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A Health System-wide Moral Distress Consultation Service: Development and Evaluation

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Abstract Although moral distress is now a well-recognized phenomenon among all of the healthcare professions, few evidence-based strategies have been published to address it. In morally distressing situations, the "presenting problem" may be a particular patient situation, but most often signals a deeper unit- or system-centered issue. This article describes one institution's ongoing effort to address moral distress in its providers. We discuss the development and evaluation of the Moral Distress Consultation Service, an interprofessional, unit/system-oriented approach to addressing and ameliorating moral distress.

Keywords Moral distress · Organizational ethics · Ethics consultation · Program evaluation

Introduction

Moral distress, now a well-recognized phenomenon among all of the healthcare professions, occurs when providers believe that they are being involuntarily complicit in acting unethically—they are doing something that they believe to be morally wrong but have little power to act differently or to change the situation. As a result, providers feel that they are compromising their own moral integrity as well as their ability to protect patients and care for them appropriately. Healthcare professionals, administrators, and clinical ethics consultants are increasingly aware of moral distress in the workplace and the damaging long-term effects of burnout, moral distancing, and attrition (Bell and Breslin 2008; Epstein and Hamric 2009;

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Hamric et al. 2013; Wall et al. 2016). Many organizations are now seeking ways to address the problem. To date, however, few evidence-based strategies to mitigate moral distress have been published. This article describes one institution's effort to address moral distress through moral distress consultation. We include discussion of the development, process, and evaluation of the moral distress consult service (MDCS) as well as tipping points that led to significant shifts in institutional thinking and lessons learned. Our aim is to assist others in developing a MDCS at their own institutions.

Background

Three categories of strategic approaches to address moral distress have emerged in the literature: direct, indirect, and general. *Direct* interventions such as the MDCS are those designed to address moral distress specifically. Examples include a writing retreat (Brown-Saltzman and Hamric 2009), moral distress mapping (Dudzinski 2016), and the American Association of Critical Care Nurses (AACN) "4 As" approach (American Association of Critical-Care Nurses 2004), though the latter strategy focuses on assessment.

Indirect interventions are those that focus on a different problem but may also have an effect on moral distress. For example, Rogers et al. (2008) designed and implemented an educational program to improve neonatal intensive care (NICU) nurses' comfort with caring for dying patients as an avenue toward improved moral distress. Although the authors found a small but significant improvement in participants' comfort in caring for dying infants, moral distress was not measured. Brandon et al. (2014) implemented an educational program on pediatric quality of life using palliative care principles and hypothesized that this intervention would address moral distress among multiple disciplines (e.g., medicine, nursing, social work, chaplains). Measures of moral distress were largely unchanged after participation in the program. One meaningful change, however, was a decrease in the perceived frequency of patients receiving care that was not in their best interest, a goal of palliative care and one of the root causes of moral distress. Two other examples of indirect interventions focused on clinical ethics problems experienced by nurses. Unit-based ethics conversations (UBECs) were developed by Wocial et al. (2010), who recognized that a unit-based strategy could be effective in addressing moral distress. UBECs involve facilitated discussion of ethically challenging issues recently encountered on a particular unit. The facilitators are trained to moderate conversations to ensure that the story is told from multiple angles, and that participants have an opportunity to express their views and concerns (Helft et al. 2009). A second example is the Clinical Ethics Residency program for Nurses (CERN) (Grace et al. 2014; Robinson et al. 2015), a grant-funded ten-month educational program including theoretical foundations, module-based lectures, simulation, and a mentored practicum. Levels of moral distress decreased significantly with both the UBECs and CERN programs (Wocial unpublished data, personal communication; Robinson et al. 2015). Wocial and colleagues used the Moral Distress Thermometer (Wocial and Weaver 2013) informally with the

UBECs and found that there was often a trend toward the mean—those with high levels of moral distress tended to have lower levels after the conversation and those with lower moral distress scores prior to the conversation tended to have higher levels afterwards, possibly due to a heightened awareness of the situation that arose during the conversation. Robinson and colleagues measured moral distress using the Moral Distress Scale-Revised (Hamric et al. 2012) and found a significant reduction in moral distress after the CERN program (Robinson et al. 2015).

General interventions target aspects of health care that constitute the institutional constraints which can give rise to moral distress. Examples of these strategies include promoting physician-nurse collegial relationships through interprofessional forums such as rounds and team meetings, facilitating changes in the work environment, educating nurse leaders about moral distress, and encouraging advocacy on behalf of patients (McAndrew et al. 2011; Karanikola et al. 2014; Wiegand and Funk 2012). In large part, general strategies have not been tested empirically for effects on clinicians' moral distress.

The Moral Distress Consultation Model

The need for institutional efforts to address moral distress arose from a seminal case that revealed a high level of moral distress among the nursing staff of two units. Initial efforts focused on education and creating a safe space for conversation, but attendance at monthly sessions waxed and waned and there was little evidence of institutional impact. As a consequence, in 2006 the first author developed a unit-based consultation model. Discussions between the senior author and the lead consultant of the institution's Ethics Consultation Service (ECS) led to the decision to develop a separate service. Reasons included viewing this effort as a pilot attempt to learn the best way to conduct such consultations, to explore whether a dedicated consultation approach could prove beneficial to staff, and to give more visibility to the concept of moral distress. If successful, we intended to merge the MDCS into the ECS. The MDCS was initially offered through the organization's professional nursing structure. Based on positive evaluations, the service was continued and in 2012 was merged with the ECS.

Combining the services provided a single pathway for addressing ethical dilemmas and moral distress. Many staff can recognize a problem on their unit but may not be able to decipher whether it is an ethically challenging problem, a morally distressing problem, or both. Staff use one pager number to reach the on-call ethics consultant, who assists the caller in deciding whether to trigger an ethics consult, a moral distress consult or both. A combined service has reduced the burden of recruiting and training for two different services, broadened consultants' knowledge and skills, and promoted collaboration within the ethics team. Most consultants are now trained to conduct both types of consults. Weekly meetings to discuss ethics cases include discussion of moral distress consultations. This weekly consult review deepens the team's understanding of individual cases and the interaction between unit and system issues and patient care, and serves as a quality improvement mechanism.

Structure and Scheduling

Of the ECS' 14 members, seven are trained in moral distress consultation and four are senior consultants with long-term experience and expertise. Consults are most often initiated by a unit manager or advanced practice nurse (APN) who recognizes staff distress; clinical ethics consults sometimes generate requests for moral distress consults on the recommendation of the ethics consultant. The MDCS team works with the requester to identify a day and time when staff are most likely to be able to attend a one hour meeting. Moral distress consults are always attended by at least two MDCS team members; one serves as facilitator and one as scribe. The facilitator introduces the purpose, goals and process of the moral distress consult, sets a respectful tone for safe, collegial interaction, and facilitates discussion. The scribe is responsible for taking detailed notes, writing the first draft of the formal summary, and tracking number and roles of attendees.

Consultation Process

The facilitator describes the consultation process and frames the discussion as a safe space for participants to voice their concerns and express value differences. Because moral distress inherently involves challenges to individual, and sometimes collective conscience, framing the discussion correctly is central to eliciting meaningful disclosure and preserving the staff's sense of their moral integrity. The facilitator then invites the group to describe the situation, ensuring that all attendees are given the opportunity to speak. Once there is a clear picture of the situation, the consultant assists the team in negotiating differences, identifying the action that most or all believe is the right one and the barriers to taking that action. In terms of "right" action, MDCS consultants maintain a focus on what is believed to be right from a professional values and standards standpoint rather than a personal values standpoint. For example, if a staff member states, "This patient has no quality of life. We should not be treating her aggressively," probing from the consultants would include questions about how much is known about the patient's life as a healthier person and her perceptions of quality of life.

On rarer occasions, a staff member will have conflicts of conscience. Although a staff member's disagreement with choices a patient has made (e.g., abortion) or a patient's actions (e.g., driving while intoxicated and being involved in a fatal accident) does not fit the definition of moral distress, moral distress consultation may serve to bring such conflicts into the open for discussion and to reframe the problem in terms of professional obligations. In some cases, it may be recommended that the staff member not be assigned to the patient when the conflict of conscience is interfering with the staff member's ability to provide care. When there is consensus/agreement among the team about right actions, the MDCS team helps the staff devise and prioritize strategies to remove barriers to those actions and plan for next steps. At the end of the consult, the MDCS facilitator summarizes the situation, the right actions, the barriers, and the strategies and seeks confirmation of accuracy from the group. A confidential summary is provided to the requestor and follow-up is often provided for support and guidance. A template (see Appendix) provides a consistent structure for the confidential

summary. The summary often includes resources such as hospital policies and procedures, journal articles, and national guidelines that the staff may find helpful in crafting or refining their strategies or in framing their discussions with colleagues. For example, if moral distress has developed around the issue of prolonged aggressive treatment with little hope of recovery, the MDCS team may include the multisociety policy statement on potentially inappropriate treatments in intensive care (Bosslet et al. 2015) or the policy statement on ICU shared decision making (Kon et al. 2016). Through this practice, the staff acquire tools that can help frame and strengthen arguments, initiate conversation, and support or more effectively shape perspectives.

EXEMPLAR

A composite example of an early moral distress consultation will serve to illustrate the steps in the process. The clinical nurse specialist (CNS) on an inpatient unit requested a consult to discuss issues of inadequate pain management with one patient in particular that were creating moral distress for the nursing staff.

Listen, Acknowledge the Distress, and Clarify the Situation

Within the first few minutes, staff identified numerous other patients whom they felt were inadequately treated for pain; it became apparent that the particular patient situation that initiated the consult did not represent an isolated case. As the discussion progressed, it became clear that the root cause of the moral distress was the structure of a particular specialty medical service rather than clinical decision-making around pain management. Specialty medical coverage for patients on nights and weekends was not provided by the specialty service; rather, coverage was transferred to a general medicine resident unfamiliar with these complex specialty patients and therefore ill-equipped to evaluate and implement an adequate pain management regimen for them. In many cases, patients were already experiencing significant pain upon admission. Continuity of medical management was problematic because resident and attending physicians rotated frequently. In addition, continuity of nursing care for these patients was being compromised because of nurses rotating care among themselves due to their distress at seeing the patients suffer, and nurse disagreement about what could be done to address the situation. This led to frustration among staff in trying to achieve continuity of care in planning and managing the patients' care. The facilitator validated the nurses' moral distress.

Discuss Concerns and Constraints Inhibiting Action

Once the key problems were understood, staff were invited to identify constraints that inhibited their ability to act in this situation. One clear constraint was physician anger: nurses who went "over the head" of an intern or resident to get a patient adequate medication for pain experienced anger from these house staff physicians. As a result, nurses were forced to choose between caring for an angry patient with inadequately managed pain and dealing with an angry physician. Nurse disagreement about what could be done to address the situation was a further constraint.

Validate Assessment, Identify Root Causes and Find Solutions

After discussion, staff agreed that the root causes of the moral distress appeared to be the structure of the specialty service in relation to weekend inpatient management of complex patients and the attendant difficulties created in terms of communication between nursing and medical staffs. Nursing staff were willing to collect data to document the frequency and severity of the problems experienced with this service, particularly: issues with off-service coverage; process problems with escalation of concerns; nursing discontinuity of care particularly over weekends; and, effect on staff dissatisfaction and turnover.

Staff further identified the following strategies:

(1) The CNS and acting unit manager agreed to discuss these issues with the Medical Director and request that an attending physician be designated to provide oversight and continuity of inpatient management of specialty service patients.
(2) Request that a clear process be developed for escalation of nursing concerns in the event that the first off-service team could not resolve the problem.
(3) Develop standing order sets or protocols for initial pain management for all newly admitted patients.
(4) Develop an ongoing care conference forum to discuss complex patient management problems so that nurses could provide systematic input into the plan of care. Particular strategies mentioned were:
    (a) Developing consistent team rounds at times that nurses could plan for and attend.
    (b) Developing a system to ensure that charge nurses receive reports on accepted patients from the admitting physician in order to prepare for the patient's arrival on the unit. This system could include a standard intake form, including some key assessment details and initial pain management orders, so that nurses could implement an initial plan when the patient arrived.
(5) Develop standard operating procedures for all of the above, so that continuity of care is not a function of particular individuals but becomes a standardized expectation for all providers, regardless of rotation or turnover.

Prioritize Identified Strategies

The request for clarification of the communication process and specialty service coverage were identified as the most important priorities. Developing consistent team rounds and a forum for discussing problems with patient management were also seen as important.

Follow-up

Resolution was complicated in this case and took months to achieve. However, the senior administrator and medical director of the service agreed in principle with the need for an improved structure. The CNS, unit manager, medical director, and area administrator began discussions that resulted in the changes needed to improve patient management and continuity of care for these complex patients. In the process, nurse continuity of care for these patients improved as well.

As this case demonstrates, moral distress is almost always a symptom of underlying unit, team, or system problems, and interventions must be directed to root causes to successfully deal with this phenomenon. In this example, the nurses not only identified the problems but readily identified a number of important strategies that could be taken to deal with the root causes.

Consultant Training

Initially, volunteer members of the MDCS were provided a packet of readings on moral distress and discussions were held on the facilitation process. Every consultation was debriefed by all team members to strengthen their skills in facilitation. More recently, an intensive 3-day training session on clinical ethics consultation was conducted using the *Core Competencies for Healthcare Ethics Consultation* (American Society of Bioethics and Humanities 2011); content about moral distress and moral distress consultation was included in this training session. In addition to this training, debriefing discussions continue to be held after each consultation to evaluate the session and identify strategies for improvement. Moral distress consults are reviewed weekly during ECS meetings attended by all consultants.

Similarities and Differences Between ECS and MDCS

Moral distress consultation addresses moral distress as it arises in the clinical setting using an interprofessional facilitated discussion approach whenever possible. The MDCS is similar to an ECS in that consult requests to both are typically initiated in response to a particular patient situation, are staffed by volunteer healthcare professionals with training in ethics and moral distress, result in a report or summary, and include provision for follow up if necessary. The MDCS differs from the ECS in that the primary goal of the MDCS is not to provide assistance in resolving patient-focused ethical dilemmas but to assist staff in identifying and addressing problems at the unit and system levels such as poor team communication, inefficient unit routines, and ineffective institutional protocols that arise repeatedly and affect patient care negatively. Because the root causes of moral distress are not solely at the patient level but also at unit and system levels, the MDCS is initiated only by healthcare providers and does not involve a review of the patient's chart. Documentation is not placed in individual patient charts as with an EC. Rather, a detailed summary is shared with those who can bring about the

necessary changes. Organizations must carefully consider the confidentiality of these summaries and the most appropriate mechanism for sharing them.

Initial and Ongoing Evaluation

Since the MDCS merged with the ECS in 2012, the volume of consults has risen dramatically. Between 2006 and 2012, we conducted 19 moral distress consults. Between 2013 and mid-2016, 40 consults have been completed (2013 n = 8, 2014 n = 9, 2015 n = 11, and the first 8 months of 2016 n = 12). Some of the volume increase is likely due to the ECS leadership's efforts to increase visibility of the ECS/MDCS and to seize opportunities to teach about ethics and moral distress consultation in the nursing, medicine, and chaplain residency programs.

The 59 moral distress consultations have been conducted on 25 different units/areas throughout the health system including all seven intensive care settings, ten acute care units, three specialty teams, and three outpatient areas. Table 1 shows the most common root causes for 56 detailed reports (three consults did not require detailed summary reports); they align primarily with root causes seen in research on moral distress (Hamric et al. 2012; Whitehead et al. 2015). Most consultations had multiple root causes; 32 different root causes were identified, and many were seen repeatedly in the consults.

Consultations were further categorized by the level of involvement seen in the case: patient/family; unit/team; and organization/system. It is noteworthy that although consults were usually initiated by a specific patient case, almost all (54 of 56 or 96%) involved problems beyond the case, at unit and/or organizational levels. Indeed, 59% (33 of 56 consults) reflected problems at two levels and 27% (15 of 56 consults) reflected problems at all three levels of involvement.

To initially evaluate the effects of the MDCS, 3-month post-consultation interviews were conducted with requestors between 2006 and early 2014. Interview data were obtained for 23 of 31 consults (74% response rate). A majority (83%) of those interviewed indicated that the consult led to resolution of key problems, and/or changes in staff or team behavior or organizational processes. After the services were combined, feedback and outcomes were largely discussed in the context of follow-up during ECS meetings. In 2015, a more formalized evaluation of the service was begun, including measurement of moral distress pre- and post-intervention, and in-depth interviews with consult attendees; this evaluation is ongoing.

Themes from Interviews

Analysis of interview and follow-up data revealed five overlapping themes in the outcomes of the consultations: acknowledgement of staff concerns; staff empowerment; staff engagement; improved team collaboration; and, unit- or organizational-level change.

Table 1 Most common root causes (N = 56 consults)

Root cause	% (n)
Inadequate team communication	41 (23)
Unclear treatment plan/lack of goals of care	25 (14)
Inadequate pain management	21 (12)
Lack of provider continuity compromising patient care	21 (12)
Futile or aggressive treatment not in the patient's best interest	19 (11)
Abusive/inappropriate patient threatening staff	19 (11)
Family wishing aggressive treatment not in the best interest of the patient	16 (9)
Team giving inconsistent messages to patient/family	14 (8)
Abusive/difficult family compromising quality of care	13 (7)
Incompetent care providers	11 (6)
Inadequate staffing	9 (5)

Acknowledgement

There was a general sense that acknowledging moral distress and the situations that cause it was beneficial. Interviewees noted that it was helpful for the staff to have been heard and to receive affirmation that they had been thinking ethically and carefully. As one interviewee noted, "It was nice to sit down and wrap our heads around this situation to put it in perspective for everyone." Several interviewees commented that the impartiality of the consult team was important. An objective view helped staff understand multiple perspectives of a case and work through the complexities of different clinical situations.

Empowerment

Increased staff empowerment was the change most commonly expressed. Several interviewees described the staffs' increased confidence and willingness to speak up in clinical situations after the consult. For example, an APN on one acute care unit witnessed an attending physician tell a bedside nurse that although a difficult clinical issue needed to be discussed with a patient and family, he did not wish to discuss it right then. The bedside nurse noted that the conversation was the physician's responsibility; she offered to accompany him as he talked to the patient and family, but she stated that this discussion needed to happen. The attending agreed and together they spoke with the patient/family. The APN believed that this level of empowerment resulted from a recent moral distress consult on that unit. Other interviewees commented:

> "Several of the nursing staff are more willing now to push communication a bit more—to investigate what's really going on and to get answers so that they can understand the patient's situation. They are less likely to jump immediately to, 'Why are we doing this? We should not be doing this."

> "Shortly after one consult, there was another very similar patient situation. The staff made it very clear that "we're not taking the route of [patient name] again." They were assertive and empowered with both the physicians and the family."

Empowerment may move too far, however. One interviewee observed that some staff had become overly assertive and that it took time to find a good balance between "being assertive in order to advocate for patients and knowing when to sit back and recognize that one's opinion isn't always right."

Engagement

Intuitively, empowerment should increase staff's ability to engage in patient- and unit-level issues. This was evident in several interviews where a demonstrated "call to action" was described. For example, following a moral distress consultation about a dying patient on an acute care unit, the nurse manager ensured that the MDCS summary demonstrating the staff's concerns was available to the medical team. A second consultation was held with the physicians and unit leadership to discuss concerns and strategies further. At this point, the nursing and medical leadership initiated an interprofessional task force to address withdrawal of certain treatment modalities in non-ICU settings.

Engagement also involved addressing moral distress specifically. One unit has had several moral distress consultations since the beginning of the MDCS. The CNS on this unit has been committed to teaching the staff about moral distress and recognizing moral distress when it occurs. She also has been instrumental in orchestrating environmental change to reduce instances of moral distress. Several of this unit's staff presented a paper at a national meeting on ethical issues and moral distress. The CNS described this event:

> "At last week's meeting, the staff presented a paper on the ethical issues of a very complicated case. [They] noted that [the situation] would have been difficult if there had been moral distress and a lack of collaboration or empowerment on the part of the nursing staff, but fortunately that was not the case in this instance. Instead, the staff were able to deal with the ethical issues well because they knew how to communicate and were cognizant of the potential for moral distress."

Collaboration

Four consults resulted in improved collaboration between units or among staff within a unit. This collaboration is believed to have improved patient care, as noted by one interviewee:

> "As a result of the [consult], there has been more collaboration between units, including the development of care plans for patients with head injury. This has improved the care of brain injury patients in the xICU and xxICU as well. This has been great for patient-centered care."

After some consultations, the medical and nursing staff were noted to be more frequently on common ground and more able to recognize that they were struggling with similar issues. Consults on a number of units over the past several years have been highly interprofessional including nursing, medicine, social work, respiratory therapy, nutritional support, chaplaincy, and other disciplines. As a result, there is improved understanding and awareness of the need for better communication and collaboration, as noted by one unit manager: "The attending who was involved in the consult is more willing to give information than before, which is great." On a different unit, an interprofessional consult led to routine "sit downs" where nurses and physicians discuss difficult cases. "Nurses and physicians attend these even on their days off. Despite initial reluctance amongst some medical colleagues, there is terrific buy-in now."

Collaboration is often the change that morally distressed staff need most. Those who are morally distressed frequently feel incapable of getting their point across or of making a difference in the treatment plan, even though a change may be necessary and in the patient's best interest. Acknowledging different perspectives and being heard is a helpful and meaningful element of collaboration. As noted by Hamric et al. (2006), "Collaboration is the goal, and it is more than a nice thing to do—it is a moral imperative for all of us to build and work in respectful, effective teams" (p. 22).

Unit and/or Organizational Changes

Most of the changes in staff and team behavior have been small, incremental changes on a local (unit) level. For example, one interviewee stated, "Since the consult, the unit's communication has improved significantly." Interviewees also stated that the summaries were helpful in getting an issue recognized and in making the staff aware of their options in these situations. Increased recognition of the MDCS has resulted in greater utilization by important groups: the service recently received a request from several physician residents for monthly MDCS meetings targeting the moral distress they are encountering, especially in ICU settings.

Some consults have brought system-level problems to the administrative level and fostered a robust organizational response. MDCS summaries have been shared with higher-level administrators who appreciated the added perspective and the seriousness with which the staff approached sensitive issues. Two examples: concerns about staff safety arose in several moral distress consults, with examples of threats to staff and patient safety and their effects on care quality. These consults have contributed to a recent medical center initiative involving administrators, managers, and staff at multiple levels to develop an institutional strategic safety plan. Institutional awareness of moral distress and ethical dilemmas occasioned by questions about aggressive treatment at the end of life has led to a complete revision of the Medical Center's Do-Not-Resuscitate policy. Multi-institutional recognition of the effects of moral distress has further facilitated a state-wide effort to develop standards regarding requests for inappropriate treatment.

It is worth noting that in some challenging situations, a moral distress consult may result in re-opening wounds thus initially creating increased tension. In such

cases, organizational help may be needed to address team dynamics and to repair interprofessional relationships. We experienced only one such consult, where we were concerned that we did more harm than good. A few months after this consult, however, the requesting physician stated that although nothing really changed, it was at least helpful to put difficult issues on the table. This physician also noted that key parties had not been present at the consult and thus the message was lost because those who needed to hear the concerns of the group did not attend the meeting.

Tipping Points

Over the past 10 years, several cases, structural changes, and events have served as "tipping points" which have led to improved staff access, administrative buy-in, and increased recognition from within and outside the institution that moral distress consultation is possible and often helpful. One of the most influential tipping points was merging the MDCS into the ECS which, overall, served to formalize and legitimate the service. It has improved our understanding of the phenomenon of moral distress as it relates to clinical ethics, and has increased the effectiveness of both ethics and moral distress consultation among staff and administrators. The merger has benefited the clinical staff and the organization at multiple levels by promoting increased visibility/use of ethics resources and has improved administrative responsiveness to and accountability for system and institutional-level problems.

Our experience combining the services has taught us that ethical dilemmas and moral distress are often, but not always, mutually exclusive. Opportunities to discuss cases from both angles lead to better understanding of the complexity of some cases, of aspects that staff have identified as morally right versus those for which there is moral uncertainty, and of the extent of the impact that moral distress can have on staff (e.g., staff not responsible for the patient at the time of an ethics consult request have experienced moral distress. They are frustrated with the system for allowing similar cases to occur repeatedly, or feel hurt by having had to do something that is morally wrong when they had previously cared for the patient.)

Another tipping point was the first time a case required involvement of the upper levels of administration. In this case, sensitive information about professional practice and staff and patient safety was brought to the forefront. The consult gave the staff an opportunity to state their concerns and the consult summary, shared with high-level administrators, was used to strengthen the case for action and to develop an organizational action plan. The right action was taken and the staff felt they had contributed to an appropriate resolution. Following this case, several administrators recognized the utility of moral distress consultation and continue to be highly supportive. Some ICUs and one acute care unit have requested scheduled moral distress consultations, either monthly or quarterly, because of the frequency of morally distressing situations on those units. These scheduled consults have not been counted in the 59 consults conducted thus far—they are additional consults. A third tipping point occurred in 2015, when the American Nurses Credentialing

Center redesignated our institution as a Magnet facility and cited the MDCS as one of two exemplary programs. These three tipping points have served to concretize the MDCS as part of the environment of the organization. They have increased the visibility of the service both within and outside the institution, given it some influential "teeth" at administrative levels, and built rapport and support for clinical teams and the MDCS from the organization's administrators.

Challenges and Limitations

Despite the successes, the MDCS faces continued challenges and limitations. It is certainly not a panacea for any complex healthcare system. Our MDCS started off very slowly, with only four consults in the first three years. Since 2014, however, there have been 32 consults, and moral distress is now widely understood throughout the institution.

The MDCS approach requires a significant commitment of time and effort to develop the service, train consultants, advertise the service, achieve buy-in from administrators, and carry out the service. This time commitment is, for the most part, above and beyond the job description of most consultants. We are an "all-volunteer army." Consults themselves are time-intensive. Each consultation takes at least an hour, the summaries can take 2–4 hours to write, and, in cases where follow-up or assistance in implementing solutions is required, several additional hours may be required.

The MDCS is not without risk to the staff or the consultants. This is not work for the "faint of heart". Consultants need ongoing support from institutional leadership, as serious organizational-level problems may be uncovered and consultants can be seen as "stirring the pot". Ideally, there should be buy-in at the senior administrative level that when such problems are encountered, there will be willingness to hear them with no repercussions against those who bring the problems forward, including staff and consultants.

During the early years of starting a MDCS it can seem as if the work being done is addressing only a tiny fraction of the moral distress in the institution. We questioned whether a case-by-case approach was helping the larger institution, particularly since so many issues were larger than any one case. Feelings of inadequacy and ineffectiveness can be a bit disheartening. Patience and perseverance are key. In the last few years, we have noticed a shift in awareness and understanding of moral distress among many staff, better knowledge about the benefits of the MDCS among management groups, and increasing evidence that the service is now a benefit to the institution.

Finally, evaluation is an important component of the service, but creating an efficient and effective evaluation program can be complex. During consults, we do not collect attendees' names, making follow up interviews challenging. However, we do invite attendees to provide their email address if they would be willing to be interviewed briefly on their experience. Additionally, we have recently begun using the moral distress thermometer (Wocial and Weaver 2013) to evaluate pre- and post-consult moral distress.

Discussion

As more organizations recognize the impact of moral distress on highly skilled, valuable staff of every health profession, creating a MDCS or including moral distress consultation as part of an ECS may be worth consideration. Development of a consultation group, gaining support from the administration, and crafting a MDCS structure that works within the organization are worthwhile challenges.

The MDCS has important similarities and differences with other programs to address moral distress, such as the UBECs and CERN programs. As with the UBECs (Helft et al. 2009), the MDCS uses a unit-based approach for several reasons. Staff generally prefer to discuss ethically challenging and morally distressing cases within their units ("keeping it in the family") rather than with a broader audience. A unit-based approach provides an opportunity for multiple disciplines involved in the care of a particular patient or struggling with a particular issue to access the consultation. Often, the charge nurse or unit manager covers for staff so that they can attend the meeting. Nursing staff in particular often have difficulty leaving their units for a scheduled meeting. Unit-based consultations permit staff to attend more easily.

The MDCS is also similar to the UBECs in that neither is intended to be a substitute for ethics consultation, no chart review is needed, family members are not engaged in the process, and no note is placed in the patient's chart. Both the MDCS and UBEC programs have identified that communication, hierarchies, and aggressive treatment not in the best interest of the patient are common underlying themes of moral distress. Both programs have shown some efficacy in ameliorating these types of problems (Wocial et al. 2010; Hamric et al. 2011).

Unlike the UBECs and most other interventions, the MDCS is focused solely and directly on moral distress. In a number of consults, we have recommended that an ethics consult be requested, but generally we have not provided ethics consultation in the MDCS session. The UBECs program seeks discussion about ethically challenging cases within a unit and, very often, it is the morally distressing components of ethically challenging cases that are most deeply discussed (Helft et al. 2009). Another important difference between the MDCS and the UBECs and CERN programs is that nurses are the primary focus group for the latter, whereas the MDCS is an interprofessional service. We have found this to be an enormous benefit because, as noted, morally distressing situations almost always involve an interprofessional problem such as ineffective communication between members of the team, uncertainty about which medical service is in charge, or abrupt, unwarranted changes in a patient treatment plan with rotations of the medical team. With an interprofessional approach, problems such as these can be better understood and directly addressed. A majority of attendees at our MDCS meetings are nurses and this seems to be a group that is highly invested in addressing the morally distressing situations they encounter at the bedside. As Helft et al. (2009) noted, "Bedside nurses are hungry for opportunities to process the ethical challenges that affect their daily lives and are generally grateful that others recognize that their work includes substantial ethical dimensions" (p. 32). Several empirical studies of

levels of moral distress have demonstrated that bedside nurses consistently have higher levels of moral distress than their medical or other healthcare professional colleagues (Dodek et al. 2016; Hamric and Blackhall 2007; Hamric et al. 2012) although this is not uniformly true. A recent study of moral distress within an entire healthcare system suggested that non-medical, non-nursing healthcare providers who have direct interactions with patients (e.g., respiratory therapists) have levels of moral distress that match or exceed those of nurses (Whitehead et al. 2015). Additionally, Trotochaud et al. (2015) found that pediatric physicians had higher levels of moral distress than pediatric nurses.

Conclusion

Developing an effective institutional mechanism to address moral distress was a complex undertaking that took multiple attempts to reach a feasible and effective model. The most valuable lesson learned in the initial phase of this endeavor was that while there is no doubt of the need to address moral distress in healthcare institutions, addressing it effectively in a complex healthcare system with limited resources requires patience, persistence, and unflagging dedication to the goal. We have been able to sustain the MDCS with volunteer professionals, and this is significant. A second valuable lesson is that while moral distress may be triggered by a particular patient case, it is almost always rooted in causes that extend beyond patients and surrogates to unit/team and organization/system levels. Consultations must look beyond the presenting case and individual professionals to address these broader levels in order to prevent and mitigate moral distress in any meaningful way.

The goal of the MDCS is not to eradicate moral distress, but to address it when it occurs and intervene early so that those providing care are empowered to act and know there are resources to help them in difficult situations before moral distress escalates. It is illuminating for staff to see that their experience is grounded in larger issues with a team, unit, or their organization. The overriding goal of the MDCS, as with any institutional ethics resource, is to contribute to a work environment where healthcare providers are encouraged to collaborate and problem solve in order to provide safe, high-quality care, while maintaining their moral integrity in the process. The MDCS assists staff to recognize moral distress in themselves and others, improves staff understanding of the dangers of moral distress, and provides empowerment in situations where staff feel unheard and powerless. By highlighting patient-, unit -, and organizational-level problems, the MDCS has improved the way strategies are created and implemented to manage moral distress in the institution.

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Appendix

MDCS Confidential Summary Template

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Moral Distress Consult

Unit and date

At the request of *xxx,* the Moral Distress Consult Service team met with *x#* staff to discuss a recent situation.

The purpose of the Moral Distress Consult Service is to…The consult seeks to provide a safe space for serious and productive discussion… This document provides a summary of the group's concerns and several strategies that were identified during the discussion.

Brief summary

Causes of moral distress and problems that prevent staff action

Strategies

Thank you….Please do not hesitate to contact us…

Names and contact information of consultants present

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