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COMMENTS TO RESEARCH ARTICLE

First quantitative study in Spain on moral distress and ethical climate in ICU healthcare professionals☆

Primer estudio cuantitativo en España sobre desasosiego moral y clima ético en profesionales sanitarios de UCI

Commentary

The concept of moral distress (MD) was first coined in the 1980s in the nursing profession to describe the process of pain or anguish that occurs when, in the care context, a nurse ''knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action''.[1] From its definition and subsequent study including other healthcare professions, components of MD have been determined such as complicity in wrongdoing (external pressures), lack of voice in decision-making, wrongdoing associated with professional (not personal) values, repeated experiences that generate a ''moral residue'', at three levels: patient, unit and system. Although the construct is an old one, much of the empirical study on it and its longitudinal and cumulative aspects has been from the 2000s onwards thanks to the development of an assessment instrument, the most updated version of which is The Measure of Moral Distress for Healthcare Professionals (MMD-HP).[2]

The Spanish literature provides different translations of moral distress such as ''*distrés moral*'', ''*estrés moral*'', ''*sufrimiento moral*'' or ''*angustia moral*'', but until recently there has been no adapted and adequately validated instrument for the measurement and empirical development of the concept in Spain. For this reason, publications on the subject by Spanish healthcare professionals are mainly theoretical reviews, technical and teaching guides or documents, and qualitative research works. It was not until 2021 that the Spanish version of the MMD-HP was translated, validated, and published by the same team that signed the article we are discussing here: The Measure of Moral Distress for Health Care Professionals (MMD-HP-SPA).[3] In this instrument, the authors translate the concept for the first time as ''*desasosiego moral*''. This translation makes it possible to avoid using the anglicism and provide a

Rodríguez-Ruíz E, Campelo-Izquierdo M, Veiras PB, Rodríguez MM, Estany-Gestal A, Hortas AB, et al. Moral distress among healthcare professionals working in intensive care units in Spain. Med Intensiva. 2021;Jul28:S0210-5691(21)00170-4. doi:10.1016/j.medin.2021.06.004

Abstract

Objective: To assess moral distress (MD) among Spanish critical care healthcare professionals (HCPs).

Design: Cross-sectional, prospective study.

Setting: ICUs in Spain.

Participants: HCPs currently working in Spanish ICUs.

Interventions: A 55-item questionnaire was electronically distributed.

Main variables: The questionnaire included work-related and socio-demographic characteristics, the Spanish version of the Measure of Moral Distress for Health Care Professionals (MMD-HP-SPA), and the Hospital Ethical Climate Survey (HECS).

Results: In total, 1065 intensive care providers completed the questionnaire. Three out of four validity hypotheses were supported. MD was significantly higher for physicians (80, IQR 40–135) than for nurses (61, IQR 35–133, $p = 0.026$). MD was significantly higher for those clinicians considering leaving their position (78, IQR 46–163 vs. 61, IQR 32–117; $p < 0.001$). The MMD-HP-SPA was inversely correlated with the HECS ($r = -0.277$, $p < 0.001$). An exploratory factoranalysis revealed a four-factor structure, evidencing the patient, team, and system levels of MD.

Conclusions: In the study sample, Spanish intensivists report higher MD than nurses. Strategies to improve ICU ethical climate and to correct other related factors in order to mitigate MD at a patient, team, and system level should be implemented. Both groups of HCPs manifest a relevant intention to leave their position due to MD. Further studies are needed to determine the extent to which MD influences their desire to leave the job.

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term in our language that is very descriptive of the construct. However, because of the former terminology the new nomenclature in our language will need to be disseminated in research and scientific publication, so that its use becomes known and generalised without it being considered a new or different problem. Having a validated measuring instrument will undoubtedly help in this regard.

As a continuation of this validation work, in this study, Rodríguez-Ruiz et al. conducted the first quantitative, prospective, and cross-sectional analysis of moral distress in Spanish intensive care units, which is of immense value, as it offers the first quantified picture of the problem in Spain. The authors include the items and the exploratory factor analysis of the instrument in annexes to the article, which in this second publication verifies the construct validity of the MMD-HP-SPA, its fidelity to the structure of the original questionnaire and the very adequate reliability indicators, in its application for nurses as well as doctors.

The study sample includes more than 1,000 ICU professionals ($n = 1065$). In addition to MD, the authors assessed sociodemographic and work-related characteristics, the desire to leave, and the hospital ethical climate. The latter is an interesting variable that the literature reports as closely and inversely linked to MD, and which describes organisational practices that (if present) facilitate ethical decision-making, participation in shared reflections and decisions, conditions of power, trust, inclusion, role flexibility, and research in the organisation. The Hospital Ethical Climate Survey-Short Version (HECS) is the standard instrument for measuring this variable.[4] The authors state that they use a Spanish version of this scale, constructed following the same steps and scientific criteria used to translate and adapt the MMD-HP-SPA, and whose items are shown in the appendix to the article. However, they do not indicate prior publication of its validation or provide data on the reliability of the scale in the study sample.

This first quantitative assessment of MD in Spanish ICUs shows that the problem is present their staff. More specifically, the authors find higher MD in doctors than in nurses and in professionals who have considered leaving their jobs. The significant weight of the first finding should be studied further in the future, as it contradicts other international findings where nurses suffer higher rates of MD more frequently.[5,6] As the authors note, this result may be linked to the specific characteristics of the Spanish healthcare organisation, work patterns in the ICU, and the distribution of functions among professionals. This study provides important data that should be considered regarding wishing to leave the job, since this is present in both doctors and nurses in association with MD. However, we also know that in these units it is related to other syndromes that overlap with each other, such as burnout, compassion fatigue or secondary traumatic stress.[7,8] Future research should study this situation in Spanish critical care professionals, as it threatens the interprofessional structure of these units, their quality of care, and the occupational health of their staff.

The analysis included in the publication on the main causes of MD in the ICU merits special mention. These data open the door to evidence-based lines of prevention and intervention based on the specificities of each professional group. In this sense, the authors give significant weight to organisational causes related to the number of patients that can be attended safely and the lack of continuity of staff, and to aspects related to patient care that may involve therapeutic obstinacy. In addition to these main shared factors, there are other differential factors such as a higher incidence in doctors of the effect of lack of resources, equipment, beds, etc. that compromise adequate patient care. Here we should note that the data collection period for this research was prior to the COVID-19 pandemic (October to December 2019). Knowing the importance of the ranking of the causes of MD that they provide, its cumulative effect, and how it affects the emotional health of professionals, research will be essential that evaluates these aspects during and after the pandemic in ICU professionals.

The mean score on the perceived hospital ethical climate varied little between professional groups and its negative correlation with MD was confirmed. In turn, the regression analysis conducted by the authors indicates the predictive capacity of this variable in relation to MD, confirming it as a protective organisational aspect against MD. This result should be analysed in depth in subsequent prospective and longitudinal studies, but it provides very useful practical data as it underlines the importance and need to promote this ethical climate as a protective measure against MD. Individual measures to promote bioethics training in professionals and moral resilience, as well as actions at group and team level, facilitating a culture of ethical practice, humanisation of care and interprofessional spaces for reflection and shared debate will be necessary.

Studies such as this one are absolutely necessary and respond to a call to action from the medical and critical care nursing societies on syndromes and psychosocial aspects of ICUs that overlap with each other and greatly affect health professionals.[8] As with all research work, this study has some limitations which are appropriately indicated in the text by the authors, and further work should provide more information on the Spanish version of the Ethical Climate Scale. Beyond these issues, the publication is of great theoretical, methodological, and applied relevance. For the first time through quantitative data, it describes and explains MD in ICU healthcare professionals in Spain, providing clues as to its specificity according to the professional group. It opens doors to future research (in ICU and in other healthcare services) with the contribution of two new assessment instruments on MD and the hospital ethical climate and provides the necessary empirical support on specific lines of prevention and intervention to combat MD.

In short, this research study helps underline the importance of the ethical dimension of work as an essential part of the quality and humanisation of patient and family care, as a variable closely related to the well-being of healthcare professionals.

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