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Towards a New Narrative of Moral Distress: Realizing the Potential of Resilience

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ABSTRACT

Terri Traudt, Joan Liaschenko, and Cynthia Peden-McAlpine's study contributes to a much-needed reorientation in thinking about and working with the challenges of moral distress.[1] In providing a vital example of nurses able to navigate morally distressing situations in positive and constructive ways, and offering an analysis of the component elements of these nurses' success, the study helps identify promising directions we might take in addressing the epidemic of moral distress. It also invites important questions, concerning the challenges faced by clinicians who do not who work in healthy "moral communities," who lack the ethical competencies, and who don't have the presumptive authority and recognition enjoyed by the seasoned clinicians studied here. We explore some of these questions, and suggest ways we might build on the insights of Traudt and colleagues' study.

What is it that enables some critical care nurses to navigate morally distressing situations effectively, aware of the ethical challenges they confront, but without experiencing painful or disabling threats to their integrity or moral efficacy? Traudt, Liaschenko, and Peden-McAlpine's qualitative study published in this issue of *The Journal of Clinical Ethics* highlights the often-overlooked possibility that both morally distressing situations and moral distress itself can be skillfully engaged without detrimental effects. Their data begin to illuminate a "counter story" about moral distress that suggests that the negative consequences of moral distress are not inevitable if clinicians can work intentionally, skillfully, and in integrity-preserving ways with the ethical challenges they confront. Instead of reinforcing the prevailing narrative of moral distress, in which themes of victimization, powerlessness, and negative emotion prevail, the authors offer us a study of self-identified critical care nurses who exemplify forms of moral resilience and skill that enable them to navigate morally distressing situations in positive and constructive ways within their own clinical contexts. Their analysis of the component elements of these nurses' success offers valuable stimulation in examining those conditions both within individuals and within systems of practice that contribute meaningfully to the support of individual integrity and ethical practice in morally distressing circumstances.

The literature on moral distress provides extensive documentation of the negative impact of situa-

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tions that challenge the integrity of nurses and other clinicians. In part, this may reflect the focus of the instruments used to measure the frequency and intensity of moral distress, which have not included inquiry into the positive potential of moral distress, or the strategies and support conditions that clinicians themselves have found helpful, both in sustaining integrity in challenging contexts and in mitigating the damaging consequences of their moral distress.[2] While Traudt, Liaschenko, and Peden-McAlpine intriguingly suggest that the subjects of their study did not show evidence of moral distress, despite the "morally distressing" circumstances they confronted, it may also be true that at least some of the nurses in this study experienced moral distress—felt the challenges or threats to their integrity—but saw this distress as a signal of moral concern, a call of conscience, and were able to work strategically so as to preserve their integrity and well-being.[3] It is, in any case, critical that the self-chosen subjects in the study are seasoned and confident clinicians; and indeed part of the point of the study is to highlight the forms of competency these clinicians confidently deploy in addressing moral complexity and conflict. The study also, and crucially, highlights key characteristics of the nurses' practice environments that supported their effective moral agency. At the same time, it leaves unexamined important challenges that arise for clinicians who may be less seasoned, less skilled, less confident, less supported by their practice environments, or who do, for a myriad of reasons, find themselves disrupted by moral distress.

Traudt, Liaschenko, and Peden-McAlpine organize their findings around three themes, each of which captures "antidotes" to moral distress: (1) "moral agency," (2) "moral imagination," and (3) "moral community." These themes offer promising direction for dismantling the detrimental effects of moral distress, but they also raise further questions. Consider, for example, the first theme, of moral agency. The authors draw a distinction between "moral agency" and "empowerment." Moral agency, they write, "implies self-directed capacity or choice to act," whereas empowerment "implies authorization or permission to act."[4] They suggest that the concept of "empowerment" is problematic, and should be replaced by a concept of "moral agency," thereby highlighting the value of "self-direction" and "choice" in clinicians' navigation of moral challenges. While we may well embrace the idea that nurses should own their own power and authority—power and authority formally granted them by their role as nurses, and secured by their license to practice—formal authorization alone is insufficient to secure the "authorization" needed to exercise effective moral agency and voice in the day-to-day of practice. It must also be secured through the community in which nurses practice. The narratives included in the study reveal critical care nurses who, in exercising "moral agency," are already in significant ways "empowered" or "authorized" within their practice environments. They are formally authorized by the *Nursing Code of Ethics* to advocate for the interests of their patients, to address their suffering, and to speak on their behalf.[5] But more than this, they are, because of their recognized clinical and ethical competence, authorized as moral agents who enjoy influential impact and voice within their practice communities. Significantly, in its focus on moral communication and moral community, the study itself points to factors beyond the individual's "self-directed capacity or choice to act" that are key in securing the respect and uptake needed for effective moral agency.

The study also helps us to identify the ways in which many clinical contexts diverge from ideal conditions, inviting us to ask what challenges exist for clinicians who do not enjoy the forms of presumptive authority and recognition, who don't work in healthy "moral communities," and who lack the ethical competencies of these seasoned clinicians. Individual moral agency is a necessary foundation, but cannot alone ensure that one is able to contribute meaningfully and constructively—in a way that is heard by others and can have constructive impact—in complex moral situations. We need to examine the complex interplay between individual capacity and effort and other, more environmental cultural factors in play, and to acknowledge the root causes of moral distress that may lie in actual disempowerment, a lack of moral authority, and voice. There are very real constraints on nurses' moral agency—imposed by policy, by professional codes, and by patients, families, and colleagues. The next step is to work with a new paradigm that acknowledges these factors and creates multifaceted strategies to leverage individual agency, address system contributions, and shift the culture of practice in ways that can enable nurses to practice with integrity.

Consider a second recommendation these authors make, to replace the focus on teamwork with a focus on "moral community." It is an open, and intriguing, question whether the paradigm of "moral community" might hold more promise than that of "teamwork" in guiding the efforts needed to create an ethical culture of practice within clinical organizations—efforts that will ultimately need to include

all "stakeholders" within clinical institutions—leadership, managers, and front line clinicians—if we are to significantly address the impediments to integrity in day-to-day clinical practice.[6] In considering this recommendation, we must soberly acknowledge the realities, including the power and gender dynamics, the pervasive depletion and burnout reflecting clinicians' despair and discouragement, and the external organizational pressures often impacting clinicians' moment-to-moment practice.

Working with the paradigm of moral community might, for example, invite a more robustly moral understanding of the collaborative dimensions of clinical practice. Teams are often hierarchically structured by virtue of the diverse roles of those configuring them. Approaching clinical teams as "moral communities" might encourage norms of mutual respect and mutual understanding, and highlight virtues that can counteract hierarchical dynamics, thus encouraging more inclusive and mutually respectful collaborative processes. It might also encourage clinicians to think not just in pragmatic terms, gauging success in terms of solution-generation and goal-achievement within the clinical unit, but in terms of the moral "health" of the shared work of the clinical unit itself.

While problem solving is an essential part of clinical practice, there might be a focus as well on the moral health of the practice itself, as a shared undertaking. Imagine, for example, a forum in which members of the interprofessional team—nurses, doctors, social workers, chaplains, and administrators—come together weekly to explore ethically complex cases using evidence-based triggers that systematically flag moral distress risk factors. Once cases are identified, collaborative, interprofessional processes would be employed in forging integrity-preserving solutions in the midst of the inevitable organizational and clinical constraints. Understanding such forums as "moral communities" might encourage participants to engage in their work together in ways that seek to preserve the integrity of individual team members, but also, and importantly, the integrity and "moral health" of the interprofessional team.

Traudt, Liaschenko, and Peden-McAlpine offer us a rich and important model of moral communication and moral agency. Thus they capture that the kind of agency needed to navigate morally distressing circumstances is not found in paradigmatically solitary exercises of individual will or moral resoluteness; nor is sustaining integrity, on their implied model, a matter of achieving what one regards as the optimal moral outcome, or perfect alignment with and fidelity to one's own moral commitments and values. Rather, the authors recognize that moral agency is characteristically exercised in the context of deeply interconnected relationships, and that solutions to moral challenges must be forged collaboratively and carried out through collective effort. They highlight the role of "moral imagination" in this process—a skill that is central to the respectful, inclusive communication at the center of the nurse's practice, that enables both higher levels of mutual understanding and more open and creative consideration of possible resolutions in the face of conflict and other moral challenges.

While a healthy moral process is important, it may nonetheless require moral compromises and trade-offs that can result in painful "moral remainders." Consider the nurse in the intensive care unit (ICU) who must navigate a conflict between, on the one hand, respecting the preferences of her patient, whose chronic, debilitating condition makes him dependent on expensive healthcare technology but who views his diminished quality of life as acceptable, and, on the other, her obligation to be a good steward of limited resources in a context in which there is pressure to secure beds for patients who have a greater chance than this patient of benefitting from intensive care technology. Even if communication with the patient, the patient's family, and the other involved clinicians is respectful, open, empathic, and inclusive, the nurse may carry an unsettling and morally distressing sense that she has not met important moral obligations, however the situation unfolds. Nurses routinely struggle to balance alignment with their own moral commitments, the moral obligations of their profession, and the economic and legal priorities of their organizations with their primary obligation to privilege the interests of their patients. Moral distress can thrive in the midst of these conditions, despite individuals' or teams' best efforts. In the absence of skills in self-awareness, self-regulation, and ethical competence, nurses are more acutely at risk of disruptive forms of moral distress.

Notably, the nurses in this study demonstrate skills and competencies that are aligned with moral resilience. Moral resilience, the capacity to "restore, sustain or deepen integrity in response to moral complexity, confusion, distress or setbacks"[7] includes elements of self-awareness, empathy, perspective taking, reflective listening, and conflict negotiation. Crucial to moral resilience are also self-regulation skills that contribute to creating the conditions in which other dimensions of moral agency and moral imagination can flourish. Mindfulness, the awareness that arises by paying attention to the present moment without judgment and in service of self-

understanding and wisdom, is a skill that can be learned to support self-regulation, discernment, and well-being.[8] Current neuroscience research suggests that, with training in mindfulness techniques, people are able to release strong sensations and emotions more easily.[9] Whether the nurses in this study exercised mindfulness skills and techniques is unknown, as they were not explicitly thematized. The Mindful Ethical Practice and Resilience Academy (MEPRA), an ongoing study into the moral resiliency of nurses at the Johns Hopkins Hospital, includes ten minutes of daily mindfulness practice to support nurses' ability to be more grounded, nonreactive, and self-aware, capacities needed to sustain the kind of empathic understanding and communication central to constructive and compassionate ethical practice.[10] Additionally, experiential sessions exploring elements of ethical competence (ethical embodiment, perception, reflection, and behavior[11]), communication skills using high-fidelity simulation, and strategies for moral resilience are included. Preliminary findings suggest that, following the six-session program, there are significant gains in nurses' ethical competence and confidence. This suggests that educational approaches such as MEPRA and Clinical Ethics Residency for Nurses (CERN), which go beyond cognitive skills, may be highly valuable in the cultivation of ethical competence.[12]

This study is inspiring in capturing and analyzing components of practice that render nurses able to exercise effective moral agency in navigating ethically complex and demanding clinical situations in the ICU, especially at the end of life. While it is a tribute to how much might be possible within specific clinical units, there is a broader story that must be told if we are to take insight and inspiration from their findings. It is a story we can only tell if we attend to the challenges nurses confront, given their position within broader systems, including the often inevitable and deeply entrenched hierarchies of power and authority within clinical organizations and practice, the fact that actual communities of practice may be less than healthy, or may be acutely challenged by resource constraints, poor communication, and the like. The dynamic interplay between individual moral competence and the culture of clinical practice was the focus of a recent national state of the science symposium, "Transforming Moral Distress to Moral Resiliency in Nursing," cosponsored by the Johns Hopkins University School of Nursing, the Berman Institute of Bioethics, and Wolters Kluwer Health/*American Journal of Nursing.*[13] This symposium sought to create recommendations for developing individual capacities for addressing moral distress through the cultivation of moral resilience and cultures of ethical practice by focusing on clinical practice, education, policy, and research priorities. The report of the symposium will be disseminated in early 2017. Traudt and colleagues' study provides important insight and data to support a paradigm shift that leverages positive, integrity-preserving solutions to address the recalcitrant and growing problem of moral distress in clinical practice.

NOTES

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4. T. Traudt et al., "Moral Agency, Moral Imagination, and Moral Community," see note 1 above.

5. *Code of Ethics for Nurses with Interpretative Statements* (Silver Spring, Md: American Nurses Association, 2015).

6. C. Rushton, "Creating a Culture of Ethical Practice in Health Care Delivery Systems," *Hastings Center Report* (2016, in press).

7. C.H. Rushton, "Moral resilience: A capacity for navigating moral distress in critical care," *AACN Advanced Critical Care* 27, no. 1 (2016): 111.

8. Adapted from J. Kabat-Zinn, *Wherever You Go, There You Are* (New York: Hyperion, 1994).

9. C. Ortner, S. Kilner, and P. Zelazo, "Mindfulness, Meditation and Reduced Emotional Interference on a Cognitive Task," *Motivation and Emotion* 31, no. 4 (2007): 271-83; H. Slagter et al., "Mental Training Affects Distribution of Limited Brain Resources," *PLoS Biology* 5, no. 6 (2007): e138, doi:10.1371/journal.pbio.0050138.

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12. P.J. Grace et al., "Clinical ethics residency for nurses: An education model to decrease moral distress and strengthen nurse retention in acute care," *Journal of Nursing Administration*, 44, no. 12 (2014): 640.

13. *https://ajnoffthecharts.com/nurses-take-action-on moral-distress/.*