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Using Moral Distress for Organizational Improvement

James E. Sabin

ABSTRACT

Moral distress is a major problem for nurses, other clinicians, and the health system itself. But if properly understood and responded to, it is also a promising guide for healthcare improvement. When individuals experience moral distress or burnout, their reports must be seen as crucial data requiring careful attention to the individuals and to the organization. Distress and burnout will often point to important opportunities for system improvements, which may in turn reduce the experience of distress. For this potential virtuous cycle to happen, individuals must be able to articulate their concerns without fear of retribution, and organizational leaders must be able to listen in an undefensive, improvement-oriented manner.

INTRODUCTION

It's a mark of creative ideas that once we understand them, they often seem obvious. Just so with Carse and Rushton's crucial insight—that if we interpret moral distress properly we will see that it is not just a problem to be dreaded but also a promising guide for improving healthcare.[1] Their insight accords with the Japanese aphorism about quality improvement: "Every defect is a treasure." Moral distress is serious health system defect. It is a source of demoralization for massive numbers of health professionals and a major cause of turnover, especially among nurses, where the phenomenon was first described by Andrew Jameton in 1984.[2]

Paradoxically, the nursing profession's admirable ideals make nurses uniquely vulnerable to moral distress. Nursing students are selected in large part for their patient care values, and nursing education strengthens their capacity for empathy with patients and families. For the past 15 years, the Gallup poll has found that nurses are rated highest among all surveyed professions for their honesty and ethics![3] As Rushton writes elsewhere,[4] in the hospital environment where they "practic[e] at the point of care, nurses are intimate witnesses to the pain, suffering, and hope of the people they serve." In their caretaking roles, nurses are perilously poised between the patients and families they empathize with and the hospital systems that give them directives – whether in the form of "doctor's orders" or "policies and procedures." As a result, when the health system fails to alleviate pain and suffering and disappoints patients' hopes, nurses suffer along with their patients. Jameton defined this suffering as moral distress, a condition that "arises when one knows the right thing to do, but *institutional constraints* make it nearly impossible to pursue the right course of action."[5]

In this commentary I will focus on how the organizational settings within which moral distress oc-

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curs can, at one extreme, intensify the individual clinician's experience of moral distress, and at the other, harness its promise for health system improvement.

STRENGTHENING MORAL RESILIENCE

In Carse and Rushton's view, the starting point for harnessing the promise of moral distress is moral resilience within the individual staff member. Except in paradise, organizations inevitably create frustrations for the staff. Resilience allows us to bounce back. If I frame my workplace distress as a call for quality improvement, I'm less likely to feel like a disempowered victim and more likely to undertake moral activism. Carse and Rushton identify two pathways to heightened moral resilience—individual self-strengthening through such means as mindfulness practice and eschewing perfectionism, and creation of "moral-reflective spaces."

For persons whose temperaments support the move from distress to advocacy, strengthening resilience is the most direct path to achieving the positive potential of moral distress. I agree with Carse and Rushton that for some clinicians, mindfulness practice can foster this transformation.[6] But for those for whom activism does not come naturally, and my guess is that this is a substantial number, focusing on the individual's response to moral distress risks adding one more burden for persons who already feel overwhelmed. If clinicians believe that resilience will immunize them against moral distress, and that mindfulness practice will make them resilient, they may frame moral distress as their own "fault," and blame themselves for the experience. If I blame myself for distress that is actually caused by a system problem, I deprive the system of feedback that could lead to improvement of quality.

With regard to "moral-reflective spaces," Carse and Rushton explain that "joining with others in grappling with the sources of moral distress can enhance mutual understanding and respect, and create shared ground for proposing and experimenting with changes in practice and protocol." One example of a "moral-reflective space" is Schwartz Center Rounds, in which clinicians discuss the social and emotional aspects of their clinical practices. Schwartz Rounds are conducted in more than 425 healthcare organizations in the U.S. and Canada and more than 120 in the United Kingdom.[7] Another is Balint Groups, in which physicians and other clinicians meet to discuss challenging situations, with the primary focus being the clinician-patient relationship.[8]

I've participated in Schwartz Rounds and Balint Groups, and have experienced firsthand how these kinds of moral-reflective spaces of can invite exploration of clinical experience, including experience of moral distress, in an atmosphere of mutual support. Venues of this kind can strengthen resilience and the voice of clinicians as potential catalysts for change.

But voice is only half of the equation. For voice to be effective, the organization must be prepared to listen!

THE DIFFERENTIAL DIAGNOSIS OF MORAL DISTRESS

Not every subjective experience of moral distress arises from defects in the health system. Some people tilt towards feeling mistreated and victimized. And sometime distress arising in other areas of life shows up as workplace distress. If you never whined as a child, you're in a minority. Fables tell us about a princess who is so sensitive that she can't sleep if there is a single pea under 20 mattresses. There are risks in assuming that moral distress means the organization must change (false positives), but even more serious risks in not taking moral distress seriously enough (false negatives).

When I was recruiting physicians to work at the not-for-profit Harvard Community Health Plan HMO (HCHP), I tried to assess this dimension of personality by direct inquiry. I emphasized that while I liked working at HCHP, no organization was perfect, and moments of disagreement and distress with aspects of how the organization functioned were inevitable. What was the applicant's experience with this kind of situation? Does the applicant tend to feel victimized? Had she or he been an effective advocate in the past? This wasn't a foolproof method, but it is important to discuss Carse and Rushton's "moral resilience" in advance, just as it is important to discuss side-effects when prescribing a medication.

MORAL DISTRESS AND BURNOUT

Interestingly, while the *nursing* literature is replete with articles about "moral distress," the *medical* literature is comparably replete with articles about "burnout." My hunch is that moral distress and burnout are closely related phenomena, but labeled and conceptualized differently in accord with factors of hierarchy and perhaps of gender. "Distress" is associated with a structurally more subordinate position, like that of nurses, who are expected to

follow "doctor's orders" and the "policies and procedures" of the organizations in which they work. Physicians have historically been more autonomous. "Burnout" sounds like the exhaustion that a runner might feel at the end of a race. I speculate that burnout from what is experienced as excessive or misguided demands and encroachment on autonomy is a more acceptable conceptualization for a profession that has been accustomed to seeing itself as the leader. Historically the nursing profession has been more female, and the medical profession has been more male, adding an element of gender to the alternative ways of conceptualizing work-related dysphoria.

LEADERSHIP'S RESPONSE TO MORAL DISTRESS AND BURNOUT

In 1957, Chairman Mao Zedong launched a campaign to "let a hundred flowers bloom and a hundred schools of thought contend" to encourage intellectuals in the Peoples' Republic of China to recommend improvements in governance. The intellectuals obliged. But when Mao saw the torrent of criticism, he reversed course and jailed many of the critics.[9] So much for voice in post-revolutionary China!

Openness to working with moral distress requires leaders to overcome the natural human tendency towards defensiveness that Chairman Mao illustrated so dramatically. Moral distress frequently includes an element of accusation of the organization and its leaders. I experienced this shortly after starting the role of Associate Medical Director at HCHP in 1980. In making rounds at a facility I was responsible for, I came upon a physician and nurse, both Caucasian. They were discussing their work, and said to me, "The doctors and the nurses are the new N—— ["N word"]!" I was shocked, and my reflexive response was defensive—"That makes me the new plantation owner." They said they didn't mean anything personal, but by failing to draw them out on the sources of their distress, my defensiveness cost me an opportunity to work constructively with their experience. If I could redo that experience I would: (1) tell myself—"Don't take this personally—find out what they are reacting to!" and then (2) ask "Wow—that's a strong reaction—what are the key things that lead you to feel that way?"

Just as distressed staff may need support from others and techniques like mindfulness to transform moral distress into constructive activism, organizational leaders need to undergo a similar process to transform themselves into receptive, improvement-minded listeners. Overcoming defensiveness takes hard work. But giving voice to moral distress accomplishes nothing without a listener who is influenced by it!

Empathic listening to what morally distressed staff members say doesn't require agreeing with their advocacy. The fact that staff members are distressed by the organization's policies and procedures doesn't mean that they are right and the policies and procedures are wrong. But even if leaders are not going to change the factors that have caused the distress, they should listen with empathy, provide an undefensive explanation of the rationale for the *status quo*, and make a good faith effort to mitigate the negative impact on the staff.

The Mayo Clinic has been a leader in studying and responding to staff distress. While their published work focuses on "burnout" in physicians, their perspective is just as applicable to "moral distress" in nurses as well. According to the Mayo CEO and the Director of the Program on Physician Well-Being, "Mistakenly, most hospitals, medical centers, and practice groups operate under the framework that burnout and professional satisfaction are solely the responsibility of the individual physician . . . [in reality] reducing burnout and promoting engagement are the shared responsibility of individual physicians and health care organizations."[10]

The very fact of creating a program focused on physician well-being reflects a management decision that burnout is a serious problem requiring a systemic approach to prevention and amelioration. Individual physicians are expected to identify ways in which the program can be improved. Leaders are expected to listen and respond. Mayo Clinic teaches us that dealing constructively with moral distress and burnout requires collaboration between the distressed individuals and the organization.

The most comprehensive approach to organizational ethics to date is found in the Veterans Health Administration IntegratedEthics program.[11] The program explicitly asks organizational leaders to foster a culture in which staff can articulate their concerns: "In a healthy organization, leadership creates an environment where open communication is welcome and encouraged. Employees can speak up without fear of having their comments held against them. In a 'morally safe environment,' staff is less prone to unethical behavior."[12] When employees identify a significant "ethics gap," they are expected to bring it forward, and the concern may generate a formal ethics quality improvement project.[13] As at the Mayo Clinic, leaders are expected to listen and respond. Clinicians and patients will be well-served

if organizations follow the VA's wise recommendations.

CONCLUSION

An emerging literature, to which Carse and Rushton make an important contribution in this journal, links individual clinicians' experience, organizational leadership, and quality improvement in a potentially virtuous cycle. When individuals experience moral distress or burnout, their reports must be seen as crucial data requiring careful attention to the individuals and to the organization. As Carse

and Rushton demonstrate, distress and burnout will often point to important opportunities for system improvements, which may in turn reduce the experience of distress. For this potential virtuous cycle to happen, individuals must be able to articulate their concerns without fear of retribution, and organizational leaders must be able to listen in an undefensive, improvement-oriented manner.

As I thought about how to conclude this commentary, a series of images such as the *pas de deux* in ballet came to mind, all involving interactive dualities. Perhaps the most fitting is the ancient Chinese concept of Yin and Yang, as a way of conveying that organizations, like conversations, can only thrive if vigorous voice and empathic listening are both present.

NOTES

The artwork used to depict Yin and Yang is in the public domain.

1. A. Carse and C.H. Rushton, "Harnessing the Promise of Moral Distress: A Call for Reorientation," in this issue of *JCE,* 28, no. 1 (Spring 2017).

2. A. Jameton, *Nursing Practice: The Ethical Issues* (Englewood Cliffs, N.J.: Prentice-Hall, 1984).

3. "Americans Rate Healthcare Providers High on Honesty, Ethics," 19 December 2016, *http://www.gallup.com/poll/200057/americans-rate-healthcare-providers-high-honesty-ethics.aspx?g_source=Social%20Issues&g_medium=newsfeed&g_campaign=tiles.*

4 . C.H. Rushton, "Creating a Culture of Ethical Practice in Health Care Delivery Systems," *Hastings Center Report* 46, no. 5, supp. 1 (September 2016): S28-31, S29.

5. Jameton, page 6, emphasis added.

6. J.E. Sabin "Meditation and Medical Ethics," healthcareorganizationalethics, 30 May 2016, *http://healthcareorganizationalethics.blogspot.com/2016/05/meditation-and-medical-ethics.html .*

7. Schwartz Center for Compassionate Health Care, "Schwartz Rounds: Supporting Providers. Improving Quality of Care," *http://www.theschwartzcenter.org/supporting-caregivers/schwartz-center-rounds/;* B.A. Lown and C.F. Manning. "The Schwartz Center Rounds: Evaluation of an Interdisciplinary Approach to Enhancing Patient-Centered Communication, Teamwork, and Provider Support," *Academic Medicine* 85, no. 6 (2010): 1073-81.

8. J. Salinsky, "Balint Groups and the Balint Method," *http://balint.co.uk/about/the-balint-method/.*

9. R. MacFarquhar, *The Hundred Flowers Campaign and the Chinese Intellectuals* (New York: Praeger, 1960).

10. T. D. Shanafelt and J. H. Noseworthy, "Executive Leadership and Physician Well-being: Nine Organizational to Promote Engagement and Reduce Burnout," *Mayo Clinic Proceedings* 91 (2016): in press.

11. E. Fox et al., "IntegratedEthics: An Innovative Program to Improve Ethics Quality in Health Care," *Innovation Journal* 15, no. 2 (2010): article 8.

12. E. Fox, B.-J.. Crigger, M.M. Bottrell, and P. Bauck, "Ethical Leadership: Fostering an Ethical Environment and Culture," *http://www.ethics.va.gov/ELprimer.pdf*, p. 25.

13. M.B. Foglia, E. Fox, B. Chanko, and M.M. Bottrell, "Preventive Ethics: Addressing Ethics Quality Gaps on a System Level," *Joint Commission Journal on Quality and Patient Safety* 38, no. 3 (2012): 103-11.