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Research Article

Coping with moral distress – The experiences of intensive care nurses: An interpretive descriptive study

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ABSTRACT

Background: Over the last three decades, there has been a growing body of literature that has described moral distress as a prominent issue that negatively affects intensive care nurses. Yet, little focus has been given to how intensive care nurses cope and continue in their practice despite being exposed to moral distress.
Objective: To describe intensive care nurses' experiences of coping with moral distress.
Research methods/setting: A qualitative design using an interpretative descriptive approach. Semi-structured interviews were conducted with seven intensive care nurses.
Findings: The shared experience of coping with moral distress was explicated through the overarching theme of being *Like Grass in the Wind*. Four major themes emerged: *Going Against What I Think is Best*, *Moral Distress - It's Just Inherent in Our Job, It Just Felt Awful*, and *Dealing with It*. The findings also reflected actions associated with *turning towards* or *turning away* from morally distressing situations.
Conclusion: By developing coping strategies such as seeking social support, nurses can move forward in their practice and meaningfully engage with patients and families experiencing critical illness. When successful coping is not attained, nurses are at risk of becoming morally disengaged within their practice.

Implications for clinical practice

- Nurses' experiences with moral distress should be recognised, validated and supported by nursing management and the larger organisation.
- Providing nurses with the physical space and time needed to access social support is essential in helping them cope with moral distress.
- Novice nurses may require greater support as they may lack the knowledge and skills necessary to cope with moral distress.
- Critical reflective practice can assist nurses to remain morally engaged in their practice and successfully cope with their morally distressing experiences.

Background

Experiences of moral distress result from a "perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action" (Epstein and Hamric, 2009, p. 2). Moral distress is problematic for nurses as it is associated with negative emotions such as anger, sadness, frustration and guilt (Choe et al., 2015; Deady and McCarthy, 2010; Wiegand and Funk, 2012). Nurses who experience such distress and its associated negative outcomes may change positions and, in some circumstances, leave the profession entirely (Piers et al., 2012; Wiegand and Funk, 2012; Wilson et al., 2013).

Nurses working within intensive care units (ICUs) are exposed to a clinical context that is pervaded with ethical issues that can

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cause moral distress. ICUs provide highly specialised care using advanced technology to meet the needs of critically ill patients (Canadian Critical Care Society, 2014). ICU clinicians (including nurses) intervene with life-sustaining therapies such as mechanical ventilation, advanced cardiovascular life support, and dialysis. Due to the severity of their illness(es), patients can be incapacitated (e.g. sedated to aid mechanical ventilation) and therefore their wishes and preferences regarding goals of care may be unknown if undisclosed to family or the health care team prior to their admission. Instead, patients' substitute-decision makers must elicit their own personal beliefs concerning their interpretations of patients' preferences for decisions of whether life-sustaining treatments are withheld, withdrawn or continued (Wallen and Baker, 2012). The use of life-sustaining therapies in ICUs can also pose ethical challenges. While these therapies may help restore health and improve the quality of life for some, when ICU nurses care for patients with life-limiting illnesses who do not improve despite aggressive interventions, they may perceive these therapies as causing undue suffering and prolonging the dying process (Browning, 2013). Though other sources of moral distress exist for ICU nurses such as working with unsafe levels of staffing and inadequate resources (Browning, 2013; Choe et al., 2015), issues that involve end-of-life care are the most frequently captured sources within the nursing literature (Browning, 2013; Choe et al., 2015; Cronqvist et al., 2004; Elpern et al., 2005; Gutierrez, 2005; Hamric and Blackhall, 2007; McClendon and Buckner, 2007; Mobley et al., 2007; Shorideh et al., 2012; Wiegand and Funk, 2012).

While researchers have focused on nurses from a variety of clinical settings and their experiences with moral distress in order to understand its sources and characteristics (Austin et al., 2003; Choe et al., 2015; Elpern et al., 2005; Piers et al., 2012; Wiegand and Funk, 2012), there is scant literature that has examined how nurses cope with the experience of moral distress. Coping refers to "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus and Folkman 1984, p. 141). The type of coping used in a situation changes as the person reappraises the demand and any changes in the environment that have occurred. Therefore, coping is viewed as a 'process' using cognitive appraisal and is influenced by the context (Lazarus and Folkman, 1984). Problem-focused and emotion-focused coping strategies are involved. Problem focused strategies include efforts to manage the problem (i.e. problem solving activities and seeking information). Emotion focused coping may include efforts to avoid or distance oneself from a situation. Studies on coping in nurses have examined areas such as workload and found that nurses used problem-focused strategies such as planful problem solving and seeking social support as concrete actions (Healy and McKay, 2000). Studies that have explored the experience of coping with moral distress have found that nurses often employ evasive strategies. These strategies entail escaping or avoiding the distressing issue without confronting it directly (Barlem et al., 2013; Deady and McCarthy, 2010; Gutierrez, 2005; McClendon and Buckner, 2007; Zavotsky and Chan, 2016). The inherent risk with these evasive strategies is that nurses can become withdrawn or morally disengaged from their practice, which might affect the nursing care they provide. Collectively, these studies have not provided details to any great extent about the process of coping that nurses employ. As such, this study was designed to address this research gap.

Objective

The objective of this study was to describe intensive care nurses' experiences of coping with moral distress.

Methods

Design

This qualitative study incorporated Thorne's (2008) approach to interpretative description. Interpretative description drives investigators to engage with the data beyond what has been assumed or previously established and allows for investigators to discover what relationships and patterns exist within a phenomenon to understand what will likely be encountered in future practice (Thorne, 2008). Findings of interpretive description studies are based on inductive reasoning where observations made lead to broader generalisations (Thorne, 2008). This approach facilitated an understanding of the individual realities of ICU nurses who have coped with moral distress, as well as the commonalities that they shared between them.

Ethics

Ethical approval was obtained from the research ethics board of the hospital and the educational institution of the authors (ethics file A12-15–01). Each participant provided written informed consent prior to being interviewed. To protect participants' identities and ensure confidentiality, each participant was asked to choose a pseudonym to be referred to in the study.

Setting and sample

This study took place in two medical-surgical ICUs located at two different sites of a 1000+ bed, tertiary care academic hospital in Ontario. Site A, with 33 patient beds, specialised in neurological, vascular and trauma care (i.e. patients with severe brain injuries, ruptured aortic aneurysms, and blunt and penetrating traumas). Site B, with 32 beds, specialized in cancer related complications, burns, respiratory and thoracic care (i.e. patients with septic shock, oncological emergencies, and extensive thoracic surgery). The study sample consisted of seven ICU nurses. The sample size was continuously reassessed as the study progressed until rich descriptions of the phenomenon of interest with numerous comments and examples were generated (Munhall, 1994). Purposive sampling was employed to seek participants who had experienced the phenomenon of interest. The inclusion criteria ensured that participants were registered nurses, employed full-time or part-time in the ICU, who had experienced moral distress on at least one occasion, and spoke English or French. All of the participants were English speaking. Their years of ICU nursing experience ranged from eight months to 27 years and the median was two years. Of the seven participants, five had three years or less of ICU experience and therefore the majority of the sample had limited ICU experience. As data collection progressed, the researchers found that the sample was all less experienced nurses. Therefore the study team reminded the unit staff of the study and encouraged senior nurses to participate. This intervention resulted in two very experienced nurses participating in the study.

Data collection

Individual, face-to-face, semi-structured interviews were conducted by the first author (DF) with the participants. They were asked to elaborate on their morally distressing experiences and their coping process. Interviews were 30–80 minutes in duration and were audio-recorded. Examples of interview questions included: 'Describe to me what moral distress means to you.'; 'Tell me about a situation you encountered where you experienced moral distress. 'Verbatim transcription was completed within

24 hours of each interview. All transcripts were verified against the original recording for accuracy of the transcription. Individual follow-up interviews (member checking) were also conducted with four of the seven participants in an effort to ensure the analysis was reflective of their experiences.

Data analysis

Thematic analysis (Aronson, 1995) was utilized to analyze the collected data. The transcribed interviews were first reviewed to note what patterns of experience were described. The identified patterns were then categorised. Related patterns were subsequently catalogued into sub-themes. Theme statements were then formulated, which allowed for the development of a story line. Steps were taken to ensure that methodological rigour (or trustworthiness) was established using the criteria outlined by Lincoln and Guba (1985): credibility, transferability, confirmability, and dependability. To ensure credibility (truth value), the first author (DF) had consistent consultation with the members of the research team who had expertise in critical care (BVW, FFB), nursing ethics (DKW) and/or qualitative research methods including interviews (BVW, FFB, DKW, DM). Member check interviews were employed for participants to comment on the research findings and themes (Noble and Smith, 2015). To enhance transferability, descriptions of the setting have been presented, as well as descriptions of the participants. Confirmability refers to the extent to which the study findings originate from the experiences of the participants and not as a result of researcher supposition or bias (Lincoln and Guba, 1985). Quotes from the participants were used to explain each theme to ensure confirmability.

Findings

The shared experience of coping with moral distress was explicated through the overarching theme: *Like Grass in the Wind*. Four major themes emerged: *Going Against What I Think is Best*, *Moral Distress – It's Just Inherent in Our Job, It Just Felt Awful* and *Dealing with It***.** Many of the participants reflected on performing actions that, in the bigger picture of their patients' situations, were not helpful. These participants tended to have less experience and they represented the majority of the sample in this study.

The overarching theme *Like Grass in the Wind*, reflected that the experience of moral distress was comparable to how zebra grass was affected by the wind. Diane, the most experienced nurse, explained that zebra grass is flattened in the wind but that it is able to get back up. She stated, "*It is a beautiful tall grass. . ..every year it comes back. Even after the biggest winters.*"

Going Against What I Think is Best represented the participants' descriptions of moral distress. They referred to performing an action that was inconsistent with their perception of what was right. Working with physicians and families placed the participants in situations where they would have to act in accordance with their beliefs as opposed to their own. As Diane explained: "*It is having to deal with the difference between what they want and what you think is the right thing. Sometimes it is that duality. I'll call it the duality because it's a conflict inside*". While the latter reflected a cognitive process where participants thought through their actions, there were negative emotional consequences that resulted. The participants provided descriptions of how the characteristics of moral distress impacted their biopsychosocial health. Participants used words such as "*awful*", "*angry*", and "*traumatised*" when speaking about these experiences and describing their feelings. Valerie described: "*It just felt awful. I knew what I needed to do but I could not do it because I did not have the order*". Participants with less than three years of ICU nursing experience described emotional, bodily and social consequences to their own wellbeing such as feeling stressed, frustrated and anxious, experiencing insomnia and exhaustion, withdrawing from family and friends, and dreading going into work. Many had considered working less hours or contemplated ending their employment in the ICU.

The theme *Moral Distress - It's Just Inherent in Our Job* revealed the participants' sources of moral distress, which centered on lack of clarity surrounding patient wishes, questioning the decisions of others and lack of information given to families. For instance, Christine reflected on experiences wherein discrepancies between family members regarding the patient's wishes painted an unclear picture of the right course of action. She added,

> "*. . .we have patients. . .a lot of times it's not very clear. We don't have a clear set of advanced directives, but you have a lot of hearsay from families. Like they'll be saying things like, 'Oh, he wouldn't have wanted this' or 'He would want this.' But you have a lot of different family members saying different things and you don't necessarily know the right thing. The patient is in no state to tell you what they would've wanted.*"

Participants also described circumstances in which patients' wishes were contested by family members. In their stories, the participants frequently spoke about patients' families insisting on treatments that were inappropriate, harmful and (sometimes) directly contradictory to the nurse's own specific understanding of a patient's wishes. Jen, for example, recalled,

> *"They* [family] *made us intubate him. . .his ribs were broken. They* [family] *made us put in a feeding tube* [participant sighs]*. . .Even the language I use you can see that I don't agree with it. . .they* [family] *just insisted that everything be done and we all, myself and much of the nursing staff and physicians, felt that these measures were futile and we did respectfully give our opinions and the information that these measures were not going to bring him back and in the long-run were likely to prolong suffering. But the family was very clear that they just wanted everything done.*"

Situations were also described where physicians would withhold pertinent information from patients and their families, or would not relay messages between different services. For example, Janice felt physicians would deceive families. She explained,

> *"I find all of our deceiving is withholding information. I know that they're trying to give them time like. . . family time to deal with it. But we can't save them from the grief they're going to feel and I just feel like we need to be more upfront in saying, 'They're not going to leave here* [the ICU]*.'"*

As a result, families were not given all the details needed to make truly informed decisions.

Another important source of moral distress for study participants was their perception of how end-of-life care planning was (mis)managed by ICU physicians. Participants told stories of goals of care not being established or re-evaluated in line with patients' deteriorating health, thus prolonging patient suffering. Physicians were perceived as disregarding patient autonomy when they would convince patients or their families to rescind their "do-no t-resuscitate" orders and opt for full ICU treatment instead. The distress the nurses felt from the withholding of information from patients' families was accentuated by a sharp disconnect between what they witnessed physicians say to families directly (e.g., "*It doesn't look great. We're not thinking that he's going to have a great quality of life*") and what they would then say in private (e.g., "*Yeah, he's lucky to live a couple of more days*"). This framing of information resulted in families not receiving the full picture of patients' deteriorating conditions. The result was prolonging care in which patients who were dying received treatments that were *"aggres-*

sive" in nature. Summer explained, "*We went into nursing to help people. We went into nursing because we want to make things better and here we are causing people pain and distress…it's such a torturous experience and I'm like, that's me…I'm the torturer.*"

For the participants, knowing their patients' wishes – even if these contradicted their own ideas around good end-of-life care – mitigated potential feelings of moral distress. Julia added, "*If they* [patients] *were willing to give it that chance, if they were like, 'I'm willing to die like this in order to give myself a chance', then that's less distressing.*" Similarly, Julia also reflected, "*Because my patient might have different beliefs than I do, so I would want to do everything I can to follow what their wishes are, as opposed to just my own.*"

Dealing with It: Turning away – Turning toward

Nurses' descriptions of coping were dynamic processes of both *turning away* from and *turning toward* their moral distress. In the words of participant Julia, *"Everybody's coping methods are different. So whether it's something you do to deal with something head on, or distract… Basically whatever you do to get through.*" This quote evokes two different ideas that more broadly characterise nurses' coping with moral distress: avoidance/distraction (turning away) and connection (turning towards). Participants described avoidance as a sometimes necessary approach to distance themselves. Strategies included making use of certain outlets, within and outside of work, which enabled them to suspend their thinking about whatever was causing them distress. Christine explained,

> *"I think it's honestly just to escape it all. Typically, I'll bring a book or my phone and I distract myself. I like to go somewhere quiet…I'll give myself a minute or two to be like, 'Okay, this is a stressful day or this is distressing'…I'll distract myself.*"

Christine also added, "*Like I need to go and get a coffee and getting off the unit, getting away from everyone, going outside. Those sorts of things really help.*"

Interestingly, because of the pace of nursing work in the ICU, participants sometimes distracted themselves (or turned away) by busying themselves with other caregiving efforts. Christine described,

> *"Sometimes it's so busy…I guess that might be a way of coping, by doing what you have to do, right? … I have to change my IV tubing, I've got to bathe them, change them, they're unstable. It's not a great coping mechanism, but it's letting your mind rest.*"

One participant, Summer, also spoke about how she would sometimes avoid the ICU by calling in sick. She felt that this was a necessary action because the only alternative would be to show up at work and *"fake*" an attitude that masked her moral distress, a pretense she felt unable to maintain. She added, *"So I know if I've gone through a particularly bad stretch, it will not take much for me to call in sick.*"

In contrast, turning towards (or connecting) was revealed through participants' descriptions of actively acknowledging their moral distress. Participants elaborated on their purposeful efforts to establish supportive relationships with colleagues. They sought out connections with people who, in their words, *"get it*". With respect to this sample and based on the experience level of the majority of the participants (i.e. less than three years of ICU nursing experience), colleagues typically sought out were those with more experience (such as senior nurses, educators, charge nurses), who offered understanding and support. They affirmed for participants their perspectives and their distress, and offered suggestions about possible actions to take. Participants emphasised the importance of trust in these supportive relationships. When reflecting upon whom to seek for support, Christine explained,

> *"People that I can trust. People that I aspire to be like a little bit. Like she has all the qualities of a good nurse, and she's empathetic and seems to understand what the right thing to do is most of the time, or she's been through it.*"

Importantly, the participants emphasized that it was most helpful to seek the support of those with a contextual understanding of the ICU environment. They noted that they often felt unable to discuss morally distressing situations with the people in their lives who did not work in the ICU.

Relationships with more experienced colleagues instilled in nurses (with less experience) a sense of hope that it was possible to work through and cope with their experiences of moral distress. While more experienced nurses validated the participants' feelings of moral distress, because they felt it too, seeing these more senior nurses still engaged in their role after many years of ICU practice was described as inspiring. Christine recalled an interaction during her orientation as a new nurse where after a particularly distressing shift she confided in her preceptor: "*I don't know if I can work here.*" The preceptor acknowledged her distress and confided that she felt the same way. This support enabled Christine to appreciate the nature of moral distress as a shared experience, one that arises more from the context of ICU nursing practice than from personal shortcomings or limitations in her nursing practice.

Participants also sought connection by reading written accounts of other nurses about their morally distressing experiences. This type of indirect engagement with others' experiences served to mitigate against isolation and reinforce that moral distress was indeed a shared experience within the landscape of ICU nursing. Julia added, *"Reading other people's experiences too helps. Like reading nurses' blogs or books. Basically first person accounts…Nice to know you're not alone, people experience it as well.*"

Like grass in the wind

As previously described, the shared experience of coping with moral distress had the overarching theme of being *"like grass in the wind.*" Though moral distress (symbolised by the wind) would negatively affect the participants on emotional, physical, and psychosocial levels, they were able to use their skills, experience, and knowledge to work through the distress and 'move with it'. Just like grass, their roots were firmly in place, so they were able to withstand and/or work through adversity. The most experienced nurse, Diana, reflected:

> *"I have a lot of grass in my garden and it's the* [very tall] *zebra grass. Sometimes we have big winds. When it brings it flat to the ground, and then it just goes up, goes up the other way…even if you fall, it's how fast you get up…You see that's what happened with the grass. It doesn't stay there. It just moves up again. Yes, you'll fall. You'll have experiences that will bring you moral distress, but then it's like how do you get back there?*"

This metaphorical description reflects seeking ways to cope that characterized the participants' accounts. The participants were not passive bystanders to the morally distressing situations they encountered. They would advocate for what they believed was right, initiate discussions with physicians and families to share their nursing perspective, organise family meetings, speak out during interprofessional rounds, articulate concerns to management, and solicit the involvement of team resources such as social work. Although participants were not always able to impact the situation in the ways they hoped to, and therefore were sometimes unable to resolve their moral distress, their frustration did not give way to resignation. Diana articulated,

"It's either I choose to accept or choose to remain in conflict with it. But at the same time, I cannot just say, 'Okay, I accept that.' No. You go through questioning, ups and downs, frustration. You go through frustration. I remember having discussions with the team on rounds like, 'Why can't we try this?' Trying even to go around someone. We need to try to get the family around. So you need to still go through the steps. You need to go through the frustrations, the confrontations, the discussions, the reflections and just move with it."

By 'moving with' rather than conceding to moral distress, participants with many years of experience described a process of withstanding the challenges they faced. At the same time, they expressed not having control over all of the sources of their moral distress, and thus absolved themselves of culpability in distressing situations that, from their perspective, were non-modifiable. Even in these situations however, nurses did not speak of disengagement, but rather of ongoing reflection and learning. Diana explained,

"It's like I can't change necessarily stuff, but I can maybe look at it differently. I can maybe use a different pair of glasses…I don't think you can work in ICU and not have self-reflection because it catches up to you."

Importantly, in considering that the majority of the study sample were less experienced nurses, self-reflection and a nuanced understanding of the clinical context that evolved over time provided an important perspective on coping with morally distressing situations and being able to remain engaged in ICU nursing practice. This nuanced understanding of moral distress in the ICU was reflected through Diana as the most experienced nurse in the sample.

Discussion

Like many other studies about moral distress in nursing, our participants described providing care in ways that contradicted their values and their conscience. Importantly, participants described moral distress as *inherent* in their everyday work and not limited to discrete events. This broad description of participants' experiences provided the background for a more focused interpretation about nurses' coping, which was found to be a dynamic state between avoidance, connection and moving with it. Together, these three coping strategies speak to the variable ways that nurses engage/disengage with patients, families, and colleagues when faced with situations that they perceive to be morally distressing. The discussion will also reflect on the inexperience level of the majority of the sample in this study.

Moral distress: is it recognised?

When the participants felt that they could not go into work because of the distress they were experiencing, they did not believe that they could tell nursing management the truth. Instead, they would fake an illness and take a sick day off work. While it was noted that nursing management would sometimes recognise certain situations as distressing, the participants felt the frequency of these gestures was not reflective of the number of times they experienced moral distress. Additionally, most participants felt uncomfortable requesting an assignment change as it would appear they could not handle the situation.

Some of the inexperienced participants in this current study indicated that they had considered leaving the nursing profession or their positions. Decades ago, Kramer (1974) cited lack of support as a reason many nurses leave their practices and it continues to be associated with nurse attrition (MacKusick and Minick, 2010; Young et al., 2008). According to the Canadian Institute for Health Information (2015), Canada's supply of nurses has been declining and in 2014, more nurses left the profession than entered. Many studies have indicated that nurses have left their positions or the profession as a direct result of having their moral values compromised (Elpern et al., 2005; Hamric and Blackhall, 2007; Nathaniel, 2006; Piers et al., 2012; Wiegand and Funk, 2012; Wilson et al., 2013). Nurses' experiences with moral distress should be recognised and validated by nursing management and the larger organisational (hospital) system.

The professional practice environment can contribute to moral distress by constraining the moral agency of nurses. Nurses need spaces in their environments to exercise their autonomy and to act on their responsibilities such as contributing to rounds and being freed up to participate in family meetings to ensure their voice in end-of-life decision making. Moral distress interventions need to be multifactorial to match the complexity of the ICU environment and the ethical conflicts created by technological advancement and frequent exposure to death.

The importance of connecting with others

The majority of the sample in this study had less that three years experience and these nurses sought out more experienced nurses to help them cope. However, even very experienced nurses sought social support from their colleagues. Seeking support from colleagues has been identified as a common strategy to cope with moral distress (Deady and McCarthy, 2010; Gutierrez, 2005; McClendon and Buckner, 2007; Zavotsky and Chan, 2016). Nurse colleagues are often selected as sources of support because they can identify with, and understand the moral distress that their colleagues have experienced without making judgements. As a result, peer-to-peer support is essential in helping nurses cope with stress symptoms (de Boer et al., 2013). The importance of senior nurses supporting less experienced nurses is crucial in creating an atmosphere of respect and trust. Research has examined how resilience can be fostered in nurses so they can deal successfully with adversity (Mealer et al, 2012).

Further, the participants in this study expressed the importance of having an allocated 'safe haven' where they could access social support. De Boer et al. (2013) state that to sufficiently meet nurses' needs for social support, they should be provided with the necessary conditions (such as having a quiet place and time to receive support). Nursing management in ICUs should strive to provide nurses with access to private areas where they can connect with others for support when they are feeling distressed.

Given that the critical care environment can be unconducive to having time away from the bedside (due to the vigilance required in caring for critically ill patients), mechanisms that help ensure nurses are able to leave the bedside for breaks should be emphasised. Break times, for example, allow nurses to have moments for personal leisure and downtime (Hurtado et al., 2015) and to actively engage some of the other coping strategies that were described, like going for a walk or getting a few minutes away to read a book. These strategies allow for emotion focused coping. Designated break times have been shown to help reduce psychological distress and enhance nurses' mental health (Hurtado et al., 2015). By providing nurses with an accessible quiet place and time away from the bedside, nursing management can convey that the role of nurses is valued and that their well-being is important.

Coping skills and experience

In this current study, the participants utilised many of the problem focused coping strategies put forth by Folkman et al. (1986)

such as seeking social support (seeking informational and emotional support from others) and planful problem-solving (attempts made at altering the situation through problem focused interventions). In addition, positive re-appraisal (i.e. focusing on personal growth to find meaning in situations) (Folkman and Moskowitz, 2004), was utilised by the more experienced nurses. These nurses reappraised situations and reflected on how they could learn from them, grow and move forward.

The participants' years of ICU nursing experience was an important factor that influenced how they coped with moral distress. Coping skills were acquired as they gained experience in ICU nursing practice. The majority of the participants, as predominantly novices or advanced beginners, were at the point in their practice where they were beginning to understand not only what it entailed to be an ICU nurse, but also recognizing moral distress and establishing different ways of coping with it. In contrast, the more experienced nurses could easily recognize when moral distress occurred in their practice and knew what coping strategies were most effective for them. Since newer nurses may lack the knowledge and skills necessary to cope with moral distress, experienced ICU nurses and nursing management should strive to mentor these newer nurses so that they can move forward in professional growth and development.

The ability to get yourself back up and "move with it"

Being able to think through a morally distressing event and come to terms with it was a difficult task for the participants, but it was essential. Rushton et al. (2016) state that "although nurses' primary obligation is to their patients, they also have an obligation to address their own suffering" (p. 44). The participants engaged in a process of learning how to address their moral distress without normalising or becoming complacent with the experience. According to Rushton et al. (2016), moral distress can foster growth and be symbolic of moral conscientiousness. The participants exhibited growth as they learned from previous experiences and used their knowledge, skills, experience, and confidence to work through morally distressing situations. Critical reflective practice may help nurses to identify the complexities within an experience and develop strategies to reframe the situation (Peter and Liaschenko, 2013; Rushton et al., 2013). Being able to reflect with members of the interprofessional team can be helpful in learning multiple perspectives of complex situations. By engaging in reflection, nurses can also become aware of the effectiveness of their coping strategies.

Moral engagement in ICU nursing practice

The participants in this study had a keen sense of who they were as nurses and what their values, principles and beliefs were. Even in situations where they disagreed with the plan of care, they would continue to provide patients with quality nursing care. They valued therapeutic nurse-patient relationships and strove to maintain them by contributing to the well-being of patients and families. However, when nurses lack the skills to cope successfully with moral distress, they may purposefully morally disengage themselves so that they can perform actions that are inconsistent with their personal and professional beliefs without having to feel distressed (Fida et al., 2016). The risk of moral disengagement is that it can lead to nurses becoming less proactive and involved in their practice, ceasing to help other colleagues, and working less hours (Fida et al., 2016). It is therefore imperative that nurses are able to develop the skills necessary to cope with their distress so that they can avoid becoming morally disengaged within their practice.

Implications for nursing research and practice

This current study has important implications for both nursing research and nursing practice. Further research is merited that explores the differences between how moral distress is experienced by novice and expert practitioners. This is particularly important with respect to new graduate nurses who are known to be more at risk for leaving the profession than their more experienced colleagues (Kovner et al., 2007; O'Brien-Pallas et al., 2010). It would also be interesting to consider the availability of unit resources (i.e. human, educational, and fiscal) and to consider whether moral distress is more or less inherent in resource deplete versus resource rich ICU environments. From a practice perspective, it would be prudent to explore interventions that promote social support (i.e. formal mentorship programs) and involve innovative strategies to enable nurses to have time to attend activities pertinent to patient care, such as family meetings, in an effort to support shared decision making and enhance nurse-physician communication.

Although the focus of our study was about how individual nurses cope with moral distress, our focus on coping should not be read as an acceptance of the conditions that give rise to moral distress in the first place. Indeed, individualist accounts of moral distress, while valuable, paint a partial picture. The moral experiences of nurses are relational, shaped by "the complex relationships that exist between organizational structures and healthcare providers as moral agents" (Musto and Rodney, 2018, p. 16). Several of our findings do point to the ways in which nurses' moral distress was shaped by the social context of their practice (e.g., a disconnect between nurses' capacity for clinical judgement and the scope of their professional autonomy). Future research about moral distress in ICU nursing should therefore focus on the reciprocity of structure and agency (Musto and Rodney, 2018); that is, on the relationships that exist between the individual experiences of nurses and wider structures that determine the conditions of possibility for ethical nursing practice (Musto and Rodney, 2018).

Limitations

The experiences that the participants shared were influenced by the context of a tertiary-care academic hospital. As such, they may not reflect the experiences of nurses who have worked in other environments such as community or non-teaching hospitals. All the participants were Caucasian females, therefore the influence of gender and/or culture on the experience of coping with moral distress could not be deduced. Notably, the majority of the participants were relatively inexperienced. As a result, the findings related to levels/years of experience are speculative. To be eligible for the study, participants were required to self-identify that they had experienced moral distress at least once. With this eligibility criterion, nurses who did not use the term 'moral distress' to label their challenging experiences were not necessarily captured within the sample. In addition, perhaps more exposure to moral distress than once might have brought forth other strategies.

Conclusion

ICU nurses work in a challenging environment where despite recognizing their professional ethical obligations, they cannot always enact them. This study's findings helped create an understanding of the process of coping that nurses engage in when they are faced with moral distress. Findings from this current study suggest that with increasing years of experience, nurses are able to cope with moral distress and can remain morally engaged in their practice. The knowledge generated from this study provides ave-

nues for organizations to support nursing staff and recognise the vital role of peer support and mentors. Interventions aimed at shared decision making and nurse physician communication, as well as enhancing organisational ethical climate can all contribute to addressing moral distress in nurses.

Conflict of interest

None.

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Ethical approval details

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