UK Moral Distress Education Project
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TELL US YOUR NAME, THE ORGANIZATION YOU'RE WITH AND SOME OF THE ASPECTS OF YOUR DAILY ACTIVITIES.

My name is Dr. Vicki Lachman and I'm a Clinical Professor at Drexel University in Philadelphia, Pennsylvania. My primary role is I teach ethics to the doctoral and the masters nursing students at Drexel.

HOW DO YOU DEFINE MORAL DISTRESS WHEN YOU TEACH AND WHAT SCENARIOS DO YOU SUGGEST THAT COULD UNFOLD WHEN THEY GET INTO THEIR CAREERS?

I see the definition of moral distress as when an individual knows what they should do ethically or morally but they cannot act. Now, the reason they cannot act on what they know they should can either be internal or external. It might be the person experiences so much fear of repercussions, consequences that could be up to being dismissed from school or whatever it might be. Or it could be external that the organizational culture in which that individual practices does not honor nurses and the feedback that that nurse might provide around a high profile physician or whatever it might be.

WHAT ARE SOME OF THE CARE SCENARIOS WHERE YOU SEE MORAL DISTRESS COMING UP?

I see them at all levels. As a national health care consultant too, I have the privilege of dealing with CEOs and I can remember an experience where this particular CEO was told by the legal Counsel to not come forward and state that his hospital was infected with Legionnaires disease. He felt that the moral thing to do was to come forth to the staff and community because people had died in his ICU. He said, "When people die on my watch, I feel I have a moral responsibility." That goes down to the critical care nurse who talks to me about the torture she feels as she's delivering to this fifty-five year old man, who had a stroke and has diabetes and had an amputation of one leg and they're now talking about the amputation of another leg and he's now on dialysis which means he has an AV shunt in. The only place they can put an AV shunt in is his ankle. He's blown every vein in his body and the family won't say enough is enough.

So, it doesn't matter what level in the organization. I can give you nurse-manager stories, director stories, physician stories, where it's not just nursing. It's many of the health care providers or even the respiratory therapist who is forced to do CPAP, forced oxygenation on a patient. It's very uncomfortable to have those masks on. The situations

vary but any one of them either experiences a personal or organizational consequence that they feel they can't deal with.

WHAT HAPPENS WHEN SOMEONE ENDURES A SCENARIO, THEY'RE IN A STATE OF MORAL DISTRESS, AND IT'S NOT BEING DEALT WITH? WHAT ARE SOME OF THE SIGNS, SYMPTOMS, AND EFFECTS?

What we say is that, when a nurse or any healthcare provider has moral distress, they're in an integrity compromising situation. Your integrity is when you act according to your beliefs. When you're not acting according to your beliefs and you do that over and over again, you're going to get some moral residue. What I always say to people is that when you don't act on your feelings, you're going to implode or explode. If you implode, that is going to have consequences physically, emotionally, spiritually. Depending upon what your weak link is. Hans Selye, the founding father of stress research, talks about the fact that we all have a weak link depending upon our family history, how well we've taken care of ourselves. Wherever that weak link is, that could implode, it could be a migraine, a low back pain, could be a heart attack, god knows where it's going to go. Or you can explode. When you trap emotions in, it's like a champagne cork effect. Eventually they're going to come out. They could come out in an anxiety reaction, which is the fear side of stress, or in an anger reaction. So, the health care provider could look like they're over the top in their reaction to the situation and then it ends up getting discounted. It doesn't get focused on rectifying the situation which actually was the cause of that individual's moral distress.

IN TERMS OF PHYSICAL SIGNS, WHAT ARE THE SOME OF THE EFFECTS THAT HAPPENED TO PEOPLE WHEN THEY'RE EITHER IN THE STATE OF IMPLODING OR EXPLODING?

Some of the signs that you might see if someone has an anxiety reaction or depressive reaction could be that the individual has difficulty sleeping or they want to sleep too much. They can overeat as a way to stuff the feelings. And they can end up with weight gain in that situation. It could go to their muscles and they could have aches and pains. It could go to their GI system and they could end up with upset stomachs and be living on Pepto Bismol. If they have a vulnerability to hypertension, it could cause the blood pressure to go up. It could also lead to what I call the spiritual symptoms where the nerves starts to lose or the individual loses their compassion, and they don't have concern for patients anymore. They become a task. It's one more bath or one more blood pressure I have to do. There are significant consequences when an individual compromises her/his integrity on a continuous basis.

WE TALKED ABOUT THE INDIVIDUAL SIGNS, EFFECTS. DO YOU SEE A COLLECTIVE GROUP HAVING MORAL DISTRESS AND WHAT ARE THE SIGNS AND EFFECTS OR OUTCOMES WHEN NOW IT'S GONE TO MANY PEOPLE IN A GROUP?

You can see that within a department or within a nursing unit where I see it happening collectively. That tells me automatically that there are organizational barriers to the nurses being able to have a voice to correct the problem. There's an organizational cultural issue that's not really supporting a true ethical practice. Some organization say, "The patient first," but do the policy, the mission, vision match what in fact is actually happening? If there are too many people complaining about the same thing, then there's something wrong organizationally. And it can create an enormous patient safety, patient quality issues when someone is not being listened to repeatedly.

Collectively, there could be a real disruption in the teamwork of the individuals that are working together. They start the blaming; it becomes more of a blame culture. A lot of people don't even know what the underlying cause of it is because they've stuffed it for so long that they've lost sight of how it started back there. They are thinking that it really is that evening shift or it really is that other department or administration or whatever it is. When, in fact, it's just the suffering that these individuals experience within that group. It's got a type of an organizational response to that kind of situations.

PLEASE GIVE US A FEW EXAMPLES OF WHAT PRESENTS WHEN A GROUP IS SHOWING COLLECTIVE MORAL DISTRESS? GIVE US A FEW EXAMPLES OF THINGS THAT YOU OBSERVE WHEN IT'S A COLLECTIVE SCENARIO OF MORAL DISTRESS?

In a collective scenario of moral distress, you can see people acting out more passively such as back stabbing, gossiping or overly criticizing. It can be an even more overt demonstration of group moral distress where they could be screaming at each other, or not engaging in teamwork because there's such disruption in the group that they stop helping each other out. They don't have each other's backs anymore like they used to.

CAN YOU GIVE US EXAMPLES OF EXTREME BEHAVIOUR? LIKE BULLYING AND OTHER THINGS?

I have a real situation that I was called into, a bullying situation that had major consequences. The irony of this, this was a surgical, intensive care unit that had just won the unit of the year award. They had a culture of teasing. They would tease each other. For example, in that culture, I could say, "Oh, you're just the dumbest nurse we have on the group." That was affectionate, okay? So, they had this funny culture of teasing. In every group there's an "in" group and an "out" group. In this particular group, the "in" group took the newest nurse on the unit and had her give one of the persons that was on the "out" group a false shift report on a patient. That poor nurse spent the first

hour and a half of her shift trying to figure out why the report she'd gotten on the patient and what she actually saw happening with the patient, in no way jived. She was confused, trying to figure this all out until the charge nurse came over and said, "Hey, it's all a joke." That's not a joke when you do it to a patient. But it is the major example of bullying this nurse who's not part of the "in" group. And in that particular case, the charge nurse was fired. The young nurse who they picked on sat three days suspension and I was brought in as the ethics counsel to really talk about "What happened here?" We went over the line. Helping them understand that they went over the line in bullying...

DO YOU SEE EXTREME BEHAVIOR COLLECTIVELY DUE TO MORAL DISTRESS THAT CAN LEAD TO BULLYING AND OTHER TYPES OF ACTIVITY?

Yes. When we have moral distress, we are upset. I can either take that out on myself or I can take it out on others. So, the moral distress that I might feel could be directed towards you in a bullying way. You might not have been involved in the cause of my moral distress, but it's safer to bully you on a lateral level than it is to go after the person who is in power, who may have actually caused my moral distress.

WHAT RESOURCES ARE YOU SEEING INSTITUTED OR WHAT DO YOU ADVISE WHEN YOU CONSULT? DESCRIBE SOME PROCESSES OR ACTIVITIES OR ANYTHING SYSTEMIC THAT CAN ADDRESS OR PREVENT MORAL DISTRESS.

In terms of preventing or in treating moral distress, it starts at the top, the organizational culture of the organization. Is it transparent? Is there open communication, both up and down the organization? Are there systems in the organization that if I'm experiencing moral distress, that I can go to and say, "I need help here." Are there debriefings after a major incident of death, especially of a child? The responsibility of the senior administration is to make sure some of those things are in place.

Another very important one in an organizational structure is a process to deal with disruptive individuals. Whether they are physicians or nurses, there has to be zero tolerance for bullying or disruption that occurs. Another one would be a 24-hour a day compliance hotline. Sometimes, the bully or problem might be the person I directly report to and it's not safe for me to go to you. Having the ethics committee come out and help in these ethical situations that could rise to moral distress is called preventive ethics. It's that, okay, we've gotten three ethics consults from this particular unit. It's all been similar. Maybe we need to go out and do an educational event or intervention here, because it's becoming too similar. So, we actually might go out and do an educational event on that particular unit to prevent further occurrence.

IN THE OPPOSITE SCENARIO, WHAT RESOURCES OR WHAT GUIDANCE WOULD YOU GIVE TO A PERSON WHO DOESN'T NECESSARILY HAVE SYSTEMS IN PLACE IN THEIR ORGANIZATION?

If I'm experiencing moral distress and I now know it, I might not have known before but I know I didn't feel good, the American Association for Critical Care Nurses, has a wonderful process that they have outlined and a booklet that the individual could buy off the association website. It goes through all the steps that one needs to take a look at beyond just the recognition and how they can begin to deal with it. They could use the EAP or Employee Assistance program if that exists in the organization. Pastoral counselors in an organization are wonderful around these issues of moral distress. So, maybe talking to their pastoral counselor or to their own priest or rabbi, bringing it up to other nurses or other practitioners or their manager, to open up the conversation, the dialogue about it... Because when you're experiencing it individually and you don't know what's the matter with you, you always tend to imagine the worst.

IS YOUR INSTITUTION UNIONIZED IN ANY WAY AND DO UNIONS RECOGNIZE MORAL DISTRESS OR MAKE IT A WORKPLACE HAZARD ISSUE THAT IS PUSHED TOWARDS MANAGEMENT?

In unionized organizations that I've consulted to, some do and some don't recognize moral distress. Most of the time, in a unionized environment, it has to come up from the bottom to the top. Otherwise, if it's management's idea, it'll never work. So them going to your website and finding out about the stuff and then coming to management to say, "Look, this website really talks about the signs and symptoms, steps and solutions, could we try even this one solution? Could we get this in our contract for the next time around, so that we can have some of this kind of support that they're talking about in this website?"

IS THERE A UNION THAT YOU'VE COME ACROSS THAT IS MAKING THIS ISSUE?

No. There is one hospital that I consult to where they looked at the moral distress issue and what they're doing is training. Part of the leadership development now has a module on recognizing ethical issues and how you help people deal with those ethical issues. Because clinicians are great at identifying the clinical issue but sometimes they don't know how to make a moral or an ethical diagnosis. We, ethicists, see everything as an ethical issue so we have to be careful how we label things, but we try to help people see the ethical issue that's haunting this individual.

CAN YOU SHARE A PERSONAL STORY WHERE YOU EXPERIENCED MORAL DISTRESS?

Yes. It was my final day in a hospital. I was a staff nurse in a critical care unit and for that evening I had been caring for a 96-year-old African American woman who had metastatic carcinoma of the breast. She was cachexia, skin and bones at this point. The cancer had really eaten through her body. She was clearly dying. I talked to her family earlier in the day and they were ready to make her a DNR, Do Not Resuscitate. But the doctor had not gotten around to writing the order for the DNR yet.

She coded in the ICU and the interns and residents come rushing in, and because she didn't have a DNR order, they started to resuscitate her, and I said, "Wait a minute; the family is in an agreement. The only thing that's not done is the order. This woman should not be being resuscitated." One of the doctors grabbed my arm and threw me up against the wall to get me out of the way so that they could resuscitate this woman. She died and of course it was awful. They broke every rib in that poor woman's body and she was left like this, and then they walked out. I went to my manager and to the Director of Nursing and I got no support for what I'd done, to try and intervene in this hopeless situation and it was a matter of paperwork. Everyone in that unit knew... There was one family member there saying, "No, no, no! We made her a DNR."

That was my final night in a hospital. I never went back to a hospital after that. I went on and got a master's degree in Psychiatry and headed my own private practice and consulting firm since then. And most nurses who leave have this defining moment. That was a defining moment. If they were not going to protect that woman, I could not have anything to do with that hospital.

WHAT WERE THE EFFECTS ON YOU AS A PERSON OTHER THAN HAVING TO LEAVE THE SCENARIO? HOW DID YOU TURN THAT INTO SOMETHING POSITIVE?

I did do a number on myself, what could I have done more of to protect her? Because I felt like I hadn't protected her from the system at that point. I felt some anxiety and didn't sleep very well that night. But through some conversations and support from colleagues and friends, I worked through it. I saw that I did everything that I could have done and there was a system problem here. That system problem began to get fixed and we were able to get DNRs written faster so that somebody else wouldn't have experienced that.

In the long term, it got me interested in ethical issues, because I saw it as an ethical issue. If it happened to her, it could happen to me or a loved one. At that time, in my career, there was a master in Bioethics. Later I got a master's degree in Bioethics and now that's what I do. It was one of those defining moments. It also got me to do a lot of work with hospice and palliative care because that woman should've been on hospice. But back in the 70's, we didn't move them as fast to hospice and palliative care. My support of hospice and palliative care organizations through my consulting changed.

THANK YOU FOR SHARING THAT WITH US. IS THERE ANYTHING ELSE THAT YOU WANTED TO TALK ABOUT TODAY OR SHARE WITH FOLKS WATCHING?

I think there are some other things that organizations could do to reduce moral distress for individuals. One, when a patient is seriously ill, there should be a family meeting within the first forty eight to seventy two hours, so that the discussions start earlier. There should be ongoing training for physicians and advance practice nurses on how to deliver bad news. The Buckman's model is clear and simple and has been around for a long time. If people can talk about these things sooner so that we're not doing these things to patients. The Joint Commission support of palliative care teams can really make a difference. What we noticed on the two ethics committees that I serve, is that the number of ethics consults gets cut in half when you get a palliative care team in place. Because then, you're dealing with the issues of the individual end of life.

Most ethical issues occur at the beginning of life and at the end of life. Whether you're in a NICU or in an ICU, it's how we help people deliver the bad news. Physicians are notoriously bad about giving a prognosis. Sixty-two percent of the time, they say the patients are going to live longer than they are. It's helping physicians get clear to say, "Let's prepare for the worst and hope for the best" conversation earlier on. We're putting that more in medical schools now. We have it our advanced practice program. If the doctor walks out of the room, the patient will turn to the nurse and say, "Did he just tell me I'm going to die?" The nurses or the respiratory therapist need to know how to use that Buckman's model about bad news. For nurses, a lot of the moral distress occurs at the end of life.

YOU'RE TALKING ABOUT RESOURCES OR BRIDGES THAT MIGHT HELP SCENARIOS, AND END OF LIFE IS ONE OF THEM. TALK ABOUT THE END OF LIFE AS AN ISSUE AND A TOOL?

Most ethical issues around moral distress occur either at end of life or around informed consent, but any ethics committee will say that most of the referrals they get are around end of life. I think it's because we don't want to have the conversations that are necessary to look at where we want to go with this patient in terms of the plan of care. What kind of interventions do we want to make and not make. Because the rule of thumb is, you never make an intervention, a test on a patient if you're not going to do something with the results. That's the reason that we pull in palliative care.

There are some models out there that can help move that process along to have conversations about prognosis and plans of care. The most common one is what we call the Buckman model or the SPIKES model where there are six steps. The first step is to set the tone. That means I turn off my beeper. I make Kleenex available. I sit down and I prepare the environment for the conversation. The second step is I find out what you or your family member knows about your illness. Once I know what you know and what you want to know, I'm going to deliver the news, right? And I'm going to deliver it in the most succinct way and we usually start with, I'm sorry but I have some bad news for you. That

gives you that fraction of a second to prepare for "Oh, my God. Here it comes. This is not going to be good." That gets your mind ready. Once I've delivered the bad news, now my job is to deal with the emotional response. That could be crying, screaming, falling out of the chair, anything. But I give you space to emote. Then the final step is really following up and saying, "The next steps here are we really need to do more tests" or "Next step here really is, I don't think, given your response, it's safe for you to drive. Let me get a taxi for you to go home" or "Is there somebody else in your family you'd like me to talk to?" So it's really the follow up steps and making sure the person is safe after you deliver that news. It's not something you do once but something that you do over and over again. Because people only hear what they're ready to hear when you're talking to them about these issues.

WHAT'S THE EFFECT ON THE PRACTITIONERS WHO USE THIS TOOL?

They are feeling that they've not compromised their integrity. They're telling the truth. They're practicing the veracity, the duty to tell the truth, and fidelity, the duty to keep our promise to patients. Because trust is based upon honesty. And if you've pretended that my prognosis is better than it is, then the trust gets reduced. Practitioners who are able to deliver that bad news reduce the moral distress for the other individuals on the team, too, because they don't have to pretend that everything's going to be okay with mom. The doctor or the advanced practice nurse has already delivered the information, and now we're potentially dealing with moving to comfort care first, rather than pretending that we're still in treatment phase here.

ANY GUIDANCE YOU WANT TO GIVE TO THE STUDENTS OR PRACTITIONERS?

I like to leave people with the idea that moral distress occurs when you are not living up to your own ethics and values. And when you compromise your integrity, you're heading down a path that could potentially get worse physically, mentally and spiritually for yourself and for your patients and other team members. It is a matter of you taking care of yourself and learning the conflict resolution and assertiveness skills that are necessary for you to speak up and participate in organizational processes and teams that could improve the systems in the organization to make it safer for nurses and other practitioners to eliminate moral distress.

THANK YOU...