The Role of Regret

By Richard H. Savel, MD, MBA, and Carolina Escobar, MD

Retaining the "best and brightest" in the field of critical care remains a national priority. Since the COVID-19 pandemic, however, the ominous cloud of burnout has loomed, leading more health care workers (HCWs) to consider leaving critical care than ever before.[1] Although prior commentaries in this journal have shown cognizance of the potential exodus of HCWs from critical care by explicitly addressing such topics as moral distress, mindfulness, spirituality, and burnout, recent literature has attempted to frame the issue around a different paradigm. The recent focus is on the emotion of "regret" and what role it may play in HCW burnout. In this commentary, we elucidate what is meant by regret in this context, how the emotion can be recognized, and what the potential causes of regret might be. We then comment on the relationship of regret to burnout and share some important evidence-based techniques that may help to prevent, mitigate, and manage regret.

Moral Distress

We first describe moral distress so that we can share with readers how it differs from regret.[2] The emotion called moral distress—commonly felt and documented in many HCWs in intensive care units (ICUs)—occurs when HCWs are put in a situation where they know what they "should do" but are unable to act in that manner. Moral distress is occurring in real time while the HCW is interacting with the patient and/or the interprofessional team on rounds. A reasonable example might be a nurse seeing a moribund patient whose family asks to have "everything" done—a situation where the bedside nurse acknowledges that providing this care may do very little other than "prolong the dying process." Another common example is disagreement among members of the interprofessional team, where one group might recommend that an invasive procedure be performed while other members of the team think that the procedure might do more harm than good. One of the many problems with these events of moral distress is that when the HCW is separated from these stressful events (either when the shift is over or when the patient leaves the ICU), the HCW's stress level may not go back to the baseline they were at before the event. This aftereffect is known as *moral residue*.[3]

One potential antidote for moral distress is moral courage,[2,4] where well-organized and receptive teams work together to make sure that every voice on the team is heard, represented, and truly has a meaningful "seat at the table." Additionally, it is critical that ICU HCWs receive appropriate training in mindfulness and spirituality to allow them to care for their patients despite events over which they may not have control and situations in which they might disagree with the plan.[5,6] But, as many of us who work in the ICU know, given the international crisis of burnout in ICU HCWs, recognition and management of moral distress alone has not been sufficient to address the problem.

Regret

The definition of *regret* as it is used in the context of ICU HCWs does not differ much from how the term is used in common parlance. Some authors have described regret as the "retrospective twin" of moral distress; by that, they mean that regret is an emotion that happens after the event in question has passed.[7,8] We like to call it the "if only" emotion. "If only we had been able to meet with the family sooner, perhaps this prolonged hospital course could have been prevented." "If only I had consulted palliative care earlier in the hospitalization, we might have been able to avoid this very upsetting 'code' situation." "If only the team could have come to consensus sooner . . . ." Numerous other examples can be found in the recent literature.[9-12]

doi:https://doi.org/10.4037/ajcc2026518

> “Having a well-organized, structured hospital protocol in place that can be used when *any* member of the team feels that potentially inappropriate care is being provided may help prevent regret and burnout.”

As we just mentioned, one of the major differences between regret and moral distress is that regret happens after the event whereas moral distress occurs during the actual care of the patient. In addition, a critical difference between moral distress and regret is that in defining moral distress, powerlessness is a key factor. When a HCW is in a situation of moral distress, they know what they want to do, but they are unable to do it—for some of the various reasons just articulated. Regret implies that they could have done something different (in retrospect) and “if only” they had taken that alternative path, the outcome would have been different. The concept of impotence—a critical part of the definition of moral distress—is not necessarily integrated into the definition of regret. Importantly, for the purposes of this commentary, it appears from the recent literature that the connection between regret and burnout is significant and clear.

Regret: Connecting Futile Care With Burnout

In their recent work, Wozniak et al[13] surveyed HCWs for regret, burnout, and intention to leave the field. Their conclusions were critical for nurses, physicians, and other HCWs who work in the ICU. First, the authors found that it was the *intensity* of the regret rather than the *frequency* that was more highly correlated with burnout. Second, the authors report that nurses had a higher level of regret compared with physicians and were more likely to report leaving the profession. Finally, the primary determinant of regret was found to be perceived futile care, and, using their analysis, they found that regret acted as a mediating factor—a connector, if you will—between perceived futile care and burnout. The authors were able to document 4 causes of regret that were associated with higher intensity: perceived futility, a decision made regarding the patient’s care, disagreement within the circle of care, and a medical action that was performed.

Preventing, Mitigating, and Managing Regret

So, from a broader perspective, how does adding the concept of regret help us work to decrease burnout for nurses, physicians, and other HCWs in the ICU? Primarily, it allows there to be a structured approach to try to prevent, mitigate, and manage regret. Innovation here will be key, as what appears to be most important is “perceived futility.” Although the literature is somewhat optimistic because perceived futility is associated with the highest intensity of regret and, therefore, if prevented, would in theory lead to a decreased incidence of regret, there are some real potential issues to be grappled with.[13,14]

The biggest problem with working to prevent regret and burnout related to potentially futile care is that interventions that are often thought to be “potentially inappropriate care” from the perspective of the ICU team are frequently considered to be completely appropriate and reasonable care from the perspective of the patient’s family.[15] Nevertheless, even when the treating team and the family may disagree regarding potentially inappropriate care, we believe that having a well-organized, structured hospital protocol in place that can be used when *any* member of the team feels that potentially inappropriate care is being provided may help prevent regret and burnout. Recommended examples include automatic triggers for palliative care, hospice, and ethics consultation when these situations arise.

Of equal importance—and potentially easier to execute—would be the implementation of techniques to manage regret once HCWs notice they are having symptoms of regret.[9,12,16] Given the association of self-blame and rumination with higher burnout levels, tackling these symptoms head-on is mission critical.

About the Authors
Richard H. Savel is chair, Department of Medicine, Jersey City Medical Center, Jersey City, New Jersey, and a clinical professor of medicine, Rutgers New Jersey Medical School, Newark. He is a former coeditor in chief of the *American Journal of Critical Care*. **Carolina Escobar** is the director of medical critical care and the medical intensive care unit at RWJBarnabas Health | Jersey City Medical Center in New Jersey.

Corresponding author: Richard H. Savel, MD, MBA, Jersey City Medical Center, 355 Grand St, Jersey City, NJ 07302 (email: rhsavel@gmail.com).

Specific approaches that can be used are as follows: begin by creating an atmosphere where team members work with one another to inquire about and spot these symptoms early. Foster an environment of open discussion to share common experiences. Emphasize self-forgiveness and other regret management programs. Creating a supportive culture is the key to success here.

Conclusion: Circle Back to Burnout

As has been emphasized many times before in the pages of this journal, no matter what your role is in the interprofessional critical care team, being part of that team is a privilege and a calling. When someone asks any of us what we did today, we always get to answer, "I worked with patients and families in that overwhelmingly complex and important area between life and death. I made a difference." But doing this kind of work takes its toll. We owe it to each other and to our patients and their families to constantly be working as a community to find better ways to determine why ICU HCWs develop burnout so that we can prevent, minimize, and manage it. The recent expansion of the literature as it relates to regret and burnout is another example of how we are making evidence-based progress that has real-time implications for HCWs, families, and patients across the world.

FINANCIAL DISCLOSURES
None reported.

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