Responding to Moral Distress: Applying Research to Our Ministry of Staff

Workshop Objectives

• Be able to identify and discuss research findings in defining moral distress, root causes for such distress, its biological, psychological, and stress-related impact and potential interventions.

• Be able to apply research in ministry to staff experiencing moral distress.

• Be able to understand how one can review the literature for identifying research findings for application to other areas of ministry.

Organizational Context of the Issue

What led to this review of the research literature?
Organizational Context—Institutional Factors

- Catholic Healthcare System in the Midwest
- Flagship Hospital of a Small System
- Metropolitan Location
- Centers of Excellence for Cardiac Care, Orthopedics, Women's Services, and Oncology
- Three Adult ICUs (2-cardiac) and Level III NICU
- Palliative Care Program – Closure of Designated Unit
- Not a Trauma Center but Busy ED
- Recent Reduction in Staff
- Longevity of Staff – Very Committed to Mission – Number of Retirements
- Staff Morale Lower than Historic Norms
- Ethics Committee Dominated by MDs and RNs
- Ethics Consultations by RNs
- Formal CISM Program under Development
- Nursing Leadership's Concern for Staff

Organizational Context -- The Pastoral Director Perspective/Role

- New to the organization
- First meeting with Critical Care Executive Director the issue of moral distress raised
- As an ICU Chaplain and Director of PC in other hospitals had experienced moral distress of critical care staff in EOL care – primary interest re the topic
- Perceived moral distress in AICU (medical ICU) staff and the palliative care nurse re EOL care when attending rounds/providing care/ethics consults
- Member of the Ethics Committee – asked to become one of the Ethics consultants
- As a result of a critical incident first week as director and CISM experience became a major player in implementation of formal CISM program
- Perceived confusion within institution re stress from Critical Incidents, Emotional Distress, and Moral Distress
- Question: How to begin addressing moral distress in the midst of other priorities?

Organizational Context -- Precipitating Event

A registered nurse who had served on the Ethics Committee and as one of the ethics consultative team resigned effective immediately. Also, as the palliative care nurse usually assigned to the ICU she asked not to be assigned there any longer. This RN had been employed at the hospital for many years. In her resignation she stated “I am a prime example of moral distress that has accumulated over months and years. I cannot function objectively anymore…” Subsequent to this the RN took a medical leave of absence and was using the services of the EAP. Also, in her resignation, she stated “Many of you have little or no idea of the intense emotions that occur in a critical care unit, and the feelings of utter helplessness experienced by bedside nurses on a daily basis.” She also noted that most ethics consultations were requested due to moral distress.
Questions

What questions did I hope to learn from a review of the research literature?

- What is moral distress? -- What are its characteristics or symptoms? What does it feel like? What does it look like?
- What is the impact of moral distress?
- What causes moral distress?
- How can one prevent moral distress or ameliorate the effects?

Research Findings

Brief Summary of Early Research
Research Findings -- Defining Moral Distress

• First defined by Andrew Jameton in 1984 as a phenomenon that occurs when nurses can't carry out what they believe to be ethically appropriate actions because of institutional constraints. Theorized that it had two components: initial distress, and reactive distress now usually referred to as moral residue. Initial distress is of an acute nature, occurring as the situation unfolds. The reactive distress or moral residue is what remains after the situation ends and the initial distress is not addressed.

• Webster and Bayliss (2000) defined moral residue as “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.”

Later researchers extended constraints in the definition to include internal constraints related to sense of powerlessness, lack of knowledge, or lack of understanding. Some of the nursing research has focused on identification of constraints.

• Kelly (1998) stated moral distress is the consequence of the effort to preserve moral integrity when one has acted against one’s moral convictions and is characterized by painful feelings, or a psychological disequilibrium.

• General agreement that psychological characteristics may include frustration, anger, guilt, anxiety, depression, withdrawal, self-blame, and reduced self-worth. McCarthy and Deady (2008) noted that in exploration of the experience of moral distress has blurred the meaning of the original concept. (i.e. confusion of psychological distress in general vs. perceived violation of one’s core values and duties, concurrent with feeling of being constrained in doing the right thing.

Nurses experiencing moral distress reported physical symptoms of headaches, back pain, and stomach pain. (Schluter et al, 2008)

• Epstein and Hanrck proposed in a 2009 article a preliminary model they called the crescendo effect to describe the interrelationship between moral distress and moral residue. This model was developed from an empirical study of RNs and MDs in a NICU.
One of the first studies was Corley study of 111 members of the Association of Critical Care Nurses published in the American Journal of Critical Care on July 1, 1995. Three factors most associated with moral distress were aggressive care (unnecessary tests and treatments) at the EOL, lack of honesty with patients/families, and inadequate/incompetent treatment by physicians. Nurses in private hospitals indicated a higher degree of moral distress as well as those not practicing in ICUs. 12% indicated they had left a position due to moral distress.

In 2001 Corley and her co-investigators published their landmark study of their moral distress scale (MDS) developed from 1994-97. Initially this instrument had 32 items, revised later to 38 items, with a 7 point Likert format – the higher the score, the higher the degree of moral distress. Results supported the reliability and validity of the MDS. Mean scores of 3.9 to 5.5 indicated moderately high levels of moral distress; the highest mean was 5.47 which regarded working where number of staff is so low that care is inadequate. This study showed a lack of correlation between the level of moral distress and demographic or professional variables such as age, years of experience, or education.

Other studies, such as Elpern, Covert, and Kleinpell (2005) found a positive correlation between moral distress and years in current position. Schluter et al (2008) showed less moral distress for those with more education and experience. For age and education, positive, negative, and no correlations have been reported such as age, years of experience, or education.

Although the majority of studies focus on nurses, there are some studies regarding other health professionals, including physicians.

One study consists of the development of an instrument for measuring moral distress in medical students at Vanderbilt is of particular interest because it is the only study found to include a board certified chaplain as one of the co-investigators. The web-based survey developed consisted of 55 potentially distressing situations that students were asked to rate frequency they had encountered these events as well as intensity of their distress from the event. The situations were developed from (1) modification of Corley’s MDS questions applicable to medical students, (2) situations discussed over 7 years of voluntary monthly discussions between students and faculty of situations that raised ethical/moral questions. In addition, students were asked to rate the frequency of six reasons why they felt constrained in taking what they believed to be ethically. These included their fear regarding grades, insecurity regarding their knowledge, and relationship with the team. 108 4th year students were surveyed during a 3-week period in 2007 – 64 or 60% responded. The women witnessed more potentially distressful events, but the men tended to become more distressed with each subsequent event. Incentives such as movie tickets were given via a raffle for participation. (Wiggleton, et al, 2010)
Research Findings – Impact of Moral Distress

- Past research has shown that moral distress results in job dissatisfaction, high nursing turnover, nurses leaving critical care, or leaving the profession entirely. (12 to 25% RNs reported leaving a position due to moral distress) Whether or not quality of care in compromised is less clear. Guiterrez (2005) reported that nurses surveyed did not believe they provided a lower level of care, but a majority admitted that they had requested not to care for a patient and/or had become less involved with the family (professional distancing). Meltzer and Hackabay (2004) also reported that the frequency of moral distress was significantly related to emotional exhaustion which led to an inability to care and give of one’s emotional self to patients, the depersonalization of patients and families. This, of course, could lead to lower patient satisfaction scores.

Research Findings – Causes of Moral Distress

- Nursing research has focused on the professional practice (work) environment and the constraints placed on the nurse, such as policies and procedures, lack of time, staffing level, leadership style and support, communication issues, lack of empowerment, and the ethical environment. Correlations have been shown between these factors and greater frequency and/or higher intensity of moral distress. However, of course, correlation does not mean these factors cause moral distress.

- Pauly et al (2009) showed an inverse correlation between ethical climate and moral distress using an instrument developed by McDaniel and Olson to measure the ethical climate.

Recent Research Studies of Interest
Study by McAndrew, et al Re Critical Care

- Influence of Moral Distress on the Professional Practice Environment During Prognostic Conflict in Critical Care, *Journal of Trauma Nursing* – 2011
- Descriptive, correlational, prospective survey design
- Article includes an excellent review of earlier studies leading to their study
- Research Questions:
  - What is the level of moral distress in critical care setting?
  - What is the perception of the professional practice environment?
  - What is the relationship of moral distress to the professional practice environment?
  - What effects does moral distress have on the delivery of nursing care?

- Eligible to participate: All the critical care RNs at a major Midwestern academic medical center with Level 1 Trauma were eligible to participate. An informational sheet explaining moral distress, prognostic conflict, and professional practice as well as the requirements to participate was distributed with the printed questionnaires – approximately 10 minutes for completion.
- Surveys collected over 4 months and were submitted anonymously.
- Demographic information obtained
- Moral distress measured by Corley moral distress scale
- Practice Environment Scale (PES) used to measure professional practice environment – 31 items re: 5 areas: leadership and support, participation in hospital affairs, collegial relationships, resource and staffing adequacy, and quality of care foundations. The PES uses a scale of one to 4, strongly disagree to strongly agree and its reliability and validity are well established.

- Data analyzed by SPSS version 17 software
- Total means computed for intensity and frequency of items for the MDS, total composite and subscale scores for the PES, and associations among demographic characteristics moral distress, and professional practice were explored using correlational and multiple regression procedures.
- Results:
  - 33% critical care RNs participated (78 of 235) – 39% were in MICU, 32% surgical/trauma, 10% neuro ICU, and 13% in CVICU.
  - Employed as RN: Range of 1 to 47, critical care for 0.5 to 40 years.
  - 62% - BSN, 19% - associate level, 15% - diploma, 4% - master's; 77% did not have critical care certification.
  - No significant differences among demographic variables to responses in MDS or PES; thus, not used as covariates in subsequent analysis.
Study by McAndrew, et al: Re Critical Care

- **Moral Distress Scores**: Range from 0.13 to 5.89. The highest mean score of 4.61 was for item "assisting a physician who in your opinion is providing incompetent care". Overall responses regarding intensity were greater than frequency.
- **PES total scores** ranged from 1.87 to 3.77. The most positive PES category was foundations for quality of care; nurse manager leadership and support had the lowest average score at 2.18. The subscale scores significantly and positively related to one another.
- The intensity of moral distress was negatively related to physician/RN collegial relations ($r=0.25$ and $P = .03$). The frequency was statistically significant and negatively related to all aspects of professional practice except foundations for quality of care ($r = -0.12$, $p = .31$).
- The authors noted that the intensity and frequency of moral distress were similar to other studies except lack of significant relationship between nursing experience and level of moral distress. Also, that the most frequent moral distress situations are not those that cause the greatest level of distress – consistent with other studies.

Limitations:
- One setting
- Low response rate
- Participants self-selected

Recommendations:
- Replication of study in other areas of country
- Educate RNs to recognize moral distress
- Educate leaders so they can be more proactive,
- Provide strategies to improve RN-MD relationships
- Conduct more research re the relationship between moral distress and practice environment.

A Study from the Netherlands


Objective: Identification of individual & job characteristics associated with moral distress

- Questions:
  - What kind of situations trigger moral distress?
  - Is intensity of moral distress related to job satisfaction?
  - What kind of situations trigger moral distress?
  - What individual & job characteristics are associated with moral distress?

Two Surveys with time interval of 3 months

- First Survey – Job characteristics/satisfaction
- Second Survey – Moral distress (frequency & intensity)

365 Nurses – employed in nursing homes, homes for elderly, home care, and acute hospitals

- Age & Sex of Sample corresponded to age and sex of nursing population
- 66% response rate on job characteristic survey & 62% on moral distress survey
- 91% engaged in direct patient care/79% also involved in management tasks
A Study from the Netherlands

• Questionnaire developed from qualitative group interviews with approximately 100 nurses on a for exploration of frequent situations that cause moral distress plus review of international literature for additional items – none added. Then the questionnaire was reviewed by an RN specializing in nursing ethics, an RN researcher, and 3 healthcare ethicists – this resulted in the addition of one more item. 24 Items in all – 4 point Likert type scale used for 1 – no distress, and 4 – very distressing. Respondents were also asked to rate frequency of each situation on a 5-point Likert scale (daily, weekly, monthly, less than monthly, and (almost) never. All but one item recognized by at least ½ respondents as occurring in daily practice.

• One item eliminated – “I don’t agree with a particular EOL decision concerning treatment policy that has been made. - more than ½ answered that (almost) never took place.

A Study from the Netherlands

• Job satisfaction measured with a short version of MUS-GZ (Landeweerd et al, 1996) – 7 subsections: contacts w/colleagues, contacts w/pts, consultation possibilities, personal growth, and leadership. Three items for each subsection – 5-point Likert scale (very dissatisfied to very satisfied) Job satisfaction score was mean of all 21 items plus one – 11 scale question with “my job is the worst possible job” – 0 and “my job is the best possible job” – 10.

• Statistical analysis included exploration of bivariate relationships between individual and job variables; and multivariate regression analysis of all bivariate relationships with p < .05 included in the analysis.

A Study from the Netherlands

• Results
  • Most moral distress occurred when discrepancy perceived between wishes of patient & family
  • Second greatest – Felt treatment decision of physician was inappropriate or in conflict with what patient wanted as well as when RN discovered she was not aware of code status or other patient care agreements
  • Job satisfaction scores inversely related to moral distress – those less satisfied had higher moral distress scores
  • Weak but statistically significant relationship between education and number of hours worked – Associate RNs – higher level of moral distress, and those who work less hours – more moral distress
  • Nursing home RNs – higher level of moral distress and home care nurses the lowest
  • Trust for colleagues not related to moral distress, all other items were significantly related.
A Study from the Netherlands

- Study Strength: Secondary Analysis – intensity of moral distress unlikely to be influenced by job determinants
- Weaknesses: Did not have information re determinants that from theoretical perspective may better explain moral distress, for Example moral reasoning style, coping style, ethical climate
- Authors noted that their study produced similar results to Zuelo, 2007 in that situations involving patient-family conflict, MD-RN disagreement, and perceived unsafe staffing levels produced the most moral distress.
- Authors noted that although some moral tension should be expected, that moral distress should be reduced.

Interesting Research Protocol from UK Researchers

- Will look at moral distress in relatives, MDs, and RNs
- Narrative inquiry case study methods – qualitative research
- Digitally recorded interviews
- EOL situations: 3 categories: withdrawal of treatment including cardiac organ donation, non-escalation of treatment, and brain stem death-request for organ donation-3 cases each
- ICU mortality rates of 15-24% with majority preceded by decision to withhold or withdraw life-sustaining therapies

Interesting Research Protocol from UK Researchers

- Questions:
  - What are the triggers of moral distress for families and professionals?
  - How are these triggers influenced by external and internal constraints?
  - How do those impacted view the consequences of moral distress?
  - How can the insights gained inform education and practice in ICUs?
- Will include 3 hospitals and 3 ICUs – pediatrics and cardiac surgical units excluded
- Purposive Samples: Two relatives (18+ age), one MD, and one RN
- Senior clinicians identify and make initial approach to family at suitable time after EOL decision made to provide introductory information re study and to ascertain permission to contact them 10-12 weeks later
- Family given opportunity to have interview audio or video recorded to be shared on Healthtalkonline (HTO) website so others can benefit – pseudo names used
- After the interview, given copy of transcript (audio/video copy) – 2nd consent obtained
- Opportunity to debrief as well as bereavement services – all contacted 2 weeks later
Interventional Study

- Cross-sectional Survey of 370 health care providers’ perceptions 3 years after implementation of multidisciplinary conference – Comprehensive Care Round (CCR) for purpose of facilitating communication and consensus-building to prevent or address moral distress – 1 hour facilitated, structured meeting open to all NICU staff – avg 20 participants – not ethics or palliative – anyone can request anonymously
- Questions addressed perceptions re: comfort in expressing distress, team member support in moral distress situations, and barriers to communications and attainment of CCR objectives – 34 questions – Survey Monkey – anonymous – 2 week period – one email reminder – 31% (116) participants - 42% RNs, 37% allied health, 21% MDs

Interventional Study

- Survey Participants, 51% had previously attended CCR – attendance at CCR greater for those aged >35, and those who cared for CCR pts.
- General perception was that discussion should have occurred earlier; neonatologists most likely to report that referred cases not overdue for discussion & that families appreciated CCR attention to their child
- CCR appeared to better serve the HCP already comfortable in expressing distress
- MDs most likely to attend CCR and perceived team support when expressing concerns/making suggestions
- 24% of those who attended perceived barriers (unequal opportunity to contribute or present – sense of hierarchy – more RNs perceived barriers
- Question: Those who feel more comfortable are more likely to attend CCR or does CCR attendance make professionals more comfortable?

One Additional Article

“A Healthcare Chaplain’s Pastoral Response to Moral Distress”
Journal of Health Care Chaplaincy 20:3-15, 2014
Michael Guthrie, Presbyterian St. Luke’s Medical Center Rocky Mountain Hospital for Children, Denver
Chaplain's Response to Moral Distress

- Good review of the literature – research and “moral distress model”
- Lash (2007) developed a theory of how individuals maintain moral integrity in face of moral conflict with the “drawing of a line” – how far one would go in situation w/out violating integrity
- Lutzen & Kuist (2012) suggested that moral distress may have a beneficial role in strengthening individual’s exercise of moral agency
- Guthrie suggested that chaplain can enter into process to facilitate healing & growth for other health care professionals experiencing moral distress
- Provides a “case study” of RN experiencing moral distress re ICU – code status situation – tells “story of encounter” with the chaplain
- Guthrie outlines negative response would be to suggest that she call ethics consultation vs. pastoral response

Pastoral Response: Initial Goal: Encourage safe sharing of her story & emotional response

- In terms of healing, Guthrie asserts that the experience of moral distress can be a “transformational process” that allows for growth & development of character
- Sustaining (Presence): preservation, consolation, consolidation, and redemption
- Guiding: reflectively listening/facilitating person’s own decision making of what s/he should do
- Reconciliation: restoring broken relationships – discipline to address internal & external constraints
- Nurturing: enabling person to explore creative solutions and empower implementation

Questions for Discussion
Questions for Discussion

- Based on the research literature, as a chaplain how would you respond to an individual staff member who seems distressed regarding the care being provided to one of their patients?
- As the designated chaplain for a particular clinical unit, you perceive that the staff is experiencing a high level of moral distress. How do you respond based on the research literature?
- You are a Pastoral Care Director and you are hearing of multiple instances of moral distress within staff from both clinical directors and/or chaplains. What is your response based on the research literature?
- What role should chaplains play in future research on moral distress? What special perspective can chaplains contribute?
- What research questions would you like to see answered regarding moral distress?