Moral Distress
Causes, Consequences and Strategies for Prevention

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Prayer for Physicians, Nurses and all Caregivers

God of Compassion, we bless You for calling women and men into the healing vocations. We ask You to anoint their hands and to keep all their senses clear as they bring healing and hope to Your people. Give them the gifts that flow from Your Spirit. May they be wise, understanding, and sensitive. Above all, may they always be mindful that their gifts and talents have their origin in You! May their work always be done in Your honor and for the glory of Your name. AMEN. (from St. Peter’s Prayers for Patients and Families)
Objectives

- To define the concept of moral distress as it is used in healthcare today
- To identify causes of Moral Distress
- To state Consequences of Moral Distress
- To Discuss what individual organizations can do to address Moral Distress
Background

- Ethics Consults
- Ethics Rounds
- Nursing Literature
- Nursing Research
- Allied Health Professions Literature and Research
Moral distress

- Concept recognized as it applies to patients

- Explosion of recognition of moral distress as it applies to caregivers or providers in the last 30 years especially nurses

- Early conceptual work
  - Andrew Jameton – 1984 – differentiated concepts of moral uncertainty, moral dilemmas and moral distress in nursing
Moral Uncertainty

Arises when you are unsure whether there is an ethical dilemma, or if you assume there is an ethical dilemma, then you are unsure which values or principles to apply.
Moral Dilemma

Arises when two or more principles or values conflict. When this occurs, there can be good reasons to support mutually inconsistent actions (I.e. both are ethically permissible). It is not possible to take one action without some form of loss by not taking the other action.
Moral Distress

The discomfort or suffering that occurs when you act in a manner contrary to your personal and professional values. It occurs when you take an action that undermines your integrity or when you know the ethically appropriate action to take but are unable to act upon it.
Moral Residue

- Concept developed from Moral Distress Research on Nurses by Epstein and Hamric (2009)

- “Moral residue...is the sum of the nicks in one’s moral integrity and the self punishment inflicted when one does not do the right thing” (Epstein and Delgado, 2010)

- Crescendo Effect described by Epstein and Hamric

- “The concern is that as moral residue crescendo rises over time due to repeated episodes of moral distress, a breaking point may occur.”
A Challenge to the Concept

- Repenshek article 2009, “Moral Distress: Inability to Act or Discomfort with Moral Subjectivity.”

- Critique of the lack of clarity in the definition of the term “moral distress” in that some of the narratives seem less about an “inability to act” and more about an individual’s discomfort with the moral subjectivity of end of life decision making.
Research findings

- Nearly 50% of nurses have acted against their conscience in providing care to terminally ill patients. (Solomon, 1993)

- In critical care nurses, frequency of moral distress perceived to be related to providing futile care has a significant relationship to the experience of emotional exhaustion. (Meltzer, 2004)

- Nursing resignations because of moral distress rose from 15% in the early 1990’s to 26% in the late 1990’s. (Corley, 2002)

- In a national study of New Zealand Nurses, 16% were considering leaving their positions and 48% had at least considered leaving a given nursing position in the past because of moral distress. (Woods, 2014)
What Does Moral Distress Look Like?
Stories

Maria was a developmentally disabled patient who was had been admitted for dehydration, became septic, ultimately coded and was resuscitated and now was on a vent unable to be weaned. Prognosis was poor for ever extubating her and even if her condition improved, she would require long term care in a facility able to manage a ventilator. She would not be able to return to her group home. Maria had no family and no guardian. Medical recommendation to remove her from ventilator and provide palliative care was challenged by State Mental Health Legal Services. During drawn out court proceedings, nurses and physicians were required by court order to provide aggressive care.
Stella was an ICU patient with multi-organ system failure, sepsis, massive decubiti saturating dressings and requiring hourly dressing changes, on maximum doses of pressors with falling BP. Son and HCP of pt insisted on maintaining ventilator and further demanded that patient NOT be given Morphine as he thought it would hasten her death. HE kept asserting that he had been a medic in Viet Nam and “knew all about morphine.” Pulmonologist wanted to withdraw from the case. Nurse who cared for patient for three 12-hour shifts reported nightmares on her two days off and said she prayed that when she came back to work the patient would be dead. Family practice resident became so upset after family meeting that she was unable to find car in the parking lot.
Just after Tony completed the moral distress survey, she reported the “worst moral distress of her career.” The patient was a young cardiac surgical patient with multiple complications and despite the poor prognosis, the MD refused to make the patient a DNR. He also refused to order pain medication so an awake patient was defibrillated dozens of times before dying several days later.
Jodie is an RN working in the OR. She tells of a time when she was assigned to a DCD case. An awake 3 year old quadriplegic was wheeled into the OR and disconnected from ventilator in presence of OR staff who remained until child died and then proceeded with organ harvesting. (NOTE: This was an INAPPROPRIATE CASE for DCD). RN felt powerless to do anything - took part in the procedure and even though it took place almost a decade ago says “it will haunt me for the rest of my life. I wish I had never been involved.”
Ricardo was a 45 year old Hispanic male. The State parole board referred him for substance abuse treatment due to his use of crack cocaine. He also had a diagnosis of schizoaffective disorder. After inpatient substance abuse treatment and inpatient psychiatric treatment, an Intensive Outpatient Program (IOP) was recommended for him. He participated in this for two months attending sessions three days a week for three hours a day. He was stable, participating well, and showed no use of illicit substances. He was building an active support system through his church and self help meetings and had a supportive family. Against the recommendations of the treatment team and the parole officer, the insurance company refused to continue him on the IOP and dropped him back to clinic level care which included meetings two days a week for 1.5 hours each. Several weeks later Ricardo started to show signs of decompensating, missed appointments, stopped using his psychiatric meds and isolated himself from his support group. He had psychotic episodes and thoughts of killing strangers. Despite this, the Insurance company would not budge nor would parole violate and incarcerate the patient. After numerous attempts to keep the patient engaged he was finally discharged from care and arrested two weeks later for committing two bank robberies within 30 minutes of each other.
75 year old post stroke gentleman admitted to acute care rehab hospital. He is non-verbal and has difficulty swallowing. Currently he is fed through a g-tube that was placed at the hospital. Patient was progressing slowly but was making discernable progress. Patient’s wife who is the HCP arrived one day and announced that she would like to hold tube feeds and let him die stating he would not want to live like this. The patient was evaluated and determined not to have capacity but was determined to be depressed. Antidepressant therapy had been initiated but there had not been sufficient time to evaluate its effectiveness.
SOURCES OF MORAL DISTRESS

- End of life decision making
- nurse-provider conflict
- disrespectful interactions
- workplace violence
- disagreement with patient/family wishes
- perceived lack of administrative support
- co-worker shortages/incompetency
- personal lack of skill or competency
- Third party interferences – i.e insurance, regulations
HOW CAN MORAL DISTRESS AFFECT NURSES? (AACN)

- Physically withdraw from the bedside
- Lose capacity for caring
- Avoid patient contact
- Experience physical and psychological problems
- Fail to give good physical care
- Leave the profession altogether
OTHER EFFECTS OF MORAL DISTRESS

- Nurses attitudes about transplantation or becoming an organ donor
- Preparation of Advanced Directives
- Refusal to be a blood donor
- Crisis in spiritual beliefs
- Discussions with family/friends about HCP or Advanced Directives.
- Altered perspective on all end of life treatment
- Loss of sense of ethical integrity
HOW CAN MORAL DISTRESS AFFECT THE WORKPLACE ENVIRONMENT? (AACN)

Nurses may “experience” the following:

- Poor communication
- Lack of trust
- Defensiveness
- Lack of collaboration across disciplines
- High turnover rates
Implications of Moral Distress For Patients

- Fragmented care
- Conflict with care-giving staff
- Delayed treatment
- Prolonged Dying
- For future patients:
  - availability of donated organs
  - blood products
  - status of advanced directives
Moral distress is a critical, frequently ignored problem in healthcare work environments. Unaddressed, it restricts nurses’ ability to provide optimal patient care and find job satisfaction.

AACN asserts that every nurse and every employer are responsible for implementing programs to address and mitigate the harmful effects of moral distress in the pursuit of creating a healthy work environment.
Addressing Moral Distress

- There have been a lot of suggestions as to how to address moral distress but few intervention studies.

- This is an area that is ripe for research since the studies documenting moral distress are now being replicated in many other members of the health care team in addition to nursing.
St. Peter’s Project

- Use recognized Measure of Moral Distress to assess Moral Distress in Critical Care Units – Corley’s Moral Distress Scale (MDS)
- Design an Intervention Program
- Re-Measure Moral Distress
- ICU, CCU and NICU were chosen
- There are other areas
- This must be an integrated, organizational effort.
Addressing Moral Distress

- Staff focus forums
- Presentation to Administrators
- Case Studies
- AACN Program
- Robert Wicks Book
- Sandra Thomas Book
- Assorted Articles
ADDRESSING MORAL DISTRESS

Session 1  Why Do I Feel So Bad About Something I Love So Much?

Session 2  The Four “A’s” to Rise Above Moral Distress (AACN Program) Part I

Session 3  The Four “A’s” to Rise Above Moral Distress (AACN Program) Part II

Session 4  A Case In Point - Working Through Case Studies In Moral Distress

Session 5  I’m Mad As #*!#* and I’m Not Going To Take It Anymore!! A Look At Nurse’s Anger.


Session 8  Journal Club - What Are They Saying About Moral Distress In Nursing?

Session 9  Another Case In Point

Session 10  Two Steps Forward - One Back. Dealing With Setbacks.
ASK
You may be unaware of the exact nature of the problem but are feeling distressed.

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 for Action
Prepare personally and professionally to take action.
Take Action
Implement strategies to initiate the changes you desire.
Anticipate Setbacks
Temporary setbacks may occur due to personal or professional change.
Maintain Desired Change
Continue to implement the 4 A’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
• Work 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 establish an action plan.
MORAL DISTRESS SCALE RESULTS

Total item score reflects Intensity (0-6 scale) multiplied by Frequency (0-6 scale) with 6 indicating greatest distress and highest frequency. Total score range (0-36)

Highest Scoring Moral Distress Scale Items - ICU - (Total score) (Intensity/Frequency)

1. Follow family wishes to continue life support even when not in patient’s best interest. (19.4) (4.75/4.08)
2. Working with levels of nursing staff that I consider unsafe. (17) (4.92/3.45)
3. Initiate extensive life saving actions when I think it only prolongs death. (16.4) (4.61/3.57)
4. Follow family wishes for patient care when I do not agree with them because hospital fears a lawsuit. (13.02) (4.22/3.08)

Highest Scoring Moral Distress Scale Items - NICU - (Total Score) (Intensity/Frequency)

1. Work with levels of nursing staff that I consider unsafe. (7.99) (3.89/2.56)
2. Observe without taking action when health care personnel do not respect the patient’s privacy. (6) (3.39/1.78)
3. Work with nurses who are not as competent as patient care requires. (5.3) (3.67/1.44)
4. Carry out physician order for unnecessary test or treatment. (4.35) (2.61/1.67)

DEMOGRAPHIC SUMMARY

1. Age: 60% over the age of 40
2. Years in Critical Care: Average 13 years
3. Education: 43% Baccalaureate degree or higher
4. Came to work sick: 66% (significant difference between ICU and NICU)
5. Took “Mental Health Day”: 21% (significant difference between ICU and NICU)
6. Took vacation: 81%
7. Participated in nurturing or restorative practice: 86% (82% engaged in practice daily to weekly)

Most frequent words associated with Moral Distress: anger, sadness, overwhelmed, frustration.
A success and an ongoing challenge: NICU and ICU

NICU
- Reluctant at first
- “You’re causing me distress!”
- Began to talk about materials that were left on the unit
- Started asking for the sessions
- Began to identify more issues
- Attendance increased
NICU

- Worked through the AACN materials (see Participant Guide Classroom exercises)
- SPH cases
- Trisomy 13 article
- NICU ethical environment survey
- Differentiating moral distress from everyday workplace stress
If you were telling the story of the Moral Distress project, what would you say....?

- “It’s created a safe place for us to vent.”
- “I feel less alone.”
- “It’s helped us to see where we might be able to change things.”
- “Now I’m distressed if I can’t get to the sessions.”
- “It’s gotten the discussions and the complaining off of the unit.”
- “It’s validated my feelings.”
- And from the manager...”I’ve seen a real change as a result of the sessions.”
Keys to Success

- Regular sessions
- Uncomplicated materials or single articles
- A cheerleader or two
- Food
- Buy – in from the manager
- Staff seeing results
- Responding to staff requests for sessions
ICU

- Difficult finding time for sessions
- More 12 hour staff – hard to have continuity
- Change in CNS
- Change in Director
- Very high turnover
- Personally less familiar environment
KEYS to SUCCESS

PRESENCE
A New Frame of Reference

- Not eliminating Moral Distress but rather acceptance of the fact that it will occur
- Rigorous study of what mitigates the effects of Moral Distress or decreases its intensity and frequency
- Literature full of suggestions and trial programs
Some Suggestions

- Ethics education – orientation and ongoing
- Unrestricted access to ethics services
- Debriefings after Morally Distressing events
- Unit Based Ethics Champions (Wocial)
- More frequent family conferences and team meetings
- Shared Governance
- Create a climate where it is safe to speak up
- Utilize Professional organizations like AACN
- Utilize other resources (like chaplain) – article by Michael Guthrie on “A Health Care Chaplain’s Pastoral Response to Moral Distress.” Feb 2014 Journal of Health Care Chaplaincy
Moral Distress Puts Our Mission At Risk

- Mission

- We, St. Peter’s Health Partners and Trinity Health, serve together in the spirit of the gospel as a compassionate and transforming healing presence within our communities. Founded in community based legacies of compassionate healing, we provide the highest quality comprehensive continuum of integrated health care, supportive housing and community services, especially for the needy and vulnerable.

- Core Values:
  - **Reverence** — We honor the sacredness and dignity of every person.
  - **Commitment to Those Who are Poor** — We stand with and serve those who are poor, especially those most vulnerable.
  - **Justice** — We foster right relationships to promote the common good, including sustainability of Earth.
  - **Stewardship** — We honor our heritage and hold ourselves accountable for the human, financial and