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The Intensity and Frequency of Moral Distress Among Different Healthcare Disciplines

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ABSTRACT

Introduction

The objectives of this study are to assess and compare differences in the intensity, frequency, and overall severity of moral distress among a diverse group of healthcare professionals.

Methods

Participants from within Baylor Health Care System completed an online seven-point Likert scale (range, 0 to 6) moral distress survey containing nine core clinical scenarios and additional scenarios specific to each participant's discipline. Higher scores reflected greater intensity and/or frequency of moral distress.

Results

More than 2,700 healthcare professionals responded to the survey (response rate 18.14 percent); survey respondents represented multiple healthcare disciplines across a variety of settings in a single healthcare system. Intensity of moral distress was high in all disciplines, although the causes of highest intensity varied by discipline. Mean moral distress intensity for the nine core scenarios was higher among physicians than nurses, but the mean moral distress frequency was higher among nurses. Taking into account both intensity and frequency, the difference in mean moral distress score was statistically significant among the various disciplines. Using *post hoc* analysis, differences were greatest between nurses and therapists.

Conclusions

Moral distress has previously been described as a phenomenon predominantly among nursing professionals. This first-of-its-kind multidisciplinary study of moral distress suggests the phenomenon is significant across multiple professional healthcare disciplines. Healthcare professionals should be sensitive to situations that create moral distress

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for colleagues from other disciplines. Policy makers and administrators should explore options to lessen moral distress and professional burnout that frequently accompanies it.

BACKGROUND

Moral distress in healthcare was first described by Jameton as a phenomenon unique to nursing.[1] He defined moral distress as painful feelings and/or the psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires but cannot follow through with that action because of institutional obstacles. Stated more broadly, healthcare professional moral distress may be felt when a professional (who has taken an oath to serve the good of the patient) believes he or she knows the ethically correct action but cannot follow that action because of some constraint, whether interpersonal (with colleagues, patients, or families) institutional, regulatory, or legal.

Most of the research on moral distress has been among nurses, reflecting nurses' feelings about situations of "medical futility" and the overall ethical climate of healthcare delivery.[2] Among nurses, unresolved ethical conflicts and moral distress lessen job satisfaction and cause burnout. In one study, 25 percent of nurses experienced moral distress to the point of wanting to leave a current position; another study revealed that 15 percent of nurses had resigned from a position because of moral distress, and there are other reports that some nurses have left the profession entirely as a result of moral distress.[3]

But what about moral distress among other medical professionals? If one accepts the premise that the best healthcare delivery is provided in a collegial, team-based fashion, it is important that all team members understand not only the technical role of each professional, but also the ethical challenges perceived from different professional standpoints. In the moral life of the healing professions, physicians should better understand how the attitudes they carry or the orders they write affect a nurse, social worker (SW), or other team members; however, other team members should also understand the ethical challenges that physicians perceive.

Although members of multiple healthcare disciplines, including physicians, have privately expressed moral distress to clinical ethics consultants, only one study was found exploring moral distress among physicians,[4] one among SWs,[5] and one among pharmacists.[6] No studies of moral distress among other allied health professionals, including therapists, nutritionists, or hospital chaplains, were found.

With this background in mind, the authors set out to explore differences in the intensity and frequency of moral distress among healthcare professionals (physicians, residents, nurses, SWs, chaplains, therapists, and pharmacists) and how different clinical situations affect moral distress by discipline.

METHODS

Setting

This study was conducted among healthcare professionals working within Baylor Health Care System (BHCS), a nonprofit organization serving approximately 1.4 million patients annually. Based in the Dallas-Fort Worth Metroplex, BHCS comprises 27 hospitals ranging from a 1,000-bed tertiary care referral center to a 50-bed rural hospital, more than 100 primary and specialty care centers, more than 4,500 affiliated physicians, and more than 10,000 employed nurses and allied health professionals.

Instrumentation

Corley and colleagues developed a Moral Distress Scale and documented its validity and reliability in an effort to explore, measure, and better understand nurses' moral distress and its consequences, primarily in the hospital setting.[7] The Baylor University Medical Center Clinical Ethics Committee and BHCS Clinical Ethics and Palliative Care Council modified, adapted, and expanded Corley's Moral Distress Scale to address situations encountered by physicians (attendings), residents (physicians in training), nurses (RNs), pharmacists (RXs), physical therapists (PTs), occupational therapists (OTs), respiratory therapists (RTs), speech therapists

(STs), nutritionists, social workers, and chaplains (see figures 1 and 2). Intensity and frequency were independently scored by respondents on a seven-point Likert scale (range, 0 to 6). Respondents were allowed to score the intensity of each situation item even if they had experienced the situation infrequently or never, because the intensity, rather than the frequency, of certain situations tends to have a lasting effect on one's level of distress. The moral distress survey instrument consists of nine core clinical scenarios that are applicable to all professions, and additional scenarios designed to address the uniqueness of each discipline's potential moral distress encounters, based upon the ethics committee's 25 years of ethics consultation. High scores reflected extreme intensity or frequency of the moral distress situations. The survey took approximately 15 minutes for participants to complete.

An initial cover email described the nature of the moral distress survey and addressed all informed consent criteria via an invitational site link. Informed consent was implied once participants chose to proceed past the cover page. Participants had the option to start the survey, stop, and then return to complete the survey at a later time. The participants could complete the survey only one time, which protected against multiple surveys by a single participant. After two weeks, three weekly reminders requesting participation were sent before the survey was closed.

Only results related to the nine core clinical scenarios that were common to all participants are reported and analyzed in this article. Scores for moral distress intensity and frequency were compiled for each core scenario by an individual respondent. Then the mean moral distress intensity and frequency scores were calculated for each core scenario item by professional job role (see table 1). Composite mean moral distress intensity and frequency ratings for the nine core scenarios were then calculated by professional job role (see table 2). Finally, a total moral distress score was calculated for each of the nine core items by multiplying each respondent's moral distress intensity rating by his or her moral distress frequency rating on each core scenario (maximum score 36). These scores were summed and averaged by professional job role to create a total moral distress score by job role (see table 3).

Data Analysis

Statistically significant differences in mean moral distress score by age, sex, years of service in the system, and years of service in the current job were tested using the Kruskal-Wallis nonparametric test. Statistical significance was defined as $p<.05$ with a two-tailed test. The analysis of variance (ANOVA) procedure was run to test for statistically significant differences in mean moral distress scores by job role and by demographic characteristics within each job role. Finally, Cronbach's *alpha* was estimated to measure the reliability/internal consistency of the moral distress intensity and frequency scales used for the nine core scenarios.

Categorical variables are expressed as percentages and continuous variables as the mean ±SD (standard deviation), unless otherwise stated. SAS statistical analysis software was used for data analysis.[8]

RESULTS

Demographics

A total of 2,271 healthcare professionals responded to the survey, including > 2,000 nurses and > 200 physicians. The survey response rate was 18.14 percent across BHCS (see table 4). Response rates by job role ranged from 5.17 percent (physicians) to 47.92 percent (SWs), with the two largest groups of respondents, nurses, and therapists, comprising approximately 86 percent of all participants. At least one reason for the low response rate by physicians was a previously unrecognized problem with inaccurate email addresses. Although physicians' response rate was low, the total number responding represents the largest number of physician respondents to a moral distress study yet published.

The participants' demographics are reported by job role in table 5. Demographics were not available for MDs and residents, who are not employees of BHCS. Women aged 30 to 49 years

working full time made up the majority of nurses, RXs, SWs, and therapists; men aged 60 years and older, working full time, were the largest demographic among chaplains. Average years of service ranged from 5.9 to 8.4 years; the largest proportion of clinical staff had been in service for one to four years.

Statistical Analysis

Cronbach's *alpha* for both moral distress intensity and frequency scales revealed high internal consistency at *alpha* = 0.88 and 0.91, respectively, thus confirming the nine core scenarios had good internal consistency. The ANOVA revealed statistically significant differ-

Figure 1. BHCS moral distress survey: nine core questions

BHCS Moral Distress Survey

In these times of turmoil within healthcare, your clinical ethics committees across Baylor Health Care System are concerned about levels of moral distress among all healthcare professionals. We are asking physicians, nurses, social workers, chaplains, pharmacists, therapists and others to complete this anonymous survey. The information will be used to help our clinical ethics committees work with medical and administrative leadership to better understand any feelings of moral distress which healthcare professionals may perceive in their work and to lower its intensity if possible.

Moral distress may be felt when a person believes they know the ethically correct action to take but cannot carry out that action because of some constraint. Constraints may be perceived as interpersonal (with colleagues, patients, or families), institutional, regulatory, or legal.

This survey is designed to measure your perception of moral distress related to your work within healthcare in two dimensions:

1. The intensity level of any moral distress you perceive in your work
2. The frequency of the situation(s) causing you moral distress

The following clinical scenarios may or may not cause moral distress for you. Based upon your past two years at Baylor (or whatever amount of time you have been at Baylor if less than 2 years), please respond to each situation by noting:

1. The intensity with which you have experienced moral distress where 0 = no moral distress at all and 6 = a great amount of moral distress
2. The frequency with which you have experienced the particular moral distress causing scenario where 0 = never and 6 = very frequently.

Please note that all persons will be asked to answer certain common scenarios, after which physicians; nurses, pharmacists and other therapists; and social workers/chaplains will each have their own unique sections of the survey to take.

Clinical scenario: all professionals	Intensity of of distress 0 1 2 3 4 5 6	Frequency of distress 0 1 2 3 4 5 6
I follow the patient's wishes for treatment even when I do not think it is the right thing to do.		
I follow the family's wishes for patient treatment when I do not think it is the right thing to do.		
I participate in starting or maintaining life-sustaining treatments when I do not think it is right to start or maintain such treatment.		
I participate in withdrawing or withholding life-sustaining treatments when I do not think it is right to stop such treatment.		
I participate in the discharge of patients who I do not believe are medically ready for discharge.		
I participate in the discharge of patients into circumstances of inadequate social support.		
I provide different treatment for those who can afford to pay or have insurance than for those who lack insurance or cannot pay.		
I provide better treatment for U.S. citizens, regardless of the ability to pay, than I provide for undocumented immigrants.		
I participate in hiding information, especially bad news, from patients because of family requests.		

Figure 2. BHCS moral distress survey: profession-specific questions

Clinical scenario: physicians only	Intensity of of distress 0 1 2 3 4 5 6	Frequency of distress 0 1 2 3 4 5 6
I start or maintain life-sustaining treatment at patient request even when I do not believe it is in the best interest of the patient. I start or maintain life-sustaining treatment at family request even when I do not believe it is in the best interest of the patient. I start or maintain life-sustaining treatment at family request because I fear a lawsuit. I order or participate in CPR in terminally or irreversibly ill patients that I believe won't work. I order or participate in PEG placement in terminally or irreversibly ill patients that I believe will only prolong dying. I order withholding or stopping life-sustaining treatment at patient request. I see that sometimes living wills are ignored. I order withholding or stopping life-sustaining treatment at family request because I fear a lawsuit. I order withholding or stopping life-sustaining treatment because of pressure from fellow physicians. I order withholding or stopping life-sustaining treatment because of pressure from nurses. I order withholding or stopping life-sustaining treatment because of pressure from social workers or care coordination. I order withholding or stopping life-sustaining treatment because of pressure from insurance carriers or patient inability to pay. I order withholding or stopping life-sustaining treatment because of pressure from the ethics committee.		
Clinical scenario: residents only		
I participate in starting or maintaining treatments, including CPR, even when I do not believe such treatments are in the patient's best interest because the attending physician has told me to do so. I participate in withholding or stopping treatments, including CPR, even when I do not believe such withholding or stopping is in the patient's best interest because the attending physician has told me to do so. I carry out work assignments for which I do not feel adequately trained. I practice medical procedures such as intubation or line placementr on the newly deceased without permission from the family. I practice medical procedures such as intubation or line placement on the newly deceased with permission from the family.		
Clinical scenario: RNs and other therapists (PTs, OTs, STs, RTs, nutritionists, pharmacists)		
I carry out orders for tests or treatment that I do not believe are in the interest of the patient. I assist a physician who performs a test or treatment without informed consent. I ignore situations in which patients or families have not been given adequate information to insure informed consent. I carry out work assignments for which I do not feel adequately trained. I work with levels of staffing that I consider unsafe. I observe without taking action when patients have poorly treated pain. I provide treatment that does not relieve the patient's suffering because I fear increasing doses of pain medication will harm the patient. I provide treatment that does not relieve the patient's suffering because the physician fears increasing doses of pain medication will harm the patient. I observe without taking action when healthcare personnel do not respect patient privacy. *(continued next page)*		

ences in the mean moral distress score among job roles, and Tukey's *post hoc* test identified nurses and therapists as the two job roles with significantly different mean moral distress scores (see table 3). Nurses had the highest mean moral distress scores, followed by SWs, residents, MDs, chaplains, RXs, and therapists.

Mean moral distress intensity and frequency ratings for each of the nine core scenarios are displayed by job role in table 1. Respondents in all job roles consistently rated moral distress intensity higher than frequency. The mean moral distress intensity rating across all nine scenarios was both highest and equal among physicians, chaplains, and SWs, and was closely followed by that of nurses and resident physicians (see table 2).

Physicians ranked their source of greatest moral distress intensity as having to follow families' wishes for patients' treatment when the physician did not think it was the right thing to do. Residents and nurses follow physicians' orders and, not surprisingly, rated the item "I participate in starting or maintaining life-sustaining treatment when I do not think it is right" as causing the highest intensity of moral distress. On the other hand, discharging patients into circumstances of inadequate social support caused the greatest moral distress among RXs, SWs, and therapists; chaplains' greatest moral distress surfaced when they participated in the discharge of patients whom they did not believe were medically ready for discharge.

Although intensity of moral distress was similar among physicians and nurses, nurses experienced moral distress more frequently, and mean moral distress scores by job role were highest among nurses, followed by SWs, then residents (see table 3 and figure 3). These professional group differences in mean moral distress scores, however, reached statistical significance only between nurses and therapists. This was due in part to the larger sample sizes available in these subgroups.

Figure 2. *continued*

Clinical scenario: RNs and other therapists (PTs, OTs, STs, RTs, nutritionists, pharmacists)	Intensity of of distress 0 1 2 3 4 5 6	Frequency of distress 0 1 2 3 4 5 6
I follow physician or family orders not to disclose information to patients, even when I believe the patient is competent. I participate in the treatment of demented patients who have had a G-tube inserted that I believe may not have been in the patient's best interest. I participate in the discharge of patients who I do not believe are ready for discharge.		
Clinical scenario: SWs and chaplains		
I observe without taking action when healthcare personnel do not respect patient privacy. I observe without taking action when healthcare personnel are not respectful of a patient's culture or religious faith. I follow physician or family orders not to disclose information to patients, even when I believe the patient is competent. I participate in the treatment of demented patients who have had a G-tube inserted that I believe may not have been in the patient's best interest. I participate in the discharge of patients who I do not believe are ready for discharge. I participate in the discharge of patients to locations that I believe are not safe. I observe without taking action when healthcare personnel are not respectful of a patient's culture or religious faith.		

CPR = cardiopulmonary resuscitation; G-tube = percutaneous endoscopic gastrostomy tube

TABLE 1. Mean moral distress intensity and frequency ratings by core clinical scenarios and job role

Job role	Mean moral distress intensity (0-6)	Mean moral distress frequency (0-6)
Scenario 1: I follow the patient's wishes for treatment even when I do not think it is the right thing to do.		
Chaplain	2.38	2.65
MD	3.48	2.91
Resident	2.91	2.38
Nurse	3.19	2.93
RX	2.47	2.88
SW	2.59	3.33
Therapists	3.13	2.43
Scenario 2: I follow the family's wishes for patient treatment when I do not think it is the right thing to do.		
Chaplain	3.20	3.10
MD	4.19	3.00
Resident	4.24	2.62
Nurse	3.82	3.04
RX	2.81	3.07
SW	3.39	3.23
Therapists	3.61	2.64
Scenario 3: I participate in starting or maintaining life sustaining treatments when I do not think it is right to start or maintain such treatment.		
Chaplain	3.52	2.50
MD	4.18	2.85
Resident	4.09	2.86
Nurse	3.60	3.06
RX	2.75	3.20
SW	3.53	3.57
Therapists	3.32	2.95
Scenario 4: I participate in withdrawing or withholding life-sustaining treatments when I do not think it is right to stop such treatment.		
Chaplain	3.9	2.47
MD	3.82	1.56
Resident	3.42	1.25
Nurse	3.35	1.98
RX	2.39	2.28
SW	2.64	1.71
Therapists	3.08	2.02
Scenario 5: I participate in the discharge of patients who I do not believe are medically ready for discharge.		
Chaplain	4.81	3.06
MD	3.90	1.85
Resident	3.50	1.80
Nurse	3.85	2.43
RX	2.82	3.00
SW	4.26	2.95
Therapists	3.67	2.63
Scenario 6: I participate in the discharge of patients into circumstances of inadequate social support.		
Chaplain	4.36	3.05
MD	3.92	2.72
Resident	3.23	2.76
Nurse	4.02	2.77
RX	3.35	2.80
SW	4.37	3.44
Therapists	4.02	2.73
Scenario 7: I provide different treatment for those who can afford to pay or have insurance than for those who lack insurance or cannot pay.		
Chaplain	4.33	2.58
MD	3.54	1.85
Resident	3.45	2.10

(continued next page)

TABLE 1. *continued*

Job role		Mean moral distress intensity (0-6)	Mean moral distress frequency (0-6)
	Nurse	3.21	1.32
	RX	2.81	2.25
	SW	4.29	1.87
	Therapists	3.19	1.04
Scenario 8:	I provide better treatment for U.S. citizens, regardless of the ability to pay, than I provide for undocumented immigrants.		
	Chaplain	4.50	2.06
	MD	3.14	1.05
	Resident	3.13	1.10
	Nurse	2.93	1.13
	RX	2.48	2.11
	SW	3.75	1.25
	Therapists	2.75	0.84
Scenario 9:	I participate in hiding information, especially bad news, from patients because of family requests.		
	Chaplains	3.89	2.35
	MD	3.67	1.31
	Resident	3.13	1.20
	Nurse	3.91	1.93
	RX	2.85	2.19
	SW	4.50	1.83
	Therapists	3.40	1.79

Nurse = all direct-care employees in nursing department

TABLE 2. Mean moral distress intensity and frequency ratings for nine core scenarios

Job role	Mean moral distress intensity (0 to 6)	Mean moral distress frequency (0-6)
Chaplain	3.79	2.64
MD	3.79	2.18
Resident	3.47	2.02
Nurse	3.58	2.33
RX	2.71	2.64
SW	3.79	2.63
Therapist	3.39	2.12

Nurse = all direct-care employees in nursing department

TABLE 3. Mean moral distress score by job role

Job role	*n*	Mean moral distress score (0-324)*	95% confidence interval
Nurse	1,464	68.00	64.86, 71.14**
SW	41	66.51	53.80, 79.22
Resident	21	64.33	46.10, 82.56
MD	172	62.60	54.77, 70.43
Chaplain	29	60.76	37.64, 83.88
RX	40	53.98	31.50, 76.46
Therapist	239	51.27	45.05, 57.49**

* Range: 0-324.

** Mean score comparisons significantly different at 0.05 level.

Nurse = all direct-care employees in nursing department

DISCUSSION

This study calls attention to three key findings. First, the experience of moral distress is a significant problem across the spectrum of healthcare disciplines, not only among nurses. Although nurses reported the highest overall moral distress scores (taking into account both intensity and frequency of moral distress), the range of mean moral distress scores among several professions was narrow, with the core-scenario mean moral distress score sum for nurses only 5.3 percent higher than that of residents and 7.9 percent higher than that of attending

TABLE 4. Survey response rate

Job role	Survey recipients	Survey respondents	Response rate (%)
Chaplain	79	36	45.57
Nurse	8,558	2,043	23.87
RX	453	57	12.58
SW	96	46	47.92
Therapist	1,474	331	22.46
MD	4,562	236	5.17
Resident	52	22	42.31
Total	15,274	2,771	18.14

Nurse = all direct-care employees in nursing department

TABLE 5. Nonphysician participants' demographics

	Job role (%)				
Demographic	Chaplain	Nurse	RX	SW	Therapist
Gender					
Female	22.22	88.89	71.93	97.83	82.18
Male	77.78	11.11	28.07	2.17	17.82
Age group, years					
<29	5.56	14.80	8.77	15.20	16.31
30-39	13.89	25.10	33.30	39.10	30.82
40-49	19.44	25.60	33.30	28.30	27.49
50-59	25.00	27.20	22.80	10.90	17.82
60+	36.11	7.34	1.75	6.52	7.55
Employment status					
Full time	69.44	91.50	91.20	84.80	82.48
Part time	30.56	8.47	8.77	15.20	17.52
Service in system, years					
<1	11.11	10.80	12.30	15.20	8.76
1-4	33.33	40.80	36.80	41.30	37.76
5-9	30.56	19.60	21.10	30.40	22.66
10+	25.00	28.90	29.80	13.00	30.82
Service in current job, years					
< 1	19.44	66.70	26.30	17.40	20.85
1-3	36.11	14.30	22.80	26.10	32.02
> 3	44.44	19.00	50.90	56.50	47.13

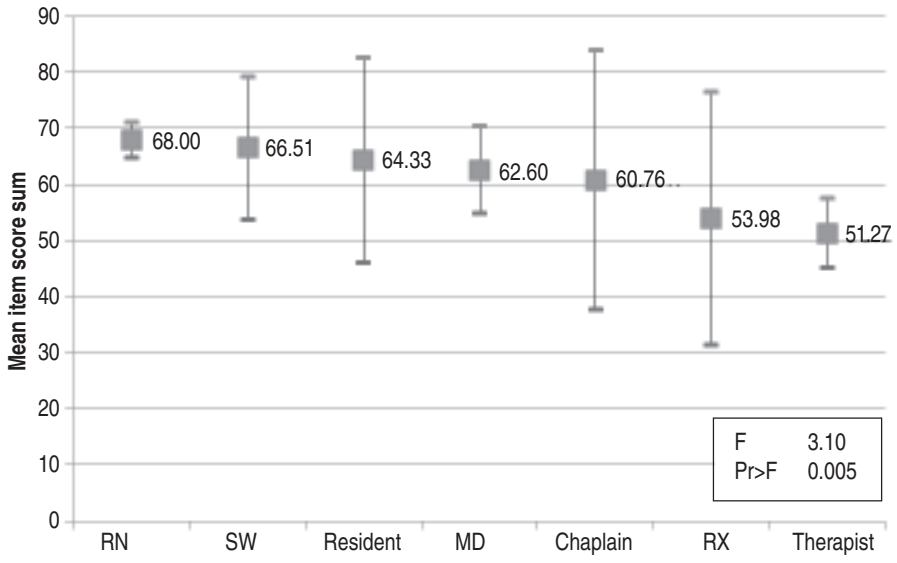
physicians. Second, intensity and frequency of moral distress varied by clinical scenario, across disciplines. Physicians, chaplains, and nurses experienced the highest intensity of moral distress even if they experienced moral distress less frequently. Third, end-of-life clinical scenarios produced the highest intensity of moral distress for physicians (both attending and resident) and nurses, especially when physicians felt constrained to follow the family's wishes when feeling it was not right to do so (see table q, scenario 1) and in the medical futility scenario (see table 1, scenario 3).

Multidisciplinary Experience of Moral Distress

To understand the impact of moral distress on healthcare professionals, it is essential to explore the perspectives of multiple healthcare professionals who must work as a team in caring for patients. The rank order of overall mean moral distress scores are reported in table 3, from highest to lowest, and, as noted elsewhere, nurses reported the highest overall mean moral distress, although it was only 7.9 percent higher than that of attending physicians. However, when evaluating the mean moral distress *intensity* for the nine core items (see table 1), chaplains, physicians, and SWs were tied for first, followed by nurses. Of some interest is that physicians and residents experienced the greatest moral distress related to issues they no doubt perceived as more clinical in nature, such as starting or maintaining a medical treatment they disagreed with, while chaplains and SWs experienced the highest moral distress in areas that might be interpreted as relating to social justice, such as discharging patients into unsafe circumstances (see tables 6 and 7).

Differences in the experience of moral distress may be explained by the different responsibilities of various professional groups. An attending physician may feel obligated to honor the family's requests for maintaining or starting life-sustaining treatment even if the physician believes this is not in the best interest of the patient. This indicates the hierarchical nature of constraints in the field of medicine, in which a doctor perceives the family has power, but is obligated to the patient. Nurses and residents, in turn, may feel obligated to carry out an attending physician's "family-driven" order, even when they feel it is wrong. Meanwhile, SWs who are tasked with post-hospitalization discharge plans experienced the greatest moral distress related to discharging patients into "circumstances of inadequate social support."

Figure 3. Mean moral distress score by job role, with 95 % confidence interval



F=F statistic; Pr=P-value

In reviewing our mean moral distress intensity scores across professions, one group stood out with interest: chaplains. When evaluating the mean moral distress intensity for the nine core items, chaplains, physicians, and SWs were tied for first, followed by nurses. In analyzing the nine core items individually, chaplains scored highest in moral distress intensity in four of nine core items and a close second in two of the items. Of the scenarios in which chaplains had the highest mean intensity, their overall highest mean moral

distress intensity was for the item "I participate in discharge of patients who I do not feel are medically ready for discharge." Following this scenario were the scenarios of "providing better treatment for U.S. citizens regardless of ability to pay, compared to undocumented immigrants" and "providing different treatment for those who can afford to pay, or have insurance than for those who lack insurance, or cannot pay." Chaplains ranked a close second to SWs in terms of moral distress intensity regarding the scenario of "participating in discharging patients into circumstances of inadequate social support."

The common theme of the aforementioned three scenarios is one of social justice. While the exact reason for the high scores among chaplains in these areas may be unclear, one could speculate that there may be an inherent influence from the background of these individuals, from a Judeo-Christian/biblical perspective of societal justice and "loving your neighbor." Another interesting dichotomy was that, for our chaplains, the mean moral distress intensity scores for the scenario involving "participation in withdrawing or withholding life-sustaining treatments when I do not think it is right to stop such treatment" (right-to-die scenario) were the highest, whereas the opposite scenarios, "maintaining life sustaining treatment when I do not feel it is appropriate" and "following family's request for treatment when I do not feel it is right to do so" (futility scenarios), scored much lower. In light of the fact that the frequency of requests to stop treatment when chaplains do not feel it is appropriate is less than the frequency of scenarios of being asked to start or to maintain such treatment, the mean moral distress score is higher for the latter. Therefore, if one were to concentrate on the mean moral distress score alone, one would miss a key issue that is a leading cause of moral distress intensity for this group.

The next question is why the difference in moral distress intensity between a right-to-die scenario and a medical futility scenario. One could speculate that the background of a chaplain would compel him or her to place great value on life (as many practitioners do), which may compel her or him to have greater moral distress intensity for a request to "cut a life short." Perhaps it is, in part, because many chap-

TABLE 6. Mean scores for chaplains by question

Item	Mean item score (0-36)	Mean intensity (0-36)	Mean frequency (0-36)
I participate in the discharge of patients who I do not believe are medically ready for discharge.	19.31	4.81	3.06
I provide better treatment for US citizens, regardless of the ability to pay, than I provide for undocumented immigrants.	14.54	4.50	2.06
I provide different treatment for those who can afford to pay or have insurance than for those who lack insurance or cannot pay.	14.43	4.33	2.58
I participate in the discharge of patients into circumstances of inadequate social support.	13.12	4.36	3.05
I participate in starting or maintaining life-sustaining treatments when I do not think it is right to start or maintain such treatment.	11.19	3.52	2.50
I follow the family's wishes for patient treatment when I do not think it is the right thing to do.	11.00	3.20	3.10
I participate in withdrawing or withholding life-sustaining treatments when I do not think it is right to stop such treatment.	11.00	3.90	2.47
I participate in hiding information, especially bad news, from patients because of family requests.	10.17	3.89	2.35
I follow the patient's wishes for treatment even when I do not think it is the right thing to do.	6.78	2.38	2.65

lains do not have the clinical training to fully evaluate such decisions. Alternatively, in light of their faith background (Christian at our institution), and with an accompanying belief in the afterlife, one could speculate that there may be a certain degree of "solace" or comfort in knowing that, in the end, for a patient who is receiving medically inappropriate treatment/futile interventions, the patient's suffering will cease, and he or she will proceed to a "place devoid of suffering." This is pure speculation, but could serve as an area for further research. Prior research in the nursing literature by Meltzer suggests that nurses who viewed religion as important in their lives experienced less emotional exhaustion than nurses who did not rate religion as important.

Intensity, Frequency, or Both in the Experience of Moral Distress

As mentioned in the methods section, the moral distress score was calculated utilizing both intensity and frequency of moral distress. By examining the intensity of moral distress for particular scenarios, one may gain insight into a comment that many in clinical ethics have heard fellow healthcare professionals make: "To this day, I can still remember that one terrible case." The current study is similar to that conducted by Rice and colleagues, using a Likert scale (0 to 6)-based moral distress score that measured both the intensity and frequency of potentially distressful situations.[9] However, the Rice study included only nurses, whereas this study included participants from seven different healthcare disciplines. Both studies found that cases of futile intervention posed particularly high levels of distress, with high-encounter frequencies noted in the Rice study and high intensity noted in the current study.

This study does not answer the question of whether intensity or frequency of moral distress has a greater impact on the psychological health of healthcare professionals, although mean moral distress intensity was higher than frequency for all professional groups in the study (see table 2). Also, it is not known if higher intensity but less frequent moral distress has the same impact on critical-care nurse burnout as does the overall frequency of moral distress situations perceived as futile as reported by Meltzer and colleagues.[10]

TABLE 7. Mean scores for social workers by question

Item	Mean item score (0-36)	Mean intensity (0-36)	Mean frequency (0-36)
I participate in the discharge of patients into circumstances of inadequate social support.	15.97	4.37	3.44
I participate in starting or maintaining life-sustaining treatments when I do not think it is right to start or maintain such treatment.	15.54	3.53	3.57
I participate in the discharge of patients who I do not believe are medically ready for discharge.	12.54	4.26	2.95
I follow the family's wishes for patient treatment when I do not think it is the right thing to do.	11.56	3.39	3.23
I provide different treatment for those who can afford to pay or have insurance than for those who lack insurance or cannot pay.	11.48	4.29	1.87
I follow the patient's wishes for treatment even when I do not think it is the right thing to do.	9.83	2.59	3.33
I participate in hiding information, especially bad news, from patients because of family requests.	9.36	4.50	1.83
I provide better treatment for U.S. citizens, regardless of the ability to pay, than I provide for undocumented immigrants.	6.55	3.75	1.25
I participate in withdrawing or withholding life-sustaining treatments when I do not think it is right to stop such treatment.	4.40	2.64	1.71

Moral Distress As It Relates to Decisions Near the End of Life

Facing ethical disagreement near the end of a patient's life is a common scenario in which ethics consultants/committees or palliative care teams often assist bedside professionals. In some situations, a surrogate may request withdrawing or withholding interventions, but the treatment team disagrees. Such circumstances are typically referred to as "right-to-die" scenarios by the medical ethics community. Alternatively, there are many more cases in which the treatment team believes that medical interventions should be withheld or withdrawn, but the surrogate disagrees. This scenario is often referred to as "medical futility." Debate over the true meaning of medical futility and the best mechanism for facing the problem clearly exists.[11] However, the present study suggests there should be little debate about the moral distress evoked among healthcare professionals by medical futility cases.

In this study, all professional groups except chaplains found the intensity of moral distress associated with participation in futile interventions to significantly outweigh the intensity of moral distress associated with right-to-die situations. The intensity of such moral distress in the futility scenario was highest among attending physicians and residents, closely followed by that of nurses.

LIMITATIONS

Although this study was conducted in a large healthcare system and had the largest sample size in a moral distress study reported in the literature to date (N=2,771), findings should be generalized cautiously, as this sample was based on a response rate of a bit over 18 percent. Respondents were recruited through the system's intranet via job code; thus, not all participants were in direct patient care positions and potentially may not have been exposed to situations that could cause moral distress and angst. This could result in reduced frequency and intensity scores among nurses, therapists, and pharmacists. After embarking on the study, it was found that the email addresses for physicians affiliated with BHCS were often inaccurate. This may help explain the just over 5 percent response rate of physicians. Nonetheless, the 236 physician respondents represent the largest study of moral distress involving physicians published to date. Lastly, as is the case with many studies, there may have been a component of self-selection bias. There may be individuals who perhaps felt more compelled to answer the survey in light of inherent higher levels of background moral distress, as opposed to individuals who simply did not feel this was an important topic and hence did not participate in the survey.

CONCLUSION

Moral distress is not unique to any one professional discipline within healthcare. However, members of different healthcare professions experience moral distress for different reasons. As long as suffering, mortality, and social inequality remain components of the human condition, those in healthcare must face at least periodic moral distress. The results have provided direction regarding vulnerable healthcare professionals and have moved beyond the previous information regarding the nursing profession. It is hoped that this study will evoke questions such as, Why don't we feel each other's pain? Why don't doctors share nurses' concerns more, and why don't nurses share doctors' concerns more? Does each see needs only from his or her perspective? Is this as it should be, or should we consider whether and how we should change this?

The next question might be, What do we do about it? Two basic options would be to acknowledge the existence of moral distress and focus on efforts to mitigate it to the extent possible, versus a stoic response of "just deal with it" that organized medicine has practiced for decades. When a healthcare organization, or even a major group within medicine (doctors, nurses, therapists) chooses the latter, the results are harmful to the psychological health of individuals, not to mention the end result of burnout. This is not an option the healthcare community can entertain, as there are already short-

ages of healthcare professionals across the spectrum, as well as ever-growing demands on the delivery system. That leaves the first, more "therapeutic" option, starting with the acknowledgment that moral distress is real across the spectrum of healthcare professionals. A simple acknowledgment that another colleague could be struggling with moral distress can offer a starting point for possible mitigation, starting with active listening.

In the authors' clinical ethics consultation experience, it is not uncommon for diverse healthcare professionals to request formal ethics consultation or to simply talk about or seek counseling concerning a particularly distressing clinical scenario. This "counseling" aspect of clinical ethics is one that is often under utilized and under valued. It also happens to be an ethics intervention that requires only active listening and acknowledgment of the moral distress that a colleague is experiencing. Beyond such one-on-one support, structured interventions could include broader education related to medical ethics in general and the promotion of moral confidence through ongoing facilitated dialogue and study. Survey participants were asked about opportunities for further clinical ethics education; the majority answered that they felt adequately educated, but would attend additional education if it were offered (see table 8). Additionally, both formal and informal debriefing sessions following stressful cases may help some team members, as can more in-depth and structured support programs such as Schwartz Center Rounds.[12] Lastly, utilization of palliative care services may mitigate many potentially distressful situations, particularly those involving end-of-life scenarios. In the process of focusing on increasing the intensity of "care" (not necessarily intensity of medical intervention or treatment), palliative care teams may help a primary treatment team at the same time that the patient and family are helped.

Further research is needed to examine the impact of education programs on reducing the intensity of morally distressing situations, as well as the impact of treatment protocols or guidelines related to specific scenarios such as medical futility or discharge into circumstances that are seen as less than optimal.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

NOTES

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TABLE 8. Clinical ethics education

Survey participants were asked about further clinical ethics education, and the majority answered they felt adequately educated but would attend additional education, if offered.

		Job role (%)				
	Education Value	Chaplain	RN	RX	SW	Therapist
Adequately educated	Yes	82.76	85.6	83.33	90.24	93.48
	No	17.24	14.4	16.67	9.76	6.52
Would attend additional education	Yes	100.00	84.15	76.19	100.00	83.04
	No	0	15.85	23.81	0	16.96
Future ethics education format						
Lectures	--	3.45	16.87	16.67	2.44	13.04
Case conferences	--	10.34	13.76	11.90	4.88	10.00
Combination	--	86.21	69.37	71.43	92.68	76.96

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9. Price et al., see note 2 above.

10. Meltzer and Huckabay, see note 3 above.

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