Catholic Health Alliance of Canada
Alliance catholique canadienne de la santé

The Ethics Network of the Catholic Health Alliance of Canada has developed this framework document, one in a series of ethics resources to support each sponsor organization's response to COVID-19. While it reflects a consensus of opinion of relevant principles and moral approaches to address issues arising during the pandemic, the framework is meant to be adapted to each sponsored organization's unique context and circumstances. For more information, please contact Dr. Hazel Markwell, Theology, Policy and Ethics Advisor at hazel.markwell1@gmail.com

CHAC Moral Distress and Resilience

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Executive Summary

The COVID-19 pandemic has caused significant changes to the environment and delivery of health care in Catholic health organizations. Moral distress has emerged as a theme that brings to light the struggles faced by those committed to delivering quality compassionate care. Moral distress occurs when individuals recognize and take responsibility for the moral aspects of care but are then prevented from acting in alignment with their values or act contrary to their values due to real or perceived barriers. Moral distress is often deeply felt and not easily remedied. It may be triggered by a variety of factors such as safety concerns, PPE issues, triage protocols, visitor restrictions or confusing directives. Moral distress during COVID-19 may be layered over pre-existing tensions about inappropriate/aggressive treatment, inadequate pain control, patient rights, or team dynamics. Though moral distress is seen as endemic in health care, its management is crucial to sustaining the Catholic health care mission. As moral distress surfaces, clinicians, leaders, and organizations seek guidance and support for actions that ensure a healthy and vibrant moral community during a difficult time. This document offers such guidance to relieve moral distress in health care delivery.

Introduction

Across health care today, expressions of moral distress have emerged in response to the challenges of the COVID-19 pandemic. Clinicians typically enter Catholic health care to offer compassionate care and healing to others (Health Ethics Guide, 2012). During a pandemic, care that is normally focused on individual patients and residents is supplanted by a public health ethic of community protection. This shift has resulted in tensions surrounding justice, fairness, safety, stewardship, accountability, obligation, and trust.

Rooted in a commitment to promote and defend human dignity (Ethical and Religious Directives, 2019), Catholic health care organizations protect their employees' safety and well-being. Yet, moral distress happens frequently, especially in the face of a pandemic. Clinicians voice their moral distress in a variety of questions. Examples include: "Am I sacrificing my professional standards and practices at this time?", "Is it fair to burden these vulnerable people?", "What about my non-COVID-19 patients?", "How can I

sustain myself given that the pandemic continues or may get worse?", or "I want to help, but what if I bring it home?" Questions such as these demonstrate how clinicians struggle to enact Catholic values such as integrity, just resource allocation, responsibility, and human dignity.

Clinicians reportedly think the quality of care has eroded, that their patients risk abandonment, all while they face ongoing fear for the safety of all those served and those with whom they serve. The insidious impact of COVID-19 is revealed in a recent comment by a psychiatrist who, in consulting with an ethicist, stated, "Never before in my medical career have I medicated a patient not for his own benefit but for that of others".

Public trust is tenuous with some citizens accepting restrictions and others questioning the measures in place particularly visitor restrictions in palliative and end-of-life care. And now with restrictions lifting in many sites, some clinicians question the sacrifices made in recent months to protect their patients and residents, worrying that they are again risking the lives of those they have safely harboured.

Clinicians, patients, families, administrators, and health care communities struggle as we navigate uncharted COVID-19 territory. While COVID-19 continues, we need to attend to moral distress and its implications for health care.

This document is intended to educate about moral distress and to offer guidance to individuals, leaders, and Catholic health care organizations about how to respond with integrity and compassion.

Definition

The concept of moral distress first appeared in health care over 30 years ago (Jameton, 1984). Since then, definitions evolved as research continued to refine the concept. Today moral distress can be defined as the suffering experienced as a result of situations in which individuals are aware of a moral problem, acknowledge moral responsibility, and make a moral judgment about the correct action to take, yet due to constraints (real or perceived) cannot carry out this action. Thus they believe that they are committing a moral offence by compromising their personal and professional values. The suffering may present as feelings of anger, frustration, guilt and/or powerlessness associated with a decreased sense of well-being. Action or inaction will be tainted by these feelings. Familiar expressions of moral distress include, "I can't stand by and watch", "This is wrong but what can I do?", "My hands are tied", or "It's out of my hands".

Further, if moral distress is left unattended, repeated occurrences of similarly morally distressing situations can lead to stronger reactions as moral integrity is repeatedly threatened, leading to experiencing moral residue. Moral residue is "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 et al., 2000).

Triggers

Identified triggers for moral distress in the health care setting include pursuit of aggressive treatments of little benefit, no benefit, or creating harm; inadequate pain control; inappropriate use of valuable and scarce health care resources; poor team dynamics; poor team communication leading to confusion about goals of treatment; and violation of patient rights such as incomplete or insufficient disclosure; poorly defined treatment goals; or disregard for patient choice (Epstein et al., 2009). During COVID-19,

these triggers remain and continue to cause marked moral distress across health care. Specific to a pandemic situation, moral distress triggers may also include unclear policies or constantly changing directives, the perception of poor quality care, supply and staff shortages, PPE protocols leading to slower responses to patients in medical distress, and visitor restrictions impacting patient well-being.

Effects

There is a long list of negative effects and consequences individuals can experience as a result of moral distress. These include: the physical effects of loss of sleep, loss of appetite, nightmares, feelings of worthlessness, heart palpitations, changes in body functions, headaches, and psychological effects such as decreased self-confidence, guilt, remorse, anxiety, frustration, lack of energy, emotional exhaustion, feeling unproductive, withdrawal from family and friends, and deep sadness (Corley, 2002; Fry et al., 2002; Gutierrez, 2005; Wilkinson,1987-88).

Impact

The *Health Ethics Guide* reminds us that in a pandemic, health care professionals have an "obligation to provide care to others who depend on their special skills and training." (HEG, 2012, p.104). However, this "duty to care" also requires that health care professionals recognize other duties to care – to self, family, and others (HEG, 2012). Those experiencing moral distress in the health care environment may sense an increased threat to their professional and personal values.

Ultimately, moral distress may impact patient care. Patients suffer when those caring for them are not fully attentive to their needs. Moral distress is a system wide concern that is often linked to patient safety, absenteeism, and staff turnover (Rushton et al., 2017).

Management

Studies show that moral distress cannot be avoided but can be managed with a number of coping mechanisms, especially learning about the power of resilience and moral imagination. Indeed, researchers suggest that experiencing moral distress can be an occasion for positive moral growth as it presents an opportunity for self/institutional-reflection and effective patient and system advocacy (Rodney, 2017).

Experienced ICU nurses in a study examining moral agency identified relationship, collaboration and community as means to forestall potentially harmful consequences in morally distressing situations. The study authors stated that participants described navigating their environment by "enacting moral agency, exercising moral imagination, and fostering moral community" (Traudt et al., 2016, p.209). These clinicians also reported supportive work environments. By implication, this study suggests that less skilled clinicians in less supportive environments may be at greater risk of harm to their integrity and the subsequent fallout as previously described (Rushton et al., 2016).

Actions to address moral distress

Responding to moral distress is not only an individual responsibility but a system-wide response. Catholic health care organizations acknowledge that work is a dimension of a person's creativity, for it provides a community and sense of meaning and purpose (HEG, 2012). Thus, creating a supportive environment requires Catholic health care leaders at all levels and the organization itself to take responsibility for providing a safe and healthy workplace. To this end, the HEG offers a vital framework

for the formation of a moral community that focuses on the needs of vulnerable people receiving health care. The actions outlined below find support throughout the HEG where our foundational Catholic values are expressed.

For Individual Clinicians:

Most importantly, moral distress is best addressed by the individual clinician with a trusted other in a safe and accepting setting.

- When a morally distressing event occurs, a clinician can actively seek a trusted colleague to assist in debriefing. Ethicists and chaplains are well suited to support a clinician in this endeavor. These professionals provide guidance in exploring values and integrity restoring activities.

As stated earlier, moral distress and residue are uniquely tied to one's sense of integrity. Therefore, self-care activities, while useful in situations of burnout or compassion fatigue in restoring physical, mental and emotional balance do not directly address moral injury. However, self-care may be helpful in an overall plan that includes debriefing as described above. Self-care may involve the following actions:

- Clinicians should plan and prepare for morally distressing situations since moral distress is endemic in modern health care. Having a moral resilience plan is a valuable tool that each clinician can personalize. General coping strategies such as journaling, creating art, and movement activities are expressive forms that may be suited to processing difficult emotions that arise in moral distress.
- Self-awareness and self-regulation are linked to resilience. Mindfulness practice, in particular, is known to reduce reactivity in stressful circumstances and promote a positive mental approach (Rushton, 2017). Related practices such as prayer and contemplation can serve this purpose as well.
- Self-stewardship regards the clinician as a valuable resource. Practicing self-stewardship involves activities directed toward sustaining one's energy, focus, and balance physically, emotionally, and spiritually.

Additionally, clinicians can take actions in advance to strengthen their moral knowledge.

- Learning communication skills for conflict and mediation may contribute to overall reduction in moral distress experiences. Clinicians can be coached to use non-confrontational language to initiate a discussion in a potentially morally distressing situation. For example, opening statements such as: "Help me understand…", "I'm concerned that …", and "This is the way I feel when you ask me to do that" set the tone for an exploratory conversation (Grace et al. 2017, S16-17)).
- The literature affirms that ethics education is vital to increase clinicians' understanding of and ability to address moral distress (ANA, 2017). Clinician should afford themselves of opportunities for ethics education in their workplace or with their professional associations.
- Clinicians should familiarize themselves with the HEG as a resource for understanding the mission and values that guide decision making in Catholic health care. The Health Ethics Guide app extends the opportunity to increase our understanding Catholic health care through examples of leaders' lived experiences (*Health Ethics Guide app*).

- Periodically reviewing of codes of ethics from their respective professions can serve to strengthen ethical knowledge. A shared understanding of codes of ethics among multidisciplinary colleagues can facilitate access to their common moral framework and create a sense of moral community among peers (Kondrat, 2014).
- Clinicians should be encouraged to take informal leadership roles by sharing ethics resources with their teams and colleagues.

Implicit in these suggested actions for individual clinicians are Catholic values promoting solidarity and community. Contemporary health care is characterized by teamwork. Therefore, no one clinician working in Catholic health is solely responsible for mitigating moral distress. The following sections offer actions for ethicists, leaders and organizations to support the overall moral climate of Catholic health care.

Ethicists

Ethicists play a direct role in assisting individuals at clinical and organizational levels to process moral distress experiences and build moral resilience.

- Ethicists can assist clinicians as they process moral distress by acknowledging its presence; framing the context in relation to the clinician's values, obligations and responsibilities; identifying the perceived constraints on ethical action; and exploring root causes and possible solutions that uphold important values. A tool such as the Moral Distress Map guides discussion of morally charged clinical situations (Dudzinski, 2016).
- Create moral distress-related education and offer health care professionals terminology to name and formulate plans for addressing moral distress.
- Liaise with colleagues in spiritual care and wellness to coordinate moral distress responses and to develop and deliver moral distress and resilience education.
- Build relationships with clinicians to foster awareness of ethics services. Clinicians are often not aware of service/committees/hotline and in a morally distressing situation may not have the time to access services if they are not already well known.
- Provide safe spaces for discussion of morally distressing situations e.g., moral distress debriefs or regularly occurring moral distress rounds (Hamric). For example, in response to COVID-19, Cynda Rushton and her colleagues at Johns Hopkins University created the Frontline Nurses WikiWisdom Forum https://nurses.wikiwisdomforum.com/ , an online forum for nurses (Pearce, 2020).
- Using consult audits, ethicists can work with organizational leadership to identify recurring themes that may indicate systemic issues and innovative solutions (Grace et al., 2017).

Clinical Leaders

- Recognize that moral distress can evolve into a narrative of powerlessness by those who experience it. Negative narratives can be contagious and affect all clinical team members (Rushton et al., 2016).
- Periodically monitor moral distress levels in clinicians using tools such as the Moral Distress Survey-R, a widely recognized tool in research and ethics education. Another tool, *the Measure*

of Moral Distress for Health care Professionals (MMD-HP) is usable by all clinicians in adult and pediatric critical, acute, or long-term acute care settings (Hamric et al., 2012).

- Communicate the results of moral distress surveys to organizational leaders.
- As outlined in the actions suggested for individuals, develop ethical competence to support point of care clinicians through regular engagement with ethicists and their counterparts in spiritual care and wellness.
- Assist clinicians in developing a moral resilience plan that aligns organizational resources addressing moral distress and resilience building.
- Recognize that moral distress is not solely experienced by clinicians. Moral distress has been evidenced at all levels of health care (Kondrat, 2014). Resources developed for clinicians may also have resonance with clinical leaders and administrators.

At the Organizational Level:

Catholic health care organizations are required to be identified in a tangible way as visible expressions of the ministry of Christ (HEG, 2012). But, as previously stated, Catholic health care organizations potentially face striking fall-outs if moral distress is left unaddressed. Our Catholic health mission can be jeopardized by staff turnover, absenteeism, and other consequences of moral distress.

- When clinicians identify moral distress, organizational responses should uphold the principle of subsidiarity, a principle in the Catholic social tradition affirming that decisions ought to be handled by the smallest or lowest competent authority (HEG, 2012). This thereby avoids the temptation to reinforce hierarchical structures that take resolution away from those experiencing moral distress (Kondrat, 2014).
- Provide opportunities for debriefing sessions with one's direct supervisor following the most difficult cases.
- Honour and respect the voice and capabilities of individual clinicians who experience moral distress by providing resources needed.
- Create a first response ethics service that includes support for critical stress and exceptional situation response multidisciplinary teams.
- Engage in root cause analysis and other strategies to uphold an ethical climate in the organization. For example, specific policies such as Protection for Whistle Blowers can serve to create safety in the event that team level resolution is not achieved.
- Offer education sessions on ethics, in particular on moral distress, with pathways for staff to follow when faced with these struggles. Ethics education in professional training programs varies in content and quality. We cannot assume that staff are similarly equipped to address ethical issues or situations causing moral distress.
- On-boarding activities should include an introduction ethics services, naming the Health Ethics Guide as one of a range of tools that promote Catholic health values.
- Create mission teams to make sure the values of the organization come alive and to engage staff in fostering a positive organizational culture that inspires, gives hope, and re-charges staff's emotional and spiritual well-being.
- Consider offering staff retreats that address the spiritual aspect of their work as a vocation.

- Articulate both in word and in policy a commitment to support all people in the organization experiencing moral distress.
- Identify and develop advocacy plans to ensure adequate and fair operational funding.

When the organization communicates to its staff that all voices are acknowledged and encouraged to participate in solidarity and integrity-preserving activities, a healthy workforce can ensure the mission of Catholic health care is promoted and protected during a time of pandemic and beyond.

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