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Moral Distress, Ethical Environment, and the Embedded Ethicist

Donna Messutta

ABSTRACT

Interest in understanding the experience of moral distress has steadily gained traction in the 30 years since Jameton first described the phenomenon. This curiosity should be of no surprise, since we now have data documenting the incidence across most caregiver roles and healthcare settings, both in the United States and internationally. The data have also amplified healthcare providers' voices who report that the quality of the ethical environment is pivotal to preventing and containing the adverse effects caused by moral distress. Healthcare providers are asking for a moral space where ethics occurs at the bedside, in real time, applied to real cases. They are asking for ethics expertise to be available as part of the care team during their daily work, when treatment goals must be determined and decisions must be made. They are asking for an embedded ethicist who can help cultivate an ethical environment where formal ethics policy is properly applied to practice. This discussion advocates for an embedded ethics resource model that responds to contemporaneous ethics needs as a strategy to mitigate the effects of moral distress.

INTRODUCTION

In 1984, Andrew Jameton proposed that moral distress (MD) occurs "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."[1] MD research is a relatively recent endeavor, but there is already a plethora of published data and commentary, including multiple systematic reviews. Although the concept of MD was initially applied to nurses, it has now been identified across many healthcare provider (HCP) roles, both domestically and internationally. MD research includes data about its incidence, intensity, contributing factors, as well as its negative effects on individuals, members of the HCP team, and the quality of patient/family care. Interventions to ameliorate MD are gaining momentum, but are not as well analyzed. Research data strongly suggest an inverse relationship between MD and morally habitable environments.[2] Formally structured, "explicit" ethics resources, while valuable, may alone be insufficient to cultivate a robust ethical environment. Feedback from HCPs suggests a need to integrate informal or "implicit" ethics resources at the bedside. The current bioethics literature supports having an ethics consultant embedded in daily clinical operations to decrease MD by contributing implicitly and explicitly to a more morally habitable environment.

RESEARCH

Tools and Measurement

Several tools have been developed and validated to measure MD and institutional ethical climate, in-

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cluding the Moral Distress Scale (MDS),[3] the Moral Distress Thermometer (MDT),[4] and the Hospital Ethical Climate Scale (HECS).[5] Amended versions, the Moral Distress Scale-Revised (MDS-R),[6] and the Hospital Ethical Climate Scale-Shortened (HECS-S),[7] have been developed to adapt to non-nursing HCPs and other study variables.

In 2001, Mary Corley developed the Moral Distress Scale, an instrument to measure MD as a way to better understand the factors that influence nurses' job satisfaction and turnover. Corley's research is motivated by the hypothesis that nurses' practice includes their own value systems, and nurses competently identify ethical issues and rate how these issues cause MD. Corley discovered that an institution's ethical environment is a major factor in nursing attrition.[8]

The MDS is based on Jameton's concept of moral distress, role conflict theory by Robert J. House and John R. Rizzo,[9] and Milton Rokeach's work on values.[10] In 1993, Jameton expanded the concept of MD to include initial and reactive distress. *Initial distress* describes the feelings experienced when actions are constrained by institutional barriers or differences in values with others. *Reactive distress* describes when nurses are unable to act upon initial distress. House and Rizzo's role conflict theory explains how competing authorities can create conflicting professional expectations. Rokeach's value theory describes the way that personal values affect and motivate behavior. Incorporating the understanding that nurses frequently have greater amounts of responsibility than authority, these theories can be applied to nurses' autonomy and their ability to balance their professional responsibility to the patient with institutional authorities.[11]

Ethical Environment

Corley found moderately high MD scores, and also that demographic variables and prior resignations were not predictive factors; 15 percent of the nurse subjects reported that they had left a previous position due to MD caused by poor communication, a factor influencing the quality of an ethical environment. Corley recommended further research regarding how relationships with others (peers, management, physicians) and the "ethical work environment" could help to clarify the relationship between MD and job attrition.[12]

In 2005, Sara Hart researched the influence of an ethical environment on nurses' intent to leave their position or their profession. She reported that 25.4 percent of the nurse subjects considered changing positions and 15.8 percent contemplated leaving their profession due to a poor ethical environment.[13]

In 2007, Ann B. Hamric and Leslie J. Blackhall surveyed nurses and physicians in intensive care units (ICUs) to investigate relationships between MD, ethical environment, collaboration, and the quality of care. They found similar results: 28 percent had considered quitting and 17 percent had previously resigned. Nurses rated their ethical environment lower than physicians.[14]

In 2011, Phyllis B. Whitehead and colleagues furthered understanding of the link between MD and the ethical environment, as well as the prevalence of MD found in nonnursing- and nonphysician-only studies. They used the MDS-R and added two questions about the subjects' intention (currently or in the past) to leave a position, and Olson's HECS-S to study MD among all HCPs in all practice settings of a Virginia hospital system.[15] MD was found to be prevalent in all HCPs across all practice settings in HCPs serving both pediatric and adult patients. MD was higher for those who had previously considered leaving a position (36.9 percent), who had actually left a job (16.7 percent), or were considering leaving when surveyed (18.7 percent).[16] MD was found to be inversely related to a positive ethical climate for all HCPs. Continuity of care and inadequate team communication, factors directly related to the quality of an ethical environment, were ranked by all HCPs as the most common causes of MD.[17]

ETHICS RESOURCES

Requirements

Since 1992, the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations—JCAHO) has required that institutions have in place a mechanism by which HCPs, patients, and families can address health-related ethical issues. Most institutions utilize an ethics committee, ethics consultation service, individual ethicists, or a combination of all three. The goals of these ethics resources are to provide ethics case consultation, develop ethics-related policies, and disseminate ethics education.[18]

To achieve the effective use of these ethics resources, stakeholders must have a "moral space" where ethical values and obligations can be negotiated. Ann B. Hamric and Lucia D. Wocial describe four characteristics that are essential to promoting an effective moral space: knowledgeable ethics representatives, resource visibility/awareness, 24/7 availability, and institutional support.[19] In other words, HCPs need to know how to ascertain the

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"who, what, where, and how" of integrating the science and the ethics while practicing in the live theatre of healthcare. They need a bridge between formal ethics resources and the immediate care needs at the bedside. They need an embedded ethicist.

Inter-Ethics

Historically, the traditional model of bioethics was directed at doctors and focused on codes of conduct. It was a bioethical point of view that was "normative and prescriptive," derived from moral theory and principles.[20] But Tineke A. Abma and colleagues suggest that it is not enough for today's bioethicists to coach HCPs from the sidelines. Instead, since learning is contextual and accomplished by doing, ethicists must facilitate learning by combining theory with practice. Abma and colleagues call this expanded approach "inter-ethics," and contend that ethicists need to be "embedded and interactive" with those they serve.[21] Inter-ethics is relational, multidisciplinary, and based on moral knowledge derived from experience. Theory becomes more meaningful when applied to practice. The embedded ethicist's role is strengthened as it becomes more integrated.[22]

Implicit Versus Explicit

A Dutch study investigated the types of clinical ethics support (CES) found in healthcare facilities. The authors categorized types of CES as either implicit or explicit. Explicit CES includes an organization's structured processes, roles, and tools codified by policy, such as ethics committees, ethics consultation services, ethicists, codes of conduct, and ethics education. Explicit CES is a systematic approach to creating an ethical environment dedicated to serving all HCPs' roles.[23]

Implicit CES is not formally structured, but instead is spontaneous and narrative. Sometimes implicit CES is provided by pastoral care, team exchanges, or curbside conversations.[24] Implicit CES avoids the delay and formality sometimes associated with explicit CES. Implicit CES integrates ethics into the daily work of HCPs and may identify ethical issues missed by formal mechanisms. Implicit CES helps HCPs to address ethics spontaneously by responding to the immediacy of their cases. Implicit CES is necessary to "anchor values and norms" initiated by the structured goals of explicit CES. Explicit policies alone cannot change a culture or create an ethical environment. Instead, combining implicit and explicit CES "embeds" ethics into a system's culture, heightens moral awareness, encourages ethical reflection, and promotes an ethical environment that is helpful in ameliorating MD.[25]

The ethical environment establishes the context in which ethical decision making occurs in a facility. A Canadian health system implemented a Clinical Ethics Needs Assessment Survey (CENAS) to assess staff's perceptions of everyday ethics in their own units and how well values shaped ethical practice.[26] The authors found that less than 50 percent of staff were "aware" or "very aware" of the system's ethicist, hospital ethics committee, ethics consultation service, the hospital ethics website, and ethics grand rounds. Ironically, and while lacking awareness, more than 80 percent of staff indicated that ethics education was "important" to patient care. The participants identified the greatest barrier to making an ethics referral was "access," citing confusion regarding whom to call, who can call, and availability.[27] Staff favored interactive ethics education such as interdisciplinary rounds, informal discussions, and workshops rather than self-study or web-based learning. They requested information on topics including communication skills, decision making, end-of-life issues, and the integration of personal and professional ethics with clinical practice.[28] A poignant finding was the variability in units, suggesting that local leadership, team dynamics, history, and context are influential variables to consider when developing education that is responsive to each unit's microculture.[29]

EMBEDDING STRATEGIES

Rounding

One way that an embedded ethicist can implicitly increase the quality of an ethical environment is to participate in clinical rounds. Rounding occurs when an ethicist joins the medical team's daily patient presentations to integrate ethics at the bedside, in real time, with real cases.[30] This opportunity allows any HCP to raise ethical concerns before a situation escalates and actions occur that contribute to MD.

Medstar Washington Hospital Center in Washington, D.C., incorporates the practice of ethics rounding, and reports that the patient mix on individual units influences the types of ethical challenges. For example, surrogacy issues occur more frequently on surgical units compared with medical or mixed units. This helps ethicists to stratify relevancy and tailor education to each unit's need.[31] Evan G. DeRenzo and colleagues report that rounding at Medstar refutes reports that physicians can be averse to consulting ethics committees because of time delays and context-less advice. Ethics rounding is "practical and concrete" because it tackles the

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complexity of daily care while reinforcing medicine while it is simultaneously scientific and ethical.[32] Rounding also helps to build skills that clinicians can use in future cases. Rounding models the use of ethical terminology, concepts, and dialogue with the interdisciplinary team. The authors report, "Rounding brings ethics training to where the training occurs."[33] Rounding increases the ethicist's visibility, establishes trust, and builds collaborative relationships.[34]

An ethicist's presence during rounding can flatten some of the hierarchy and power imbalance that contributes to MD. By creating a safe environment where ethical concerns can be raised early, moral courage is promoted across different HCP disciplines.[35] Carol L. Pavlish and colleagues developed and tested an Ethics Screening and Early Intervention Tool, and found that nurses could accurately identify ethical cases early, but often avoided speaking up because they feared affecting professional relationships or blatant retribution. "Feeling considerable dissonance between moral obligation and fear of repercussions, nurses experienced uncertainty about initiating action."[36] An embedded ethicist can be instrumental in normalizing the interprofessional ethical collaboration that is essential to a supportive ethical environment.

The Medstar Washington Hospital Center reports that rounding increased moral confidence in decision making, which subsequently enhanced moral safety. The staff (especially nurses) showed "signs of relief" when an ethicist rounded, appreciating being able to meet patients' ethical needs. Patient advocacy about moral concerns improved.[37] Rounding prevents cases from escalating, utilizes teachable moments, increases moral language/dialogue, and increases the sophistication of ethical analysis. Familiarity with the ethicists increased the number of informal, "curbside consults" that promote early intervention, and subsequently decreases the repetitiveness of cases known to contribute to MD.[38]

Curbside Consults

As Medstar Washington Hospital Center reports, increasing familiarity with an ethicist may lead to curbside consults, which occur when an ethicist responds to an HCP's request for ethical direction without including other stakeholders, completing a chart review, or entering documentation into a patient's chart. Lauren Edelstein and colleagues describe curbside consults as an opportunity for "conflict coaching" that create new "spaces" for contemporaneous ethical collaboration.[39]

A Canadian quality improvement survey found that 62 percent of respondents would confer with a colleague before requesting a formal ethics consultation. Physicians frequently use this form of collegial consult in the course of their practice. Embedded ethicists are accessible for curbside consults to promote communication, normalize ethical concepts, and prevent case escalation. The long-term effects of such capacity building decreases risk factors for MD.[40]

The American Society for Bioethics and Humanities (ASBH) Clinical Ethics Consultation Affairs (CECA) standing committee cautions about providing recommendations for specific patients during curbside consults. Curbside consults on individual patients lack comprehensiveness because they do not involve other stakeholders and do not obtain information from the patient's chart or document the consult in the patient's chart. This committee advises ethicists to be "sensitive" to staff who are averse to formal consults, and endorses coaching on routine tasks and providing generic education.[41] The embedded ethicist does have an opportunity to slowly build relationships and trust with those staff who are uncomfortable with formal consults.

Pro-Active Ethics

In 2015, Carol L. Pavlish and colleagues hypothesized that identifying common ethical risk factors could be a catalyst for a "proactive system-wide approach" to ethical conflict that improves patient/family care while mitigating MD. They surveyed physicians to generate lists of ethical risk factors and effective actions by which to address the issues. The physicians requested open/frequent communication, improved teamwork, and applicable ethics education, such as incorporating ethics topics into daily rounds. "Several respondents emphasized not only the need for professional ethics consultation services but also an ethics presence, such as specific team members who have ethics training or who sit on an ethics committee."[42] The authors suggest cultivating an environment of "ethical mindfulness," including accountability for communication that addresses difficult ethical topics.[43]

Houston Methodist Hospital did this, and proved just that, when it created a pro-active program with the transplant population in two critical care units. The hospital developed an embedded ethics consultation model in which an ethicist attends rounds, transplant selection meetings, and pretransplant consultations. Not only did HCPs appreciate the ethics presence, the number of requests for formal consultations increased four times on the general units

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and five times in ICUs. This suggests that the increased presence of ethicists heightened the staff's awareness of ethics resources.[44]

BARRIERS

Opposing Views

Some may object to the embedded ethicist model because it lacks the plurality and diversity of a formal ethics committee. But ethics committees are retrospective, away from the bedside, and begin with conflict. Even when formal consultations conclude with resolution, moral residue may remain when a problem has become chronic. Many cases that make it to formal consultation are missed opportunities for an earlier intervention on festering issues. Mediation has been suggested as a way to provide the due process missing in the formal consultation model, but it too is retrospective, begins with conflict, and suffers from layers of oversight. The embedded ethicist, especially one who participates in rounding, can provide staff with immediate access to tackling the root cause of repetitive ethical issues. Rounding imparts ethical knowledge and models ethical analysis. Moral courage and assertiveness may increase in staff who feel comfortable with ethical dialogue. As their moral expertise increases, so does the moral safety of their environment, decreasing the likelihood of MD.[45]

Cost and Value

Cost and satisfaction are common metrics used to measure the quality and necessity of healthcare services. The value of ethics consultation has been measured by calculating length of stay (LOS) in the hospital and ICU and the number of days requiring life-sustaining interventions. A study of the efficacy of a pro-active ethics consult model found no decrease in LOS, however, nor a reduction in nonbeneficial care nor an increase in patient/staff satisfaction.[46] Using these outcomes to evaluate the effectiveness of an ethics service is problematic. It assumes that early palliation uses fewer resources, subsequently reducing costs, and so justifies the worth of ethics consultation. It does not account for the individual reasons that patients and surrogates make decisions, or when and why they make these decisions. Some patients opt to continue aggressive treatment or lifesaving interventions to survive until a particular milestone, such as a birth or wedding. A decision to prolong life does not suggest that an ethics consult was less successful or was ineffective.[47]

Similarly, dissatisfaction with ethics services by patients, family members, or staff does not always mean ethics services have been ineffective. Moral deliberation involves challenging and emotional choices that are value laden and context dependent. Patients and family members may be dissatisfied that their choices were restricted by the patients' clinical status or technological limitations, but that does not imply that the ethical resolution was not morally sound. Dissatisfaction with a clinical outcome is different than being displeased with an ethics service.[48]

Even though they are mandated by the Joint Commission, ethics services do not directly generate revenue. Ethicists do contribute to the responsible management of resources, but measuring the value of ethics resources based on the dollars saved risks prioritizing cost reduction over patients' ethical needs. A focus on cost savings might give the appearance that ethics interventions are coercive, with a fear that they may promote end-of-life decisions to save money. This association can impact the public's trust in an institution's commitment to ethical integrity.[49]

Instead, the value that ethics resources add should be considered "intangible assets" or "intangible benefits." Intangible assets are created by innovation, institutional design, or human/intellectual capital. An ethicist's expertise is considered to be an example of human capital. Direct benefit is difficult to measure, but indirect benefit can be assessed by factors such as data regarding the retention of staff and feedback about ethics training. Embedded ethicists add value in terms of future benefits that advance the mission and goals of an institution and promote a healthy ethical environment.[50]

FINAL ARGUMENT

Anita Ho and colleagues state, "The key to preventive ethics is access to ethical expertise, ongoing exposure to ethical wisdom, a culture of ethical reflection, and a mechanism for regular team communication."[51] The present discussion has advocated improving the moral environment of health facilities by embedding ethicists in the daily activities of patient care as a strategy to decrease MD.

HCPs contend that formal ethics consults are not their first choice during their daily work, but instead that they need and want ethics support at the bedside.[52] An embedded ethicist is uniquely situated as a bridge between explicit ethics structures and the implicit resources that are suited and essential to daily clinical activity. An embedded ethicist promotes an awareness of resources and collaborative relationships with staff, so as to better stratify the

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needs that are specific to the microculture of each unit. Embedded ethicists are available in real time, debunking objections that ethics consult responses are delayed, difficult to access, or time consuming. Ethicists can mitigate power imbalances and dispel fears of retribution that may impede some HCPs from raising ethical issues.[53] When HCPs act against their moral intuition, their moral identity is eroded, further fragmenting their ability to practice ethically, and increasing the risks of MD. Creating a moral community depends on the support of healthcare institutions in cultivating staff's courage to voice their ethical concerns. An embedded ethicist promotes open communication and transparency, both of which are key to enhancing our moral spaces by transitioning moral reasoning into moral practice. As Wing May Kong notes, "A thriving community will provide the critical mass to enable the language of ethics to flourish and to move out of the classroom into everyday clinical discourse."[54]

CONCLUSION

When I was a young ICU nurse in the early 1980s, my colleagues and I used to joke about quitting our nursing jobs and going to work at the grocery store across from the hospital. It wasn't because we didn't like being nurses, or were opposed to working hard. It wasn't because the cases we encountered were often tragic and sad—that was a part of our job. Instead, we were looking for relief from the cases fraught with ethical issues that went unaddressed. And, to make matters worse, there was the perpetual recurrence of the same ethical conflicts: another day, different case, same issue. There was no expertise available to incorporate ethical principles with new lifesaving technology that indefinitely sustained patients like never before. Paternalism was still actively contributing to decisions that caused patients to linger, suffer, and endure nonbeneficial treatment. Some of those cases still haunt me, and always will. We needed someone at the bedside with us then, a moral voice to help integrate ethics with the emerging science, so as to better care for our patients and alleviate our own MD. And we still need that guidance today. It may be unlikely that we can eradicate MD. But by "embedding" our expert resources—our ethicists—we can proactively build a more robust ethical environment and mitigate the effects of MD.

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