Barriers and Values of Moral Distress Among Critical Care Nurses

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The views expressed are those of the author and do not necessarily reflect the official policy or position of the Air Force, the Department of Defense, or the U.S. Government.
Objectives

- Define moral distress experienced by a critical care nurse.
- Identify three negative outcomes of moral distress on the healthcare environment.
- Compare moral distress experience by civilian and military critical care nurses.
- Identify future efforts to develop interventions for moral distress in critical care nurses.
Moral distress is pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong” (Nathaniel, 2006, p. 421).
Definitions of Moral Distress

“the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment” (Varcoe et al., 2012, p. 59).
Impact of Moral Distress

- Link between healthy work environments, patient safety, nurse recruitment, and nurse retention (AACN, 2001)
- ~880,000 nurses in the U.S., or one in three nurses, experience moral distress (Bureau of Labor Statistics, 2013)
- Psychological (Rushton, 2006)
- Social (McClendon & Buckner, 2007; Meltzer & Huckabay, 2004; Rice et al., 2008)
- Physical (Burston & Tuckett, 2013; Jameton, 1993; Wilkinson, 1987)
- Organizational (DeTienne, Agle, Phillips, & Ingerson, 2012)
- Others (Cimiotti et al., 2012)
Problem Statement

There are inconsistencies in the theoretical underpinnings of moral distress.
  - The values stated in the Moral Distress Theory (2002) are not well established.

The link between moral distress and personal and professional values is not well established.
  - It is suggested that when moral distress is present, barriers exist to providing the best care possible by not permitting a nurse to act upon personal and professional values (Corley, 2002; Nathaniel, 2006).

ANA recently revised Code of Ethics including value statements of the profession.
Research Aims

Barriers and Values of Moral Distress Among Intensive Care Nurses

1) Understand barriers critical care nurses have encountered during moral distress experiences.

2) Explicate values identified by critical care nurses that have experienced moral distress.
Results

Seven critical care nurses interviewed

- Consistent with other moral distress qualitative studies (Edison, Lunardi, Lunardi, Tomaszewski-Barlem, & Rosemary, 2013; Hanna, 2005; McClendon & Buckner, 2007)

Demographics

- Ages represented: 20-30 (1), 31-40 (3), 41-50 (0), 51-60 (2), and 61+ (1)
- Bachelors (4) and Masters (3) prepared
- Years of experience: <3 years (1), 5-10 (2), 10-15 (1), 20-30 (1), and 30+ (2)
- Race/Ethnicity: “non-Hispanic, white race” (6), “black, Afro-Caribbean, or African American” (1)
- All female
- All Christian
Results

Barriers

- Inadequate when less than perfect
- Inadequate training, preparation, education, or mentoring
- Insufficient organizational support
- Untrusting relationships with nurse colleagues
- Inappropriate or controlling actions or behaviors of non-nurse providers
## Results

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<tr>
<th>Professional</th>
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<td>Loyalty to</td>
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<td>Quality</td>
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### Example:

- Professional and personal values: ‘Fairness’, ‘Loyalty to’, ‘Commitment’
- Final ANA value ‘Fidelity’
Overall Example

Barrier: Inappropriate or controlling actions or behaviors of non-nurse providers

“I think it was about the doctor getting aggressive with the family and then with the other doctors, even though there was already a conversation he wasn’t a part of the initial agreement to even understand what was going on with her, he got the Savior complex. [accountability, advocacy, compassion]. ‘Well, you guys said you were -- I can do something. I can fix this.’ Then he kind of got a family member on board and against the RNs and saying that oh, the ‘RNs just want to pull the plug’, and then there was no pain control [collaboration, responsibility]. And a couple of nurses, myself and another nurse really had gotten upset because we’re like ‘you’re not at her bedside 24/7’ [accountability, fidelity, nonmaleficence]. ‘You’re not seeing the look on this woman's face to know’ [compassion, respect for persons, responsibility]. I mean she is in pain. She’s dying of cancer. She’s has metastases in her bones. So the charge nurse and the nursing supervisor got involved and they called the physician who had said no narcotics [accountability, collaboration, courage]. He said I feel like you're ‘ganging up on me’ [collaboration]. Your nurses need to be professionals and leave their emotions at the door. If you want, I will transfer the patient to the other ICU. I'm concerned about the patient's hemodynamics and keeping the patient alive for the family wishes, and even when we started the morphine drip, he wouldn't let us turn up what we thought was adequate [compassion, responsibility]. You could increase it two milligrams every four hours, which was not our standard. Our standard was much more aggressive in that end-of-life [compassion, responsibility], but it was just to have him tell us to leave our emotions at the door and to have us tell him that like we're ganging up on him because he’s trying to keep someone alive for the family's wishes, even though that's not really what the family's wishes were [advocacy, fidelity, nonmaleficence]. It was just a really uncomfortable situation where we're like, you know, you start to second-guess yourself.” [accountability, self-regarding duty] “It’s just a tug and pull where the nurse is saying please keep my patient comfortable and the doctor is saying don't kill my patient. I'm like well, they’re dying. We're not killing them. The cancer is killing them. I mean, you know, we've already reached that point.” [advocacy, collaboration, responsibility]
Discussion

- Five barriers identified are consistent with other moral distress studies (Hamric, 2012; Huffman & Rittenmeyer, 2012)

- Research directed at identifying barriers and values experienced by nurses is key to identifying effective interventions for moral distress (Musto et al., 2015)

- The workplace environment is relational and highlighted as professional and personal values are exhibited (Varcoe et al., 2012)
Current Research

United States Air Force School of Aerospace Medicine Aeromedical Research Department
Example of En Route Care (ERC)

Regulated Transport

First Responder Care

Forward Resuscitative Care

Theater Hospital

Definitive Care

Leg 1 (120: Kandahar or Bagram to Bagram) → 400 miles
Leg 2 (C-17, KC-135: Bagram to Ramstein) → 4,400 miles
Leg 3 (C-17, KC-135: Ramstein to Andrews) → 4,000 miles
Background

- Limited research moral distress and military
  - Emotional exhaustion, anxiety, depression and PTSD are similar in nurses who provide wartime care as in combat warriors (Dukes et al., 2015)
- Nonexistent in Critical Care Air Transport (CCAT) or ERC environment
- CCAT team members’ role
- Stresses of flight
- Moral distress in U.S. Army Corps and Canadian Force nurse officers (Fry, Harvey, Hurley & Foley, 2002; Hurley, 2003; Bradshaw, 2010)
Moral Distress in the CCAT Nurse: A Phenomenological Examination.

Explore the phenomenon of moral distress in CCAT nurses’ stories of patient care.

What is the lived experience of moral distress in CCAT nurses?

What themes are described by CCAT nurses that occur during moral distress situations?
Method

- Qualitative descriptive study utilizing an interpretative phenomenological analysis (IPA) design
- Framework: Moral Distress Theory
- Sample: Purposive sampling with semi-structured interview
- Recruit CCAT nurses from hospital, CCAT advanced course, and schoolhouse
- Goal 10-15 interviews
Status

- Funding received for study
- Letters of Support from each command
- Interview guide approved by USAF Survey Control office
- Recruitment started
- 7 interviews completed
- NVivo for data analysis
- Team members added for data analysis
Preliminary Findings

- 75 to 185 minutes interview length
- Interviewer non-military nurse
- Wartime exposures
- Civilian exposures
- Repetition of experiences described
Future Work

- Presence of moral distress in Air Force CCAT team nurses
- Secondary analysis for barriers and values in CCAT team nurses
- Comparison between civilian and critical care nurses
- Dr. Ann Hurley (retired U.S. Army) has agreed to allow me to update and validate tool for military nurses developed in 2002
- With updated tool, measure effectiveness of interventions for moral distress in military nurses
- Interventions based on work with DNP students
- Efforts toward interventions to lessen the impact of moral distress
Thank you for your attention!

Personal photo by Melissa Wilson
References


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Questions?

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