specific clinical situations most likely to evoke moral distress centre on initiating or continuing aggressive measures at the request of patients or (more commonly) surrogate decision makers, even where it might be medically inappropriate to do so. Here, critical care clinicians report feeling "ineffectual" and "hopeless" at directing the treatment plan in accordance with what they feel to be most ethically appropriate (Corley 2002). Discontinuation of treatment that is perceived to be appropriate or, alternatively, discontinuation of treatment in an inappropriate manner may also create moral distress for ICU clinicians.

Moral distress research has only recently conclusively determined that moral distress is experienced by all healthcare professionals, regardless of their disciplinary background or gender. The frequency and source of moral distress, however, might differ depending on professional background. A recent study found that social workers were distressed by discharge planning issues (Houston et al. 2013). Chaplains were distressed by feelings that life-sustaining treatment was withheld or withdrawn prematurely, a perception that was uniquely experienced by chaplains for reasons that are unclear (Houston et al. 2013). Critical care nurses and physicians experienced moral distress from issues pertaining to continuation of aggressive measures where it was viewed as medically inappropriate, although nurses experienced this with greater frequency than physicians. A logical explanation for this finding may be that nurses have greater contact presence at the bedside and are unable to remove themselves from the distressing situation (Houston et al. 2013; Bruce et al. 2014a). Whether and to what extent moral distress manifests differently between various disciplines is worthy of further exploration.

Efforts are underway to build a more comprehensive knowledge base about root causes of moral distress and the interconnections between system, ICU-based, and individual factors (Hamric 2012). Presently we know that factors that affect moral distress intensity and frequency include: individual characteristics of a healthcare professional (discipline, years of experience, education, or belief system), ICU culture and organisation, institutional culture, and the healthcare environment, but the interconnections between these factors are not well understood (Hamric 2012; Lützén et al. 2006). For example, providing medically inappropriate treatment has consistently been identified as a major, if not the primary, root source of moral distress, as noted above. However, a more nuanced view might elucidate intra-team dynamics as a corollary root cause that somehow connects or influences feelings about medical appropriateness or inappropriateness of treatments. Some of our work suggests that discordance between team members regarding prognostic information or plans of treatment might exacerbate moral distress, whereas well-functioning teams with a supportive staff network might help in mitigating moral distress (Bruce et al. 2014b; Weinzimmer et al. 2014). More work is needed to characterise the interplay between team dynamics and individuals' moral distress

Impact of Moral Distress

Moral distress may have a significant impact on individual members of the ICU team, team dynamics and patient care. Others researchers' work and our own suggest that moral distress results in compromises in professional identity or integrity, surfacing in a variety of ways including emotional detachment or desensitisation (Bruce et al. 2014a; Epstein and Hamric 2009). Critical care clinicians have reported "stepping back" and "watching from the sidelines as the disaster unfolds" as a means of "self-protection" (Bruce et al 2014a; Weinzimmer et al. 2014). Efforts may be taken to transfer patients to different hospitals or services, change shift schedules or patient assignments, limit time with the patient and family or other similar strategies to remove healthcare professionals from morally distressing situations. These transitions could potentially affect quality of patient care and patient/family satisfaction. Aside from detachment, other symptoms suggestive of moral distress include frequent crying, physical illness, or a change in appetite or sleep patterns (Hamric 2010).

Repeated exposure to moral distress likely results in a cumulative building of the "residue" remaining from prior morally distressing cases, ultimately creating a new, higher baseline of moral distress (Epstein and Hamric 2009). With this cumulative buildup, professional integrity eventually erodes and clinicians opt to desensitise in order to, as one interviewee said, "inoculate" themselves. If this theory holds true, which has yet to be consistently demonstrated empirically, it is anticipated that experienced, senior clinicians might feel or have the appearance of becoming "jaded" or withdrawn in order to protect themselves from repeated exposure to morally distressing cases (Epstein and Hamric 2009).

Interventions to Mitigate Moral Distress

Given that moral distress is ubiquitous in ICUs, the question then becomes what to do to mitigate it. One option would be to ignore it, reasoning that some moral distress is acceptable because it indicates a healthy recognition of the moral domains of medicine. Such an approach, in our opinion, would be deleterious. Several studies have demonstrated at least an attenuated connection between moral distress and job dissatisfaction, and some studies have found links between moral distress and actually leaving one's profession (Beumer 2008; Elpern et al. 2005; Gordon and Hamric 2006). Ignoring a phenomenon that clearly impacts staff turnover and morale (and could affect patient care) only creates institutional risk.

Interventions to decrease moral distress could involve individual and system level strategies. One might assume that moral distress can only be

addressed by the healthcare professional on an individual basis. While there are techniques that could be used individually (e.g. meditation, journalling, self-care, exercising), such approaches are limited in mitigating moral distress (Gordon and Hamric 2006; Hamric 2012). System strategies should supplement individual techniques in order to better and more fully support clinicians. System approaches to intervening on moral distress can take many forms, depending on organisational culture and resources, making it difficult to formulate generalisations, but they can generally be grouped according to three main activities: increasing education, cultivating mentoring networks, or conducting debriefing sessions.

Unfortunately, very little investigation has been done on system-level education interventions (Beumer 2008; Hamric 2012). Of the few studies that exist, most system-level interventions focus on increased bioethics education with mixed results. The premise for this is the belief that more education could help healthcare professionals identify moral distress and develop strategies to mitigate it. Regular inclusion of a bioethicist in ICU rounds at our institution improved recognition of morally distressing cases, validated the clinicians' concerns, and facilitated intra-team communication (Bruce et al. 2014a), suggesting another means of education.

Alternatively, some system interventions encourage cultivating effective mentoring networks and setting up unit-based debriefing sessions (Gordon and Hamric 2006; Rushton 2006). The logistics of debriefing sessions and the means by which to facilitate mentoring networks are often context-dependent. Debriefing sessions could be facilitated by a chaplain, an ethicist, or an independent outside consultant. The topics of the sessions could range from orchestrating core content lessons to free-style 'venting' opportunities. The timing of the debriefing sessions could range from episodic meetings (e.g. during and after a particularly complex case) to regularly scheduled meetings not related to cases. A top-down approach wherein hospital leaders plan system interventions without essential input and buy-in from bedside clinicians will likely be perceived as authoritarian, heavy-handed, and unresponsive to the moral distress needs of clinicians. For this reason, involving bedside clinicians in shaping and selecting system approaches is prudent. More importantly, it is likely to lead to the selection and adoption of a plan that will be successful in particular ICUs.

Conclusion

In summary, there are profound implications in allowing critical care professionals' moral distress to go unchecked and unmitigated, especially given that is an experience that is shared by most— if not all—members of the ICU team. We lack a complete understanding about moral distress causes and the interconnections between system, ICU-based, and individual factors. Terminology and definitions have been inconsistent, further frustrating efforts to investigate moral distress. Intervention research is limited, and studies that exist often yield mixed results. Despite these limitations, recent efforts aimed at developing systematic approaches to studying moral distress suggest that inroads are being made to refine our understanding of this complex experience.

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