SESSION B3

**Theme**
Organizational and Structural Pressures which Interferes with Patient Voices

**Title**
Coping with Moral Distress in Clinical Practice

**Speaker**
Denise Dudzinski, Ph.D., M.T.S

**Date**
Thursday, April 11, 2019

**Time**
11:10 – 12:20 PM

**Location**
Hansberry/Ferber

SESSION B3 OBJECTIVES

- Define moral distress and identify examples from clinical practice.
- Utilize the moral distress map to differentiate moral from emotional aspects of moral distress.
- Develop skills and strategies for identifying and reducing moral distress.

SESSION B3 SPEAKER

Dr. Denise Dudzinski is Professor & Chair of the Department of Bioethics & Humanities, Adjunct Professor in the School of Law and in the Departments of Pediatrics & Family Medicine at the University of Washington School of Medicine. She earned her PhD in Ethics from Vanderbilt University and her Masters of Theological Studies (MTS) from Vanderbilt Divinity School. She is Chief of the UW Medicine Ethics Consultation Service, which is active in three hospitals.

She was a member of the American Society for Bioethics & Humanities Board of Directors and of the Task Force to update the Core Competencies in Health Care Ethics Consultation. She is also on the editorial boards of the American Journal of Bioethics and Cambridge Quarterly of Healthcare Ethics.

Her articles often pertaining to clinical and organizational ethics have been published in the New England Journal of Medicine, Pediatrics, Hastings Center Report, Theoretical Medicine & Bioethics, the American Journal of Bioethics, the Journal of Clinical Ethics, the Journal of Medical Ethics, and Annals of Thoracic Surgery.
Tackling Moral Distress Using the Moral Distress Map

Denise M. Dudzinski, PhD MTS
Professor & Chair, Bioethics & Humanities
Chief, UW Medicine Ethics Consultation Svc.
UW Medicine; UW School of Medicine

Objectives

1) Define moral distress.
2) Identify strategies to ameliorate moral distress.
3) Analyze a case using the moral distress map.
Moral Distress Map

<table>
<thead>
<tr>
<th>Case</th>
<th>Emotions</th>
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<tr>
<td>What emotions are you experiencing? E.g. sadness, frustration, anger</td>
<td>What precisely is the source of the moral distress? E.g. inadequate staffing leading to suboptimal patient care</td>
<td>Name the internal and external constraints to taking action. E.g. fear my concerns will be ignored; patient does not qualify for the services she needs</td>
<td>Value/obligation/responsibility X conflicts with value/obligation/responsibility Y</td>
<td>What actions could you take? To improve outcomes for the patient To cope with your own moral distress</td>
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So many definitions of MD!

| Table 1 | Definitions of Moral Distress
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<tbody>
<tr>
<td>Definition</td>
<td>Source</td>
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<td>When one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action When the practitioner feels certain of the ethical course of action but is constrained from taking that action The psychological equilibrium that results from recognising the ethically appropriate action, yet not taking it, because of obstacles such as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy or legal considerations You act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity</td>
<td>Lanteen</td>
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<td>The pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility and makes a moral judgment about the correct action: yet, as a result of real or perceived constraints, participates in a perceived moral disempowering</td>
<td>Hamric and Blackhall</td>
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<td>Moral distress occurs when situational constraints prevent a nurse from implementing a moral decision she has made ... For moral distress to occur, a case must arise in which the nurse recognizes a moral issue and believes she or he is responsible for the patient's own actions in the situation</td>
<td>Conley et al</td>
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<td>The suffering experienced as a result of situations in which individuals feel morally responsible and have determined the ethically right action to take, yet owing to constraints (real or perceived) cannot carry this action, thus believing that they are committing a moral offense</td>
<td>Wilkeson</td>
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<td>Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the healthcare provider feels she is not able to preserve all interests and values at stake</td>
<td>Miltan et al</td>
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<td>Moral stress is experienced when nurses are aware of what ethical principles are at stake in a specific situation and external factors prevent them from making a decision that would reduce the conflict between the conflicting principles</td>
<td>Kähärmä et al</td>
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<td>Litzin et al</td>
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Moral Distress

When people believe they know the ethically appropriate course of action but cannot carry out that action because of institutional obstacles such as lack of time, lack of supervisory support, physician power, institutional policy, or legal limits. *One feels morally responsible while also feeling unable to change what’s happening.*


Moral Distress

The negative responses that occur when you know the ethically appropriate course of action but cannot carry it out

Jameton, 1984, 1993

Your moral values interface with professional values/obligations

We won’t all experience moral distress about the same things

*Some moral distress is unavoidable in hc.*
Moral Uncertainty

Unease & questioning when the person is not clear about the right course of action; ambiguity about how moral rules or principles apply or about the nature of the ethical dilemma itself

Solution: Gather facts, ask questions, investigate

Moral Dilemma

The person sees conflicting but morally justifiable courses of action & feels in a quandary about which course of action ought to be taken.

Response: ethical deliberation, collaborate, carve compromise, there may be no good solution – we look for the best of several sad options
Moral Residue

“That which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised”

Webster & Bayliss, 2000, p.218

The Crescendo Effect

Each time we experience moral distress & suppress our responses/actions, it builds.

We carry that threat to our integrity & the negative emotions into the next encounter.

A Model Linking Moral Distress and Moral Residue: the Crescendo Effect

Moral Distress leads to

Burn out
Nurses leaving the profession/turnover
Moral blunting
Decreased quality of pt care
Absenteeism

Increased mistakes
Fatigue
Loss of senior staff
Avoiding pts/staff
Also leads to powerful insights & moral/professional growth

Moral distress scholarship

Has focused primarily on nurses’ experience of moral distress

“Nurses often have more responsibility than authority”
- Corley et al. 2001

But all kinds of clinicians experience it – they may not talk about it or may call it something else

Examples

Your examples

AMA Virtual Mentor by Ann Hamric

Situations that cause moral distress

Continue LST when not in best interest of pt
Initiate life sustaining actions that only prolong death
Inappropriate use of resources
Continue aggressive care b/c no one will make decision to w/d
Work with colleagues who are not as competent as care requires
Inadequate IC, pain relief
Providing ‘false hope’


Emotions

How do these situations make you feel?
Helpless/Powerless

Features of Moral Distress

The person who experiences moral distress also feels heightened moral responsibility.
The experience of moral distress is directly related to the well-being of a patient. Moral distress is not self-centered. Harm to the clinician comes by way of perceived harm to the patient.
Moral distress is often caused or accompanied by a perception of powerlessness.

Features of Moral Distress

Blame often underlies moral distress – the perception that someone else chose wrongly and that person’s choice is constraining the clinician OR one’s own lack of courage or sense of powerlessness is constraining.

At least two obligations or responsibilities are in conflict, at least one of which is a professional responsibility.


Features of Moral Distress

Ameliorating moral distress may involve personal risk, and avoiding risk can threaten integrity.

When determining the best course of action, we should distinguish between actions that ease the clinician’s moral distress and actions that improve the care or experience of the patient.

The primary moral goal is not to alleviate moral distress, but to address the underlying ethical issues causing moral distress.

Sources of Moral Distress

- Inadequate staffing
- Inexperience
- Decreased/poor communication
- Subverted or inadequate pt advocacy
- Believing one is alone
- Being afraid to speak up

“Reducing moral distress calls for identifying efficient and effective mechanisms to support health care providers who have limited time to focus on ethical issues but know that the intensity of these events lingers well beyond the occurrence.”

**Constraints**

**Internal**
- Self-doubt
- Lack of assertiveness
- Socialization to follow orders
- Perceived powerlessness
- Lack of courage (lack of moral support)

**External**
- Inadequate staffing
- Priorities conflict w/ pt care needs
- Authority of attending MD
- Inadequate communication
- Fear of litigation
- Pt lacks access/coverage for svcs

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**Competing Obligations**

Name the competing moral/professional obligations.

**Example:**
A 30yo patient with recurrent leukemia and poor prognosis, intubated and no longer decisional. Family is hoping for a miracle. The entire team is on the same page, recommending shift to palliative care, yet family is insistent that additional treatments be attempted. You feel like you’re torturing a dying patient.
Moral Distress Map

1. What emotions are you experiencing?
2. What precisely is the source of moral distress?
3. Value/obligation/responsibility X conflicts with value/obligation/responsibility Y
4. Name the internal & external constraints to taking action.
5. What actions COULD you take?
6. What actions SHOULD you take?


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Case Discussion


See handout

Case

Gerard works as a registered nurse in the intensive care unit (ICU) at a large city hospital. Mrs. Smith, an 80 year-old widow, suffers a myocardial infarction and is admitted to the unit for treatment. She has no significant past medical history apart from mild hypertension and arthritis, and her vital signs are stable. Symptoms include shortness of breath and pleuritic chest pain. Crackles were heard on lung exam and she was put on oxygen. Shortly after, Mrs. Smith goes into respiratory distress, and flash pulmonary edema (often a result of acute myocardial infarction) is diagnosed by the attending physician. Mrs. Smith is intubated and sedated, and Gerard is her primary caretaker, making sure her vital signs are good, administering medications, and speaking with her three children present about her care.

Mrs. Smith had completed an advance directive several years ago expressing her desire not to be resuscitated, nor kept alive on a ventilator if she was “in the process of dying.” The attending physician was confident that Mrs. Smith would recover, arguing that the intubation would only be temporary until her lung function improved. Consistent with the physician’s statements, Mrs. Smith improved and was extubated the following morning.
Case

Gerard had a talk with Mrs. Smith, in which she stated that she felt terrible, that she thought it was close to her time, and that she wished that the doctors would just let her die and that she was at peace with what was to come. Although stable for a short period in which the conversation occurred, Mrs. Smith soon relapsed, her vital signs destabilized, and she was re-intubated.

That night, still intubated, she spiked a fever. Antibiotics were started and cultures sent to the lab later revealed *Streptococcus pneumoniae* as the cause of infection. During this time, Mrs. Smith consistently shook her head “no” whenever new drugs were introduced or other procedures, like insertion of intravenous lines were conducted. Realizing her discomfort, Gerard asked Mrs. Smith directly if she wanted to continue life-saving measures, and she continued to shake her head “no.” Gerard took this information to the attending physician, who brushed him off, still maintaining her status as a “full code.” The physician was certain she would recover, as the antibiotics appear to be working and her ejection fraction is steady at 45% - her desire to discontinue treatment only reflects her misunderstanding of the situation.

Case

The next day, Mrs. Smith’s children told both Gerard and the attending physician that their mother was clear in her advance directives and that she would never want to be kept alive like this on a ventilator. Mrs. Smith’s heart measurements were steadily declining, as were her vital signs and consciousness. The physician maintained his hopefulness in her recovery, and so the family backed off, trusting in his medical judgment.

Gerard is not sure what to do. . . He wants to say something again to the physician or even another administrator, but fears getting in trouble with his supervisors for being unprofessional or impeding patient care. He feels he understands Mrs. Smith’s situation the best, as he has spent ample time with her during her time in the hospital. He sees himself as Mrs. Smith’s advocate, and is deeply troubled to see her suffering so greatly and in his mind, needlessly. He runs into these types of situations regularly in the ICU, and wonders if he has any recourse.
Moral Distress Map

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Actions to ameliorate Moral Distress

**IMPROVE PT OUTCOMES**
- Listen & investigate (gather facts)
- Moral community
  - Buddy system
- Speak up
- Ethical reflection
- Take group or individual action
- Ethics consultation & QI
- Initiate system changes

**COPING**
- Listen & investigate (gather facts)
- Story telling/Debriefing
- Exercise/recreation/relaxation
- Cry, laugh, complain, get mad – behind closed doors
Managing moral distress

Be deliberate in decisions & accountable for actions
Focus on changes in work environment that preserve moral integrity
Dispense with the blame game – it won’t help.
Take action together

Use forums for interdisciplinary problem-solving (like ID rounds & family meetings)
Encourage policies/culture where raising ethics concerns is OK

Cultivating Moral Resilience

### Table 2: Preliminary Suggestions to Cultivate Individual Moral Resilience

- Foster self-awareness
- Develop self-regulatory capacities
- Develop ethical competence
- Speak up with clarity and confidence
- Find meaning in the midst of despair
- Engage with others
- Participate in transformational learning
- Contribute to a culture of ethical practice

Rushton, C. AACN Advanced Critical Care Volume 27, Number 1, pp. 111-119 © 2016 AACN
Conclusions

Your moral and professional values are important & deserve attention – for your sake & the pt’s.
You need support – find people who will listen/support you (they don’t have to agree with you).
You DO have power/influence. Find it and use it.
Create/insist on an ethical climate where professionals are encouraged to respectfully exercise their moral agency

Resources

VA Health System, “Preventive Ethics: Addressing Ethics Quality Gaps on a Systems Level”.
References


References

Thank you!