Emergency department registered nurses' experiences of moral distress: It's about time

By Kevin Reedyk and Monique Sedgwick

Causes of moral distress in nurses have been widely studied and reported in both qualitative and quantitative capacities (Elpern, Covert, & Kleinpell, 2005; Maiden, 2008; McCarthy & Deady, 2008). While there is remarkable consistency as to the primary causes of moral distress in the literature (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Glasberg, Eriksson, Dahlqvist, et al., 2006; Redman & Fry, 2000; Zuzelo, 2007), the areas of focus for researchers in this regard have been almost exclusively outside of the emergency department (ED). The purpose of this paper is to begin to fill this gap by presenting the findings of a qualitative study where the experience of ED nurses' moral distress were explored.

Literature review

Hamric, Borchers, and Epstein (2012) provide the most detailed breakdown of the causes of moral distress in nurses. They classify the causes as rooted in one of three areas: clinical situations; factors internal to the provider; and factors external to the provider or situation.

Elpern, Covert, and Kleinpell (2005) indicate moral distress is particularly problematic for nurses who practise in critical care. However, the most closely related specialty nursing practice area, the ED, is virtually absent from the literature on the topic of moral distress.

Background

The ED is a dynamic area necessitating staff and physicians to think, speak, and work in terms of minutes and hours, as opposed to other areas of nursing where care is often planned and provided based on days and weeks (Fernandez-Parsons, Rodriguez, & Goyal, 2013). This study was conducted in a western Canadian province. All levels of ED care were represented from major urban level I trauma centres, regional referral hospitals, and rural EDs.

Research design

A narrative inquiry research design was used to explore registered nurses' (RNs) narratives on sources of moral distress while working in ED settings. Narrative inquiry involves determining common themes from stories collected to enable presentation of the findings in the context of which they were discovered (Riessman, 2008). Ethical approval was obtained from the University Human Subjects Research Committee (Protocol #2013-050).

Sample

With the assistance of the provincial regulatory body, participants were invited to participate in the study via email and/or telephone. Prior to agreeing to participate in the interview, the purpose of the study, along with participant rights were explained. Twelve RNs agreed to be interviewed (10 female and two male RNs). Their overall nursing experience ranged from eight to 36 years with emergency department experience ranging from seven to 20 years.

Data generation

Individual qualitative interviews lasting 60 to 120 minutes were completed primarily via Skype with others occurring face-to-face at locations of the participants' choosing. All of the interviews were recorded. Once no new information emerged from the interviews, recruitment of additional participants was discontinued. Examples of questions asked during the semi-structured interview included: Can you remember a particular situation that comes to mind from your work related to this definition of moral distress? And, are you able to describe reasons the right thing could not be done in this scenario? No participants withdrew from the study.

Data analysis

All interviews were transcribed verbatim and assigned pseudonyms. An inductive production of categories and themes was used. Initially, coding was undertaken by reading and re-reading the text and highlighting words and sentences. This was followed by relating theoretical ideas to the text, interpreting the text, and making interconnections between the codes. Lastly, notes were made of the relationship between the codes, the research questions, and the literature. Rigour was maintained with the aid of a research project supervisor reviewing transcripts and preliminary analysis, as well as providing feedback.

Results

"It's about time" emerged from data analysis as the essence of the participants' experience of working in the ED setting and the predominant cause of their moral distress. This theme is supported by three categories: (i) 'futile care': details the participants experiences of providing aggressive treatment to patients not expected to benefit from that care; (ii) 'between a rock and a hard place': describes decisions and choices the participants had to make regarding patient care; and (iii) 'one-stop shopping': details participant descriptions of how the ED is used as a primary care clinic by many patients.

Futile care: A focus in the ED environment is to prolong life with the most stress-inducing event being dealing with death and dying (Jonsson & Halabi, 2006). Participants in this study expressed frustration with providing what they felt was futile care. Indeed, several participants mentioned instances of caring for palliative patients who presented to the ED seeking comfort measures, but who were, ultimately, subjected to multiple invasive interventions. In many of these cases, unclear goals of care or an unwillingness on the part of the patients' family or

the health care team to hold back on potentially physically and psychologically invasive interventions resulted in moral distress. Chloe gave an example of a time when she felt they were actually torturing a patient by providing futile care:

> *I just felt sick, we put in a central line, a chest tube, all the poking and prodding. This poor man didn't have long to live and we were using all these resources to try and save him. I felt like it was torture (Chloe).*

In cases of trauma, participants indicated that patients' families expected that the health care team would undertake every intervention regardless of whether or not it was futile. There was speculation from some participants that this expectation was related to the sudden and unexpected nature of the situation in which they found themselves. Other participants indicated that for the health care team there was a correlation between the age of the patient and the length of time and invasiveness of interventions initiated.

> *Last week we had a stabbing. So, in those cases, it's typically younger people who are involved in violence and they get stabbed. They come into our department, you're thinking they're probably going to die from these injuries. In these cases, the whole world shows up, you get trauma team, ER, fire, EMS, police, housekeepers, everyone's in there watching. And eventually, it's "We're gonna crack the chest open and we're gonna try and save this guy's life." You lose perspective and you've got to keep in mind that this is a person, you're doing something very, very invasive, and you could be doing something very painful, it could be unsettling for their family to see this. And the outcome is almost always that they are going to die … but we've got to treat this person. The right thing to do would be to treat them more in a comfort care scenario. Allow the family in, have less intensity and less gawking at them and their insides and outsides as they die (Phil).*

Between a rock and a hard place. Physical bed management within the ED resulted in participants feeling caught between a rock and a hard place. For example, participants unanimously agreed that getting patients to a treatment space and closer to the point of physician assessment could be a source of moral distress. In fact, the increase in the number of patients who accessed ED impacted the degree of moral distress the participants experienced, since many EDs in which they were working were not designed to accommodate large increases in patient visits.

> *I can't remember the exact numbers they had set up for, but we are far surpassing these numbers [with] upwards of 250 people a day, that's two-fold what was expected for our staffing levels. The resources that we have are just not there (Ben).*

Eleven of the 12 participants also identified that the inability to move patients who were admitted to the hospital to the appropriate nursing unit was problematic. These patients occupied a bed in the department, which delayed assessment and treatment of patients waiting to be seen. In this situation, the ability to complete their work efficiently and effectively was impaired and contributed to the degree of moral distress they experienced.

The last situation that created moral distress for several participants was when they felt the right thing to do for their patients would be to spend more time with them but, due to competing demands, they could only spend a minimal amount of time with the patient before they had to move on to the next assessment or task. Rose stated succinctly, "We can't tie an old man to a chair, keep the light on in emergency, give him the Morphine and call that good nursing care!"

One-stop shopping. Many participants indicated that they experienced moral distress due to patients' use of the ED as a family care clinic. For these participants, having high volumes of non-urgent cases come into the department meant they were unable to attend to the needs of higher acuity patients. Jessica commented on the inappropriateness of placing less-urgent patients in high-acuity patient treatment areas:

> *In our intake area, we have patients who are less sick and patients who are appropriate and those who aren't. The other day I was having a frustrating day and they were sending me patients who didn't belong there. I had to call back three times because they were sending me patients who just didn't belong there.*

Ben was very direct with his assessment of emergency department use, stating:

> *The first thing people do is come running to emergency for the silliest of things. Nausea and vomiting for two hours and we give them Zofran instead of sending them home… Emergency is a one-stop shop now, you get your blood work, your radiology, and you get your results.*

Discussion/Implications

Participants in the study confirmed the existence of morally distressing situations while working in the ED. In other studies conducted in other acute care areas, one of the sources of moral distress is provision of care to patients who are not expected to benefit from that care, also known as futile care (Elpern, Covert, & Kleinpell, 2005; Lawrence, 2011). In keeping with the findings of these studies, the participants in this study also experienced moral distress in situations where futile care was provided. So, while open, honest and transparent communication among all team members is needed in all patient care situations, it is imperative in situations where futile care may be given. Once goals of care have been confirmed, the team must include appropriate and achievable outcomes in their bedside discussion with the patient and/or family involved throughout the course of patient care (Chapman, 2009).

Participants also identified triage situations and a lack of available and appropriate treatment spaces as causing moral distress. Management and administration are called upon to ensure there are sufficient treatment spaces, as well as policies and guidelines in place related to what defines an appropriate treatment space.

The call for higher levels of hospital administration to provide additional support in morally distressing situations for nurses is reiterated in a number of studies (Corley, Elswick, Gorman, et al., 2001; Pauly, Varcoe, & Storch, 2012). Examples of additional support required in EDs include formal debriefing processes, availability of pastoral care, and individual counselling services

for staff members. Each of the participants indicated they have access to an employee assistance program. However, willingness or interest in utilizing these services was not unanimous.

Timely patient disposition from triage also has implications for ED bed management. Ongoing widespread public education related to appropriate use of health care options is needed to reduce the overall number of patients presenting to emergency departments. While many EDs in the province have transition teams ensuring adequate follow-up care post ED presentation, there are many existing community services that patients are often unaware of that would eliminate the need for the patient to present to the ED in the first place. Essentially, referrals to home-care are effective from ED, but accessing these resources prior to presenting to ED benefits both patients and staffing resources while simultaneously reducing the number of ED visits.

Limitations

The findings of this study need to be considered within the study's context. To that end, it is possible some potential participants may have opted not to participate because they perceived moral distress in their work environment as 'normal.' Others may have felt powerless to change the status quo and so elected not to participate. Others may have elected not to participate due to the potentially sensitive nature of the topic and concern for the emotion and impact the interview might have. While the sample size of 12 participants is appropriate for a study of a specialized area, it is possible that the findings are not representative of the larger demographic. More specifically, the relatively small representation of participants working in rural sites leaves the possibility that the findings do not represent the experiences of rural registered nurses as thoroughly as the urban participants' experiences.

Conclusion

Increasing patient acuity and patient volumes are creating a situation where 'it's about time' results in moral distress for nurses working ED. It is imperative then, that RNs arm themselves with the ability to recognize moral distress and communicate the need for support with their leaders and management. Similarly, organizations must effectively communicate with frontline nurses while providing them with the necessary direction and resources to mitigate these situations.

About the authors

Kevin Reedyk, RN, BN, MSc, has worked in emergency nursing for 13 years, including work as a frontline clinician, an educator and as a manager.

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