Moral Distress and Burnout

Fiona Miles
PICU Starship
Questions

• What is moral distress?
• What is the cost of this?
• Resilience-is this what we should aim for?
• Where to from here?
What is Moral Distress?

Experience of frustration and failure arising from struggle to fulfil moral obligations to patients, families, public around inappropriate use of resources, end of life care and communication.

• Austin W Moral distress and the contemporary plight of health professionals. HEC Forum 2012; 24:27–38
Moral Distress:

“knowing what to do in an ethical situation, but not being allowed to do it”
– Andrew Jameton, 1984

**Moral dilemma:** multiple choices, path unclear

**Moral distress:** path clear, solution blocked
  – Perceived violation of one’s core values and duties
  – Sense of **powerlessness**

• *Am J Crit Care July 2015 vol. 24 no. 4* 276-278
Moral Residue

- After event - **moral residue crescendo** - distress continues to rise
- From new baseline = second crescendo
  - Stronger reaction to new situation as reminded of previous situations.
- Exacerbated when poor team/institution dynamics not addressed

- Long-term consequences:
  - morally immune to ethically challenging situations
  - burnout and poor staff retention

- *Am J Crit Care* July 2015 vol. 24 no. 4 276-278
Model of the Crescendo Effect

Solid lines indicate moral distress; dotted lines indicate moral residue

Common in Clinical Practice

Result of perceived violation of core values and duties, constrained from ethically appropriate action

– **EOL care:** 61%
  - Continued life support when not in patient’s interests
  - Inappropriate aggressive care
  - Litigation led management

– **Communication:** 24% Inadequate communication about EOL care
  - False hope given to patients and families

– **Resources** 15%
  - Inappropriate use of health care resources
  - Inadequate staffing/skill mix
Moral Distress Study: Doctors / nurses

• Moral distress levels with more ICU experience:
  – Lower in physicians (p = 0.08)
  – **Highest in nurses, female gender.**
    • Nurses clear about prognosis but not benefits of treatments.
    • Increased with patient complexity

• Possible reasons:
  – Nurses less directly involved in clinical decision-making
  – May conduct end-of-life plans they don’t agree with
  – Can’t step away, witness the impact of decisions directly

Moral Distress Study: Causes

Major Stressors: more often, more frequent

- **Prolonging death** with intervention
  - More complex patients and goals of care
  - Greater expectations
  - Technology and prognostic uncertainty

- **Communication** poor
  - multiple teams with different perspectives

- **Resources:** staffing, inequity

What is new?


**Lawton G**: Burnout survey 15000 physicians. Medscape 2018

**Colville et al.** Moral Distress Survey ICU practitioners in UK JICS: 2018

**Larsen et al.** Moral Distress in PICU Practitioners PCCM: 18(8):e318-e326, 2017

What is the bottom line?

- Present in all ICUs and provider groups: (58% Larsen)
- **Female gender** overrides profession, experience
- Related to EOL, communication, resources, hours and
  - Electronic health record burden
  - Increase in non-medical patient and family needs
  - Lack of respect from staff/admin
  - Intense public scrutiny from social media
- Results in burnout, depression, intention to leave
Top 5 rankings items on MDS-R

- Follow family wishes to continue life support not in BIO patient
- Initiate life saving actions which prolong death
- Participate in care on ventilator when no one will decide to withdraw support

**Doctors**
Witness false hope given to patient/family
Watch care suffer for lack of continuity

**Nurses**
Unsafe staffing
Skill mix insufficient for patient needs

*Colville et al: Moral Distress Survey ICU practitioners in UK JICS: 2018*
## Constraints Involved in Moral Distress

<table>
<thead>
<tr>
<th>Internal: personal</th>
<th>External: institutional</th>
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</thead>
<tbody>
<tr>
<td>Lack assertiveness, self-doubt</td>
<td>Interpersonal: lack of collegial relationships</td>
</tr>
<tr>
<td>Socialisation to follow orders</td>
<td>Hierarchies</td>
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<tr>
<td>Perceived powerlessness</td>
<td>Policies conflict with care needs</td>
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<td></td>
<td>Pressure to reduce costs</td>
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<tr>
<td>Lack of understanding of situation</td>
<td>Fear of litigation</td>
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<td>Resources: Staffing, admin support</td>
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Barriers to addressing issues in PICU:

• **Resources:**
  – Staffing levels preclude attendance
  – Debriefs set up for medical staff, timing

• **Counselling not accessible**
  – cost, time off / parking/access

• **Culture**
  – weak to require support
  – Concern about confidentiality
What is the cost of moral distress?
Burnout

• Real but not everyone has it!

• **Depersonalization** - strongest marker
  – lose concern about others, detach, cynicism,
  – exhaustion, unproductive, PTSD

• 2x: unsafe care, unprofessional behavior, patient dissatisfaction
• **Symptom of a broken health care system**

How common is it?

Burnout prevalence:

• Overall burnout 0% to 80.5%.
• Emotional exhaustion: 0% to 86.2%
• Depersonalization: 0% to 89.9%
• Low personal accomplishment: 0% to 87.1%

BUT: no consensus definition of burnout so ??

85.7% used Maslach Burnout Inventory
Moral Injury more apt?
- Death by a thousand cuts

Not burnout!
- medics are smart, tough, resourceful, burnout suggests failure
- Consider leaving but stay wounded, disengaged

“Deep soul wound that pierces a person’s identity...morality and relationship to society.”* which disrupts confidence....about own and other’s capacity to behave in... an ethical manner**

• **Compassion fatigue:** lack empathy from exposure to suffering

• **Complicity** in actions against deeply held moral beliefs

• **Competing demands:** Failing to meet patients needs

*Simon Talbot and Wendy Dean 07/2018 Stat news. **BT Litz et al, clinical psychology review, 29, Dec 2009
Resilience in ICU professionals

Adaptive, skillful responsiveness to stress which motivates us to act

The Goldilocks Dilemma

Moral Distress
over-responsive to routine stressors

Optimal zone
gives best care

Burnout
under-responsive to routine stressors

• PCCM August 2018 Dryden-Palmer.
Strategies to increase resilience

• **Stop the surveys- work on the system**
  – Adapt old systems to the new age

• **Support the team, don’t blame the individual**
  – Resilience is a process, not a character trait
  – Culture shift: Build up team/ work to strengths
  – Acknowledge emotional impact
  – Prioritise connection, value what we do

• **Proactive rather than reactive strategies**
  – Pre- event strategies rather than dealing with aftermath
Managing Moral Distress

Acknowledge

Acknowledge and recognise moral distress:
- Physical, emotional, behavioural, spiritual
- Cost of competing demands: EHR, business metrics

Affirm commitment to address moral distress:
- Create healthy environment, build resilience
- Focus on self care
- Validate feelings and perceptions with others
- Value talent: work to top of skill set
Bravery- moral courage

• **Act on own beliefs**
  – Advocate
  – Authentic –true to self
  – Assertive
  – Accountable

• **Cognitive reframing**
  – Positive for negative thoughts
  – Discuss with less emotionally attached colleagues
  – Mentorship / supervision
  – Self monitoring : Stresschecker*

*Am J Crit Care July 2015 vol. 24 no. 4 276-278
Colville et al. Critical Care Medicine 2017; 45: e1102–e1103; [http://www.picupsychology.net/stresschecker](http://www.picupsychology.net/stresschecker)
Causes and change

Identify sources and constraints:

– Address culture/practices perpetuating distress
  • Reframe situations: Positivity!
  • Patient welfare over metrics
  • Team over individual

Prioritise strategies that respect unit culture, integrity

• Empower staff to develop solutions
• Encourage everyone to raise ethical concerns
• Ensure ALL people feel valued
Develop Healthy Systems

- **Realistic Staffing, HR practices**
- **Forums for problem solving**
  - Family meetings,
  - Interdisciplinary rounds
  - PEACE rounds-align goals
- **Support for Staff:**
  - Mentoring, Supervision
  - Collaborative networks
  - CARED rounds- moral check of team
  - Moral distress consultation service

*Colville et al: Moral Distress Survey ICU practitioners in UK JICS: 2018*
*Paediatric Ethics and Communication Excellence*
Educate and Enable

• **Teamwork/ relational**
  - Simulation: ethics, communication, (technical)
  - Reflection: Schwartz, “the Pause,”
  - Checking in and out: reflective questions to focus and reframe experience

• **Communication**
  - Story building, ‘failure bow’

• **Ethics**
  - Ethics consultations, education
Restoring humanity:
- the importance of narratives

‘...it’s a human need to be told stories. The more we’re governed by idiots and have no control over our destinies, the more we need to tell stories to each other about who we are, why we are, where we come from, and what might be possible.’

ALAN RICKMAN
Challenges: Where to from here?

Our world has changed, we need to change too.

- **Address reasons for burnout:**
  - Foster community: staff/ families
    - Value each other, ourselves
  - Communicate effectively and positively
    - Listen to understand others’ perspectives
- **Address disconnect between expectations and reality**
  - about / for our patients, ourselves, society
    - What do we truly want- survival or more?
  - Embrace social media

Nguyen July 2018 NEJM
Connection!

Individually, we are one drop. Together, we are an ocean.

Ryunosuke Satoro

Whiria te tangata. Weave the people together.
He aha te mea nui o te ao?
What is the most important thing in the world?

He tāngata, he tāngata, he tāngata
It is the people, it is the people, it is the people