Moral Distress

An Invisible Challenge for Trauma Nurses

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ABSTRACT
It is not known how moral distress is experienced by trauma nurses and how it may affect their ability to provide care to their patients. In particular, how does moral distress affect trauma nurses’ ability to perform specific duties when a patient is dying in the specialized trauma unit of the emergency department? This article highlights aspects of moral distress for nurses and proposes specific sources of moral distress in trauma nursing such as futile care. The experiences of trauma nurses are also discussed in relationship to a caring framework of enduring and suffering.

Key Words
Caring, Ethics, Futile care, Moral distress, Trauma, Trauma nurses

CASE STUDY 1
Mary had been working in her hospital's emergency department (ED) for more than 4 years. She had seen many crises come through the ED doors and took pride in her ability to appropriately care for her patients; however, the patient who welcomed her this morning in the early Spring would change her viewpoint dramatically.

At 5:53 AM, a 25-year-old man was brought into the ED, following an execution style gunshot wound to the back of the neck. The patient had massive open cerebral destruction with no chance of recovery or survival. There was no family available or present. The trauma doctor believed that the patient was a possible organ donor, and began to order aggressive resuscitation and medical procedures. These procedures include intubation and managing blood pressure and fluids with intravenous catheters.

Mary was the primary nurse for this patient. She understood that without treatment the patient would die; however, aggressive treatment could salvage his organs for harvesting to be used in other patients. As she worked over the body, she heard her voicing asking whether this type of treatment is really warranted for this patient. Should I be postponing inevitable death in this 25-year-old man purely for the benefit of other patients? And, I am not sure about using another person as a means to an end—is this legitimate? What I am doing to this patient and why?

CASE STUDY 2
Sandy was a new graduate and promptly applied to the ED. She was given a preceptor program and finished with high marks. She was eager to be a part of the ED and felt confident in her skill level.

Several weeks pass by and Sandy was feeling that her nursing was valuable and she felt she might have found a “home” in the ED with her nursing career. However, one warm, summer afternoon a 2-year-old child was brought into the ED after having been found floating in a backyard swimming pool. The paramedics who brought the child in stated that they had found no vital signs when they arrived on scene but they made resuscitative efforts for 20 minutes. Sandy immediately hooks the child up to the monitor and only saw a isoelectric activity. This isoelectric activity alarmed Sandy as she had never seen a child dead before. She has 2 children of her own around the same age. Her heart took a moment to absorb what she was seeing.

Physical examination showed a flaccid child without any signs of cardiac activity or neurological function. Nevertheless, Sandy looked to the Code Blue team and began to attempt to resuscitate. Efforts continued for another 45 minutes. The child still did not respond and efforts were finally terminated.

Sandy lingered longer than usual by the bedside of the dead child, looking at how the child appeared after being “worked on” for so long. She began to question if they had saved the child what kind of life would the child have? Why did they attempt to save the child anyways? She argued to herself; was it to let the parents know they had done everything possible; or was it for the staff? Her head began to spin as she was paged to another resuscitation room with efforts being performed on a 28-year-old woman who was struck by a car in a crosswalk. She left the dead child to help in another case, never really getting the opportunity to emotionally discharge and reason what had just happened.

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INTRODUCTION

There is a need to understand and acknowledge the experiences of trauma nurses who have reported what they consider moral distress, emotional suffering, and endurance in unethical climates. Moral distress has been classically described as a psychological disequilibrium of a negative feeling state experienced when the nurse makes a moral decision and then does not follow through by performing the moral behavior indicated by that decision.\(^1\) Moral distress can be characterized by a particular type of pain affecting nurses' mind-body functioning as well as their relationships with their colleagues and patients. Moral distress results from a situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and then makes a moral judgment about the correct moral action to take. Whether the moral action is real or perceived, the nurse participates in the manner the nurse perceives as morally wrong.\(^2\) The concept of moral distress was first studied and described by Jameton\(^6\) in 1984. He described it as the psychological disequilibrium associated with knowing the ethical/appropriate action to take but not being able to.\(^9\)

A significant gap exists in the current literature about understanding the trauma nurse's interpretation of moral distress. This lack of literature may contribute to overlooking critical aspects of a trauma nurse's life that influence how they cope with the challenges of their practice environment. For example, a trauma nurse's awareness of boundaries may enhance self-reflective practice; this, in turn, could influence relationships among human caring, self-worth, and emotional stability in trauma nurses' practice and personal lives. Focusing on moral distress could also enable trauma nurses to articulate the emotional process and stages they experience when faced with morally challenging patient dilemmas.

MORAL DISTRESS IN NURSING

Much like what happened to Mary and Sandy, nurses experience moral and ethical situations revolving around distressing patient care dilemmas.\(^5\)\(^,\)\(^9\) The ways in which nurses interpret and define the patient care dilemma of moral distress and emotional suffering have been shown to affect patterns for both conscious and unconscious cognitive coping behaviors and their ability to manage and provide professional standard of care for their patients.\(^8\)

Moral distress is widely accepted as a contributing factor to nurses' loss of integrity, dissatisfaction with their work, and problems with nurse-patient and nurse-management relationships.\(^1\)\(^0\) Morally distressing situations are inescapable in the ED. Today's trauma nurses also face their vulnerability to violence in the workplace,\(^7\) and multiple sources of stress may deepen the burden of a potentially volatile work environment. The cost paid from unattended moral distress is significant when nurses leave their high acuity positions or even leave the nursing profession altogether.\(^8\)\(^,\)\(^11\) Nurses communicate at times they cannot identify their feelings and how to manage what they consider moral distress.\(^12\) As well, many nurses, like Sandy, may also not know how to reason and reflect on ethical dilemmas happening around them.\(^13\) These components may affect quality of care, quantity of time worked as a nurse, and rising costs of nursing care.\(^1\)

Moral distress has been found to be a common experience among nurses. In 2000, in a study conducted by Redman and Fry,\(^13\) at least one third of the nurses reported having experienced moral distress. Nearly 50% of nurses in Rushton and Scanlon's study\(^13\) stated that they acted against their conscience. Examples included watching residents and medical students "practice" painful procedures on their patients with unnecessary and/or multiple attempts at intubation, in order to try out different instruments.

In 2004, the American Association of Critical-Care Nurses (AACN) officially recognized moral distress as a serious problem in today's critical care units. By officially recognizing moral distress, the AACN is trying to give nurses tools to recognize and to address moral distress on an individual basis as well as in the workplace. In their education module on moral distress the AACN Ethics Work Group of FY04 developed the 4 A's to Rise Above Moral Distress.\(^16\) The primary focus of this document is ICU nurses and moral distress in the context of longevity of futile care. However, this emphasis on moral distress could provide the foundation for the next step of detailing how the information could apply to trauma nurses and the type of moral distress that may result from aggressive resuscitation on trauma patients.

Metzger and Huckabay\(^17\) studied burnout, futile care, and occupational hazards for critical care nurses in 60 critical care nurses who worked full-time in an intensive care unit, cardiac critical care unit, or a neurological intensive care unit for at least 1 year. Maslach and Jackson\(^18\) noted that exhaustion leads to burnout in critical care nurses and was correlated with the frequency that nurses were involved in life-sustaining interventions that conflicted with their values, standards, and beliefs about ethically appropriate treatments.\(^19\) They also discovered that frequency of life-sustaining interventions influenced emotional exhaustion and burnout. The data about frequency are particularly pertinent for trauma nursing. A trauma nurse's role is to deal with one life-saving intervention after another, often leaving one with no time to debrief or regroup before another trauma patient needs attention. Trauma nurses who face crises every shift, every hour, and every patient often experience unparalleled intensity in their daily work.
In 2002, a study by Fry et al.\(^{19}\) of military nurses explored how military nurses experience the dimensions of moral distress. The specific objectives of the study were to (1) identify moral distress in military nursing, (2) construct a model and development of a tool for measuring the moral distress among military nurses, and (3) identify the dimensions of moral distress experienced by military nurses. Fry et al used the conceptual definition of moral distress from research by Jameton\(^6\) and Wilkinson\(^1\) as the foundation for the study.\(^{20}\) Researchers interviewed 13 nurses, and their stories of moral distress were elicited from the participants using a semistructured interview guide. They addressed military nurses’ deployment conditions that prompted moral distress. These various conditions were unique setting, dangerous environment, atypical patient conditions, and military triage. They asserted that these conditions place military nurses at risk to experience moral distress. Furthermore, studies demonstrated that military nurses who are expected to maintain a high readiness capability to be able to perform at peak efficiency, for long periods of time under uncertain conditions, led to moral distress.\(^{21}\)

The work of trauma nurses may be similar to crisis deployment of military nurses who face conditions such as unique setting, dangerous environment, atypical patient conditions, and military triage. They assert that these conditions place military nurses at risk to experience moral distress. Furthermore, studies demonstrated that military nurses who are expected to maintain a high readiness capability to be able to perform at peak efficiency, for long periods of time under uncertain conditions, led to moral distress.\(^{21}\)

Futility is a situation that arises frequently in some nursing environments and can be a significant dimension of moral distress. Participating in futile care situations in the ED is impossible with the large number of patients and the broad range of circumstances. An act is considered futile if its goals are not met and its degree of success is empirically poor.\(^{15}\) Futile care is defined as aggressive “treatment” or interventions such as the use of life-support therapy in terminally ill or trauma accident patients who are unlikely to survive or have a successful outcome.\(^{20}\) Moral distress is often associated with situations of futile care in the critical care environment.\(^{21}\) When patients approach the end of their life, the perception gap of futile care widens between the physicians and nurses because of the differences in their professional roles.\(^{22}\) Critical care nurses’ perceptions of the nature of futile care are associated with experiencing moral distress and emotional exhaustion, which in turn may lead to burnout.\(^{17}\)

The incidence of futile care in EDs will only continue to rise along with technical advances in medicine and the growing number of trauma patients who are exposed to aggressive care before being allowed to die. An example of futile care would be performing cardiovascular resuscitation on a patient with a gunshot wound to the head. Performing cardiovascular resuscitation would be a physiologically futile act, and such resuscitation may be withheld because the probability of success would be zero. Philosophical and ethical discussions have explored whether heroic treatments in cases as the example described previously are viewed as prolongation of life or prolongation of death.\(^{17}\)

**EDS, RESUSCITATION ROOMS, AND TRAUMA NURSES**

The nature of care provided and the work nurses perform in EDs and resuscitation rooms are a primary source of moral distress experienced by trauma nurses. The ED represents a kind of cultural zone of protection—the center of our collective line of defense against the terrifying arbitrariness with which misfortune is distributed among us.\(^{23}\) The ED is primarily the place for sudden unforeseen events that have befallen upon people in our communities. Within most EDs is a resuscitation room that can be the portal between life and death. It is the place where helplessness emerges from both the patient and the nurse. Rescue is not always possible, and the undeniable truth that death is imminent for all looms around every drawn curtain. It is the place trauma nurses are expected to take action over morally laden questions about how and why, harm and benefit, rights, and responsibilities when seconds count in saving a patient's life.

Death and trauma in a resuscitation room is almost always considered a tragic accident, regardless of whether it was caused by a cardiac arrest, a car crash, or some other catastrophic, unforeseen event. Stress is commonly experienced by nurses working in high acuity settings like the ED resuscitation room and continues to be a problematic source of emotional suffering.\(^8\)

Nurses are expected to perform painful procedures, to bear witness to their patients’ personal crises, to face death and mayhem—all while maintaining emotional control and professional proficiency. This situation is particularly common for trauma nurses. For example, the trauma flight nurse inserts a finger into a trauma patient's stab wound to gauge the depth. There is often no time to anesthetize the patient; however, the action can be necessary to understand what anatomy was involved and whether or not the patient needs surgery. Another example would be a low-caliber gunshot wound to the chest with no exit wound. The chest would need to be opened by force in order to assess the damage from a ricocheting bullet.

Trauma nurses are challenged every day to deal with their own emotional issues, while providing emergency
care, which plays a key role in a patient's survival. The moral distress experienced by a trauma nurse may be different from other forms of distress. It may occur simply from the visual grotesqueness witnessed during resuscitation like in Sandy's case. Furthermore, it may involve an irreconcilable conflict about ethical commitments and the actions needed to find peace among the troubling dilemmas in a matter of seconds, for example, in Mary's case. These nurses are expected, by cultural norms within the ED and inside the resuscitation room, to show strength by suppressing emotional outbursts and not becoming emotionally involved in any aspect of patient care, even life-sustaining resuscitative details. This type of practice culture is a fertile environment for moral distress to live and flourish within trauma nurses.

The expectations of trauma nurses themselves or coworkers could lead to being caught in a stressful vortex of serious moral problems and dilemmas. For example, dynamic reactions, like posttraumatic stress disorder, could occur in nurses during exposure to traumatic events. They are in proximity of the patient, participating in what is perceived as futile care, working with heroic resuscitation efforts that fail, or by witnessing an unexpected sudden painful death.

Many trauma nurses fight consciously to maintain emotional control whenever any of these unforeseen catastrophes enter the ED. Trauma nurses must choose emotionally between getting through a horrific moral dilemma and not getting through the event. Incredible stress is pressed upon the trauma nurse to perform in morally charged situations in an attempt to save their patients' lives. When seconds are all these nurses have, there is no time to premeditate or look inward; they must perform—whether or not they agree with the care practices that are carried out in the situation immediately unfolding around them.

THE APPLICATION OF CARING CONCEPTS TO THE PRACTICE OF TRAUMA NURSES

Two well-known caring concepts in the practice of nursing may help further articulate and explain the role of moral distress in trauma nursing: enduring and suffering.

Enduring

Enduring is derived from the Latin word meaning "to last" and refers to the different ways humans “get through” extraordinary stressful physical or psychological conditions and remain intact. No one knows what they are capable of enduring until the moment arrives. In 1996, Morse and Carter reported that enduring is not a learned response of the human condition; it is not practiced, yet every person has the ability to endure. However, most situations that need enduring are done out of instinct or reflex when a person feels that their physical or psychological integrity is being threatened.

In order for trauma nurses to carry out their mission of trying to defeat death, they create a “cultural zone”—a place where work is endured and where trauma nurses consciously fight to maintain emotional control. Trauma nurses may perceive enduring as “being strong” and essential to maintain in the cultural norm within the ED. Enduring is a stoic state in which emotions are restrained when trauma nurses have no choice but to get through the situation. It is important to clarify the essential characteristics of enduring as the absence of emotion. When trauma nurses endure, they are literally holding themselves together. Their actions may lead to performing on patients and the scenes they are witnessing. According to Rushton, these actions can lead to psychological scarring.

Past research has linked enduring and suffering to “career suicide” in the resuscitation room during a rescue. Badger and O’Conner discussed that affective release in suffering. This opportunity could be helpful for trauma nurses to carry out their mission of trying to defeat death, they create a “cultural zone”—a place where work is endured and where trauma nurses consciously fight to maintain emotional control. Trauma nurses may perceive enduring as “being strong” and essential to maintain in the cultural norm within the ED. Enduring is a stoic state in which emotions are restrained when trauma nurses have no choice but to get through the situation. It is important to clarify the essential characteristics of enduring as the absence of emotion. When trauma nurses endure, they are literally holding themselves together. Their actions may lead to performing on patients and the scenes they are witnessing. According to Rushton, these actions can lead to psychological scarring.

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SUFFERING
Morse and Carter refer to nurses as the “caretakers of suffering” and define suffering as the distress brought on by the actual or perceived impending threat to the integrity of the nurse. The important aspect of this definition is the future-orientated perspective of “threat” in relation to the nurse and its concept of inescapability for the trauma nurse.

Suffering, to a nurse, is the emotional response to the phenomenon that is witnessed or endured. Suffering is a highly emotional state where emotions are freely expressed and visible to others that are around. However, because of the “cultural zone” in which trauma nurses work, they are unable to express their own suffering. Through rare moments of acknowledgment (not acceptance), it is possible that trauma nurses temporarily feel suffering by emotional releasing and then quickly return to the nonemotional state of enduring. This process could serve as a coping strategy for occupational survival.

It is agonizing to bear witness to another human being’s suffering. It has been common practice to associate the word suffering with something unpleasant, painful, and even agonizing. Malone found that witnessing someone’s suffering is qualitatively distinct from mere looking. Malone conceded when a nurse witnesses human suffering, it engages the nurse to a level of guttural truth that cannot be described. In the midst of tragedy and death—in the midst of life—perhaps meaning is threatened, as well as a trauma nurse’s sense of hope, safety, and security.

It must be emphasized that the difference between enduring and suffering is not found in the act of suffering but in the nurse’s relationship with both elements. Enduring and suffering are not considered morally evil or morally good. However, bow the pain in enduring and suffering is qualified in meaning by a trauma nurse may point to characteristic traits that could help nurse leaders better retain, educate, and morally support their prized staff.

DISCUSSION
This article has described the role of moral distress in trauma nursing and argued that more research is needed to identify critical intersections in a trauma nurse’s life that may contribute to the development of approaches to assist trauma nurses to cope with the challenges of their practice environment. Research needs to explore how trauma nurses endure and suffer, while witnessing traumatic events, and test strategies to intervene. Studies are needed to generate evidence-based strategies that may improve the lives and patient care outcomes and sustain the longevity of the trauma nurses’ careers, which is paramount for nurse scientists.

Helping trauma nurses recognize moral distress and its harmful effects on their lives is critically important. As trauma nurses learn to recognize highly volatile and morally, ethically charged dilemmas, they may become more effective in finding skills within themselves to maintain a sense of well-being and balance. Taking time to process what has just happened in a resuscitation room, feel its impact, put things into perspective, learn to prudently care, and respectfully move forward is essential for maintaining psychological health. All these skills need to be honed in a trauma nurse as skillfully and artfully as identifying a cardiac rhythm.

Recognition of organizational ethical dilemmas that may lead to an influential rise in moral distress in trauma nurses is essential for health care organizations. Leaders need to fully understand the implications of losing the skills of these highly trained nurses. Educators could also contribute to prevention efforts and enhance the foundation that nurses bring to recognize and cope with moral distress as a key component of practice.

Acknowledging and understanding moral distress in trauma nurses is likely the first step toward transforming suffering into compassionate action. An ethical practice environment supports nurses, requires attention be paid to the way of caring, and provides resources specifically related to moral distress, burnout, and workplace violence. Improving an ethical workplace is critical for addressing highly morally charged situations, gaining job satisfaction, and bringing down turnover rates of nurses. -

In the end, as with all unresolved ethical issues, the quality of patient care deteriorates. Advocacy of the patient has always been the shared vision among all nurses and is a nursing-role obligation. We must prepare and support emotional and mentally healthy nurses to sustain this vision.

REFERENCES
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