Moral Distress in the ICU’s

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Introduction

• Moral distress is expressed in physical and emotional ways when the right thing to do is apprehended, but constraints make this course of action difficult or impossible (Jameton, 1996:6).

• Because active treatment and end-of-life decisions are mostly made by doctors, the medical perspective is frequently emphasized and that of nursing marginalized.

• However, nurses are involved in the care of critically ill and dying patients – their mandate being to provide patient & family-centered care in intimate and intense situations, such as the Intensive Care Unit (ICU).
• In this heightened emotional climate, ethical decisions have to be made which may be contested within the MDT and may have far reaching results (ACCN, 2006).
• A South African study revealed 33% of the ICU nurse participants felt that decisions to withdraw active treatment were made too late (Langley et al., 2012).
• Distress is also experienced when the expectations of family members to continue active treatment to prolong life are not in the patients best interests, or when the medical team disregards the patient’s wishes (Gutierrez, 2005).
• Compassion fatigue is commonly found in staff regularly faced with critical illness, death and assisting families to deal with grief (Wee & Myers, 2003).
Aim and Objectives

Aim
• To explore and describe, from the nurses’ perspective, the clinical situations in the ICU’s which evoke moral distress

Objectives were to:
• To describe the consequences of these situations and the means employed to manage their distress
Methods and Procedures

• Ethical consideration
  – Approved by the University of the Witwatersrand Ethics Committee (Medical) (M121136)
  – Permission to conduct the study was given by the Provincial Health Directorate, the hospital chief executive and ICU nurse managers

• Design
  – An exploratory descriptive design was used.
  – A short survey/interview guide derived from Corley et al. (2001) was administered
Methods and Procedures

The survey asked **three open-ended** questions:

- What situation concerning the care of a critically ill or dying patient have you experienced, which caused you to feel morally distressed?
- What did you experience physically, mentally, emotionally or behaviorally, which you consider were due to the effects of this experience?
- How did you manage the feelings or thoughts in order to reassure yourself or regain composure?
Data Analysis

• A total of 65 completed surveys were collected; and analyzed by means of an initial content analysis.

• 32 responses were not analyzed as they were describing situations of emotional distress.

• 33 responses clearly described moral distress and were included for analysis.

• Data were triangulated with transcripts from previous work (focus group discussions; n=13) in the same hospitals and had discussed these specific issues.
Findings

Theme 1
• Collegial incompetence or inexperience

Theme 2
• Resource constraints

Theme 3
• Ending life: maintaining futile care or withdrawing treatment

Theme 4
• Lack of communication, consultation and negotiation

Theme 5
• Support
Theme 1: Collegial incompetence or inexperience

• Perceived incompetence of colleagues was a source of moral distress, particularly when deemed to threaten the integrity of the patient.

• Colleagues perceived to have insufficient knowledge or experience such as doctors, agency staff and students were among those inadequately prepared, this problem was mentioned in conjunction with the regular complaint of staff shortages.

• Nurses felt unable to rectify the situation due to the hierarchical nature of doctor-nurse relationships, the prevailing shortage of staff or their own inadequacy.
Theme 2: Resource Constraints

Staff shortage were a common problem causing both anger and moral distress because it was perceived, the patients lives were in jeopardy. One nurse explained: “Absenteism, sickness, family responsibilities ...I feel emotionally exhausted and guilty. Patient care is compromised no shift leader, no overall supervision”

Another one wrote: “Using nursing assistants or grabbing anyone who calls herself ICU experienced as long as there is someone in front of the patient. You get burned out, lose faith in people in charge; I am accountable, my profession is at risk”

In some cases, the shift leader was the only permanent member of staff and often the only ICU qualified nurse. The responsibility for the whole unit and the practice of others evoked anxiety, anger and a perception that they were being abused. “…coming to ICU not trained, also lacking experience, one called a cardiac monitor a ventilator. I am emotionally exhausted seeing patients in unsafe hands”
Theme 3: Lack of communication, consultation and negotiation

Two participants in the survey group and three in the focus group discussions said that the need to communicate with family evoked moral distress. “They are a challenge. They still have hopes and want to hear something different ... they’re been told by the doctor but they still come back to ask you. Miracles do happen so you can’t say the patient will die”

A focus group participant said: “Sometimes nurses disappear ... they don’t want to be asked questions” This was echoed by an experienced ICU nurse: “…I decided to keep quiet, only speak when necessary, they don’t accept the condition ... it is disheartening to consult them”

Another nurse spoke of family being angrily divided by the decision to terminate treatment. She also disagreed with the decision but had to explain. Why she was switching off the ventilator. Particularly difficult: “…there is another person with a good prognosis who needs to be admitted to the same cubicle, this is very difficult. You may have failed: maybe you were not competent enough’
The lack of communication was a common problem. One focus group participant said: “Doctors just go ahead and do their own thing, you don’t matter” Another, in the same focus group agreed: “No you don’t argue”

Poor communication also included team members ignoring suggestions for treatment. A Registered nurse recounted how she had pressed a doctor to intervene urgently but the advice was discounted. “I felt de-motivated ... my contribution ignored, the patient could lose his kidney”.

Despite the rebuff, she called a nephrology consultant and asked him to initiate treatment. “Doctors must understand that ICU nurses have worked with these patients” She was one of the few participants who stated that they acted autonomously.

In addition, to feeling their advice was ignored, nurses stated that they wanted to be included when decisions were made. “I shouldn’t feel I’m being left out and just being told. I need to understand”

All but one participant stated that they wished that they had been consulted or included in the discussion leading to the decision to withdraw active treatment.
Another two wrote that they had requested that they be involved in end of life discussions when they were caring for the patient under consideration. *For example.*

A teenage girl had sustained irreparable brain damage. Active treatment was terminated without consulting or informing the child’s family but ventilation and cardiac monitoring were continued. Only later was the family asked for organ donation.

The nurse said: “*Doctors only care for organ donors …this for me is a crisis of conscience*”

The decision of management of the case was probably ethical and correct, however it appears the nurses were not included in the decision and this nurse felt that they and the family should have been consulted before the decision was made.
Theme 4: End of Life Issues, withdrawing and withholding treatment

Three participants specifically addressed the issue of maintaining futile care in their narratives. This issue was discussed extensively in the focus group transcripts.

One RN was sanguine “I sympathize with the family, the patient is a breadwinner but according to the bible, we must all depart”

Another nurse recounted in the focus group interviews said: “You’re not adding value, just prolonging suffering the patient is going to die”.

Yet another said “They don’t want to feel guilty”

It is moot whether these nurses experienced no emotional distress or whether they were losing their capacity as a result of moral distress.
One focus group member expressed concern about the medical team’s inability to come to agreed upon decision “...orders are not clear, one will say ‘no escalation’. The other will say ‘give Voluven’. There is no clear cut and you don’t know because there is no handover from one to another”

One ICU nurse recounted her distress when a patient who had been declared brain dead was prescribed IV inotropes by a consultant. She asked: “Why was this being done but failed to get a satisfactory answer: delaying the patient and causing unnecessary labour”

Active care given to patient who has no hope of recovering prolongs the dying process and creates moral distress raises false hope for the family and is said to contribute to an extended grieving period.

Three nurses described the distress they felt when a decision was made to hasten death.

One Nurse recounted how she was told “To give high doses of morphine and dormicum. He was intact mentally just not recovering physically and aware of being killed or left to die because we are not going to do anything more for them. This is murder”
The focus group revealed another response: Two nurses disagreed with the decision to terminate active care told of condoning the process. The first said: “I will treat the patient – even if it’s not on the chart; even if it’s with a little glucose. I will not slow down”.

In the same group, a nurse said she would continue with treatment. “…even inotropes, but you forget about the colleague coming on duty. It’s going to be a shock to find out that there really is no blood pressure”.

Two nurses felt that the process of asking the family for consent to harvest organs was traumatic and poorly managed.

One nurse said: “I was so disturbed ...I shouted at the lady who came to enquire about organ donation. I shouted at the doctor ....told him to come and explain to the relatives, they must not be pressurized”.
Theme 5: Support

Fifteen people explicitly said that no support was offered by management. They felt that this should be given and said poor care support was likely to affect their care of patients.

“Things that we are exposed to are deep, but there is nothing. You survive then you become desensitized: You admit another patient, carry on, no debriefing, none expected. Someone should say ‘how do you feel? In future how should we deal with this?’

Four derived comfort from the belief that it was God’s decision as to lived or died. One person stated prayer helped.

Most discussed the situation that distressed them with colleagues.

Participants offered suggestions what they believed should be done. ‘Give us stress management’; and ‘we should be debriefed. Just talk to someone and offload’, and ‘offer EOL training junior nurses are most affected’.
Discussion

• In this study, considerable distress was evoked by the perceived morality of the situation or treatment decisions and influence on nursing care.

• Many of the narratives gave details of distress experienced by participants when decisions were made to withdraw or withhold active treatments, when they felt conflicted about the decision, when they were expected to institute the process of withdrawing and they were told of the decision without having being party to the discussion.

• Remarkable was the sense that apart from discussion with colleagues, the nurses perceived that they were totally unsupported.
• Management was perceived as *uncaring* and, of 33 written responses, five explicitly stated that there was no support or debriefing offered. More than half urged counseling sessions be arranged by hospital management.

• God and prayer were also viewed as a **means of comfort** for the family and nurse.

• Many emphasized that simply **writing their stories** had helped them deal with emotions which had lain dormant for some time.
Conclusions and Relevance for Practice

- **Support needs** to be offered on a regular basis for nurses practising in the ICU; this should be based on a non-directive ‘story-telling’ format and allow for debriefing and affirming in a safe, group context.

- At the same time, nurses’ **self-reflection and self-awareness** should be encouraged and this could be done in the group.

- Gradually assertiveness education could be addressed and skills practiced in a safe supportive group environment.

- Enhancement of collaboration, nurse autonomy and **interdisciplinary respect** is likely to promote an appreciation of nursing input and a decrease in the instances of moral distress.
References


