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Relationships of Moral Distress Among Interprofessional Healthcare Providers in Four ICU's

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Purpose:

Moral distress was initially identified as a uniquely nursing-centric phenomenon wherein the nurse knows the right thing to do but cannot act upon the right course of action due to internal constraints (Jameton, 1984). Since Jameton's initial definition, healthcare professionals have recognized that nurses are not alone in experiencing moral distress. In fact, the phenomenon has been reported in all healthcare professionals regardless of their professional role. Feelings of moral distress can significantly impact the interactions between patients and providers and result in adverse patient outcomes (Ulrich, Hamric & Grady, 2010; Hamric, Borchers & Epstein, 2012; Bruce, Miller, & Zimmerman, 2015). Professionals in the Intensive Care Unit (ICU) are particularly at risk of developing moral distress due to the severity of patient illness, the intensity of patient treatment, and the conflict-ridden nature of the daily interaction between patient, family and provider (Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015). In these high stakes settings where patients are at the brink of death, ethical conflicts and failed communication occur frequently (Hamric & Blackhall, 2007). As such, the relationships of moral distress, team dynamics, and team communication, are important issues for interprofessional teams caring for patients in all ICU settings where complex care decisions are frequently made and carried out.

Current research suggests that poor team communication can lead to moral distress and can result in compromises in patient safety leading to adverse patient outcomes (Hamric et al., 2012). While poor communication among interprofessional teams is not new in adult and pediatric clinical settings, its contributing role in the development of moral distress has only recently been considered. This may be due to the previous narrow definition and focus of moral distress in ICU nurses or the inability to examine the perspectives of healthcare professionals across all disciplines. When interprofessional adult and pediatric healthcare teams have been studied, moral distress due to poor team communication has been identified as an anecdotal factor instead of the study's focus (Hamric et al., 2012; Ulrich et al., 2010). Recent research involving interprofessional teams reveals that they may experience moral distress due to interprofessional conflicts and poor team communication (Bruce, Miller & Zimmermann, 2015).

Commonly, ethical conflicts within healthcare teams resulting in moral distress occur due to providers having their own sets of values and moral commitments that may conflict with another team member's value system (Fiester, 2015). However, the most common external factors contributing to moral distress among healthcare professionals involve organizational constraints such as: a lack of interprofessional collegiality, perceived hierarchical structure of the healthcare organization, and poor team communication (Hamric et al., 2012). Only recently has research examined the contributing factors of moral distress among interprofessional healthcare teams. The findings of these studies reveal that interprofessional teams may experience moral distress due to intra-team dynamics and poor communication (Bruce et al., 2015). The existing research is limited in that it could not differentiate how adult and pediatric healthcare professionals perceive team-based factors differently, based on their respective backgrounds and professional role.

The development of moral distress due to poor team communication can lead to professional burnout and errors in patient care, resulting in permanent patient harm or death (Whitehead et al., 2015). In the ICU setting, where the stakes are high, the ability to communicate effectively, may be one of the most significant factors in a patient's outcome. When ICU teams fail to communicate effectively, patients and healthcare professionals suffer. Patients may die as a result of failed communication and healthcare providers may suffer emotionally and professionally either leaving the profession or suffering moral distress (Epstein & Hamric, 2009; Hamric et al., 2012). As such, moral distress is a global issue for

interprofessional teams caring for patients in the ICU setting where complex care decisions are made and carried out.

Methods:

Six parallel versions of the moral distress scale-revised (MDS-R) developed by Hamric, Borchers, & Epstein (2012), were used to measure moral distress in adult and pediatric ICUs among RNs, physicians, and other healthcare providers. This descriptive, cross-sectional, correlational study using survey methodology examined the relationships between moral distress, team communication, and team dynamics among interprofessional healthcare providers working in four ICU's at a single medical center hospital in Houston, Texas. A total of 697 health professionals were invited to participate in the study. A total of 223 individuals from the adult and pediatric ICU's completed and returned the MDS-R survey. Data was collected between November 2017 through December 2017. The survey completion rate was 32%. Participants included healthcare professionals who were consistently assigned to work in an adult trauma ICU, a medical ICU, a pediatric ICU, and a neonatal ICU. The six professional groups participating in the study included direct care staff RNs and advanced practice registered nurses (APRNs) working in the ICU, residents, fellows, and attending physicians admitting patients in the ICU, dieticians, social workers, respiratory therapists and clergy who are assigned to work in the designated ICU's. The study included 96 RNs, 79 physicians, 6 social workers, 26 respiratory therapists, 10 clergy, and 6 dieticians. After in-person recruitment on the unit, paper MDS-R surveys were handed out to participants based on their professional role and ICU setting. Completed surveys were collected daily from a locked drop box on each unit.

Measures. Moral distress. A 21-item Moral Distress Revised (MDS-R) survey was used to measure moral distress using six parallel versions designed for adult and pediatric nurses, physicians, and other healthcare professionals (Hamric et al., 2012). Composite MDS-R scores are calculated by summing each of the survey's 21-items frequency and intensity scores. Composite scores for the 21-item MDS-R range from 0 to 336. Two dichotomous questions are posed at the bottom of each MDS-R survey to assess the intent of the healthcare professional to leave a position now or in the past: "Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?" and "Are you considering leaving your position now?" Two additional questions were added to the MDS-R to examine the role of team dynamics and team communication contributing to the development of moral distress. These questions were added to the MDS-R to gain the participants perspective on the extent to which team dynamics and team communication have on the development of moral distress. These questions asked, "Team dynamics has affected my level of moral distress" and "Team communication has affected my level of moral distress". The questions were answered on a scale of Strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree.

Demographic survey. The demographic questionnaire collected participants' age, education, specialty certification, professional role, years of ICU experience, gender, unit, and employment status.

Data analysis: The MDS-R results were manually imported into an IBM SPSS version 24 statistical software. Moral distress scores were calculated for all participants. Descriptive statistics were conducted to describe the sample and examine mean and composite MDS-R scores among healthcare professionals. One-way Analysis of Variance was computed to determine differences in mean MDS-R with demographic characteristics. An Independent Sample Student's *t* test was performed to examine the difference in mean MDS-R scores between specialty certification and gender. Spearman's Rank Order correlation coefficient test was conducted to determine the relationships between mean MDS-R scores and responses to team dynamics and team communication.

Results:

Participant composite MDS-R scores ranged from 2-229, indicating low to moderate moral distress among all professional roles. Significant differences in mean MDS-R scores ($F = 4.105$, $p = .001$) were

found between professional roles. Mean MDS-R scores were highest in respiratory therapists and RNs compared to dieticians. Significant differences in mean MDS-R scores between levels of education (F= 5.849, p = .001) and years of ICU experience (F = 3.180, p = .009) was found. Independent Sample Student's t tests found no statistically significant difference in mean MDS-R scores between participants who earned specialty certification versus those who had not (t (221) = -.16, p = .872) or gender (t (221) = 1.6, p = .107) despite female participants reporting composite MDS-R scores 10 points higher than males (t (221) = 1.6, p = .107). A significant relationship between mean MDS-R scores and team dynamics (r_s = .423, p = .000) and team communication (r_s = .447, p = .000) was found.

Conclusion:

This descriptive, cross-sectional study builds on previous studies examining moral distress and interprofessional teams. This study deliberately addresses the relationships of team dynamics, team communication and moral distress development. Over half of the participants agreed that adverse team dynamics and poor team communication contributed to their moral distress. Previous studies have examined team communication and team dynamics factors anecdotally. A purposeful examination of these factors allows for a more complete examination of moral distress within healthcare teams above and beyond the 21-item MDS-R survey items. Findings of this study suggest that all professional roles, regardless of decision-making authority, experienced moral distress and that future interventions to reduce moral distress should focus on interprofessional team dynamics and team communication.

Title:
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Keywords:
Interprofessional Team, Moral Distress and Team Communication

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Abstract Summary:
Using a purposeful sample of 223 healthcare professionals working in four ICUs, this study examines the relationships of moral distress among interprofessional ICU teams. Moral distress was found among all professional roles with significant differences seen between direct and indirect healthcare providers.

Content Outline:
Introduction

1. Review the literature on moral distress among interprofessional ICU teams.
2. Discuss how interprofessional collaborative relationships are impacted by the development of moral distress.
3. Discuss clinical implications of moral distress among interprofessional ICU teams.
4. Analyze and discuss factors impacting moral distress including team communication and team dynamics among interprofessional ICU teams.

Methods

1. Discuss current research on moral distress in the healthcare setting.
2. Give an overview of the design, measures, and data analysis used in this descriptive study.

Results

1. Show tables with results from analysis of One-way ANOVA and discuss significant findings.
2. Show tables with Independent Sample Student's *t* tests findings and discuss findings.
3. Show tables with results from Spearman's Rank Order correlation coefficient and discuss significant findings.

Discussion

1. Explain how findings of this study build on previous studies supporting the association between moral distress development and interprofessional team dynamics.
2. Discuss association between moral distress and interprofessional team relationships and implications for moral distress development in the ICU setting.
3. Discuss potential future interventions to reduce moral distress among interprofessional teams focusing on team dynamics and team communication.

Conclusion

Discuss the relationships between moral distress, team communication, and team dynamics among interprofessional teams.

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