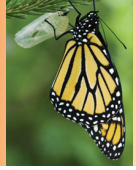

Themes of the Symposium

During the two-day symposium on transforming moral distress into moral resilience, several themes emerged.

DEFINITIONS OF MORAL DISTRESS AND MORAL RESILIENCE

Throughout the conference, the lack of definitions for moral distress and moral resilience was often mentioned. There was consensus on what moral distress *isn't*: the group agreed that moral distress must be distinguished from psychological distress. The group also reiterated that moral distress differs from an ethical dilemma: the person experiencing moral distress knows—or believes—that there is only one right action to take but is unable to take it, whereas the person facing an ethical dilemma perceives two or more equally viable actions but must choose one. However, defining what moral distress *is* was more challenging. While some situations clearly constitute moral distress—having to continue aggressive treatment that's both unhelpful and distressing to a patient, for example—other scenarios are more ambiguous, as demonstrated by an incident one symposium attendee shared involving a nurse who was slapped by a medical resident in front of a patient's family. After an animated discussion, the group could not unanimously agree on whether this incident illustrated workplace violence or constituted a situation of moral distress. Everyone concurred that moral distress must be more specifically defined.

Moral resilience, the participants said, also needs a more explicit definition. The question most frequently raised was whether some people are inherently more morally resilient than others, or whether resilience is a skill that can be learned over time—or both. Cynda Hylton Rushton, PhD, RN, FAAN, codirector of the symposium, offered two definitions. One was by Vicki Lachman, PhD, MBE, APRN, FAAN, who has defined moral resilience as "the ability and willingness to speak and take right and good action in the face of an adversity that is moral/ethical in nature."[1] The other—Rushton's own—characterized moral resilience as "the capacity of an individual to sustain or restore [her or his] integrity in response to moral complexity, confusion, distress, or setbacks."[2] She likened the quality of moral resilience to that of bamboo—supple enough to bend in a strong wind without breaking. And she referred to it as a continuous process, not a destination or an attainable steady state.

COMMUNICATION AND RESPECT

The group agreed that even though research on moral distress has focused primarily on nurses, it isn't just a nursing issue; it affects all health care workers, including physicians, social workers, pharmacists, respiratory therapists, and others. Patricia A. Rodney, PhD, RN, who for years has been involved in research on moral distress, said that while Andrew Jameton's inaugural definition of moral distress in 1984 had provided a "very good start," much work remains to be done. The moral agency of nurses and other health care workers, she said, must be further addressed, as should the interconnectedness between individuals and the systems they operate in. She disagreed with critics who have suggested abandoning the concept of moral distress altogether because of its lack of clarity. "We must continue opening up the discussion," she said, "not shut it down."

The group identified open and transparent communication between and among various professions, along with respect for the integrity of all involved, as seminal steps in diminishing moral distress. The importance of communication, both verbal and behavioral, was likened to the value of other preventive measures in a health care setting, such as infection control.

CHANGING THE DISCOURSE

'I'm just a nurse.' Many attendees pointed to this narrative of powerlessness among nurses, which, they said, leads to an absence of moral agency. They identified various elements that can help shift the discourse and allow nurses to not only maintain their integrity but also respect the American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements*.[3] These include self-awareness, self-regulation, mindfulness, the development of a strong inner compass, a holistic perception of complex situations, and a capacity to own the issue and to work with others to help resolve it.

The group agreed that considering the patient as a whole human being—and not an anonymous person in a hospital gown—was crucial to developing the ability to act according to one's sense of integrity when providing care. In her opening remarks, Patricia M. Davidson, PhD, MEd, RN, FAAN, professor and dean of the Johns Hopkins School of Nursing, mentioned the example of Kate Granger, a British

physician with sarcoma who, prior to her death in July 2016, spoke extensively of the alienation she felt when she found herself on the other side of the table—an anonymous patient. To emphasize the importance of respecting each patient's individuality, she launched a social media campaign, reminding health care workers to begin each conversation with four words, "Hello, my name is . . ."—a simple phrase that initiates the process of connecting the integrity of the patient to that of the nurse and the entire health care team.

INTERDEPENDENCE AMONG INDIVIDUALS, ORGANIZATIONS, AND COMMUNITIES

The importance of synergy was emphasized throughout the conference. Participants agreed that while individuals can develop and deepen their moral resilience, they cannot function as lone actors in an otherwise unsupportive system. Rodney spoke of "moral climate"—an organization's explicit and implicit values that affect both providers and patients. She further expanded this idea to include the notion of social justice, as organizations themselves are also part of a larger society, and they, too, cannot function as lone wolves in a system that doesn't value ethical practice.

The value of interprofessional collaboration was repeatedly emphasized by all participants, who agreed that the way forward will involve creating systems that encourage the entire health care team to practice ethically.

The group suggested multiple strategies for motivating organizations to adopt interventions to address moral distress and build moral resilience. These included establishing a strong link between a healthy workforce and higher revenues, engaging the public in the conversation in order to convey how health care workers' moral distress may be affecting the quality of care, and urging health care organizations and governmental entities to adopt policies designed to address moral distress and support the cultivation of moral resilience.—*Dalia Sofer* ▼

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Symposium participants.