

Editorial

TIME FOR A TOOL TO MEASURE MORAL DISTRESS?

By Peter E. Morris, MD, and Kathleen Dracup, RN, DNSc



Recently, a difficult family interaction left a critical care unit struggling to deliver compassionate, professional care while maintaining a safe work environment for nurses. Metastatic lesions had developed in the liver and cervical spine of a 75-year-old retired school-teacher with colon cancer (patient identifiers have been altered). At another facility, the patient had received a cervical stabilization procedure and radiation treatment for the metastatic cervical spine disease. The cervical spine lesions progressed, however, causing the patient further pain and a hospitalization.

The medical and nursing staff worried that a pathological fracture of a cervical vertebral body might develop, which could result in neurological impairment for this patient. She had an attentive husband and son involved in her health care decisions; her husband visited every day of her hospitalization.

Pain management was achieved within the first few days, and the patient expressed interest in a hospital discharge plan that included follow-up with a hospice program; however, no formal relationship was established. The evening before her discharge, the patient had severe sepsis with bilateral lung infiltrates, respiratory failure, shock, and acute renal failure. Shock resolved with resuscitative efforts, but the patient was left in a persistent vegetative state due to anoxic brain injury (no mass

lesions were identified and no evidence for ischemic or hemorrhagic stroke was identified). For the rest of her hospitalization, the patient required mechanical ventilation and dialysis. She continued to experience episodic infections related to vascular access, pneumonia, and diarrhea. The woman ultimately had a recurrence of profound shock and died on day 112 of her hospitalization.

The nursing unit's experience with this patient and family is not unique. In fact, it may be representative of a rapidly expanding number of patient-family-staff interactions in US intensive care units (ICUs). Extensive efforts were made to address the patient's poor prognosis with her family. An ethical consult was called, and family conferences were held by the attending physician 3 times a week (although not always attended by family) to discuss the prognosis and plan. Social workers, clergy, nurses, and physicians all agreed about the patient's prognosis.

However, although the prognosis was uniformly articulated to the family, they did not agree with the staff's suggestion to care for the patient with palliative measures. Despite the uniformity of staff opinion, and despite continuous offers for further family-staff discussion, the family held that the level of care should continue at full support. They remained hopeful until their loved one's death that she would recover and return home.

Understandably, during this patient's hospital stay, assignment of care became problematic. Many

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informal discussions were held among nurses and physicians about the patient's circumstances. These medical professionals felt strongly that further administration of resources would not affect the patient's ultimate outcome, a hospital death. Staff often commented that the resources could have provided benefit to some other individual not able to be transferred to our facility. A question that was frequently asked was, "How do we as nurses remain professional at the bedside on a daily basis, particularly when, in our hearts, we do not see the utility in this continued care?" Several staff members noted that no easy evaluation system was available that allowed staff to "score" the difficulties caused by the family's full-support mind-set. There was no way to grade the stress caused by daily interactions with the family and delivery of full-support techniques to the patient.

Measuring Bedside Moral Distress When Family and Staff Are in Conflict

Futility experts describe the stress of these situations for health professionals as emanating from 2 main sources: the inability to achieve appropriate pain control or relief of other patient-specific suffering (loss of dignity may be an example) and the expenditure of precious medical resources on patients who are unlikely to survive.¹ The frequency of ICU interactions causing moral distress most likely will increase, and it represents a significant health hazard for health care professionals, particularly nurses providing direct clinical care.

As Elpern and Balk² note, "Moral distress involves the perception that core personal values or ethical obligations are violated." Interestingly, recent efforts have focused on supporting health care professionals who must work in such situations. In 2006, the American Association of Critical-Care Nurses (AACN) prepared a health policy position statement on moral distress.³ This docu-

ment encourages nurses to manage moral distress effectively through familiarity with the hazards of moral distress and awareness of local and national resources to address this challenge. The policy further urges health care systems to address moral distress constructively by doing the following:

- establish mechanisms to monitor the clinical and organizational climate to identify recurring situations that result in moral distress;
- develop a systematic process for reviewing and analyzing systemic issues that create situations that produce moral distress and for taking corrective action.

A measurement tool would be very helpful in this process. How moral distress is currently measured in ICUs is somewhat subjective; it is up to us in the critical care community to make it less so. Methods are available to measure stressors, and certainly critical care professionals are familiar with using tools to measure patient acuity and with assessing other hospital-based health risks to medical professionals. A specific, uniform system approach to the health hazard of moral distress is overdue.

The US Department of Labor's Occupational Safety and Health Administration Web site⁴ describes potential psychological hazards found in hospitals as "factors and situations encountered or associated with one's job or work environment that create or potentiate stress, emotional strain, and/or other interpersonal problems." The medical literature offers frequent descriptions of staff feeling powerless when faced with such situations. Often staff members feel powerless to provide the care and treatment patients would request if they could meaningfully interact in such discussions. Think of the case just presented: the patient voiced interest in hospice, but arrested before any plans could be finalized; as a result, further care had to be interpreted through her husband. When expectations of a patient's outcome differ, health care staff are placed in direct conflict with families. Unfortunately, critical care professionals often feel isolated and are unaware of colleagues who feel similarly, whether in the same profession or across professions.⁵

The organization of ICU care may expose bedside nurses to moral distress that is more direct and prolonged than the moral distress other health care professionals—such as physicians who must be present at times in other units—inevitably encounter.

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Clinical Measurement Tools

Successful clinical measurement tools are easy to use and remember, accurate in predictive value, and constitute a meaningful and quantifiable characteristic of health care. In fact, researchers^{6,7} have carefully established through detailed measurements that nurses and physicians encounter moral distress in the types of care situations we've been discussing. However, the tools and analysis are more complex than, say, how we use the Glasgow Coma Scale.

If there were a tool for measuring moral distress, it would be easier to provide resources to health care professionals to work in such an environment without becoming overwhelmed. When faced with communicable infection risks, hospital staff draw on clear systems to minimize exposure. However, it is often unclear how to respond appropriately to a moral distress situation. Appropriate resources to enable staff to provide care without suffering an injury are not uniform.

Some hospitals provide stress management classes, others have health professionals seek one-on-one counseling, and still others urge palliative care consultation for the family. What we need is the ability to objectively measure the potential threat to the mental health of staff and to have ready access to appropriate interventions.

A Test of Our Professionalism

We have code phrases for these situations that we use when we give each other report, such as “we've got a difficult family.” A colleague mentioned during medical grand rounds recently that even our use of the term *difficult* in this context has certain connotations, such as “this family is trouble,” “this family has communication difficulties,” or “this family is hard to deal with...” (N. King, JD, oral communication, May 15, 2008). Working with families that hope for a miracle certainly presents a professional challenge. Unfortunately, mechanisms that might reduce the emotional strain of caring for patients for whom we have no hope are not uniform across ICUs or across hospitals. These situations test our dedication and professionalism.

The critical care community needs the equivalent of “stress-barrier precautions” that prevent harm to staff but allow care to continue in a positive, professional manner consistent with the promotion of dignity and respect for patients and families. The importance of identifying and taking steps to address

moral distress among critical care professionals cannot be overstated. Future research will provide us with ideas for how to deal with the impact of moral distress, particularly in the case of futile care.

A scale that depicts a moral distress situation as a high risk for personnel should trigger an appropriate protective response, whether it be a specifically stated structure to follow that distributes the conversations with families, easily accessible counseling, or a change in the distribution of bedside time spread over the nursing staff.

Until an easily applicable moral distress measurement tool is developed and “stress-barrier precautions” are commonplace, critical care professionals must do what they can to reduce this health risk; a healthy step is taking the time to reread AACN's policy statement on moral distress³:

- Recognize and name the experience of moral distress (moral sensitivity).
- Affirm the professional obligation to act and commit to addressing moral distress.
- Actively participate in professional activities to expand knowledge and understanding of the impact of moral distress.
- Develop skill, through the use of mentoring and resources, to decrease moral distress.
- Implement strategies to accomplish desired changes in the work environment while preserving personal integrity and authenticity.
- Implement strategies to accomplish desired changes in the work environment while preserving personal integrity and authenticity.
- Be knowledgeable about and use professional and institutional resources to address moral distress, such as AACN's handbook *The 4 A's to Rise Above Moral Distress*,⁸ the American Nurses Association Code of Ethics for Nurses,⁹ and the International Council of Nurses Code of Ethics for Nurses.¹⁰

The statements and opinions contained in this editorial are solely those of the coeditors.

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