An Analysis of Moral Distress and Methods Used to Combat It

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On my honor as a University Student, I have neither given nor received unauthorized aid on this assignment as defined by the Honor Guidelines for Thesis-Related Assignments

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Introduction

Everyday, more and more nurses leave the profession for other careers. If nothing is done, the United States is expected to continue experiencing a nursing shortage until at least 2030, which will result in an untold number of avoidable human deaths and further damage to the American healthcare system (*The 2021 American Nursing Shortage*, 2021). Something must be done, and the psychological distress faced by nurses is a major factor that must be better understood and addressed for the better functioning of our healthcare system. This thesis will analyze how the management of healthcare systems impacts the psychological health and function of providers. Psychological stress is a broad topic not limited to any one field or discipline. Being such a complex topic, a specific subtype, moral distress, and a specific profession, nursing, will be focused on for much of the paper. In order to prove the importance of this topic, moral distress and its effects on both nurses and their patients will be explained. Then, the effects of changes in protocol meant to alleviate the effects of moral distress will be analyzed through the viewpoint of the actor-network theory (ANT) framework. By looking at each decision as an individual actor, the cascade of consequences can be analyzed in order to estimate the benefits or drawbacks of decisions. Once the ANT framework has been applied to the topic, a discussion of what is or can be done to alleviate moral distress in hospitals will be conducted. Since a major purpose of this thesis is to raise awareness of the phenomenon of moral distress and not to "solve" it or pick a side in a debate, there will not be a major focus on counterarguments. The discussion will instead focus on the current state of the field as seen in the literature.

Actor-Network Theory Framework:

In order to better understand the relationship between technology and society, ethicists have created frameworks to visualize this complex relationship. One of these is the ANT framework which sees everything from objects to people to ideas as actors in a complex network of relationships. The framework does this by looking at the complexities of a sociotechnical system and assigns agency to each piece. It puts a strong value on the impact of non-human actors, which sets it apart from many of the other socio-technical frameworks that limit themselves to only giving agency to human actors (Crawford, 2020). This distinction is important for this specific topic because this thesis will not be deconstructing the relationship between individual people and a piece of technology, but it will instead be looking at the web of relationships held between peoples' actions, ideas, and feelings, medical institutions, and a virus. Without recognizing the cause and effect each of these actors has on the situation would greatly handicap the methodology and success of combating moral distress.

What is Moral Distress:

Moral distress is most often described by the definition created by Andrew Jameton in his book, *Nursing Practice: the Ethical Issues*, where he defines it as when a nurse "knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action"(Jameton, 1984). This definition came out in 1984, so the study of moral distress is a relatively new phenomenon compared to other mental health topics. It is typically thought of in regards to nurses (hence the initial definition coming from a nursing journal), but it is important to remember it is felt by all healthcare professionals from EMTs to doctors.(Jameton, 1984). Seemingly paradoxically, it must be noted that the occurrence of morally distressing incidents has been shown to be rare; however, the intensity of each incident is high and has a lasting effect. This lasting effect is termed moral residue (Oh & Gastmans, 2015). The accumulation or residue

of moral distress leads to several symptoms including anger, doubt, frustration, powerlessness, burnout, and attrition (Henrich et al., 2017). The most significant for the hospital is burnout. Burnout is defined as " ...a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, or feelings of negativism or cynicism related to one's job, and reduced professional efficacy." (*Burn-out an "Occupational Phenomenon,"* n.d.). The typical end result of burnout is quitting which has led to a national understaffing problem. The remaining nurses must handle increased patient numbers with less help, which leads to increased stress and further problems (Silverman et al., 2021). In fact, burnout is such a major problem for nurse retention, it was found to be a major reason for why nearly as many as one in three nurses quit in 2019 (Shah et al., 2021). Despite this serious problem, actual analysis of moral distress remains difficult due to its oftentimes subjective nature and the complexity of its causes (Sarro et al., 2022).

Why Does This Matter Now?

With the onset of the pandemic, a problem that has been ongoing for a long time in the United States, nurse shortages, has been brought to the forefront of the public eye. The lack of nurses has been a well known phenomenon, but, as will be shown, the impact of the pandemic has exacerbated the already significant problem. Nurses on the frontlines are seeing major impacts to their mental and physical health, while they continue to put their safety on the line for their patients (Lavoie‐Tremblay et al., 2021). These factors have led to a situation where studies are finding as many as one in ten nurses are planning on quitting, two percent of the total surveyed were planning on leaving the profession, and an additional eight percent were uncertain whether or not they will continue as nurses (Raso et al., 2021). These numbers paint the picture

seen in hospitals all over America. Nurses, who already were seen as highly ranked in terms of turnover intention while in a precovid environment, are now further increasing (Falatah, 2021). If nothing is done to help these nurses, more and more will leave the profession, which will result in continuously short staffed hospitals. This will then logically lead to worse and worse patient care. With burnout being a major contributor to nurses quitting, and moral distress being a contributing factor to burnout, now is the time to introduce effective measures to combat moral distress, and therefore nurse turnover, before one crisis spawns another.

Application of Actor-Network Theory:

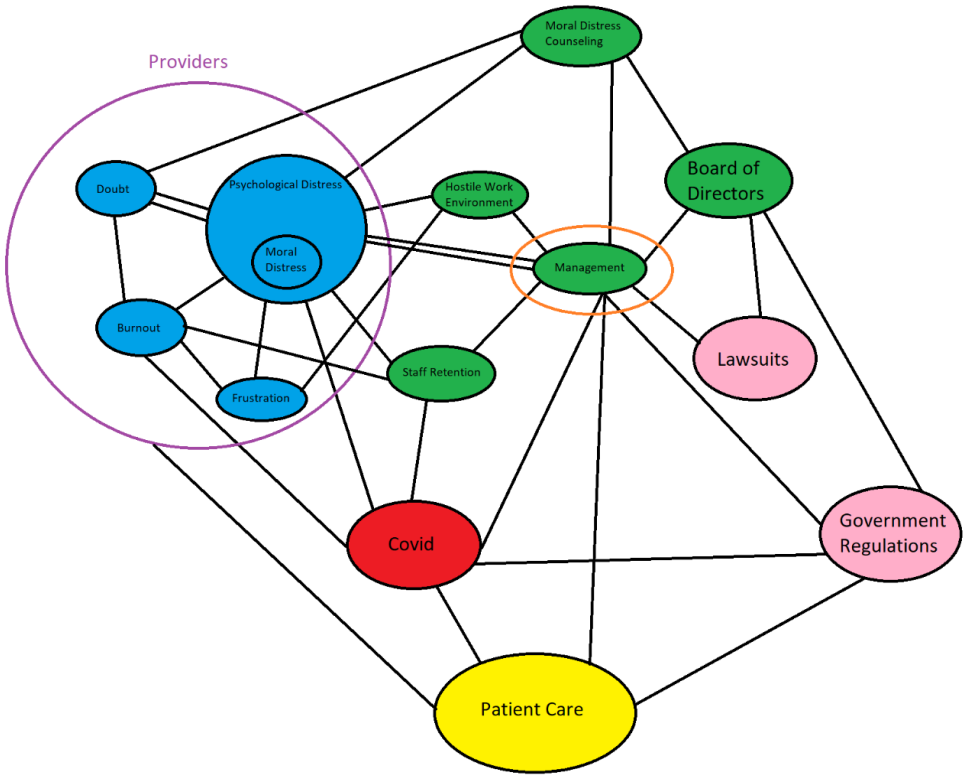

Figure 1: Sociotechnical Diagram of the UVA Hospital

Figure 1 represents the network of actors in the UVA hospital. It was chosen due to the large availability of information and proximity to the author. When breaking down the web of

cause and effect, the relationship between management and the mental health of providers is crucial to remember when any management decisions are made. In order to visualize the array of actors that are involved, this diagram uses five node colors to distinguish between the “realms" of the actors. First, blue represents the mental actors affecting the providers, all existing in the purple circle labeled providers. The circle was included to display the idea a person is not a single human actor but instead a collection of non human actors, each affected differently by external actors, that can both individually affect the external world (frustration leading to a hostile work environment) and aggregately affect the external world (link between the provider circle and patient care). This is an important aspect for the implementation of the ANT framework because it allows the figure to demonstrate the difference between the physical peoples’ impacts and the impacts on these people by their own mental factors. Second, the green represents internal hospital actors. Third, pink represents external actors that can mandate policy such as the government and the civil lawsuits. Fourth, the red represents Covid. It is an unexpected but deeply important actor that has radically altered how things are done inside and outside of hospitals as stated in other sections of the paper. Due to the uniqueness of Covid in comparison to the other actors in the network, it was given its own category. Fifth is yellow, which represents the goal of the human actors, maximizing the effectiveness of patient care. The double lines are included to show strong areas of two-way interaction. This refers to situations where two actors directly affect each other. The orange circle around management was included to label what will be looked at as the independent variable for this thesis. It would likely be impossible or practically impossible to actually run an experiment on such a complicated system with so many lurking variables and ethical constraints, so the thesis will instead focus on reviewing case studies.

Walking through the diagram, it began with two interconnected points, psychological distress/moral distress and management. Then effects caused by moral distress were added into the blue section (mental factors), represented by the three most major ones: frustration at the institution, doubt of the quality of care given to patients, and burnout. These symptoms do not stop at the individual provider. The frustration reaches out into the work environment, and the burnout causes nurses to quit. This affects the hospital by creating a hostile work environment and a nurse retention problem, which both affect how the hospital must be managed. It is important to remember that individual units in the hospital all answer to the board of directors, and must do as instructed. Moving within these constraints can be difficult, but with the help of institutions within the hospital, like moral distress counselors, moral distress can be minimized in providers, in theory. Further constraints are put upon what management can realistically do to combat moral distress by regulations and the possibility of lawsuits. An example of this is when a patient is admitted into a hospital but denies a treatment the providers see as necessary. Despite something being the best for the patient in the mind of the provider, the patient must still be listened to even when they wish to do something against their best interests. This is just one example, but it shows how the "right" thing isn't seen as the legal choice and can lead to a lawsuit if not respected. The last actor, which greatly affects the balance hospital management must maintain, is COVID-19. The pandemic has ushered in new rules, new regulations, and more work for already overworked healthcare providers. With all of these actors mapped out, their effect on the goal of the hospital, patient care, can be observed and optimized.

What Should Be Done?

Before the discussion of methods to decrease moral distress occurs, it must be restated that the main focus of this thesis is to find what is being done or recommended to be done to

combat moral distress. There will be no opinions or sides in a debate supported by the author. Instead, the remainder of the thesis will be a non-biased (as possible) review of the current tools used by hospital administrators to combat the moral distress felt by their nurses and other healthcare providers.

It is important to remember moral distress is not something that can be eliminated. People will always have different experiences, cultures, identities, and beliefs, so there will always be different moral codes. These differences between us are a good thing, but it means there will always be situations where the moral code of a nurse will conflict with that of their superiors and cause problems. This distinction is described well by what the senior director of the American Association of Critical Care Nurses once said, "Our challenge isn't to eliminate moral distress; it is becoming part of our new normal and not going away, so our new goals have become learning how to recognize and address it effectively." (*10 Best Practices for Addressing Ethical Issues and Moral Distress*, n.d.). As previously stated, the UVA hospital has already implemented a moral distress consult service to combat moral distress. This service involves the healthcare provider meeting with a consultant to discuss the morally distressing situation, discuss solutions, educate the provider on moral distress, and send a summary of the meeting to the group to which the provider belongs. This summary is sent without identifying details of the provider, and it is intended to be used to devise new strategies to combat moral distress (Epstein & Delgado, 2010). More recent work by Dr. Epstein, the primary investigator of the previous study discussed, has analyzed the overall effectiveness of the moral distress consult service. The study looked at immediate impacts on moral distress and empowerment directly after the consultation. Despite statistically insignificant changes, promising qualitative results were found in interviews conducted with healthcare professionals after their meeting with the consultation

service. The majority reported group meetings, meetings where several members of a unit met with the consult service at once, did not necessarily decrease their respective moral distress, but they did provide catharsis and benefits to the workplace environment due to being able to air their problems in a safe place and increasing the sense of empowerment felt by the providers. Another major benefit to these group meetings was gaining a better understanding of what other members of the team were going through. Providers interviewed in this study frequently reported this sentiment and were therefore more willing to take morally distressing situations seriously. The final major finding was how providers stated the consultations helped them with doubts they had about their own abilities and feelings towards morally distressing situations, and they reported they felt the consultation will have a positive impact on the patient care they provide (Epstein et al., 2021). Looking at the utility of the moral distress consult service from the perspective of the ANT framework, the direct effects of the service on moral distress seem to be minimal; however, the effects on the doubts held by providers concerning their feelings and adequacy of care provided are heavily supported. This decrease in the doubts held by providers may not necessarily decrease the moral distress felt, but it does decrease its impact on the other actors in the network like the work environment and patient care. However, there is one drawback that must be mentioned for this tool. For all of its benefits, it does not provide anonymity for those submitting claims. They meet in person, and despite the consultants being unable to reveal the reporter's identity, psychological studies have shown anonymity in reporting is a necessity for accurate reporting of mental health problems due to stigma and fears of reprisal for speaking out (Warner et al., 2011). This highlights an area for improvement in the service, but it does not tarnish the results they do achieve in regards to internal doubts and workplace dysfunction. It is also important to keep in mind this service does not directly resolve the

situations that caused moral distress. Instead, it is a tool administrators have to identify where morally distressing events are occurring.

While the consultation service is a method of reporting, many other services focus instead on raising awareness and teaching methods for personal action. Prime examples of these are moral distress workshops and regular moral distress debrief sessions. These give nurses the opportunity to discuss and learn about moral distress without having to expend personal time and are typically held within the unit, so nurses have the added benefit of proximity (Beumer, 2008; Sarro et al., 2022). The idea behind the workshops is typically to provide strategies to identify, combat, and cope with moral distress. In this specific example, the workshops were provided by internal administrators with specialized knowledge about moral distress and familiarity with the nurses. From surveys completed before and after the workshop, the researchers found the workshop to be beneficial in terms of raising awareness of resources for nurses, decreasing feelings of cynicism towards their patient interactions, and perception of patient advocacy. Some highlights of the workshop results include gratitude for greater recognition of moral distress in the workplace, validation of feelings, and thankfulness for a place to vent and brainstorm (Beumer, 2008).

An alternative to limited time workshop events, regularly scheduled debriefing sessions have also been studied to understand the impact they have on moral distress. A prime example of this is the Positive Attitudes Striving To Rejuvenate You (PASTRY) system. Despite sounding like a particularly egregious backronym, this system of monthly hour long debrief sessions has shown promising results. In this study, the sessions were administered by several clinicians including psychiatrists, meditation specialists, chaplains, and members of the ethics committee. The hour-long sessions consisted of the attending nurses raising, discussing, and reflecting on

morally distressing situations they had experienced over the previous month. The main outcomes of this system mainly focused on increases of the camaraderie and intra-team communication of nursing units. Despite these benefits, the PASTRY system did not directly decrease the moral distress experienced by the surveyed nurses (Sarro et al., 2022).

In a similar vein to the moral distress consultations, these workshops and sessions combated the symptoms of moral distress, mainly doubts about the care they are giving patients and the condition of the workplace environment, instead of directly decreasing the situations that cause moral distress. It should be noted that all three of these case studies used different tools to measure moral distress, which further shows the lack of standardization in the field and subsequent difficulty in comparing results between papers which utilized different methodologies (Beumer, 2008; Epstein et al., 2021; Sarro et al., 2022).

Conclusion and Future Work:

Moral distress has been studied for several decades now, but it continues to plague the nursing profession. With nursing shortages impacting the quality of care given to patients, the necessity of an analysis is obvious. With this analysis now completed, there are some lingering problems which must be resolved for the betterment of nurses. Firstly, most literature available focuses solely on measuring moral distress in a specific unit. Second, those that do analyze a system meant to help combat moral distress often focus on systems that provide short term results, which are mainly dealing with the symptoms of moral distress; long term studies of these systems' effects on the moral distress felt by nurses is relatively absent. Finally, the third problem which must be addressed in future work is the creation of a standard for measuring moral distress, so long term results can be accurately compared to the results of other studies.

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