The Cost of Caring: Recognizing & Reducing Moral Distress

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The Ethical Mess of Our Health Care System

Moral injury and burnout in medicine: a year of lessons learned
By WENDY DEAN and SIMON G. TALBOT / JULY 26, 2019

Why Are Nurses Leaving The Profession?
Deborah Chiaravalloti – 04/08/19

Even Doctors Can’t Navigate Our ‘Broken Health Care System’

Health-care system causing rampant burnout among doctors, nurses
As many as half of all clinicians suffer from the problem, creating risks to patients, malpractice claims and absenteeism, study finds.
Recognizing & Reducing Moral Distress

- Define Key Concepts
  - Moral Distress
  - Moral Community
  - Ethical Climate

- Recognize the Impact of Moral Distress

- Identify Strategies for Reducing Moral Distress
Disclosures

No financial or commercial relationships to disclose.
Case #1

AJ is a 13 yo M with recurrent osteosarcoma admitted for chemotherapy which confers a significant risk for infertility.

His parents believe that he might refuse treatment altogether if he learns that his fertility might be impacted, and they have asked their son’s primary oncologist not to tell him about the possibility of infertility.
Case #1

AJ’s bedside nurse is reviewing his orders and notices that the typical referral to a fertility specialist & semen collection have not been placed. He pages the resident to ask her to place the forgotten orders.

Who might experience moral distress?
Case #2

You return home from an amazing Oncofertility conference convinced that a fertility navigator will allow equitable access to fertility-related care for your patients. Your department chair refuses to budget for the position. You know that many patients and families in your institution are not receiving adequate fertility counseling but you feel helpless to make a change.

Is this moral distress?
Moral Distress: Definition & Key Components

“When one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.” (Jameton 1993)
Moral Distress: Definition & Key Components

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• Wrongdoing/complicity in wrongdoing associated with professional values
• Lack of voice/power
Moral Distress: What it is NOT

• Conscientious Objection

• Uncertainty / Ethical Dilemma

• Emotional distress: feelings of sadness, frustration, anger
Moral Distress: What it is NOT

- Secondary Traumatic Stress/Compassion Fatigue

- Always shared equally among team members
  - Factors/Root Causes
  - Roles within a Moral Community
A MORAL COMMUNITY

Health Care System

Health Care Team

Patient

Parents

Researcher

ETHICAL CLIMATE
A MORAL COMMUNITY

• Non-random group engaged in reciprocal and positive social interaction, often with a common moral purpose (DiNorcia 2002)

• Ethical Climate: the implicit and explicit values that drive health care delivery and shape the workplaces in which care is delivered (Rodney 2006)

• Can either perpetuate or work to eliminate the experience of moral distress
Moral Distress: Root Causes

Patient
• Demands for overly aggressive treatment
• Unnecessary suffering

Unit
• Poor communication/ Inadequate collaboration
• Being bullied by colleagues

System
• Chronic understaffing/ Lack of resources
• Pressure from administrators to reduce costs
Profession: Entails Moral Obligations

Individual moral agent

Intent to act morally

Action

Moral Agency

Failure to Act

Moral Distress

Moral Residue

Burn Out

Resiliency

Mattering

Family Demands

Unnecessary Suffering

Patient

Poor Communication

Inadequate collaboration

Unit

Administrative Pressures

Lack of Resources

System

ETHICAL CLIMATE

MORAL COMMUNITY: Organizational Values

MORAL COMMUNITY: Patient Unit System
Profession: Entails Moral Obligations

Individual moral agent

MORAL COMMUNITY: Organizational Values

Patient

Unit

System

ETHICAL CLIMATE
Profession: Entails Moral Obligations

Individual moral agent

Intent to act morally

- Family Demands
- Unnecessary Suffering
- Poor Communication
- Inadequate collaboration
- Administrative Pressures
- Lack of Resources

Patient
Unit
System

ETHICAL CLIMATE

MORAL COMMUNITY: Organizational Values
Profession: Enacts Moral Obligations

Individual moral agent

Intent to act morally

Failure to Act

Moral Distress

- Family Demands
- Unnecessary Suffering
- Poor Communication
- Inadequate collaboration
- Administrative Pressures
- Lack of Resources

Patient

Unit

System

ETHICAL CLIMATE

MORAL COMMUNITY: Organizational Values

MORAL COMMUNITY: Patient, Unit, System
Profession: Entails Moral Obligations

MORAL COMMUNITY: Organizational Values

Individual moral agent

Intent to act morally

Failure to Act

Moral Distress

Moral Residue

• Family Demands
• Unnecessary Suffering
• Poor Communication
• Inadequate collaboration

• Administrative Pressures
• Lack of Resources

Burn Out

Patient

Unit

System

Leaves Community

Personnel Shortages

↓ Quality of Care

↓ Trust
Profession: Entails Moral Obligations

AJ’s Bedside RN & Resident

Intent to act morally “truth telling”

MORAL COMMUNITY: Organizational Values

Failure to Act

Moral Distress

- Poor Communication
- Inadequate collaboration

Patient
Unit
System

Case #1
Profession: Entails Moral Obligations

AJ’s primary oncologist

Intent to act morally “respect the patient’s emerging autonomy

Moral Distress

Failure to Act

• Family Demands

Patient

Unit

System
Profession: Entails Moral Obligations

Fertility Champion

Intent to act morally “meet standard of care re: fertility”

Failure to Act

Moral Distress

Patient

Unit

System

- Administrative Pressures
- Lack of Resources

MORAL COMMUNITY: Organizational Values

Case #2
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Moral Distress: Impact

• ↓ Job satisfaction/ Burn Out
• Intention to leave position / ↑ Turnover
• Loss of revenue ($88,000 per nurse, $1,000,000 per physician)
• ↓ Quality of teamwork
• ↓ Quality of care
Moral Distress

• ALL HOPE IS NOT LOST...
Profession: Entails Moral Obligations

Individual moral agent

Intent to act morally

Action

Moral Agency

Mattering

Resiliency

Family Demands

Unnecessary Suffering

Poor Communication

Inadequate collaboration

Administrative Pressures

Lack of Resources

Patient

Unit

System

MORAL COMMUNITY: Organizational Values

ETHICAL CLIMATE
Moral Distress: Strategies to Identify & Reduce

• **Identifying**
  • Moral Distress
  • Root Causes
  • Ethical Climate

• **Reducing**
  • Individual
    • Ethics Education/ Moral Empowerment
  • Unit
    • Moral Distress Consultation/ UBEC/ Preventative Ethics/ PEACE Rounds
  • System
    • Policy Development
Moral Distress: Identifying

- Moral Distress Thermometer (Wocial 2013)
- Circle the # that best describes how much moral distress you have been experiencing related to work in the past week including today
Moral Distress: Identifying

- Measure of Moral Distress for Healthcare Professionals (MMD-HP) (Epstein 2019)
  - 27 items
  - Presence, Intensity, Root Causes
  - Pediatric, Adult, ICU, LTCH

If there are other situations in which you have felt moral distress, please write and score them here:

Have you ever left or considered leaving a clinical position due to moral distress?
- No, I have never considered leaving or left a position.
- Yes, I considered leaving but did not leave.
- Yes, I left a position.

Are you considering leaving your position now due to moral distress?
- Yes
- No
Moral Distress: Identifying

Hospital Ethical Climate Survey- 26 items (Olson 1998)

- **Unit/ Team**
  - “Physicians ask nurses about their opinion about treatment decisions”
  - “Safe patient care is provided in my area”

- **Patients**
  - “The patient’s wishes are respected”

- **System/Hospital**
  - “Hospital Policies help me with difficult patient care issues”
Moral Distress: Strategies to Identify & Reduce

• **Identifying**
  - Moral Distress
  - Root Causes
  - Ethical Climate

• **Reducing**
  - Individual
    - Ethics Education/ Moral Empowerment
  - Unit
    - Moral Distress Consultation/ UBEC/ Preventative Ethics/ PEACE Rounds
  - System
    - Policy Development
Individual Level: Ethics Education/ Moral Empowerment

- Provides Education
- Access to Resources
- Communication Training
- Inter-professional Opportunities
- Develop Individual Action Plan

- 4 As (Rushton 2006)
Unit Level: PEACE

PEACE Rounds (Wocial 2017)

• Pediatric Ethics and Communication Excellence (PEACE) Rounds
• ↓LOS
• No impact on Moral Distress
Unit Level: Unit Based Ethics Conversations

(Helft 2009) (Wocial 2010)

• Scheduled, Inter-professional
• Forum for processing ethical issues
• Based on recent cases
• 86% helped them to address ethical issues they faced in their clinical practice
• 67% stated they felt better able to manage ethically challenging situations
• Opportunity: No resolution to a case discussed
Unit Level: Moral Distress Consultation

(Hamric 2017)

- Requested by Unit leadership or suggested by the ECS
- Trained facilitators, Open sessions, last 45-60 minutes
- Develop an action plan
- Anonymous reports on themes to Hospital Leadership
System Level: Integrated Ethics

(Fox 2010) (Foglia 2012)
Veterans Health Administration (VA)'s National Center for Ethics in Health Care

• Adapted QI approach:
  Identify an issue
  Study the issue
  Select a strategy
  Undertake a plan Evaluate and adjust Sustain and spread
System Level: Policy Development

Code Status Orders & Associated Treatment Plans

“The Medical Center respects the rights of Health Care Team (Team) members to maintain their professional and ethical integrity.”

All DNAR orders are part of the patient’s goal-directed plan of care...

A: All Therapy but Do Not Attempt Resuscitation
B: Non-Escalation of Therapy
C: Comfort Measures Only
Medically & Ethically Inappropriate Treatment is Not Required

“Virginia law does not require physicians (and by association the Team) to provide treatment that is determined to be medically and ethically inappropriate… Relief of pain is a basic human right… The Team shall not reduce or discontinue interventions to alleviate pain at the request of the patient’s surrogate or any other person.”
MORAL COMMUNITY: Entails Moral Obligations

Profession: Entails Moral Obligations

Individual moral agent: Intent to act morally

MORAL COMMUNITY: Entails Moral Obligations

Moral Agency

Action

Moral Empowerment
PEACE Rounds
Unit Based Ethics Conversations

Moral Distress Consultation
Preventative Ethics Policy Development

ETHICAL CLIMATE

Resiliency
Mattering

Preventative Ethics Policy Development
Recognizing & Reducing Moral Distress

We must

• **Recognize** that Moral Distress occurs when a provider believes she/he is doing something wrong and has little power to change the situation

• **Understand** the implications of moral distress for the individual and the moral community

• **Apply** this understanding by creating positive individual, unit, and system level changes
Acknowledgements

Elizabeth Epstein, PhD, RN, HEC-C, FAAN
Lucia D. Wocial, PhD, RN, FAAN
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References


References


PROFESSIONAL ETHICAL LEADERSHIP MODEL

Professions
- Trust
- Integrity
- Reciprocity
- Self-regulation
- Public Service

Ethical Transformational Leadership Style

Ethical
Transformational
Leadership Style

Moral Community
- ethical climate
- clear, consistent messages
- belongingness, shared values
- self-regulated, principles-based
- Professional CSR

Degree of Sustainable Success

Isolationist Culture
- unethical climate
- ambiguous values
- self-interest
- bottom-line results, contingent rewards
- rules-based legal oversight/monitoring

+ 

-
Profession Duties: Entail Moral Obligations

Individual identifies as a moral agent

Moral Obligations: Truth telling, Respect, Autonomy, Provide, Quality/Non-biased Care, Maximize Benefit, Reduce Suffering, Advocacy, Avoid Causing Harm

Intent to act morally

Action

Failure to Act

Family Demands
- Unnecessary Suffering

Poor Communication
- Inadequate collaboration

Administrative Pressures
- Lack of Resources

Mattering

Resiliency

Moral Agency

Burn Out

Moral Injury

Moral Distress

Patient

Unit

System
Moral distress, however, is the feeling that one has failed to act according to one’s moral conviction. It strikes at one’s integrity and threatens one’s fulfilment of professional obligations to act in a patient’s best interest.

However, though there may be reasonable disagreement about what constitutes the best interests of a patient, for the person experiencing moral distress with a sincere belief that they are not acting in the patient’s best interests, the phenomenon of moral distress is still very real. Thus it does not take away from the argument that physicians can experience moral distress due to feeling constrained by parental wishes—even if another physician would not experience moral distress in this situation but only a sense of facing a dilemma.
Recognizing Moral Distress

MD
RN
MA
Genetic Counselors
PhD
SW
Other Health Professionals
Compassion Fatigue
Burn Out
Turn over

moral stress remains a statistically significant predictor of increased employee fatigue, decreased job satisfaction, and increased turnover intentions.


DeTienne, K. B., Agle, B. R., Phillips, J. C., & Ingerson, M. C. (2012). The impact of moral stress compared to other stressors on employee fatigue, job satisfaction, and...
Moral Distress: Fertility Preservation

Other frequently mentioned ethical dilemmas were as follows: workplace policies around PGT for variants of uncertain significance; workplace policies permitting patients to use embryos that tested positive for a familial mutation through PGT; workplace policies allowing patients to use embryos with mosaic test results; difficult couples’ dynamics; and concerns around screening gamete donors, including notifying intended parents of disease risks for their donor-conceived children and making judgments about whether to recommend a donor. Several GCs felt personally conflicted about workplace policies permitting patients to test for the above variants or to use embryos with abnormal results; however, all who commented felt they still counseled patients non-directively and were able to utilize support resources to successfully counsel these patients.
Forcing parents to take decisional priority in these scenarios may be unnecessary and result in moral distress for the HCPs—when the clinician is compelled to provide medical care that he/she does not believe is in the patients’ best interests.
A few participants commented they personally did not agree with some of the policies their places of work had related to these ethical dilemmas. One GC explored the possible consequences of voicing her concerns to supervisors. She described approaching her team about restricting certain practices and was unsuccessful, and she reflected on how this impacts her:

“I have thought about what the implications would be to refuse to participate in those cases. And since I’m the only genetic counselor…it would be refusing the case as a whole…there would be huge, huge ramifications to just saying, “Sorry, I’m not going to do it”…the consequences of which would be me getting fired. So that’s, that’s really hard. (P 15, Has children, has not experienced infertility)
Reducing Moral Distress

PEACE rounds
Moral Distress Consultation
Moral Empowerment
Imbedded within palliative care programs are many interventions proposed to prevent or reduce moral distress, including provider ethics education (Kälvemark Sporrong, Arnetz, Hansson, Westerholm, & Höglund, 2007; Rogers et al., 2008); multidisciplinary collaboration and consensus building (Okah et al., 2012; Rice, Rady, Rabinof, Verheijde, & Pendergraft, 2008); interdisciplinary provider, patient, and family conferences (Gutierrez, 2005; Rice et al., 2008); education strategies to manage moral distress (Beumer, 2005); and support for families (Gutierrez, 2005).
Moral Empowerment

The moral empowerment program used in this study included the steps designed by the researcher through employing Alvita K. Nathaniel's Theory of Moral Reckoning in Nursing which were implemented in a 2-day workshop (6 h a day) for the experimental group. Moreover, using pamphlet, the symptoms of moral distress and its complications were taught to the control group during a 2-h session. The Theory of Moral Reckoning has three stages: the stage of ease, the stage of resolution, and the stage of reflection (thought). If the person cannot deal with the first stage appropriately, he or she will be subject to moral conflict and, as a result, to moral distress. Thus, our interventions began from the resolution stage; however, it should be noted that in the strategies, the features mentioned in the stage of ease were also emphasized and employed as much as possible. In the present research, given the existing situation and the impossibility of intervening in issues such as organizational policies or, for instance, the workplace factors and like this, other implementable theoretical strategies were exploited. The steps of the moral empowerment program in this study were as follows:

Speech on the definition of moral distress and its symptoms by a medical ethics specialist based on the second stage of the theory (the stage of resolution), and presentation of the contents in the form of pamphlet to the subjects.

Identification of the adverse consequences of moral distress in nurses, nursing profession, and the quality of care.

Training strategies for overcoming moral distress in collaboration with the medical ethics specialist and psychiatric nursing specialist based on existing studies (with regard to the second stage of the theory: the stage of resolution) which includes the following.

1. Teaching the techniques useful in overcoming moral distress through using lecture, PowerPoint, group discussion; mentioning examples of nursing education and its ethical skills;
2. Improving communication and encouraging participation in an inter-professional environment;
3. Asking for emotional support as well as spiritual support in the face of moral distress;
4. Strengthening the problem-solving skill, self-expression and daring behavior; collective techniques such as plays and scenarios;
5. Moral group meetings; narrative and storytelling methods such as discussing moral distress experiences as well as individual and professional approaches in dealing with it.

Efforts to strengthen and apply strategies for dealing with moral distress under the directions of the researcher and through organizing small focused groups and sharing moral distress experiences in the form of a story (based on the third stage of Moral Reckoning Theory: the stage of reflection). To do so, the nurses were divided into five groups (six subjects in each group). Then, from the experiences provided by the nurses during their work experience, one experience was presented by the representative of each group. Then, after training on strategies effective for reducing moral distress in the workshop, each group was asked to offer some appropriate solutions to their experiences regarding moral distress and also solutions to minimize moral distress with regard to the scenarios given to them. The researcher corrected the solutions if required.

At the end of the workshop, pamphlets of the strategies for dealing with moral distress were provided to the nurses of the experimental group and a telegram group was designed for sharing the experiences of the nurses and providing a solution to them.

The control group also trained the symptoms and signs of moral distress and its complications in a 2-h session with the help of pamphlet. The moral distress questionnaire was completed 2 weeks later and 1 month after the workshop by nurses in the experimental and control groups.
<table>
<thead>
<tr>
<th>Time</th>
<th>Experimental group</th>
<th>Control group</th>
<th>Independent t-test</th>
<th>Independent t-test</th>
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<tr>
<td></td>
<td>Mean ± SD</td>
<td>Mean ± SD</td>
<td>t</td>
<td>p</td>
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<tr>
<td>Before the intervention</td>
<td>4.05 ± 2.26</td>
<td>4.12 ± 2.70</td>
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<td>Two weeks after the intervention</td>
<td>3.38 ± 2.11</td>
<td>4.23 ± 2.70</td>
<td>1.36</td>
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<td>One month after the intervention</td>
<td>2.64 ± 2.23</td>
<td>4.04 ± 2.54</td>
<td>2.26</td>
<td>0.03</td>
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<tr>
<td>Repeated-measures ANOVA</td>
<td>F 3.18</td>
<td>0.09</td>
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<td></td>
<td>p 0.04</td>
<td>0.92</td>
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SD: standard deviation; ANOVA: analysis of variance.
# PEACE Rounds Record

**Patient Name:**

**Study ID:**

**Date:**

**Diagnosis:**

**Developmental Level:**

## Discussion

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<th>Question</th>
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<td>Would you expect patient will survive ICU Stay?</td>
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<td>Would you expect patient will survive hospital stay?</td>
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<th>Are we on track for attaining these goals?</th>
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<td>Intensivist 2</td>
<td>Yes/No</td>
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<tr>
<td>Nursing</td>
<td>Yes/No</td>
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<th>Is all care team in agreement? Yes/No</th>
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## Plan

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<th>Action</th>
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Moral Distress Workshop

Moral Distress Questionnaire

Shared experiences of moral distress

Definition of moral distress

Identification of signs and symptoms of moral distress

Identification of barriers that cause moral distress in the intensive care unit setting

Presentation of American Association of Critical-Care Nurses’ 4As to rise above moral distress

Development of individual action plan

Development of unit action plans

Processes of self and others are available for self