UK Moral Distress Education Project

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WHAT IS YOUR NAME, THE ORGANIZATION YOU WORK FOR, AND SOME OF YOUR DAY-TO-DAY ACTIVITIES?

My name is Carol Taylor. I work at Georgetown University as a professor of nursing and as a senior research scholar in the Kennedy Institute of Ethics. At Georgetown, I both designed and taught the ethics curriculum for our medical students, advanced practice nurses and undergraduate nurses. For a while I directed the ethics consultation service at the hospital and continued to serve on the ethics committee. I do a lot of speaking seminars for the public, locally, nationally and internationally, and I've done some consulting with health systems about organizational integrity.

TELL US ABOUT YOUR LECTURING.

The concept of moral integrity is very important to me. I think as people who prize simply being good and being trustworthy, integrity matters. It's usually in the context almost of an Ethics 101 lecture that I would invite participants to think about when they feel their integrity is being compromised. For those of us in the healthcare professions, when we can't deliver on a moral judgment about what ought to be done, either because of internal factors or because of constraints externally, then I believe we experience distress. It initially was a nursing phenomenon that our dear colleague Andy Jameton named. Right now, physicians have written about it in the New York Times and many other individuals have taken up the concept. Part of what I'm blessed to be able to do is to shine a light on the phenomenon and to help people figure out what role it plays in their lives and what we can do to not simply be the passive experiencers of distress, but how do we deal with it.

HOW WOULD YOU DEFINE MORAL DISTRESS?

For me, ethical distress is what I experience or a colleague experiences when they're in an ethically challenging situation. They believe they know the right thing to do, and yet something is preventing that right action from happening. It means I can't translate my judgment about what ought to be into reality. If I accept that situation, then I compromise my integrity.

IN A CARE SITUATION, WHAT HAVE YOU SEEN OVER TIME REGARDING THAT?

Recently, in ethics rounds with our undergraduate nursing students, an undergraduate student, who was with her preceptor down in the operating room, actually saw surgeons and/or the circulating nurse or the nurse who was setting up the procedure, the tech, break the sterile field. She knew, because she had followed the surgeon's pediatric patients on the unit, that he had a higher incidence of postoperative infection and complications. Yet she was acutely aware of being a student and a visitor in the operating room, that setting, and didn't know if she should, she knew she should call attention to that, but didn't realize what the consequences would be. In that instance, it was both her own reluctance to move beyond her comfort zone, to throw a red flag on the field, as well as concerns about what the consequences of her doing so would be.

I see it all the time with medical students and with residents. I've had residents say, "We're doing this surgical procedure", plastic surgery residents, "and the referring physician wants us to do something that we believe is wrong and if we do it, we're going to dry up that referral source." Our medical students will say, "If I bring attention to something that I don’t think is right, I'm going to be perceived as not being a team player. This is the person who's going to write my evaluation. I don’t want to get on the wrong side of him or her." There are lots of reasons for why these situations exist.

WHEN TEACHING MORAL DISTRESS TO NURSES AND MEDICAL STUDENTS, HOW DO YOU INTRODUCE THE CONCEPT TO NURSES AND DOCTORS AND THE DIFFERENCES BETWEEN THE TWO?

I actually think that moral distress among professional caregivers is a universal phenomenon. While our roles and responsibilities differ, I'm not sure that the experience of distress is that different, because whether I'm a physician, who, because of inadequate resources, can't execute the plan of care that I believe is best for a patient; or I'm a medical student or resident operating under somebody's supervision, an attending, that I doubt is going to be sensitive to my concerns; or I'm a nurse, in similar situations, implementing a plan of care that I don’t believe is the best plan of care. I think that experience of not being able to deliver on my judgment about what ought to be done is pretty common.

For me, as an educator, who shines a light on that experience, it's, first of all, trying to help the students understand that what's at stake is our ability to be trusted. That the public who comes to us and depends upon us needs to be able-- when we say our primary commitment is the patient, they take us at our promise and they want to believe that’s so. It was stunning. Just yesterday I was giving a talk to a room of almost 400 nurses; 50 percent of them said they participated in implementing plans of care that they believed didn't adequately meet the needs of patients. That’s an astounding percentage. You say, what violence do we do to ourselves, if we come to work every day and do that and what recourse do we have? That’s why part of my work is educating the next generation of healthcare professionals, but my work in organizational integrity with

systems is to say how do we grow institutional work cultures that communicate the expectation that we're not going to passively endure distress and that there will be mechanisms to help individuals who step forward to say, "This is an intolerable situation."

WHEN YOU TEACH, IS THERE A DIFFERENCE BETWEEN THE GROUPS?

I don't see, certainly, not a substantial difference in the way nursing and medical students experience distress. Once they begin practice and they experience either the internal or the external variables that make it difficult or sometimes almost impossible to be who they think they need to be, I think the experience of distress is similar. They can be helped to understand the consequences of not addressing it. What differs a little bit is whether or not they perceive if they come forward with a story of distress that it will be heard and whether or not the person who's listening to the story of distress will take it seriously and help them to wrestle with it. There may be a little less willingness among the medical school faculty to take those complaints seriously. Sometimes I think it's still the good old boy network that you got to tough it up and get with the program. It's been a phenomenon that's been recognized and addressed longer within the nursing profession than it has been in the medical profession, but I do think that's beginning to change.

WHAT RESOURCES OR PROCESSES DO YOU HAVE THAT ADDRESS STRESS IN TERMS OF RECOGNIZING IT OR DEALING WITH IT?

I actually read an article, I guess several years ago now, by Lesser & Colleagues and in JAMA, and it was an article written about professionalism. I think it was titled "A Behavioral and Systems Approach to Professionalism". The genius of the insight, he said we're trying to utilize professionalism to save medicine, but we almost exhort our physicians to reach into this virtue or something in their character. He thinks those efforts are doomed to failure because he said "So much of what professionalism is", and he'd rather see it as a highly skilled set of competencies that are either exhorted and supported by the system, by the institutional culture, or thwarted. And so his research and the work that he's doing is to try to look at the organizational culture, to say what are we doing? Do we have standards and do we support their implementation? That's where I see organizations needing to go and the profession to say, if this is a central component of the public's ability to trust us, we can't just rely on health care professionals so valuing their integrity that they're always going to be able to respond sometimes in heroic ways. We need to, one, communicate a clear expectation that we do expect that, but then support them doing that.

In my institution and in others, one, we've developed some grassroots education. Probably the most valuable thing, and, for me, the most blessed thing that I do as an ethicist is to create the moral space and time to talk about things like this. When did you feel paralyzed or feel badly because you couldn't be who you needed to be? When that happens, how do you address that? You get a group of individuals in a safe place who

can begin to talk about those experiences, then you grow awareness, then you begin to ask, so, what mechanisms do we have? I was working with a group in Southern California last year, and they were all in leadership positions in their organizations, multi-professional interdisciplinary group, and I said, "How many of you, either yourself or with your colleagues, have experienced moral distress?" The only person who said seldom or never was a surgeon. And he said, "How could I know what my team is experiencing?", which was pretty telling. Everybody else said, 50 percent or more, like I've encountered this. Some of us, not in addition to the ethics consult teams, have ethical distress resources. Usually it's the ethics committee who has created a mechanism that at least people feel, when I'm experiencing this, somebody knows what the phenomenon is, can talk me through the situation and point me to helpful resources.

WHAT ARE SOME OF THE OPTIONS TO PRACTICALLY ADDRESS A MORAL ISSUE?

Suppose I work in a surgical intensive care unit where I take care of patients who have had transplant procedures, let's say liver and small bowel, and I repeatedly experience difficulties with transplant surgeons following up with patients who are not optimally responding postoperatively. It's not a one-time phenomenon and I'm saying, "I'm not getting that collegiality. The team doesn't seem to be working." What do we do about that experience? Well, one, I would hope that that nurse, and most likely she's not the only nurse who's feeling that way, would be able to have a conversation with the unit manager and that the unit manager would feel prepared to address those concerns and not say, "Eat that concern. You got to go with the program", but would listen. In conversations that I've had with bedside caregivers, frequently they'll say, "The good unit manager is the one who invites you into his or her office, turns away from the computer, gives us the listening, and then begins to strategize with us about do we need a conversation between nursing and physicians about what's happening here?"

If that first level of approach isn't met with a successful response, then what's the next step? Oftentimes, if individuals believe that the chain of command clinically isn't going to work, that's when they might seek out the ethics committee or the ethics consultant. Within certain institutions there might be a practice counsel, but part of it is trying to understand what resources exist within an institution to address those factors. The power differential is huge.

BETWEEN WHO?

Power hierarchies, they're ubiquitous within hospitals. It might be between any healthcare professional, anybody who's wearing a badge and a patient and a family member. It might be between nurses and physicians. It might be between medical residents and attending. There are power differentials at every level.

CAN YOU DEFINE THE DIFFERENCE BETWEEN MORAL DISTRESS AND REGULAR DISTRESS?

I think there are multiple sources of distress. I can watch the evening news and feel distressed at what's happening in my neighborhood or in my city or in my global community. But if I go to work and I'm taking care of a newborn with necrotizing enterocolitis, which in essence is a rotten gut, and we've done surgery and we "opened and closed" because the damage was so diffuse that we were not going to be able to save this infant. So, in the mind of the nurse and the professional caregiving team, the appropriate call is to transition to purely palliative goals, where the goal really becomes to prepare for a comfortable, dignified death.

But we've got parents who believe somehow, for religious or other reasons, that somehow, with an act of God or nature, their child is going to survive and they want us to "do everything" to save their child. I'm the nurse who's caring for that infant and I know that every day we utilize the not life sustaining but death prolonging measures, we're tormenting this child. In order to meet the parent's expectations, to keep their baby alive for another day until God or nature works a miracle, I have to provide cruel and inhumane treatment. While I certainly want to support the family in their hopes, this is a false hope. I can only do that by doing violence to myself. That’s moral distress. I'm unable to be who I believe I need to be for that infant. That, to me, is very different than feeling sad because a random act of violence has snuffed out the life of somebody in my city. There I'm not linked to that tragic situation. Here it's my integrity that’s on the line.

IN THAT SCENARIO, WHAT WOULD THE ACTION BE?

In the scenario described about the baby, I want to work really carefully with that family to bring them sooner rather than later to a place where they could authorize a new goal. But I also believe that if we can't move them there, and this is what the classic feudal treatment debate has been about, does medicine have the authority to say what you're asking us to do isn't good medicine, isn’t good nursing. The difficulty in our country with that sort of scenario is because there's no agreement about the value of life, are we in a position, within the medical community, to say we cannot do this? There can certainly be a difference of opinion. There are scenarios where there's more clarity and there are scenarios where there's less clarity. I think, as we move to the consumer model of healthcare, it’s literally that the customer, and the customer is always right, that has come at the expense of healthcare professionals remaining true to their craft and doing what we believe is good.

IN THAT SCENARIO, THE HEALTH CARE PROFESSIONALS NEED TO DEAL WITH THEIR EMOTIONS REGARDLESS OF THE OUTCOME?

Absolutely.

WHAT ARE SOME OF THE EFFECTS OF MORAL DISTRESS?

I actually like to use the image of a heart as a pump because, if we experience distress and don't address it, the term in the literature is moral residue, but that distress, we tamp it down and it creates blockages and then eventually, to save myself, I begin to disengage. I'm not going to allow myself to be – I have to remain in that distressful situation. It's almost like I don't want to feel it. If you think of the heart as a muscle that contracts and pumps, if we've got enough distress and residue over time, I'm not going to be able to pump effectively. So there's a sense almost that I, as a moral agent, as a nurse or a physician or other caregiver, become like a flabby heart muscle that's weak and ineffectual. So I show up to work and I go through the motions, but I'm no longer letting myself be committed to being that critical difference, and that's a sad world for patients and the public that we serve. It's why this work is so critical that we not only exhort professional caregivers to be who they need to be, but we find ways within the profession and within our system, caregiving systems, to support individuals as they do that.

WHAT IS THE EFFECT OF MORAL DISTRESS ON INDIVIDUALS OR GROUPS?

I believe if I joined a team, a professional caregiving team, so I come into the chemotherapy infusion team or the neurosurgical ICU team or a surgical team, you get what this team is about. It's not what's written in a job description, but it's what brings people to work every day. You get if people are happy about the work they're doing, if they're proud of the work that they are doing, and you get a team that experiences enough distress and fails to address it, people either leave or they stay and ramp their expectations down. And you ratchet your expectations down enough, morale becomes a major problem. Everybody just shows up to work and does another day and can't wait for the day to be ended or my two days off to happen. That's a terrible place to work, but you know it. You can feel it sometimes when you walk onto a unit, and that's where you begin to see turnover, you begin to see oftentimes physical illness. People call out more; they're not willing to be there when jobs need to be done. You know you've got a problem.

IS THERE ANYTHING YOU WOULD LIKE TO EXPAND ON?

We talk a lot in medical education about the hidden curriculum. As somebody who is passionate about forming the next generation of health professionals, I can do as much as one person, one educator can, in the early years of formation. Our graduates need to, in the real world, find experienced mentors, who, when they're in distressing, ethically distressing situations, know what to do with that distress and how to transform it into moral action that respects the dignity and promotes the best interest of patients and preserves the integrity of clinicians. If I would have one cry, it's that those of us, who have been in the trenches for a long time, take the challenges of integrity seriously, ask ourselves at the end of the day, are people better or worse because they got me, got my

team, got my institution. If not, find partners who are willing to address those challenges to integrity and being to model for our new graduates that we're always going to have problems. Any human institution is imperfect. If we can't have the will to address those challenges, there are huge pressures toward efficiency in the system right now. As important as our revenue stream, as important as the latest science that's driving best practices, is our ability to be who we need to be for the public we serve every day. So, my wish would be that our experienced health professionals would be as aware of ethical challenges as they are of clinical, legal, financial challenges and find the will and the expertise to address them.

AS WE MOVE FORWARD, ARE YOU FINDING THAT INSTITUTIONS ARE BECOMING COGNIZANT OF THE DIFFERENCE BETWEEN TECHNOLOGY AND MEDICAL CARE?

In my work with organizational integrity, one of the facilitating forces is senior leadership gets it. I think there are huge discrepancies around the country in terms of senior leadership who value organizational integrity and the integrity of each of their employees. If they don't get it, then we're like fish swimming upstream and trying to make this a priority.

THANK YOU...