Objectives

At the completion of this session, the participants will be able to:

1. Define moral distress and identify individual, case-specific, and institutional risk factors for developing it.
2. Understand the clinical phenomena of moral distress, and triggers in the healthcare system and environment, that increase MD and burnout.
3. Discuss the level and intensity of moral distress among ICU nurses when compared to adult/pediatric medical surgical nurses.
4. Discuss an innovative interdisciplinary program to assist in the recognition of moral distress, along with strategies to achieve moral resilience.

The Speaker has No Disclosures or Conflict of Interest related to this educational topic.
Moral Distress: Definition

- "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."

Moral Distress: Prevalence & Intensity

- 1 in 3 nurses have experienced moral distress (Redman, & Fry, 2014)
- Nearly 50% of nurses studied left their units or the nursing field because of moral distress (1)
- Intensity of moral distress was higher than frequency (Corley et al. 2001; 2005; Pauly et al. 2009 Rice et al. 2008)

Impact of Moral Distress

- Prolonged or repeated moral distress leads to loss of nurses’ moral integrity (Wilkinson, 1987-88; Liszenco, 1995; Kelly, 1996; Rahton, 1995);
- Detach emotionally or withdraw from the situation when they are no longer able to deal with the stress (Fenton,1988, Hefferman & Heilig, 1999, Davies et al.,1996)
- Moral residue (Webster & Kayles (2000); Nurses experienced unresolved feelings long after the moral distress incident—(Powell, 1997)
- “Crescendo effect” Cumulative moral distress and moral residue (Epstein and Hairric, 2010)
What we Know Now

- Higher levels of moral distress (MD) are linked to decreased job satisfaction, increased turnover and decreased patient satisfaction, particularly among critical care. (Wilson, 2013)

- Intensive care units (ICUs) are a busy, high stress, complex environment in which health care professionals routinely provide numerous forms of advanced life support and life sustaining measures to a wide mix of critically ill patients. This may subject staff to considerable psychosocial stressors and increase susceptibility to MDs and burnout (1)

Gap

- Patients hospitalized on medical/surgical units are very acutely ill, thus it’s very likely their Moral Distress is growing, yet, little research exists, comparing these two populations and the impact on Staff retention and Burnout.

Study Purpose / Aims

To identify the frequency and intensity of MD among adult ICUs, NICU, and PICU versus medical/surgical nurses across Memorial Care Hospitals.

Aims and Hypotheses of the Project

- **Aim 1a.** To determine if there is a difference between the prevalence, intensity and frequency of moral distress of nurses in (adult, pediatric and neonatal) intensive care units (ICU) compared to non-critical care units (medical surgical).

- **Hypothesis 1a.** The intensity and frequency of moral distress is greater in ICU nurses compared to non-critical care nurses.

Study Aims/Hypotheses

- **Aim 2a.** To determine if there is a correlation between predictive variables (demographics, work related or personal predisposing factors) and moral distress, intention-to-leave and avoidance behaviors in ICU nurses and non-critical care nurses.

- **Hypothesis 2a.** There is a positive correlation between predictive variables and moral distress intention-to-leave and avoidance behaviors in ICU nurses and non-critical care nurses.

- **Aim 3a.** To determine if there is a relationship between moral distress, avoidance and intention-to-leave behaviors in ICU nurses compared to non-critical care nurses adjusting for age.

- **Hypothesis 3a.** There is no difference between moral distress and avoidance behaviors by nurses after adjusting for age.
Methodology

Design:
A prospective, cross sectional survey of all nurses within a 5-Hospital Healthcare System.

Sample:
The survey target all registered nurses working across all in-hospital settings (Adult / Pediatrics)

Data Collection:
The data for this study was collected from December 2014 – January 2015.

Ethical Review:
This study was approved by the institutional review board (IRB) at MemorialCare Health System.

McAndrew’s Moral Distress Model Served as Conceptual Framework

McAndrew’s Moral Distress Model addresses the interconnectedness between the institutional factors, nursing characteristics, specific situations which cause moral distress and the quality of care.

INSTRUMENT

- The Moral Distress Scale (MDS) assesses the prevalence, distress and intensity of moral distress. (Corley, 2001).
  - Initial MDS by Corley was 100% valid and reliable, with a 38-item survey asking RNs to identify scenarios and report the frequency they encounter and the intensity of moral distress.
Results

- Total of N=426 Nurse Surveys Completed
- Descriptive and inferential statistic analysis of demographics and survey data using SPSS v26

Results: Characteristics of participating nurses

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>295 (69.3%)</td>
</tr>
<tr>
<td>Age - mean (SD) [range]</td>
<td>43.6 (14.0) [21-69]</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>281 (64.9%)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>21 (4.9%)</td>
</tr>
<tr>
<td>Other</td>
<td>29 (6.7%)</td>
</tr>
<tr>
<td>Highest Education in Nursing</td>
<td></td>
</tr>
<tr>
<td>Degree in Other Field</td>
<td>30 (7.0%)</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>67 (15.8%)</td>
</tr>
<tr>
<td>Bachelor/BS</td>
<td>266 (62.5%)</td>
</tr>
<tr>
<td>MSN/PhD</td>
<td>46 (10.6%)</td>
</tr>
<tr>
<td>Care Unit</td>
<td></td>
</tr>
<tr>
<td>1. ICU Adult</td>
<td>65 (15.3%)</td>
</tr>
<tr>
<td>2. ICU Pediatric</td>
<td>43 (10.1%)</td>
</tr>
<tr>
<td>3. ICU Neonatal</td>
<td>47 (11.4%)</td>
</tr>
<tr>
<td>4. ICU Other</td>
<td>5 (1.2%)</td>
</tr>
<tr>
<td>5. Non-ICU Adult</td>
<td>71 (16.8%)</td>
</tr>
<tr>
<td>6. Non-ICU Pediatric</td>
<td>61 (14.4%)</td>
</tr>
<tr>
<td>7. Non-ICU: Labor and Delivery/Post-Partum/Perioperative Service/ETT</td>
<td>39 (9.6%)</td>
</tr>
<tr>
<td>8. Non-ICU Other</td>
<td>37 (8.7%)</td>
</tr>
</tbody>
</table>

Results: Moral Distress (MD) Intensity/Frequency

<table>
<thead>
<tr>
<th>Moral Distress Intensity</th>
<th>Estimated Mean (SE)</th>
<th>% Nurses Score = 4.0 or High/mixed intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>12.25</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>p = 0.77</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.90 (0.59)</td>
<td>11.2%</td>
</tr>
<tr>
<td>Male</td>
<td>2.55 (0.50)</td>
<td>15.0%</td>
</tr>
<tr>
<td>Age (per one year increase)</td>
<td>-0.007 (0.01), p=0.16</td>
<td>-0.002 (0.01), p=0.44</td>
</tr>
<tr>
<td>Race</td>
<td>p = 0.99</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>1.90 (0.21)</td>
<td>12.5%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>3.80 (0.24)</td>
<td>94.6%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>2.60 (0.32)</td>
<td>23.3%</td>
</tr>
<tr>
<td>Other</td>
<td>2.20 (0.27)</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moral Distress Frequency</th>
<th>Estimated Mean (SE)</th>
<th>% Nurses Score = 3.0 or Low/mixed intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>1.00 (0.00)</td>
<td></td>
</tr>
<tr>
<td>Degree in Other Field</td>
<td>p = 0.37</td>
<td></td>
</tr>
<tr>
<td>Associate Degree</td>
<td>1.70 (0.04)</td>
<td>11.0%</td>
</tr>
<tr>
<td>Bachelor/BS</td>
<td>2.10 (0.15)</td>
<td>11.3%</td>
</tr>
<tr>
<td>MSN/PhD</td>
<td>1.80 (0.22)</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest Education in Nursing</th>
<th>Estimated Mean (SE)</th>
<th>% Nurses Score = 3.0 or Low/mixed intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree in Other Field</td>
<td>1.90 (0.47)</td>
<td>20.0%</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>1.70 (0.14)</td>
<td>10.9%</td>
</tr>
<tr>
<td>Bachelor/BS</td>
<td>2.10 (0.23)</td>
<td>11.5%</td>
</tr>
<tr>
<td>MSN/PhD</td>
<td>1.80 (0.22)</td>
<td>8.3%</td>
</tr>
</tbody>
</table>
Results: Avoidance and Intention to Leave Corresponding with Care Unit

<table>
<thead>
<tr>
<th></th>
<th>Avoidance</th>
<th>Intent to Leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Male</td>
<td>0.96 (0.52, 1.76), p = .869</td>
<td>1.07 (0.26, 4.37), p = .898</td>
</tr>
<tr>
<td>Age (per one year increase)</td>
<td>1.00 (0.98, 1.02), p = .900</td>
<td>1.01 (0.99, 1.03), p = .439</td>
</tr>
<tr>
<td>Race:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Caucasian</td>
<td>2.09 (0.94, 4.66), p = .058</td>
<td>1.10 (0.45, 2.96), p = .831</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>1.46 (0.74, 2.91), p = .528</td>
<td>1.43 (0.55, 3.52), p = .503</td>
</tr>
<tr>
<td>Other</td>
<td>0.98 (0.34, 3.35), p = .876</td>
<td>0.64 (0.13, 3.22), p = .604</td>
</tr>
<tr>
<td>Care Unit Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.C.U. Adult</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>I.C.U. Pediatric</td>
<td>2.79 (0.77, 9.91), p = .209</td>
<td>15.40 (0.27, 84.89), p = .001</td>
</tr>
<tr>
<td>S.I.C.U. Neonatal</td>
<td>1.90 (0.85, 4.28), p = .159</td>
<td>5.30 (0.73, 31.09), p = .134</td>
</tr>
<tr>
<td>S.I.C.U. Adult</td>
<td>1.69 (0.78, 3.68), p = .268</td>
<td>7.12 (0.24, 23.58), p = .002</td>
</tr>
<tr>
<td>Non-I.C.U. Adult</td>
<td>1.48 (0.72, 3.04), p = .327</td>
<td>2.32 (0.46, 11.93), p = .290</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>(per one unit increase)</th>
<th>(per one unit increase)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moral Distress Intensity</td>
<td>1.17 (0.93, 1.47), p = .176</td>
<td>1.13 (0.84, 1.53), p = .430</td>
</tr>
<tr>
<td>Moral Distress Frequency</td>
<td>2.33 (1.26, 4.37), p &lt; .001</td>
<td>2.08 (1.24, 3.48), p &lt; .001</td>
</tr>
</tbody>
</table>

*Odds ratios estimated from model that includes effects for age, gender, race, care unit type, moral distress intensity and intent to leave frequency.

Nurses Narrated Sources of Moral Distress

- Causing harm to patients; overly aggressive Rx
- Inadequate pain management
- Ineffective communication
  - Poorly defined goals of treatment
  - Disregard of patient choices
  - Incomplete or inaccurate disclosure
  - Lack of informed consent
- Objectifying patients
- “Futile” treatment
- Intra professional conflict; authority differential
- Inappropriate use of health care resources

Nurses Narrated Expressions of MD

- “They (patients, families, surrogates) want us to DO EVERYTHING!”
- “They (doctors, legal, ethics committee, policy, JCAHO) are making us do this”
- “Or keeping us from doing this”
- “There is nothing more that we can do”
- “I can’t stand to watch”
- “They don’t care”
- “It’s FUTILE!!!!!”
Literature Impact of Moral Distress

- Affects the Whole Person
  - Physical
  - Emotional
  - Behavioral
  - Spiritual

Moral Distress leads to Moral Residue


Moral Residue

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

(Webster and Baylis, 2000)

MemorialCare Health System

ACTIONS TO IMPROVE MD

- Strategies to assist nurses from moving to moral distress to “Moral Resiliency
- Communication and conflict resolution,
- Interdisciplinary collaboration,
- System reforms,
- Mediation and ethics consultation,
- Grief counseling and employee assistance programs

References:

HEALTH SYSTEM APPROACH TO DEALING WITH MD …

- Personal
- Building Moral Sensitivity > Resilience
- Professional
- Institutional
- Community
- Society

Education for healthcare professionals on integration of MD Framework and new practices (Ruuttilo et al, 2013)

Building Resilience

- Involves “an individual’s ability to manifest adaptive positive coping strategies that are matched to the situation while minimizing stress or distress” [Mallack, 1998].
- At its core, resilience is about cultivating a quality of internal stability, awareness and flexibility that supports a person facing difficult challenges to navigate in a way that reduces the long term detrimental effects.
- While the situations that cause the pain and suffering cannot be extinguished from life, people can be supported to live with them with greater ease.
- MHS accelerated educational program to help practitioners understand MD and the road to Resilience.

Traumatic Event or Traumatic Triggers

- Bumped out of Resilient Zone
- Hyperarousal
- Hypervigilance
- Mania
- Anxiety & Panic
- Irritability/Rage
- Pain
- Nightmares
- Depression
- Disconnection
- Exhaustion/Fatigue
- Numbness
- Foggy thinking

- Stuck on “High” Hyper-arousal
- Stuck on “Low” Hypo-arousal

Graphic adapted from an original graphic of Peter Levine/Heller.
Moral Distress Framework

Empathy
• Emotional Arousal

Emotional Resonance
• Cognitive Arousal

Personal Experience
• Ethical Arousal

Health System Program
Teaching Mindfulness (very early phase)

Curriculum Includes:
- Teaching mindfulness practices aimed at stabilizing attention and emotion
- Develop insight to distinguish self from other (patient/family)
- Recognize triggers of personal distress
- Recognize symptoms of empathic over-arousal

Mindful Practice

“Moment to moment purposeful attentiveness to one’s own mental processes during everyday work with the goal of practicing with clarity and compassion.” [Epstein, RM, 1999]

Taking your own pulse...
Conclusions / Recommendations

- A interprofessional work group is designing the elements of a comprehensive program that supports all healthcare providers, to addresses MD and avoidance behaviors
  - Critical incident debriefing facilitated by management and volunteer RNs
  - Strategies to reduce avoidance behaviors and improve personal wellness and clinical care for all patients
- Further research is warranted to test the impact of program interventions with administration of the MDS, post-interventions

For further information, contact:
Dr. Peggy Kalowes PhD, RN, CNS, FAHA
pkalowes@memorialcare.org
References