Moral Distress and Moral Courage
Cultivating Awareness and Resilience

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Objectives

• Describe the experience of moral distress and its consequences
• Identify some of the current and possible future causes of moral distress
• Discuss strategies for how moral distress might be avoided and how and when to use moral courage
• Explore strategies to cultivate ethical awareness and resilience in students
Moral Distress

• Andy Jameton (1984) is credited with the first definition of moral distress when he sorted the moral and ethical problems in the hospital into moral uncertainty, moral dilemmas, and moral distress. “Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of actions” (p. 6).
Moral distress occurs when clinicians are unable to translate their moral choices into moral action. In such instances, acting in a manner contrary to personal and professional values undermines the individual's integrity and authenticity. Moral distress involves an irreconcilable conflict between one's ethical commitments and the action required for congruence between or among them. (Rushton, 2006).
Essential to Health Care Professional Well-being

MORAL INTEGRITY
Integrity

• 1. soundness of and adherence to moral principle and character; uprightness and honesty. 2. the state of being whole, entire, or undiminished. 3. a sound, unimpaired, or perfect condition. *Webster’s Encyclopedic Unabridged Dictionary of the English Language*

• Integrity is that condition or state in which moral activity (valuing, choosing, acting) is intimately linked to a particular conception of the Good, the Good Life.
Types of Ethical (or moral) Experience

Ethical...

• problems
• uncertainty
• dilemmas
• distress
• residue
• disengagement
• violation
• courage (Canadian Nurses Association)
• Ethical Distress
• → Moral Residue
• → Disengagement
Epstein and Hamric’s crescendo effect

• Moral distress crescendo (here we go again…)
• Moral residue crescendo

→
• Numbing of moral sensitivity and withdrawal from involvement
• Conscientious objection
• Burnout and leaving a position or the profession itself
Constraints involved in moral distress

( Epstein & Hamric, 2009)

Internal Constraints

• Lack of assertiveness
• Self-doubt
• Socialization to follow orders
• Perceived powerlessness
• Lack of understanding of full situation
Constraints involved in moral distress

(Epstein & Hamric, 2009)

External Constraints
• Inadequate staffing
• Hierarchies within the healthcare system
• Lack of collegial relationships
• Lack of administrative support
• Policies and priorities that conflict with care needs
• Compromised care due to pressure to reduce costs
• Fear of litigation
Consequences of not addressing moral distress

- Lost capacity to care, avoidance of patient contact (disengagement), failure to give good care
- Physical and psychological problems
- Diminished self-worth and moral integrity or moral well-being
- Transferring from a department/service/place of work → leaving profession
- Poor communication, lack of trust, high turnover rates, defensiveness, and lack of collaboration across disciplines
- Abusive behaviors, disrespectful communication, or worse
- Erosion of team cohesion, intensifying the distress of the situation
- Quality of patient care suffers (AACN’s 4 A’s to Rise Above Moral Distress)
A Behavioral and Systems View of Integrity

• Professionalism [Substitute: Moral integrity] needs to evolve from being conceptualized as an innate character trait or virtue to sophisticated competencies that can and must be taught and refined over a lifetime of practice. Furthermore, professional behaviors are profoundly influenced by the organizational and environmental context of contemporary medical practice, and these external forces need to be harnessed to support—not inhibit—professionalism in practice. This perspective on professionalism provides an opportunity to improve the delivery of health care through education and system-level reform [Lesser, C.S., Lucey, C.R., Egener, B., Braddock, C.H., Linas, S.L. & Levinson, W. (2010). A behavioral and systems view of professionalism. JAMA, 304(24), 2732-2737.]
What are the similarities with ethical integrity?
Causes of Moral Distress
(Schluter, 2008)

• Care that is of poor quality or medically futile (non beneficial) treatment
• Unsuccessful advocacy
• Raising a patient or family’s hopes unrealistically by inaccurate or incomplete information regarding treatment outcomes and prognosis
• *Value conflicts*
Reasons for not taking action in the face of distressing situations in 64 fourth-year medical students

• Because I wanted to be perceived as a “team player.”
• Because I wanted to preserve my relationship with an attending and/or a resident.
• Because taking action might have negatively affected my evaluation.
• Because I did not want to be disrespectful of my attending and/or resident.
• Because I felt that my concerns or questions were due to incomplete knowledge and judgment.
• Because I played a subordinate role on the team (Wiggleton, et. al, 2010).
Measuring Moral Distress

Corley’s Moral Distress Scale


Measuring Moral Distress

McDaniel’s Ethics Environment Questionnaire

Measuring Moral Distress

Olson’s Hospital Ethical Climate Survey


Measuring Moral Distress


Strategies for addressing moral distress (Epstein and Hamric, 2009)

• Speak-up: Recognize and name moral distress and insist on dialogue with other parties in the situation
• Be deliberate in decisions and accountable for actions
• Build support networks to empower colleagues and speak with one authoritative voice
• Focus on desired changes in the work environment that preserve moral integrity
• Use mentoring and institutional resources to address moral distress
• Actively participate in educational activities and discussions regarding the impact of moral distress
• Design and use forums for interdisciplinary problem solving such as family meetings or interdisciplinary rounds
• Address root causes in institutional or unit culture that perpetuate moral distress and damage collaboration among team members
• Develop policies to encourage any provider to raise ethical concerns or initiate ethics consultation
Unit-based Ethics Conversations

Helft and colleagues (2009) describe a program highlighting unit-based ethics conversations to address the growing problem of moral distress and offer the following techniques to stimulate productive conversation and reflection.

• **Clarify details.** Assuring that the “whole story” is presented is an important aspect of all ethics cases analyses.

• **“Pushing” participants.** Gently “pushing” participants to reflect out loud and articulate the central ethical issues of each case under discussion leads to productive discussion.
• **“Polling.”** Stopping a case discussion at a controversial point and going around the room to poll participants for their opinions invite participants to consider on which side of an issue they find themselves at that moment and stimulate participation from all individuals present.

• **Reflective and supportive statements.** Careful listening fosters an atmosphere of trust and mutual respect. Nonjudgmental supportive statements are essential in creating an environment of emotional safety and trust within the group.

• **Resist answers and solutions.** Resolution of difficult ethical dilemmas nearly always involves reaching clarity about the potential choices and their ethical implications and then ordering them in a way that allows choice of a pathway that seems most right.

• **Best practices.** This technique of exploring what the participating nurses believe to be best practices in difficult situations leads to highly productive interactions in which novice and expert nurses share approaches and debate the merits of each approach.
The Moral Courage Conundrum

• Ann Hamric: We should all practice in environments where one does not need to be courageous to be ethical

• Vicki Lachman: So long as we are all human, there will always be a need for moral courage and we should be intentional about developing moral courage.
Moral Courage

• Moral courage: the commitment to stand up for/act upon one's ethical beliefs. This type of courage, called moral courage, is vital to the willingness of individuals to take hold of, and fully support, ethical responsibilities essential to professional values. The ultimate goal of morally courageous behavior is to put ethical principles into action and protect ethical values perceived to be at risk (Murray, 2011)
Strategies for developing moral courage

• Open dialogue about ethical principles and systems,
• Case studies,
• Role modeling by real-life exemplars, and
• Rehearsals in which learners practice what they have learned in order to build their skills related to moral decision making.

• This requires a continuous commitment to, and reflection upon personal values and moral behaviors that influence ethical decision making. Moral courage can only be developed and strengthened through regular application.
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<tr>
<th>Steps</th>
<th>Checkpoint</th>
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<td>1</td>
<td>Evaluate the circumstances to establish whether moral courage is needed in the situation</td>
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<td>Determine what moral values and ethical principles are at risk or in question of being compromised</td>
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<td>3</td>
<td>Ascertain what principles need to be expressed and defended in the situation – focus on one or two of the more critical values</td>
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<td>4</td>
<td>Consider the possible adverse consequences/risks associated with taking action</td>
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<td>5</td>
<td>Assess whether or not the adversity can be endured – determine what support/resources are available</td>
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<td>6</td>
<td>Avoid stumbling blocks that might restrain moral courage, such as apprehension or over reflection leading to reasoning oneself out of being morally courageous in the situation</td>
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<td>7</td>
<td>Continue to develop moral courage through education, training, and practice</td>
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Table 3. Inhibitors of Moral Courage


1. Organizational cultures that stifle discussion regarding unethical behaviors and tolerate unethical acts

2. Willingness to compromise personal and professional standards in order to avoid social isolation from peers or to secure a promotion/favoritism within the organization

3. Unwillingness to face the tough challenge of addressing unethical behaviors

4. Indifference to ethical values

5. Apathy of bystanders who lack the moral courage to take action

6. Group think that supports a united decision to turn the other way when unethical behaviors are taking place

Tendency to redefine unethical behaviors as acceptable
Establishing and Sustaining Positive Ethics Environments (AACN)

Standards for establishing and sustaining healthy work environments are:

- **Skilled communication**
  - Nurses must be as proficient in communication skills as they are in clinical skills.

- **True Collaboration**
  - Nurses must be relentless in pursuing and fostering true collaboration.

- **Effective Decision Making**
  - Nurses must be valued and committed partners in making policy, directing and evaluating clinical care and leading organizational operations.
• **Appropriate Staffing**
  
  Staffing must ensure the effective match between patient needs and nurse competencies.

• **meaningful Recognition**
  
  Nurses must be recognized and must recognize others for the value each brings to the work of the organization.

• **Authentic Leadership**
  
  Nurse leaders must fully embrace the imperative of a healthy work environment, authentically live it and engage others in its achievement.
Scenario

• Poor Communication Kills Patients and Compromises our Everyday Care of the Seriously Ill and Dying

• MICU nurse: “We are not allowed to call an ethics consult.”
• Medical error is the 8th leading cause of death.
• IOM: 44,000 – 98,000 deaths from medical error annually—more likely double that #
• Costs associated with medical error are $8-29 billion annually.
• 72% of errors result from Communication problems.
IOM-- *To Err is Human*

- national focus to create leadership, research, tools and protocols to enhance the knowledge base about safety;
- identifying and learning from errors;
- raising standards and expectations for improvements in safety through the actions of oversight organizations, group purchasers, and professional groups; and
- creating safety systems inside health care organizations
Silence Kills
2005

• 84 percent of healthcare professionals observe colleagues take dangerous shortcuts when working with patients and yet less than 10 percent speak up about their concerns.
The 10 percent of healthcare workers who confidently raise crucial concerns
• observe better patient outcomes,
• work harder,
• are more satisfied, and
• are more committed to staying in their jobs.
• If more healthcare workers could behave like the influential 10 percent, the result would be significant reductions in medical errors, increased patient safety, higher productivity, and lower turnover
The study pinpoints seven categories of communication problems that are frequently encountered, yet rarely addressed.

- Broken rules
- Mistakes
- Lack of support
- Incompetence
- Poor Teamwork
- Disrespect
- Micromanagement

Vital Smarts, AORN, and AACN: The Silent Treatment: Why Safety Tools and Checklists Aren’t Enough to Save Lives

Found that the effectiveness of safety tools is undercut by **undiscussables**. Every day, healthcare professionals are making calculated decisions to not speak up—even when safety tools alert them to potential harm.

1. Dangerous shortcuts
2. Incompetence
3. Disrespect
• 58 percent (1,403) of the nurses said they had been in situations where it was either unsafe to speak up or they were unable to get others to listen.

• 17 percent (409) said they were in this situation at least a few times a month.
Denise Thornby Obituary
August 2, 2012

• "Every day, every moment, you make choices on how to act or respond. Through these acts, you have the power to positively influence. As John Quincy Adams sagely said, 'The influence of each human being on others in this life is a kind of immortality.' So I ask you: What will be your act of courage? How will you influence your environment? What will be your legacy?"
Denise Thornby’s challenge:

• **Make “waves”**
• Courage is derived from the French work, *coeur*, meaning heart…
• How courageous are you in the face of health care not working for those who need it? How skilled are you in effecting needed change?
WHAT WILL BE OUR LEGACY?
References


