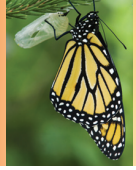


Panel Discussion 2: Promising System and Environmental Strategies for Addressing Moral Distress and Building Moral Resilience

On the second day of the symposium, five panelists began the day's discussions with a conversation on the importance of addressing moral distress at the organizational level. Moderator Sarah Delgado, MSN, RN, ACNP, clinical practice specialist at the American Association of Critical-Care Nurses, asked the panelists to talk about their facilities' efforts to create environments that diminish moral distress and improve moral resilience.

THE PANELISTS

Elizabeth Epstein, PhD, RN, is an associate professor of nursing and chair of the Acute and Specialty Care Department at the University of Virginia School of Nursing in Charlottesville. She spoke about the University of Virginia Health System's Moral Distress Consult Service (MDCS), which over the past 10 years has evolved from a monthly interprofessional forum to a formal subgroup of the institution's Clinical Ethics Consult Service. Epstein explained that when a morally distressing situation occurs, unit managers or advanced practice nurses work with the MDCS team to schedule a one-hour meeting with all staff members involved in the patient's care. All—including nurses, physicians, social workers, and chaplains—are invited to discuss the case, their impressions of the "right" action to take, the barriers to taking that action, and strategies to address those barriers. After the meeting, a formal written report is provided to the unit manager and ongoing support is offered as needed.

Morally distressing situations, Epstein said, can involve a patient's care—when staff members believe treatment is inappropriate or not in the patient's best interest, for example—but they can also be caused by such triggers as ineffective team communication or a lack of organizational guidance.

She said that periodic formal and informal evaluations have shown that the MDCS has improved collaboration across disciplines, and has helped empower staff members to honor their professional and moral judgment. Still, she added, challenges remain. These include making time for meetings and following up on recommendations (each consult can take the team five to 20 hours to complete), and recognizing the staff's sense of vulnerability when discussing issues that involve the administration.

Mary Ann Beil, MTS, is vice president of corporate ethics at Memorial University Medical Center in Savannah, Georgia. She said that although a bioethics services committee has existed at the medical center for 22 years, in 2000 it became clear that the model in place—which consists of monthly meetings and infrequent ethics consultations on an as-needed basis—was increasingly ineffectual. In 2004, a redesign of the ethics process was initiated to integrate ethics discussions and education in day-to-day patient care and health systems operations. The redesign team—the bioethics performance improvement team, or BIOPIT—led by Beil, was an interdisciplinary team that included six experienced nurses, two trauma surgeons, and two ICU physicians.

Because the majority of ethics cases occurred on ICU units, the team's initial focus was adult critical care. "The feedback from nurses and physicians was rapid and crystal clear," Beil said. Many shortcomings were identified, including the inaccessibility of the ethics committee; the infrequent and delayed requests for ethics consults, which, she said, ended up providing "too little, too late"; the staff's perception that the process was irrelevant; the medical staff's view that consults were little more than a "morality peer review"; and that logistical issues such as the timing and location of meetings made broad and meaningful participation difficult.

As a result, the time and location of the monthly meetings were changed to accommodate the staff, and a core consult team was made available on a weekly basis to consult with anyone—nurses, physicians, case managers, social workers, chaplains, even patients and their families—on ethical dilemmas that may have arisen on the unit. "By the second week," Beil said, "it was apparent that if we built this, they would come."

Thanks to the contribution of hundreds of interdisciplinary team members over the past 12 years, Beil said, ethics discussions and consults have been transformed. The integrated ethics architecture now

consists of two distinct layers; the first contains five structures that address case-specific ethics issues and concerns in real time: adult BIOPIT; pediatric BIOPIT, which includes perinatal medicine, labor and delivery, the neonatal ICU, the pediatric ICU, and adolescent medicine; behavioral services BIOPIT, which includes behavioral medicine and senior care; the urgent/called ethics consult team; and ethics rounds. This casework is based on a series of ethics triggers that are used to review cases and to better focus ethics rounds. Bioethics nurse liaisons—there are currently 32 in the system—assist in identifying cases that need ethical discernment and in presenting cases. The electronic health record is also used as a tracking system to identify cases that meet predetermined criteria. The second layer consists of teams and work groups addressing system-wide ethical issues that emerge from the casework. These system teams are ethics practice liaison education, information technology and technology ethics, equity of care, ethics and professionalism, and advance care planning.

"We now have 282 participants on the various teams who address over 800 cases per year," Beil said. The goal, she emphasized, is to create safe spaces where illuminating conversations about the most complex patients and challenges in health care can gracefully occur.

Clareen Wiencek, PhD, RN, CNP, ACHPN, is president of the American Association of Critical-Care Nurses (AACN) and an associate professor of nursing at the University of Virginia School of Nursing in Charlottesville. She spoke about the link between unhealthy work environments and moral distress. "When the AACN was formed in 1969, its initial mission was education," she said. "But in the early 2000s we felt this wasn't enough, and changed our mission to include a focus on work environments."

She said that a third national survey on the work environment conducted by the AACN in 2013—the first two took place in 2006 and 2008—revealed disturbing trends: while the frequency of moral distress diminished between 2006 and 2008 (with 6.8% and 5.6% of respondents, respectively, reporting very frequent moral distress, and 19.4% and 17.6%, respectively, reporting frequent moral distress), moral distress increased significantly between 2008 and 2013, with the 2013 results the highest ever (9.4% of respondents experienced very frequent moral distress and 23.3% experienced frequent moral distress).[1]

When AACN members were asked to identify barriers to practice, five themes emerged: staffing, disconnect with leadership, bullying and incivility by coworkers, regulatory oversight, and aggressive behavior from patients and their families. "We didn't expect this last one," she said.

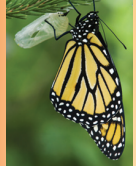
To address these findings, in March 2016 the AACN released the second edition of the *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence*.[2] Wiencek said that while the six essential standards in the first edition are unchanged (they are skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership), there is now greater emphasis on the importance of healthy work environments. "Moral distress," she said, "will not be resolved without attention to the work environment in which it occurs." The complete 2016 *AACN Standards*, as well as the AACN's Healthy Work Environment Assessment Tool, which offers institutions a starting point for evaluating their performance on the six standards, is available at www.aacn.org/nursing-excellence/healthy-work-environments.

Patricia A. Rodney, PhD, RN, is an associate professor at the University of British Columbia (UBC) School of Nursing, Vancouver, British Columbia, Canada, and a faculty associate at the W. Maurice Young Centre for Applied Ethics at UBC. She spoke about her involvement over the past 14 years in participatory action research—a community-based research approach that emphasizes collective inquiry, participation, and action. The goal of this research, she said, was to better understand and support the moral agency of nurses and other health care providers, and to empower them to provide more effective, equitable, and ethical care.

Among the research she cited was an interprofessional study she and colleagues conducted in a busy ambulatory oncology setting that resulted in the following recommendations at the individual, organizational, and regional and national levels: prestructured debriefing sessions with facilitators who can create a safe environment; rounds that allow clinicians to learn "from, with, and about" each other; transparent, reciprocal feedback between all levels of staff and administration; ethics policy initiatives; and advocacy through professional associations.[3]

Rodney said that while such studies have been instrumental in diminishing moral distress, difficult challenges remain. She defined these challenges as "primarily epistemological and political." At the epistemological level, she explained, nurses need a better understanding of themselves as moral agents in relation to the sociopolitical contexts in which they practice.[4-6] And at the political level, nurses, along with other health care providers and leaders, need to be better supported through fair and democratic processes.[7,8]

Lisa Lehmann, MD, PhD, MSc, is executive director of the National Center for Ethics in Health Care (NCEHC) at the Veterans Health Administration



(VHA) in Washington, DC. She is also an associate professor of medicine and medical ethics at Harvard Medical School, and associate professor of health policy and management at the Harvard T.H. Chan School of Public Health in Boston. She talked about the Integrated Ethics (IE) model at the VHA, a complex health system of 168 inpatient facilities and over 1,000 outpatient facilities throughout the United States, with approximately 330,000 employees serving 9 million patients. She stressed the importance of cultivating a culture in the Department of Veterans Affairs (VA) in which employees are empowered to speak up about ethical concerns. Referring briefly to the 2014 VA scandal in which government officials allegedly falsified data to hide how long veterans were waiting to receive health care at VA hospitals, she said it occurred even though an ethics center had been in place. Employees were said to have manipulated patients' appointment times so it would appear that they were not waiting longer than 14 days. Some employees were afraid to speak up when they were encouraged to circumvent the system to meet performance goals.

The IE model, she explained, was developed by the NCEHC, the VA's primary resource for addressing complex ethical questions in all aspects of care—including clinical, professional, organizational, business, and research. Implemented throughout the system, the IE model focuses on three areas: providing ethics consultations with staff, patients, or family members; preventing unethical behaviors throughout the VA by reviewing systems and processes; and improving the environment and culture of the organization through ethical leadership. She cited as an example of a successful IE intervention the repair of a system glitch that had caused patients who left a VA facility against medical advice to be automatically eliminated from follow-up scheduling. This situation, which was causing the staff considerable moral distress, was identified and addressed.

Still, Lehmann said, challenges remain, including variations among the numerous facilities of the VA, and the sustainability of ethical interventions at all levels—from scheduling clerks to individual clinicians to the organization's leadership.

DISCUSSION

Following the presentations, participants exchanged ideas on the challenges of addressing moral distress at the organizational level. One overriding theme was the question of sustainability—how to make the leadership at health care facilities more committed to moral distress interventions?

The group made various suggestions, including stressing to the administration the cost-savings aspect of a moral distress program, as employees are much less likely to leave if they feel their workplace allows them to honor their professional and moral judgment. Another idea was the reframing of the discussion as a public health issue: if the public is made aware of how moral distress can affect quality of care, leadership will more likely be amenable to addressing the problem.

Participants also discussed the AACN's finding in its 2013 survey that the frequency of moral distress among nurses is the highest it has been since 2006, when the first survey was conducted. "The 2013 variable that deteriorated the most," Wiencek explained, "was nurses' ability to impact decision making." Possible reasons for this were speculated on, including a younger workforce and distressing world events, which may be contributing to a collective sense of powerlessness.

The question of bringing moral distress interventions to smaller, more rural hospitals was also raised. Rodney said this was being addressed at smaller facilities in British Columbia, but the group agreed that more needs to be done on that front.

Finally, participants brought up the fact that discussions about moral distress often become two conversations: one about "individuals," the other about "systems." But systems, they said, are made up of individuals. The question, they concurred, is this: How do we integrate the two conversations?—*Dalia Sofer* ▼

REFERENCES

1. Ulrich BT, et al. Critical care nurse work environments 2013: a status report. *Crit Care Nurse* 2014;34(4):64-79.
2. Barden C. *AACN standards for establishing and sustaining healthy work environments: a journey to excellence*. Aliso Viejo, CA: American Association of Critical-Care Nurses; 2016.
3. Rodney PA, et al. The moral climate of nursing practice: inquiry and action. In: Storch JL, et al., editors. *Toward a moral horizon: nursing ethics for leadership and practice*. 2nd ed. Toronto: Pearson; 2013. p. 188-214.
4. Musto LC, Rodney PA. Moving from conceptual ambiguity to knowledgeable action: using a critical realist approach to studying moral distress. *Nurs Philos* 2016;17(2):75-87.
5. Musto LC, et al. Toward interventions to address moral distress: navigating structure and agency. *Nurs Ethics* 2015; 22(1):91-102.
6. Rodney PA, et al. Moral agency: relational connections and support. In: Storch JL, et al., editors. *Toward a moral horizon: nursing ethics for leadership and practice*. 2nd ed. Toronto: Pearson; 2013. p. 160-87.
7. Rodney PA, et al. A further landscape: ethics in health care organizations and health/health care policy. In: Storch JL, et al., editors. *Toward a moral horizon: nursing ethics for leadership and practice*. 2nd ed. Toronto: Pearson; 2013. p. 358-83.
8. Rodney PA, Varcoe C. Constrained agency: the social structure of nurses' work. In: Baylis F, et al., editors. *Health care ethics in Canada*. 3rd ed. Toronto: Nelson Education; 2012. p. 97-114.