Understanding and Responding to Moral Distress: Why It Pays to Do the Right Thing

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Outline

1. Nature of Moral Distress and Residue
2. Prevalence and Causes of Moral Distress
3. Impact of Moral Distress and Residue
4. The Way Forward
Camus, *The Fall*

In Camus’s Novel *The Fall*, the narrator revealed to a stranger in a bar in Amsterdam his past as an enviable Parisian lawyer who ‘was truly above reproach in his professional life’. He said:

“I never accepted a bribe it goes without saying, and I never stooped either to any shady proceedings. And – this is even rarer – I never deigned to flatter any journalist to get him on my side, nor any civil servant whose friendship might be useful to me. I even had the luck of seeing the legion of honor offered to me two or three times and of being able to refuse it with a discreet dignity in which I found my true reward. Finally, I never charged the poor a fee and never boasted of it.” (pp. 19-20)
Camus, *The Fall*

He went on to acknowledge that “I enjoyed my own nature to the fullest, and we all know that there lies happiness”. One momentous evening, however, when he was returning home an hour after midnight by way of the Pont Royal, he passed “behind a figure leaning over the railing and seeming to stare at the river. On closer view, he made out a slim young woman dressed in black. He was about 50 yards away when he heard a “sound – which, despite the distance, seemed dreadfully loud in the midnight silence – of a body striking the water”. He stopped but he did not turn around.

Almost at once he heard a cry, repeated several times, which was going downstream; then it suddenly ceased. I wanted to run and yet didn’t stir. I was trembling, I believe from cold and shock. I told myself that I had to be quick and I felt an irresistible weakness steal over me......then, slowly under the rain, I went away. I informed no one.
Camus, *The Fall*

From this time on, his life changed. For years the words that echoed through his nights were, “Oh young woman, throw yourself into the water again so that I may a second time have the chance of saving both of us!”

~~ quoted from, Austin et al. *To Stay or To Go, To Speak or To Stay Silent, To act or Not to Act: Moral Distress as experienced by Psychologists*, c. 2005.
Moral Distress Defined

Jameton (1984) 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 carry out that action because of institutional obstacles’
“I was a relatively new nurse 16 years ago when I took on the position of Administrative Coordinator, which meant that I was the administrative person in charge of the hospital at night, or on weekends and holidays. My responsibilities included doing rounds of all the units in the hospital, so that I could make administrative decisions knowledgeably in the absence of the daytime managers.

I was in the emergency department one night when a patient was brought in with an overdose. As I was there, and they were short-staffed, I went into the trauma room to assist as recorder. The patient was a First nations woman who was very upset and resisting medical care. She was in four–point restraints, was very verbal in her resistance, roundly cursing the staff. ..
The emergency physician, after demanding several times that she ‘shut up’ took a wash cloth and stuffed it in her mouth to silence her. I was dumfounded! I stood there for a moment debating whether or not to intervene as the rest of the team laughed. A combination of fear, uncertainty and the feeling that no one else in the room would understand led me to question my values. I resisted doing what I felt was the right thing to do. In the end, I handed the record sheet to another nurse and left the room.

My feelings on that night remain with me to this day.”

~~ Lorraine Hardingham, Integrity and Moral residue: nurses as participants in a moral community, 2004.
Initial/Reactive Distress

- Initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values.
- Reactive distress is the distress that people feel when they do not act upon their initial distress.
Timing?

The time seems right for this cross-fertilization (of work and soul, doing and being). It seems that all the overripe hierarchies of the world, from corporations to nation states, are in trouble and are calling, however reluctantly, on their people for more creativity, commitment, an innovation. If these corporate bodies can demand those creative qualities which by long tradition belong so directly to our being, to our soul, they must naturally make room for their disturbing presence within their buildings and borders.

A Spiritual Issue?

• Merely emotional/psychological?
• Moral distress is the violation of one’s core values and obligations and thus is qualitatively different from psychological distress which describes emotional reactions to situations, but does not necessarily involve violation of one’s core values and duties (Epstein and Hamric, Winter 2009)

Example; a psychiatric nurse may be emotionally distressed while restraining a patient, but they are likely to become morally distressed only if they believe that restraining the patient is morally wrong
As in the first marriage, the great questions that touch on personal happiness in work have to do with an ability to hold our own conversation amidst the constant background of shouted needs, hectoring advice and received wisdom. In work we have to find high ground safe from the arriving tsunami of expectation concerning what I am going to do. Work, like marriage, is a place you can lose yourself more easily perhaps than finding yourself. It is a place full of powerful undercurrents, a place to find our selves, but also, a place to drown, losing all sense of our own voice, our own contribution and conversation.

~~ David Whyte, The Three Marriages, page 24
2002 Code of Ethics of the Canadian Nurses Association

• Moral distress is defined as:

• Situations in which nurses cannot fulfill their ethical obligations and commitments (i.e. their moral agency) or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectations of ethical practice, for one or more of the following reasons: error in judgment, insufficient personal resolve or other circumstances truly beyond their control...they may feel guilt, concern or distaste as a result.
Last month a physician who serves as an ethics consultant told me about a growing concern in her hospital. Doctors and nurses “feel trapped,” she said, by the competing demands of administrators, insurance companies, lawyers, patients’ families and even one another. “And they are forced to compromise on what they believe is right for patients.” (the words of Dr. Pauline Chen, author of article)

She called the problem “moral distress.”

Since that discussion, I have not been able to stop noticing moral distress.

What is best for the patient?

- Moral distress among nurses occurs when the nurse knows what is best for the patient but that course of action conflicts with what is best for the organization, other providers, other patients, the family, or society as a whole (Corley, 2002)

- I.e., when the internal environment of nurses – their values and perceived obligations – are incompatible with the needs and prevailing views of the external work environment
Ethical Dilemmas at the Bedside

• Distress is brought on when staff are not able to do what they feel they should do in the care of patients and families by factors beyond their control

• Ethical dilemmas get trivialized or dismissed by staff or institutions as staff do not wish to be marginalized or isolated for bringing up concerns
Moral Residue

Moral residue is that which each of us carries with us from those times when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised.

Such a compromise is a betrayal – an act of yielding one’s moral values without defending those values. This results in a loss of moral identity leading to moral residue that is lasting and powerful.

Compromised integrity ‘irreversibly alters the self’

( Webster and Bayliss )
Is Moral Distress a Problem?

- A major problem in the nursing profession (Corley, 2002)
- In a study by Holfing, Brotzman, Dalrymple and Graves (1966) nurses verbalized feelings of shame, embarrassment and guilt
- Mitchell (1982) spoke ‘of the nurses’ compromised integrity’
- Moral distress, characterized by frustration, anger and guilt often led them to avoid patients and even to leaving the nursing profession (Wilkinson, 1988)
- In one study 26% stated that they had left positions in the past because of moral distress (Corley, 1999)
A key element in moral distress is the individual’s sense of powerlessness, the inability to carry out the action perceived as ethically appropriate.

As values and obligations are perceived differently by various members of the healthcare team, moral distress is an experience of the individual rather than an experience of the situation.
Disempowered

• Staff may feel ‘disempowered’ when they cannot follow through and provide the right course of action for a patient
• this undermines their integrity and authenticity on a professional and personal level
• The inability of nurses to influence medical decisions related to a patient’s level of suffering/pain contributes to moral distress
• Power Hierarchies that do not allow staff to draw upon their expertise also contributes to moral distress
Hierarchical Vulnerability

Moral distress is a very real problem.....especially in medical students, residents, nurses, respiratory care and other allied health workers...people who see themselves as involved in morally significant relationships with sick, vulnerable humans, but have little or no power to respond when what is happening appears to be “wrong”

~~ the late Dr. William Bartholome
Prevalence and Causes of Moral Distress
Wilkinson’s Study on Moral Distress

- Letters sent to sample of nurses inviting them to participate in research; with 26 responses returned and 24 one hour interviews that were taped and transcribed

- Most common moral issues mentioned were a) harm to the patient in the form of pain and suffering and b) treating persons as objects (dehumanizing them)
“Hey Nurses, it’s not all about You”

- Moral distress has been identified among nearly all healthcare professionals:
  - Physicians (Austin, Kagan et al, 2008)
  - Respiratory Therapists (Schwenzer and Wang, 2006)
  - Pharmacists (Sporrong, Hoglund et al, 2005)
  - Psychologists (Austin, Rankel et al, 2005)
  - Social workers (Chen, 2009)
  - Nutritionists (Chen, 2009)
  - Chaplains (Chen, 2009)
Impact of Moral Distress (Epstein and Hamric, 2009)

1. Providers become morally numb to ethically challenging situations and thus may no longer recognize or engage in clinical situations requiring moral sensitivity.

2. Providers may engage in different ways to conscientiously object to the trajectory of the situation to make known an opinion to overcome constraints.

3. Providers can become burnt out (Meltzer and Huckaby, 2004). Nurses may also consider leaving their profession (Corley, 1995; Hamric and Blackhall, 2007).
Nurse/Physician Experience and Perspective on Moral Distress

- Research carried out in 14 ICUs involving 29 physicians and 196 RNs in two hospitals in Virginia
- RNs reported lower collaboration, higher moral distress, a more negative ethical environment and less satisfaction with quality of care than did physicians
- At one site 45% of nurses reported having left or considered leaving a position because of moral distress
- (Hamric & Blackhall, 2007)
The operation was a success: Later, the duck, with his new human brain, went on to become the leader of a great flock. Irwin, however, was ostracized by his friends and family and eventually just wandered south.
The Moral Distress Crescendo Effect (Epstein & Hamric, 2009)

- At the conclusion of a patient crisis a clinician’s acute moral distress decreases, however painful feelings are not completely eliminated and some moral residue remains.
- The remaining moral residue serves as a new base line for moral distress.
- Over time, as repeated crescendos of moral distress are experienced, moral residue increases gradually.
Moral Residue Crescendo
(Epstein and Hamric, 2009)

• As moral residue crescendo rises over time due to repeated episodes of moral distress, a breaking point may occur.

• Three potential consequences are:
  1. Providers become morally numb to ethically challenging situations, thus no longer recognizing or engaging in clinical situations requiring moral sensitivity.
  2. Providers may engage in different ways of conscientious objection to the trajectory of the situation (calling for an ethics consult or documenting dissent in patient’s chart).
  3. Burnout.
The Crescendo Effect: Cause for Concern
Corley, 2001 (Use of Moral Distress Scale)

- Study done with 158 nurses from several United States hospitals
- Nurses were asked to rate the level of their moral distress on 32 items that cause distress
- The mean score for each item was tabulated (range was 1—7)
Long –term Effect of Moral Distress ( Corley 1995 )

• Study involved 111 critical care nurses, of which 12% had left a nursing position due to moral distress

• In another study in 1999 that number had increased to 26%

• Corley’s work discovered that the source of moral distress included:
  1. Harm to patients in the form of pain and suffering
  2. The treatment of patients as objects when meeting institutional requirements
  3. Health policy constraints
  4. Medical prolongation of dying
  5. Inadequate staffing
  6. The effects of cost containment
Physicians and Moral Distress

• Interviews took place shortly after the death of an infant with 21 nurses interviewed and 11 physicians

One resident physician commented:
‘That day Baby A had lethal arrhythmia and I was doing chest compressions. The nurse was really strongly hinting that we should just stop this and let her die, stop this, but we had no directive to do that. So there was some tension then. I didn’t want to be doing this and I kind of agreed with her. I had to do it because there was no DNR in the record.’
Physicians and Moral Distress

• Another resident physician commented:

“There are some physicians that never say die – do absolutely everything, absolutely everything. I remember one physician coding a baby with a pulmonary hemorrhage and the endotracheal tube filled with blood [that] oscillated with chest compressions and I was thinking, ‘This is wrong, this is so wrong.’"
Moral distress in NICU

In a study by Solomon and colleagues a majority of critical care physicians (80%) and nurses (69%) agreed with the statement “Sometimes I feel we are saving children who shouldn’t be saved.”
Denial?

Failure to acknowledge the frequency with which this experience is occurring in the clinical setting is a serious problem. And one of the most serious aspects of the problem is the tendency of those in power in the clinical setting to refuse to treat it as a serious problem.

~~ Dr. Bartholome
Culture of Silence

- Culture of silence promotes the ‘go along to get along’ mindset
- Staff compromise their convictions in order to be seen as a ‘team player’
- Staff may remain ‘silent’ because the price to pay for ‘whistle-blowing’ may be too great.....bullied, marginalized, loss of job.
Healthcare Bureaucracy

‘Bureaucracy develops the more perfectly, the more it is “dehumanized”, the more completely it succeeds in eliminating from official business love, hatred, and all purely personal, irrational and emotional elements which escape calculation. This is appraised as its special virtue by capitalism’

( sociologist Max Weber 1968, page, 975 )
Healthcare Bureaucracy

“In our view, religion and spirituality fell among the personal, irrational, and emotional elements that were successfully banished from the organization setting. Healthcare organizations and hospitals, in spite of their distinct functions and purposes, embraced a bureaucratic model to a greater extant than many other organizations.”

Management at the Surface?

‘Coordination and control are realized through an infrastructure comprising policies, procedures, processes/systems, and structures – things such as goal setting procedures, performance evaluation systems, financial monitoring systems, information technology systems, and hierarchical power-over structures. It follows, with depth denied, management’s role becomes administration of the surface-level objective aspects.

Those who administer don’t develop and nurture labor, they deploy it. They don’t seek labor’s understanding, and commitment, they drive and direct it. The don’t lead and facilitate labor, they oversee and govern (over ) it. This is further evidenced by the fact that management education and training deals primarily— if not solely — with the empirical, the objective, the external, the measurable realm of the organization. In this system of orientation what is counted is far more important than what counts.’

Spirituality in Healthcare?

• Increased bureaucratization in 20th century evident in large healthcare organizations

• Medical education founded upon the Cartesian worldview based upon a rigid mind-body separation founded upon science and reason

• Broader human considerations of health and well-being were deemed irrelevant or obstructive
Reductionistic Paradigm

Medical science is primarily concerned with the diseases of the body and that which can be tested ‘under the microscope’ and can be empirically verified.

A reductionist paradigm which excludes the mind or soul is intrinsic to research in areas such as microbiology, immunology and genetics where the focus is to break things apart and down into their smallest elements for examination.

This paradigm will thus likely neglect the pain of the soul.
Nursing’s Dual Responsibilities

• Nurses are subordinate to the administration and must uphold the utilitarian goals of the institution......the greatest good for the greatest number however this may conflict with meeting the goals for a particular patient

• Nurses also have obligations to carry out physician’s orders and in some cases these orders may go against the values of the nurse
External constraints mentioned were:

1. Power imbalances between members of the healthcare team
2. Poor communication between team members
3. Legal constraints
4. Fear of legal action
5. Nursing administration
6. Hospital administration and policies
7. Pressure to reduce costs
Internal Constraints (Wilkinson, 1988)

Internal constraints mentioned were:

• Nurses being socialized to follow orders
• Futility of past actions
• Fear of losing their jobs
• Lack of courage
• Self-doubt
• Anxiety about creating conflict
• Lack of confidence
Ethical Work Environment

• The nursing practice environment has been defined ‘as the organizational characteristics of a work setting that facilitate or constrain professional nursing practice’

• McDaniel described an ethical environment as one in which ethical values guide behavior, including setting priorities that provide for the ethical treatment of patients

( McDaniel, 1998 )
Moral Distress and Environment

Environmental causes of moral distress include:

• The treatment of patients as objects in order to meet institutional requirements

• Harm to patients in the form of pain and suffering

• Withdrawal of treatment without nurse participation in the decision

• Poor pain management

• Disregard for patients’ choices about accepting or refusing treatment, or the failure fully to inform them and their families about treatment options, leading to nurses’ feelings of powerlessness (Wilkinson, 1988)
Ethics Environment Questionnaire (McDaniel, 1997)

- McDaniel developed a 20 item questionnaire that offers a measurement of ethics in healthcare service.
- The EEQ asks a practitioner to reflect on each statement and provide an opinion about his or her work environment.
- The EEQ recognizes the social system of health-care delivery and the organization in which health care takes place.
Systemic Support of Nurses: Moral Distress as a Symptom?

Is moral distress a symptom of a larger and more systemic problem? Do healthcare organizations support professional nursing practice?

- In a fairly recent study of American nurses, more than 70% cited acute and chronic stress, overwork and overtime as their top three safety concerns, alongside other problems such as work design and workforce management.
- Another source of moral distress is ethical conflict with hospital policy, i.e., conflict arises when an organization requires that costs be controlled, however the needs of patients require adequate nurse time despite the cost.
- Ineffective legal and policy structures of an organization for managing bioethical problems can lead to moral distress when nurses have no means to advocate effectively for patients.
Man, Bernie, you're a mess!... You ain't itchin' anywhere, are you? Man, I had a cast on my leg years ago and boy did it itch!... Drove me crazy! Y'know what I'm sayin'?... 'Cause you can't scratch it, y'know... Don't think about itching anywhere. Bernie, 'cause it'll drive you nuts!
An organizational ethical climate can be assessed by measuring employee perceptions of organizational practices that reflect:

- How decisions having ethical content are solved, or
- The presence of organizational conditions that allow employees to engage in ethical reflection, or both.

For employees to engage in ethical reflection, Brown proposed that the conditions of power, trust, inclusion, role flexibility, and inquiry must be present.

( Brown, 1990 )
Effect of Moral distress on Nurses’ Wholeness

Nearly all the subjects believed that ongoing moral distress had been detrimental to their personal and professional wholeness and were able to name specific ways, including:

1. Loss of self-worth
2. Effect on personal relationships
3. Various psychological effects, i.e. depression
4. Behavioral manifestations – nightmares, persistent crying
5. Physical symptoms – heart palpitations, diarrhea, headaches
Effect of Moral Distress on Patient Care

• When asked if moral distress had any effects on their ability to give patient care, respondents were equally divided in perceiving their patient care to be any better, worse, or not affected.

• Researchers speculate that quality of care may have been more affected than nurses perceived.
Small Group Exercise

Identify a time when you encountered a situation where staff experienced moral distress. Describe the situation to those in your group. Use the handout provided which identifies a number of concepts related to moral distress as you talk about the event you experienced.

I.e. Moral autonomy; moral intention; moral sensitivity, moral courage, etc.
Long-term Impact of Moral Distress
“My feelings on that night remain with me to this day. I now wish that I had found the courage to walk over to the patient, remove the washcloth and say why I believed the doctor’s act was wrong, but this action did not seem to be open to me at the time. The culture of the emergency room in that hospital was such that I set aside deeply held (and publicly professed) beliefs, values and principles. Here was a very vulnerable person in our care, and we were removing the last vestige of her autonomy and, on top of that, laughing at her! I was not facing moral uncertainty in this situation: I knew there was a moral problem, and I knew what it was. I didn’t have a moral dilemma (in the classical sense): I knew what the right thing to do was. I simply did not have the courage to do it.”

~~ quoted from Lorraine Hardingham, Integrity and Moral residue: nurses as participants in a moral community, 2004.
Burnout

- Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 1982)
Causes for Burnout?

• In a study with respiratory therapists that linked moral distress factors to burnout, Schwenzer and Wang concluded that burnout is not likely to be caused by the routine burdens of patient care but by:
  1. Powerlessness related to hierarchical power structures
  2. Ineffective or obstructive policies
  3. Dysfunctional communication patterns
  4. Lack of resources
  5. Other issues beyond the control of staff
Moral Distress and Burnout (Sundin-Huard and Fahy, 1998)

- Moral distress is linked to burnout, creating in Australia a shortage of CCU nurses.
- Average length of stay in critical care environment is less than 2 years.
- Barriers to shared ethical decision-making include traditional power structures, the absence of mechanisms of support for nurse advocates, time pressures, concerns about personal and professional security.
Emotional exhaustion occurs when a person’s appraisal of occupational stressors exceeds his or her coping capabilities or they conflict with the person’s values and belief system so that he or she cannot cognitively reconcile with the stressors or cope.
Epstein and Hamric NICU study

- At the end of one infant’s death a nurse commented:

“I had one experienced co-worker say to me today, ‘That’s why I don’t choose babies that are sick [for a long time] like that, so that I don’t have to go through that heart-wrenching experience.’ I think there are some nurses who have been nurses for a long time that just don’t have the feelings anymore. They don’t have the same type of compassion because…..it’s hard work and you get to the point where I guess you have to let go of some of those feelings.”
Maslach Burnout Inventory (MBI)

- A questionnaire that assesses six components of the burnout syndrome:

1. Emotional exhaustion frequency
2. Emotional exhaustion intensity
3. Depersonalization frequency
4. Depersonalization intensity
5. Decreased personal accomplishment frequency
6. Decreased personal accomplishment intensity
Various Subscales

- Emotional Exhaustion Subscale – assesses the feelings of being emotionally overextended and exhausted by one’s work
- Depersonalization Subscale – measures an unfeeling and impersonal response toward recipients of one’s care or service
- Personal accomplishment Subscale – assesses feelings of competence and successful achievement in one’s work with people
Study in California linking Burnout with Moral Distress

• Study of 60 critical care nurses from two different hospitals, mean number of years in CCU was 11.79
• Staff were asked to complete a socio-demographic data survey, an MDS (Moral Distress Scale) and a MBI (Maslach Burnout Inventory)
• Researches were interested in knowing if there were any significant relationship between the scores of the three subscales of the MBI and the two subscales of the MDS
• Results revealed a high positive correlation between scores on the MBI emotional exhaustion subscale and scores on the MDS frequency subscale
Results of study

Results revealed that the five highest areas of moral distress were:

1. working where the number of staff is so low that care is inadequate, M=5.47
2. Carrying out physicians’ orders for unnecessary tests and treatments for terminally ill patients, M=5.44
3. Assisting a physician who in your opinion is providing incompetent care, M=5.34
4. Unsafe levels of nurse staffing, M=5.30
5. Providing life-saving treatment that prolongs death, M=5.28
Moral Concepts

- Moral Intent to Act
- Moral Courage
- Moral Comportment
- Whistleblowing
- Moral Heroism Illegal but Ethical

Impact on Patient
- Lack of Advocacy Avoids Patient
  - Resignation
  - Burnout
  - Leave Nursing
- Increased Patient Discomfort/Suffering

Impact on Nurse
- Suffering
  - High Nurse Turnover
  - Difficulty Recruiting
- Burnout

Impact on Organization
- Decreased Quality of Care
  - Reputation Accreditation
- Low Patient Satisfaction
LOST IN THE DESERT? DYING OF THIRST?

Seems like they're always full!

Next time, bring along a... JONES BROS. CANTEEN!
Individual Impact of Moral Distress

- Moral distress may manifest in:
  - Anger, frustration, guilt, loss of self-worth, depression and nightmares, as well as physical symptoms that nurses carry into their personal lives
  - Nurses suffer from feeling that their moral integrity is in jeopardy
Impact of Moral Distress

- In a study where respondents were asked to rank the frequency of items ( "I have thoughts about leaving my current position" and "I have thoughts about leaving my current profession" ) on a scale of 1-5 ( 1-never; 5-always ) the mean scores were 2.96 and 2.80 respectively.

- In one study 26% of the nurses had left positions because of moral distress.
Wilkinson’s Study

• Example of Moral residue:

“I’m really tired of that whole system ....it hurts too much to have to spend a lot of time with those patients because you know you’re helpless to change the situation for them......I think what it’s done is make me decide to get out of nursing because I don’t like being in a situation where I feel helpless or continually have to deal with situations where I have to do things I think are wrong.”
The Way Forward
The 4 A’s Model to Rise Above Moral Distress

• **Ask** – review the definition and symptoms of moral distress and ask yourself whether what you are feeling is moral distress. Are your colleagues exhibiting signs of moral distress as well?

• **Affirm** – affirm your feelings about the issue. What aspects of your moral integrity is being threatened? What role could you (and should you) play?

• **Assess** – begin to put some facts together. What is the source of your moral distress? What do you think is the “right” action and why is it so? What is being done currently and why? Who are the players in this situation? Are you ready to act?

• **Act** – Create a plan for action and implement it. Think about potential pitfalls and strategies to get around these pitfalls.
**Introduction:**
Addressing moral distress requires making changes. The change process occurs in stages and is cyclic in nature, meaning that the stages in the cycle may need to be repeated before there is success. The diagram illustrates the process.

**ASK**
You may be unaware of the exact nature of the problem but are feeling distress.
*Ask:* “Am I feeling distressed or showing signs of suffering? Is the source of my distress work related? Am I observing symptoms of distress within my team?”
*Goal:* You become aware that moral distress is present.

**ACT**
Prepare to Act
Prepare personally and professionally to take action.

Take Action
Implement strategies to initiate the changes you desire.

Maintain Desired Change
Anticipate and manage setbacks. Continue to implement the 4A’s to resolve moral distress.
*Goal:* You preserve your integrity and authenticity.

**AFFIRM**
Affirm your distress and your commitment to take care of yourself.

Validate feelings and perceptions with others.

Affirm professional obligation to act.
*Goal:* You make a commitment to address moral distress.

**ASSESS**
Identify sources of your distress.
- Personal
- Environment

Determine the severity of your distress.
Contemplate your readiness to act.
- You recognize there is an issue but may be ambivalent about taking action to change it.
- You analyze risks and benefits.
*Goal:* You are ready to make an action plan.
Importance of Self-reflective Practice

The Arizona Bioethics Network suggests holding ethical debriefings that combine elements of critical stress debriefings are instrumental in dealing with moral distress.... De-briefing is an information-sharing and event processing session conducted as a conversation between peers. Group members become informants to each other about a situation or event that occurred to them as a group.
“Practicing self-reflection may help people develop the courage to change circumstances that they view as morally wrong; however, even if enacting change is not possible, the process of self-reflection may help people maintain their sense of compassion and their sense of right and wrong, allowing them to better maintain integrity.”
Vocational calling? Hidden Vows?

‘In many ways, work must be a marriage; otherwise, why would we put up with so much over the years? We must have made hidden vows somewhere to follow something larger than the difficulties of the everyday?’


As chaplains we may prompt the questions to others:

Why have you chosen your particular profession….what brought you into it? How did you get here?
Inter-professional Care Project

The need for interprofessional care resides in understanding that:

1. Trend data indicates that Ontario faces a significant reduction in its health human resources workforce by 2010
2. Unless new ways of practicing health care are introduced, Ontario will face a significant shortage of health care workers and Ontarians will risk receiving sub-optimal care
3. The education system needs to prepare current and future providers to work in multi-disciplinary, collaborative, team-based models
4. Interprofessional care can help improve patient care while increasing provider satisfaction within a respectful and collaborative environment
Healthy Work Environment

• ‘a healthy work environment (HWE) is a work environment that takes strategic and comprehensive approach to providing the physical, cultural, social, and job design conditions that maximize the health and well-being of health care providers, according to the pan-Canadian Quality Worklife Healthcare Collaborative.’

• ‘Implementing healthy work environments and building a culture of safety for health care workers is key to ensuring quality patient care. Enhancing morale and reducing absenteeism can reduce adverse events, improve patient safety and support patient outcomes.’
Power ‘Over’ vs. Power ‘With’ vs. .....Power-Releasing

Shared governance and increased autonomy for nurses, i.e., nurses (staff) who are empowered can become whistleblowers and can employ strategies to solve problems, thus avoiding moral distress.
Shared Decision-making/Shared Responsibility

• moral distress caused by situations that occur at the bedside may be reduced by practices where healthcare teams share the decision-making and also share the responsibility for outcomes

• This may require healthcare teams to acquire a new understanding of ‘team’ and a practice that increases inter-professional collaboration
Organizational Ethical Values

Healthcare organizations face the problem of ethical bifurcation: in regards to patients and research there is usually a constantly reviewed concern about rights and responsibilities but in regards towards relationships between and among staff there is no such constantly reviewed set of ethical values

~~ Reiser, *The Ethical Life of Healthcare Organizations*, 1994
Owning and Nurturing Shared Values

- Organizational values that shape organizational life, including the care of patients are key to addressing systemic causes of moral distress
- Such values as respect, dignity, collaboration and quality of care are key to fostering a culture that promotes a healthy environment
Organizational Values

1. **Reciprocal Benefit** (Win-win frame of mind) This principle binds the practitioners and the organization of healthcare to a common standard: concern for the person. This principle restrains institutions from actions that harm some to benefit others.

2. **Dignity** – this value declares a respect for the person and the views of individuals and asserts that they have a standing and worthiness as human beings independent of their status in the organization, and thus protects them against the exercise of undue authority. Emphasizing dignity is a stimulus to assure that those affected by policies or actions will have a voice in shaping and approving them, which is
Organizational Values

“Values form a lot of the architecture of a person’s character, his shape, and personhood. They do the same for an organization, or a relationship….if a company values employees and people as well as profits, then he or it will bow to the demands of that value, even at the expense of his own self-interest.”

~~ Dr. Henry Cloud, Integrity
Collaboration and Connectedness

- The ultimate target of the spiritual dimension is unity or connectedness or intimate integration between:
- Thoughts and actions
- Beliefs and emotions
- Ourselves and others
- Between human beings and the rest of nature
- Between all of nature and the Source of all nature
Integrity

- Is a function of character
- Etymologically, the words ‘integer’, whole number, and ‘integration’, the bringing together of disparate parts into one whole are related
- Integrity has to do with *wholeness* and *oneness*
- We have integrity individually and organizationally when we bring the wholeness of who we are and what we believe in to any given situation
- Individual and organizational integrity

Interior

Subjective - Intentional
Individual Mind
qualitative,
interpretation

Exterior

Objective-Behavioural
the observable
measurable
empirical
quantitative

Individual

What does it mean to me?

What does it do?
(How well?)

Collective

What does it mean to us?
(Does it culturally fit?)

Does it fit structurally?
(How well?)

I

IT

flow of meaning

WE

IT

flow of information

Cultural-Inter-Subjective
Collective Mind
shared system of knowledge,
beliefs & values
shared interpretations

Social-Inter-Objective
the network of systems;
the formal infrastructure
Meaning at Work?

‘An increasing number of people are recognizing the need to connect spirituality to their work, for even in the face of all the efficiency, productivity, and profit the current sense of order has yielded; it is not delivering happiness and joy. No doubt we – at least a few of us – have amassed great wealth; however many more are wondering whether we have made progress. In question is the primacy of materialism in our current system of orientation, as it has caused us to enact a world devoid of depth. The activities we perform, the tasks that consume our labor, are absent of meaning -- the work we do doesn’t resonate deep within us – and therefore, the only connection we have to our work is the compensation we receive; and it is never enough to fulfill us.’

~~ The Transmutation of the Organization, Gull & Doh, c. 2004. pg. 133.
Integration of Interior and Exterior

‘Enabling spirit to unfold in the workplace requires more than material changes. Simply promoting team-based activity, or adding spiritual practices or policies (e.g. special rooms for contemplation, outdoor meetings, exercise breaks, meditation time, volunteer time, community service programs) or including human friendly buzzwords in the organization’s statement of purpose will not make for an inspired workplace. These actions, although necessary, are not sufficient as they address only the right hand quadrant of the organization.’

‘.... Because organizations may be viewed as complex adaptive systems, networks of relationships and interactions among people, the order created depends greatly on the shared way of thinking; on the shared frame of reference (Stacey, 1996). Consequently, changing structure or adding programs without simultaneously changing the organization’s governing variables – its system of orientation – is a strategy destined to fail. Accordingly the depth of change required calls for a re-evaluation of the organization’s tacitly held assumptions, values, beliefs and reason for being.

Winds of Change?

- Increasing role of ethics within hospitals
- Growing amount of research linking spirituality practices and modalities to health outcomes
- Increased focus on spirituality at the workplace, ie the soul of the culture
- Consumer demand for holistic care
- New Model of Inter-professional care within Ontario
Royal Victoria Regional Health Center

- Adoption of Studer philosophy to manage and govern hospital life based upon ‘flywheel’ thesis that all staff need to be driven by opportunity to be engaged with meaningful work and opportunity to make a difference at the workplace.

- Adoption of new branding from ‘exceptional people, exceptional care’ to ‘inspiring care’ which suggests that our care is prompted from within.
Q & A
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