

**BHA/MedChi Behavioral Health Webinar Series**

# **MORAL DISTRESS EXPERIENCED IN HEALTH CARE**

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**AUGUST 12, 2021**



**MARYLAND**  
Department of Health

# Objectives

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Upon completion of this learning activity, participants should be able to:

1. Define moral distress.
2. Compare and contrast characteristics of moral distress, post-traumatic stress, burnout and compassion fatigue.
3. Discuss the history of moral distress.
4. Recognize how moral distress is manifested in the health care setting.
5. Explain the relationship between moral distress and the COVID-19 pandemic.
6. Describe interventions that could assist health care providers in self-care and recovery from moral distress.

# Moral Distress Defined

Moral Distress is experienced by individuals who are performing or exposed to actions that contradict their moral values.<sup>4</sup>

Causes an internal conflict and detrimental impact<sup>7</sup> on psychological, behavioral, social and/or spiritual well-being.<sup>7</sup>

\*Root cause is different from moral injury, but level of impact can be the same.<sup>4</sup>



# History of Moral Distress

Believed to be first recognized after the Vietnam War when veterans who had been drafted reported post-trauma feelings related to the moral dilemma experienced during combat.

1980s - Studied in health care in situations where providers' belief of what is best for the patient conflicts with organizational, family or societal expectations or norms.

2000s - Changes in provider workload and expectations related to impact of technology and perceived ease/efficiency of technology (less time at "bedside").

Clinicians feeling forced to consider demands of stakeholders before patient needs. <sup>1</sup>

2020 - COVID-19 pandemic

# Characteristics and Differences

<b>Moral Distress</b>	<b>Post-Traumatic Stress</b>	<b>Burnout</b>	<b>Compassion Fatigue</b>
Root cause is moral conflict related to moral values vs. expectations/actions	Root cause is experiencing or witnessing a serious traumatic event	Root cause is poor stress management	Root cause is self-neglect

**\*Moral Distress and Post-Traumatic Stress are caused by extrinsic factors.**

**\*Burnout and Compassion Fatigue are caused by intrinsic factors.**

**\*May overlap, may be co-occurring. <sup>1</sup>**

# Moral Distress in Health Care<sup>2</sup>

- End of life situations
- Exposure to potentially deadly situations
- Conflict with care-specific expectations, directives



\*Knowing the “right” thing to do, but feeling powerless to do it due to an external constraint.

## **EXAMPLES:** <sup>2,10</sup>

- Patient dying of cancer and in pain. Provider following hospital pain protocol, but knows patient needs more pain medications.
- Patient with Alzheimer’s has been hospitalized for aspiration pneumonia several times in a year, guardian approves feeding tube. Staff feel the feeding tube would cause increased distress, confusion and agitation.<sup>11</sup>
- Patients dying alone due to COVID-19 protocols/visitation policies. Overwhelming number of patients dying due to understaffing, lack of appropriate medical services/equipment.
- Fear of being infected, fear of spreading disease due to lack of PPE.

# Symptoms (of Moral Distress, Post-Traumatic Stress, Burnout, Compassion Fatigue)



- ❖ Negative self-talk
- ❖ Anger
- ❖ Shame/Guilt
- ❖ Sense of betrayal
- ❖ Distrust
- ❖ Feeling of loss of meaning/purpose
- ❖ Feeling of disconnection or numbness, “going through the motions”
- ❖ Compulsive behaviors (working, eating, etc)
- ❖ Difficulty concentrating
- ❖ Self-isolation
- ❖ Physical symptoms

(7; HHS, 2020)

# Other Detrimental Effects of Moral Distress<sup>4,7</sup>



Feelings of powerlessness, shame/guilt, anger can lead to:

- Decreased job satisfaction
- Poor decision making, poor judgment
- Decreased confidence, “second guessing”
- Mistakes
- Self-doubt
- Emotional exhaustion
- Leaving the health care profession



# COVID-19 and its Impact on Health Care

***A shift from patient-centered care to public health protocols.***

- Individualized treatment goals vs.
- Public health - equity, risk/benefit to society as a whole

\*A change in priority, focus, role, resources

(Houssain & Clatty, 2020)

# Dilemmas Related to Pandemic Health Care<sup>7</sup>

- Quarantined/isolated health care workers not being able to care for patients:
  - ◆ Results in guilt, shame
  - ◆ Anger related to limited supplies, PPE
  - ◆ Feelings of betrayal
  - ◆ Fear that infection will spread to friends/family members
- Situations where death was perceived as being preventable, but occurred perhaps due to:
  - ◆ Understaffing
  - ◆ Insufficient resources
  - ◆ Limited supplies, equipment
  - ◆ Shift in priorities - who gets care?, compassionate care vs. triage vs. virtual
- Other conflicts
  - ◆ Following/issuing directives that result in negative outcomes

# Moral Distress and COVID-19

“Unprecedented Times”

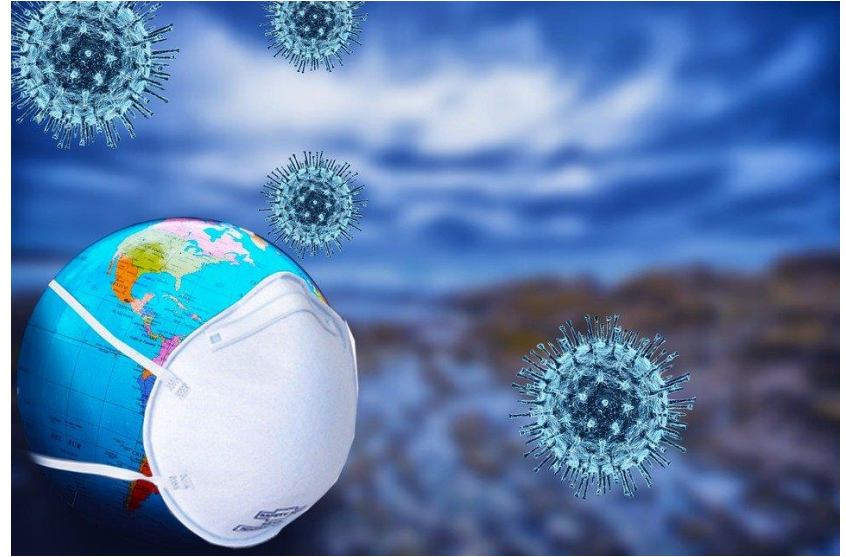
Communication

Staff Shortage, Deployed Differently

Patient Care Needs, Workload

Deprivation of Human Connection

Health Inequities/Disparities



**HEROS** (High Expectation and Risk Occupation).

# Implications<sup>1, 8, 11, 12</sup>



- Did we “sign up” for this?
- Is moral distress an “occupational hazard”?
- Are employers obligated to address it?
- How should leadership take steps to prevent moral distress?
- Will this help empower health care workers to become more united?
- Is this an opportunity to change the business framework of health care to become more compassionate to health care workers?

# Self-Care and Recovery



- ★ Daily moment of gratitude
- ★ Spirituality - What gives you hope?
- ★ Emotional intelligence
- ★ Family/colleague support
- ★ EAP/Therapy
- ★ Structural support
- ★ Self-stewardship
- ★ Education
- ★ Resilience
- ★ Structure/Routine

*I can be changed by what happens to me. But  
I refuse to be reduced by it.*

-Maya Angelou

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