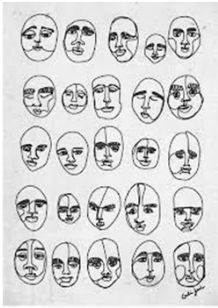


## Finding Harmony in Dissonance:





moral distress in the IDT and how to promote moral courage

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## Overview

- What is moral distress?
- Delving into dissonance: lessons from the humanities
- If people know what to do, why don't they do it?

## On Professionalism

8 elements of professionalism (from ABIM):

- altruism
- accountability
- excellence
- Duty
- service
- honor
- integrity
- respect for others

## Moral distress: definitions

“**Moral distress** is 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 perceived **moral wrongdoing**”  
 (ANA, 2002).

## Moral distress: definitions

- Moral distress is the psychological disequilibrium that occurs when a person believes he or she knows the right course of action to take, but cannot carry out that action because of some obstacle, such as institutional constraints or lack of power.

“At times, I have acted against my conscience in providing treatment to children in my care.”

- 54% of house officers
- 48% of critical care nurses
- 38% of critical care attending physicians
- 38% of hematology/oncology nurses
- 25% of hematology/oncology attending physicians

Mildred Z. Solomon et al. New and Lingering Controversies in Pediatric End of Life Care. *Pediatrics*, Oct 2005; 116: 872 - 883.

### Causes of moral distress in EOL care (Schluter et al. 2008)


- Clinician 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.
- Continued life support even though it is not in the best interest of the patient
- Inadequate communication about end of life care between providers and patients and families
- Inappropriate use of healthcare resources

### Causes of moral distress in EOL care (Schluter et al. 2008)

- Inadequate staffing or staff who are not adequately trained to provide the required care
- Inadequate pain relief provided to patients
- Unsuccessful advocacy
- False hope given to patients and families

### Moral distress: causes


- Poor quality and futile care
- unsuccessful advocacy
- raising unrealistic hope



Schluter et al (2008)

### Factors associated with Moral Distress in EOL Care

- Staff educational level
- Peer support
- Health concerns
- Psychological symptoms
  - Guilt
  - Depression
  - Frustration
  - Reduced self-worth
  - Isolation
  - Anhedonia



### Moral distress: contributing factors

<ul style="list-style-type: none"> <li>• Perceived powerlessness</li> <li>• Socialization to follow orders</li> <li>• Hierarchies within the healthcare system</li> <li>• Lack of administrative support</li> <li>• Compromised care due to pressure to reduce costs</li> <li>• Providing prolonged, overly aggressive treatment</li> <li>• Ineffective communication among team members</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of time</li> <li>• Inadequate staffing</li> <li>• Lack of collegial relationships</li> <li>• Policies/priorities in conflict with care needs</li> <li>• Fear of litigation</li> <li>• Inadequate informed consent</li> <li>• Increased moral sensitivity</li> </ul>
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<http://www.azbioethicsnetwork.org/wp-content/uploads/2011/05/Moral-Distress.pdf>

### Impact of Moral Distress on the institution

- Prolonged hospital stay
- Excessive cost
- Staff morale and retention
- Staff absence

### Effects of moral distress on the IDT and organization

- Impact on patient care
- Job satisfaction
- Sense of lack of control
- Sense of traumatized



### Additional Stressors


- Perception as the “Death Panel”
- Limited resources
  - Need to justify resources based on billing/ RVRU rather than important patient/health system outcomes

### Unique Issues in Palliative Care

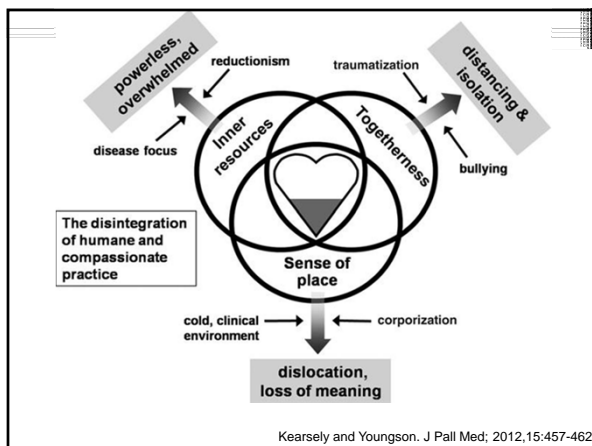
– The intimacy of the palliative care relationship provokes enhanced feelings of advocacy and protection and staff distress as goals of palliative conflict with realities of care.

### Moral distress: consequences for the individual

- Diminished professionalism
- Decreased patient/family satisfaction
- Potential decrease in quality of care
- Increased organizational costs
- Burnout



<http://www.abioethicsnetwork.org/ethics-cases/moral-distress/>




### Acknowledging moral distress

**A sign of weakness**



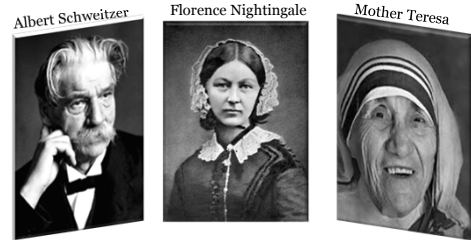
**A sign of courage**



## Moral Courage

- Moral courage is the courage to take action for moral reasons despite the risk of adverse consequences.
- Moral Courage is required to take action when one has doubts or fears about the consequences.

## Examples of those who exhibited moral courage



## Examples of health care situations that call for moral courage

- Breaking bad news
- Challenging a colleague
- Delivering care to an infectious patients
- Caring for a patient who has antisocial belief systems (racist, criminal)
- Raising concerns about unethical practice

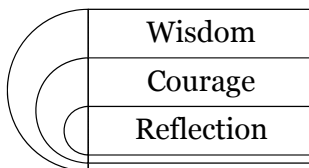
## Reasons for reluctance to show moral courage—**COST** of the action

- FEAR** --- of
- Extreme emotional reactions (themselves or others)
  - Violence
  - Contamination
  - Negative responses from colleagues
  - Job loss
  - “Whistleblower” effect



## Seeing moral courage as a professional virtue

- Demonstrating the **RIGHT** response to the fear
- Sandwich courage between wisdom and reflection



## On dissonance

- All dramatic stories always involve conflict
- the conflict is resolved
- coherence is created, even in the presence of unspeakable tragedy
- resolution is not always pretty
- Results in forgiveness and reintegration of society and personhood



On dissonance



On dissonance



Music would not speak if it were devoid of dissonance

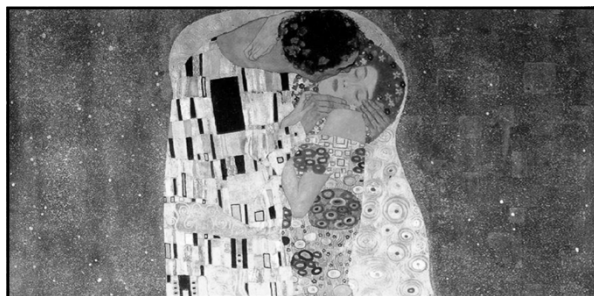
Dissonance in practice

- 42 year old Syrian immigrant with metastatic non-small cell lung cancer, intubated for post-obstructive pneumonia. Septic shock on maximal pressor support. Now with multiorgan failure.
- Diagnosed 6 months prior. Now has a 3 month old baby
- "Do everything."



Leaning in to dissonance

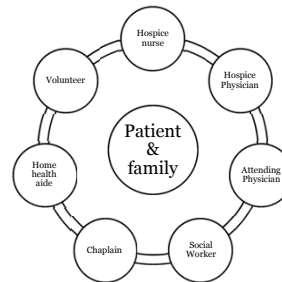
- Cognitive dissonance involves the ability of the mind to hold two seemingly opposite truths in a moment
  - "We know he's dying, but we need him to stay for his son."
  - "He doesn't want to die, but he doesn't want to suffer either."
  - "As the family Priest, I should give them advice and support, but I am afraid of this suffering as well."
- Being curiously reflective
  - How else might he be able to linger?




*Only people who are capable of loving strongly can suffer great sorrow, but this same necessity of loving serves to counteract their grief and heals them.*

Tolstoy

Moral distress in the hospice IDT





**Family**

- We know he's dying, but he needs to stay for his son.

**Intensivist**

- He's in multi-system organ failure. I know he's young, but he won't survive. But we will keep him full code, since that's what they want.

**Nurse**

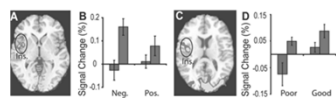
- This feels like futile care. He's not awake. He's in isolation. His baby can't even see him. I don't know why we're doing what we are.

Antoine Lutz, Julie Brefczynski-Lewis, Tom Johnstone, Richard J. Davidson. Regulation of the Neural Circuitry of Emotion by Compassion Meditation: Effects of Meditative Expertise. *PLoS ONE*, 2008;3 (3): e1897 DOI: 10.1371/journal.pone.0001897

## This is not just to make you feel good

**Association of an Educational Program in Mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians**

**P**



**A.** Voxel-wise analysis of the Group by State by Valence (negative versus positive sounds) interaction in insula (Ins.) ( $z = 2$ , corrected, colors code: orange,  $p < 5 \cdot 10^{-2}$ , yellow,  $p < 2 \cdot 10^{-2}$ , 15 experts (red) and 15 novices (blue)).  
**B.** Average response in Ins. from rest to compassion for experts (red) and novices (blue) for negative and positive sounds.  
**C-D.** Voxel-wise analysis of BOLD response to emotional sounds during poor vs. good blocks of compassion, as verbally reported. **C.** Main effect for verbal report in insula (Ins.) ( $z = 13$ , corrected, colors: orange,  $p < 10^{-3}$ , yellow,  $p < 5 \cdot 10^{-4}$ , 12 experts and 10 novices). **D.** Average response in (Ins.) for experts (red) and novices (blue).

doi:10.1371/journal.pone.0001897.g002

If people know what they should do, why don't they do it?

Is it because they can't do it because of individual or organizational factors?  
Or that they could but won't do it?

- The relationship between moral distress and moral courage
- Having moral courage does not mean one will NOT experience moral distress
  - Organizational lack of support decreases moral courage and increases moral distress
  - Unquestioning submission to authority increases moral distress and decreases moral courage
  - Concern over job security decreases moral courage
  - COMPLEXITY of the situation requires analysis

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### The relationship between moral distress and moral courage

- COMPLEXITY of the situation requires analysis
- Explanations and responses need to be provided at all three levels
  - **micro-level factors** (the attitudes and behavior of people);
  - **organizational or meso-level factors** (organizational culture, leadership, resources, and the physical environment)
  - **political or macro-level factors** (government)

### What to do to encourage the expression of moral courage and the decrease of moral distress

- engage in critical self-scrutiny-get a system in place that uses all staff levels
- invite feedback on the quality of your own professional practice
- engage in dialogue with respected colleagues e regarding how things can be improved (NHPCO MLC)

### What to do to encourage the expression of moral courage and the decrease of moral distress

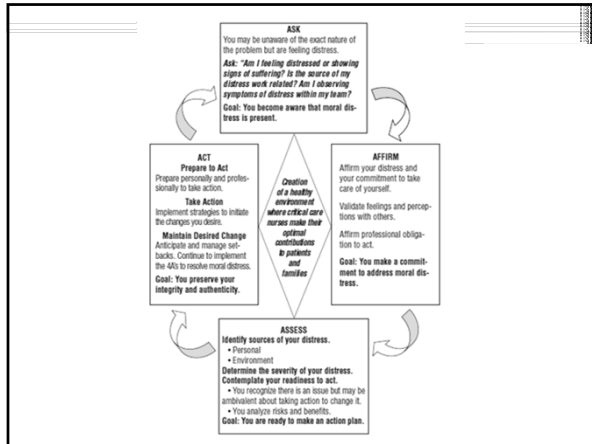
They need to become virtuous organisations listening to and valuing patients, families, and staff. They need to have policies in place so that concerns and reports of poor practice are responded to quickly and professionally. They need to commend those who raise concerns rather than trying to silence them. They need to invest in leaders who will role model and take

forward an ethical agenda. Strategies suggested by Lachman (2009), such as increasing organizational accountability and developing organizational ethics committees to facilitate ethical discourse and decision making, can help nurses to demonstrate moral courage by speaking up to make things right. I suggest that what is required is that organizations themselves also need to embrace the virtues of moral courage, wisdom, and integrity. To return then to the questions in the introduction: Do people know what the right thing to do is? If people know what they should do, why don't they do it? Is it because they can't do it because of individual or organizational factors? Or that they could but won't do it? This article has discussed key concepts, including moral distress, moral courage, and ethical climate, that enable nurses and others to do, or not do the right thing in professional practice. Insights from philosophical and empirical work on the concept of moral distress help us to understand

the challenges of doing the right thing. What should become clear is that the meaning of, and inter-relationships amongst, the concepts discussed in this article require reflection in relation to specific healthcare organizational and cultural contexts. It is important to learn from research relating to moral distress and ethical climates. However, it is equally important to engage in critical self-scrutiny, to invite feedback on the quality of our own professional practice, and to engage in dialogue with colleagues we respect regarding how things can be improved. The message, that doing the right thing is an organisational and a political as well as an individual responsibility, is one that needs to be emphasized.

### What to do to encourage the expression of moral courage and the decrease of moral distress

- Four A's (AACN ) model
- Speak up! System in place that the staff can count on
- Accountability structure that is reliable
- Build support networks
- Focus on changes in the work environment



What to do to encourage the expression of moral courage and the decrease of moral distress

- Participate in moral distress education – recognize manifestations of it
- Find root causes for problems related to moral distress
- Develop policies that support the staff exhibiting moral courage

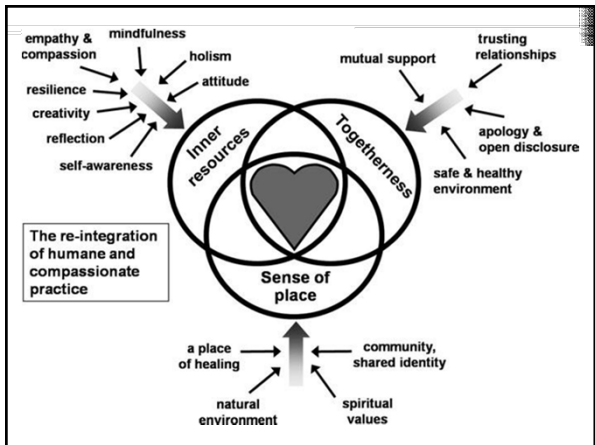
**Strategies for Palliative Care Teams**

**Specific Cases**

- ✓ Recognize high risk cases
- ✓ Frequent team meetings; daily if needed
- ✓ Staff substitution
- ✓ Counseling

**Health System Changes**

- ✓ Policies and Standards
- ✓ Sentinel cases for hospital/peer review
- ✓ System for early identification and resource allocation



**For the Individual--Create a pause**

- Anchor yourself in your breath
- Pause
- Be transparent
- Monitor your mindset
- Explore personal responses
- Ask questions
- Get clarifications
- Be open to new possibilities
- Let go of outcomes

**For the Individual--**

**Become a witness, rather than an actor**



## In Summary

- Moral distress – can occur in any clinician, it adds to risk for compassion fatigue and burnout, but there are things we can do
- Reflective practices
- Leaders need to prevent institutional contributing factors to increasing moral distress
- Leaders need to increase avenues where moral courage can be demonstrated