



HEALING OURSELVES WHILE HEALING OTHERS:

NURSING DURING THE CORONAVIRUS PANDEMIC

A Webinar Series with Tools and Resources for Professional Nurses

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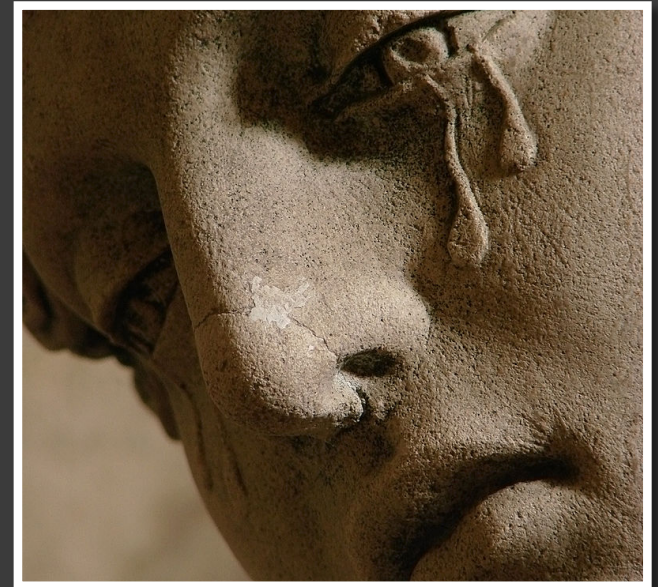


Donna is a psychotherapist, author and educator, has long addressed a wide range of life-altering experiences in the lives of children and families—loss, trauma, and stress. She has counseled professionals, young people and schools in the aftermath of individual and national tragedies — 9/11, Sandy Hook, and Hurricane Katrina. In addition to academic papers, Donna is the author of *The Seasons of Grief, Helping Children Grow Through Loss*. She taught at Columbia University and holds master's degrees from Teachers College, Columbia University; Rutgers University, and a doctorate from the University of Pennsylvania. Her post-doctoral work includes the Prudential Fellowship for Children and the News at Columbia Journalism School. Donna consults for the New York Life Foundation and the Resilient Parenting for Bereaved Families Program at Arizona State University.



Objectives

- Describe moral suffering as an umbrella term that includes: moral distress, moral injury, moral outrage, moral apathy, and moral residue.
- Recognize that the vulnerability of clinicians is unacknowledged
- Describe how vulnerability affects ones quality of life as well as the quality of care.



Vassil, Saint-Martin Church in Arc-en-Barrois, France

NOTES: Slide 4

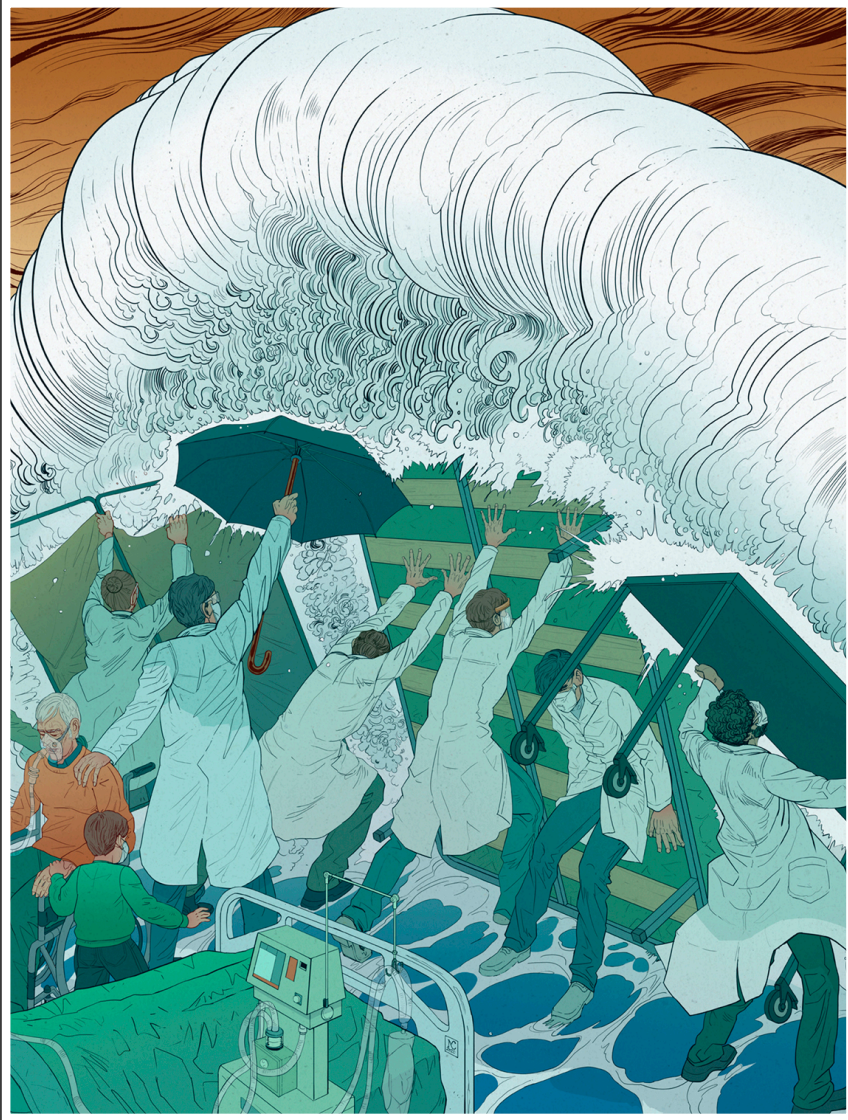
The Coronavirus pandemic has forced many health care professionals to recognize the vulnerability of frontline clinicians, a vulnerability that not only affects quality of care but has consequences for a professional's quality of life, which can ultimately influence commitment to the nursing profession.

Nursing faculty and their students **are not immune** to such vulnerabilities.

In fact, they may be at greater risk because they are coping with multiple organizational and environmental settings— administrative decisions and positions at the highest university/college level as well as those decisions made at the individual professional school. Clinical agency requirements and expectations may place additional demands and further complicate personal decision making. Nor is it unusual for faculty and students to have very different perspectives regarding support and expectations of each other.

The Coronavirus pandemic has placed added stress on faculty and students.

They face personal, academic and professional challenges. Faculty and graduate students may be at greater risk if they working full or part time in a clinical setting in addition to carrying a full course load or teaching responsibilities. Family commitments can push individuals to the breaking point—burnout or empathic distress fatigue.



Moral Distress can negatively impact patient care, causing nurses to avoid certain clinical situations and ultimately leave the profession.

Nicolas Castell, Italy

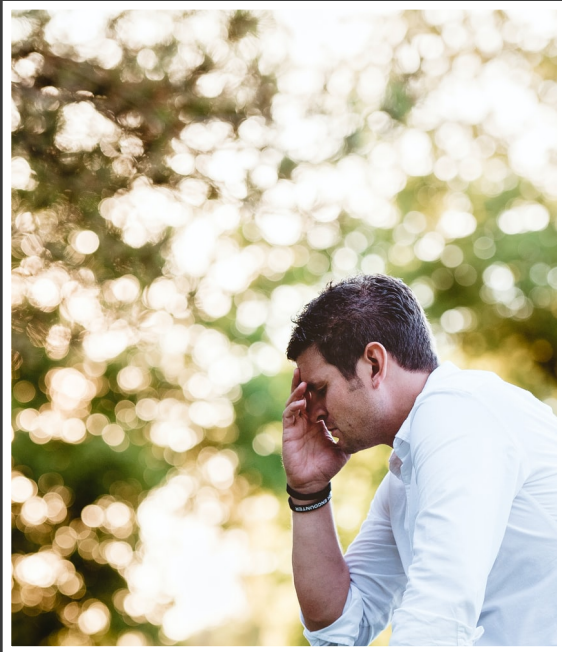


Upaya Zen Center

“Moral suffering includes moral distress, moral injury, moral outrage, and moral apathy. We have to be aware that conventional hope can drive us to violate our integrity when we are a ‘toy’ of our expectations or the expectations of others. On the other hand, integrity is founded on wise hope, the recognition of the basic goodness in others and ourselves.” Roshi Joan Halifax

MORAL DISTRESS (MD)

“Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984, 6).



Ben White

- When one knows the morally right thing to do (or avoid doing), but one’s ability to do this is constrained by *internal and/or external factors*.

It comes in two phases.

- There is “initial distress” at the time of potential action (or inaction);
- Later, there is “reactive distress” or “moral residue” that occurs in response to the initial episode of moral distress.

One’s moral integrity is compromised or one’s core values are violated.

Notes Slide 8.

Subtle variations in how different authors understand MD. These are widely held as defining elements of moral distress:

*Studies have highlighted the deleterious effects of md, with correlations between higher levels of md, negative perceptions of ethical climate, and increased levels of burnout among nurses—can negatively impact patient care, causing nurses to avoid certain clinical situations and ultimately leave the profession.

BUT AS an 'UMBRELLA TERM' MD it lacks conceptual clarity referring to a wide range of phenomena and causes— which is not helpful, how do we prevent MD? Treat it?

Some 30 years after publishing his original definition, Jameton says:

REJECTING moral judgement as even a sufficient condition and making moral uncertainty a necessary condition. . .

Moral distress expresses a decision point, a moment of emotive immobility, where ambivalence needs to be resolved toward a choice.

Once the choice is made and action is undertaken, the psychological elements of distress tend to diminish.

Necessary and Sufficient Condition of Moral Distress

For Jameton, moral distress occurred when:

- (1) A moral judgement has been made, and
- (1) There are institutional constraints that prevent that moral judgement from being acted on.

Therefore . . . the presence of 'constrained moral judgement' is both a necessary and sufficient condition

Morley et al., 2019

MORAL DISTRESS IN NURSING (MD1)



MORAL DISTRESS IN MEDICINE (MD 2)



MORAL DISTRESS IN SOCIAL WORK (MD3)



MORAL DISTRESS IN EDUCATION (MD4)



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How do we define and apply the concept of Moral distress?

THE PSYCHOLOGICAL AND PHYSICAL EFFECTS



Luis Galvez

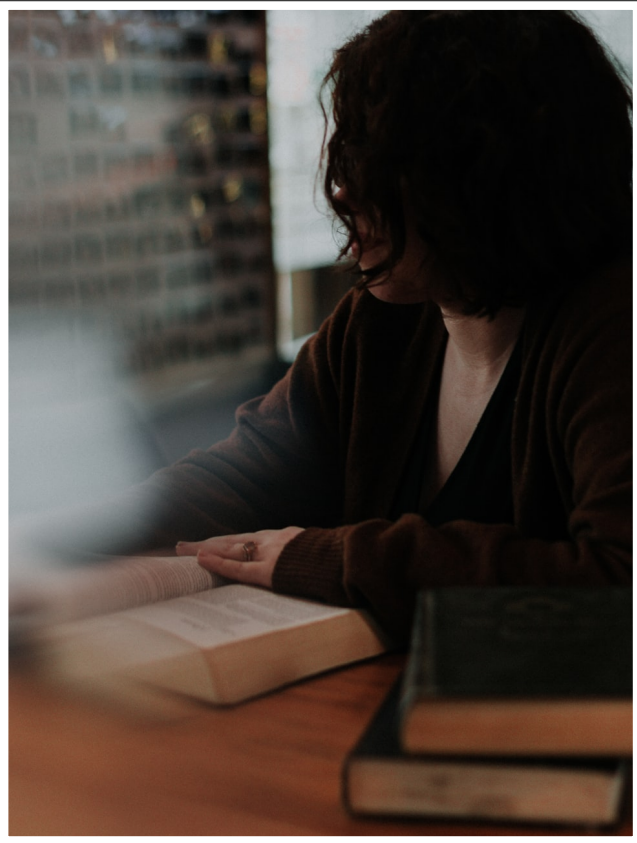
- Affective Responses
 - Frustration,
 - anger,
 - sadness,
 - psychological/physical exhaustion, helplessness,
 - distress and
 - depression

Wiegand & Funk, 2012

- Physical Responses
 - sleeplessness,
 - nausea,
 - migraines,
 - gastrointestinal upset,
 - tearfulness and
 - physical exhaustion.

Hanna, 2004

CONSTRAINTS ON ACTIONS



Priscilla du Preez

- Moral Distress Scales and Revised Scales seem to measure different concepts. Morley et al. 2019
- Ethical Climate: Constraints on nurses' moral identities, responsibilities, relationships NOT a specific external cause. Peter & Liaschenko, 2013
- Epistemic Injustice: Nurses' knowledge is dismissed, undermined or ignored. Reed & Rishel, 2015
- Internal (personal) constraints of self-doubt, lack of assertiveness, socialization to "follow orders", perceived powerlessness and lack of understanding. Epstein and Hamric, 2009

Notes Slide 13: Jameton's definition framed MD as a purely occupational issue, arising because of institutional barriers or constraints. Research assumed constraint to be a NECESSARY condition of MD, EXPLORING THE NATURE and kind of constraints that caused MD, and using the presence of constraint, and responses to it, as a way of measuring MD and its prevalence.

Positive perceptions of ethical climate to be associated with lower MD scores (studies) TOO SIMPLE- complex interplay between an individual's moral agency, the institution's interests and resulting MD.

MD is a response to constraints on nurses' moral identities, responsibilities and relationships rather than a response to specific external causes.

They emphasize the social connectedness of ethics and the belief that moral knowledge is born out of shared moral experiences.

They argue that institutions often create constraints on nurses' moral identities (rather than on discrete actions), restricting their ability to act as autonomous moral agents and so preventing them from acting in accordance with their core values and professional responsibilities.

Nurses acting as mouthpieces for others rather than as autonomous moral agents.

Feminist ethics, as an emancipatory approach, is committed to changing un- even distributions of power and privilege in everyday life, resulting in a blurry boundary between ethics and politics (Liaschenko and Peter 2006).

MORAL INTEGRITY

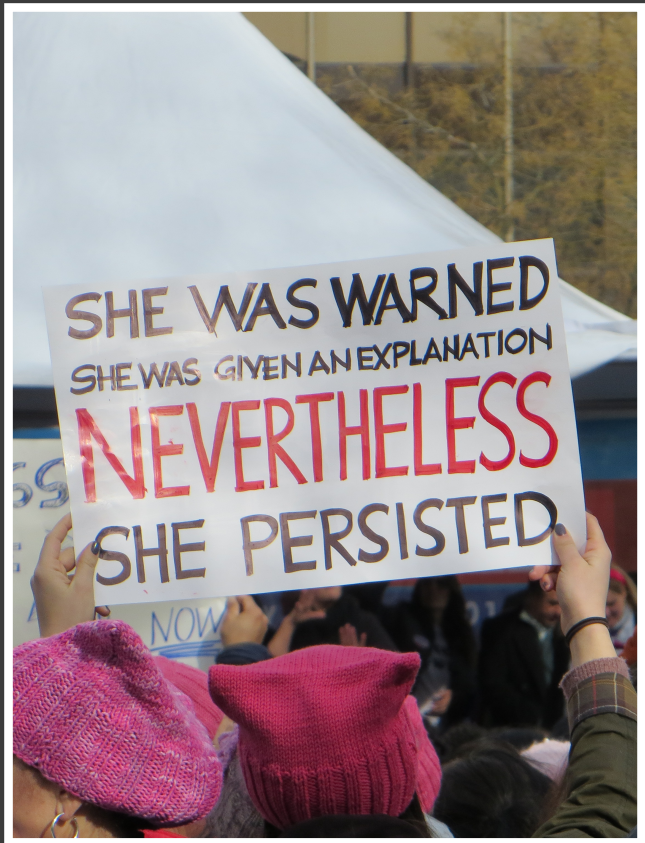
- Moral distress occurs when: One knows the ethically appropriate action to take, but are unable to act upon it. One acts in a manner contrary to personal and professional values, which undermines [moral] integrity and authenticity. AACN, 2006
- Thomas and McCullough (2014) state that MD could be divided into six philosophical categories:
 - Challenges to, threats to, and violations of professional integrity;
 - Challenges to, threats to, and violations of personal integrity.
 - Causing different degrees of MD.

What Elements of MD are Necessary *and* Sufficient?

Psychological distress is a necessary condition of MD but not a sufficient one.

- “A person may experience psychological distress linked to other events but for MD to occur it seems necessary that the distress is directly *causally* related to a ‘moral event’.
- This would make the combination of :
 1. The experience of a moral event,
 2. The experience of ‘psychological distress’ and
 3. A direct causal relation between (1) and (2) necessary and sufficient conditions for MD. “ Morley et al, 2019

Moral Outrage



D Gaffney

- An externalized expression of indignation toward others who violated social norms.
- A reaction involving both anger and disgust.
- Unethical situations can drive us to take action and demand justice and accountability .
- In our own internal experience we can experience the extremes of righteousness, of casting shame and blame on the institution or on others.
- Principles Moral Outrage: There's an important balance that we're to understand: there's a value in moral outrage at an episodic level, but chronic moral outrage will erode our morale in a significant way and could also actually harm our institutions.

Roshi Joan Halifax

**Notes Slide 17. Tools for Cultivating the Conditions for Principled Moral Outrage
(Rushton, 2013)**

Notice your body, emotions, and thoughts.

Source actions from wisdom. (pause, ground, connect, reflect)

Determine what is at stake in this situation.

Monitor the tone and content of discussions.

Engage in ethical analysis.

Identify contributing factors and consequences.

Explore alternatives.

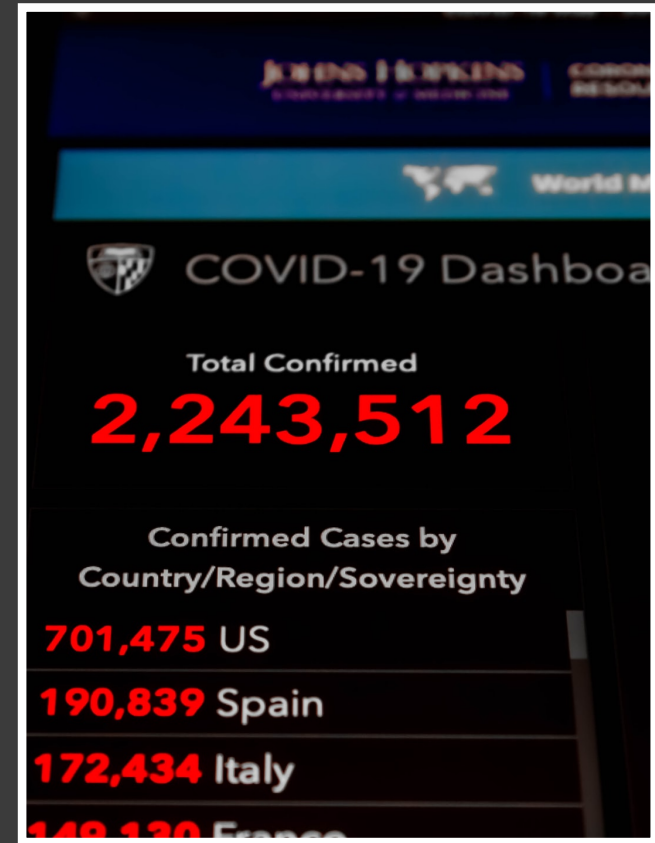
Create mechanisms for responding to conscience violations.

Identify personal and professional resources.

Learn from experiences of moral outrage.

MORAL INJURY

- A psychological wound resulting from witnessing or participating in a moral distressing act or anticipating a morally transgressive act.
- It is a toxic combination of the *dread* of guilt and shame.
- While nurses not be directly or purposively involved in such acts (transgressive of our moral values) they may be under the influence of the *institutions and/or the conditions*
- Resulting in a sense of deep shame, a violation of one's moral principles.



James Yarema

MORAL APATHY

“Ignoring the suffering of others, especially those we are to serve. It can arise in response to our environmental situation, for example the ways in which the current pandemic impact that what we know as familiar.”

Roshi Joan Halifax

April 20, 2020

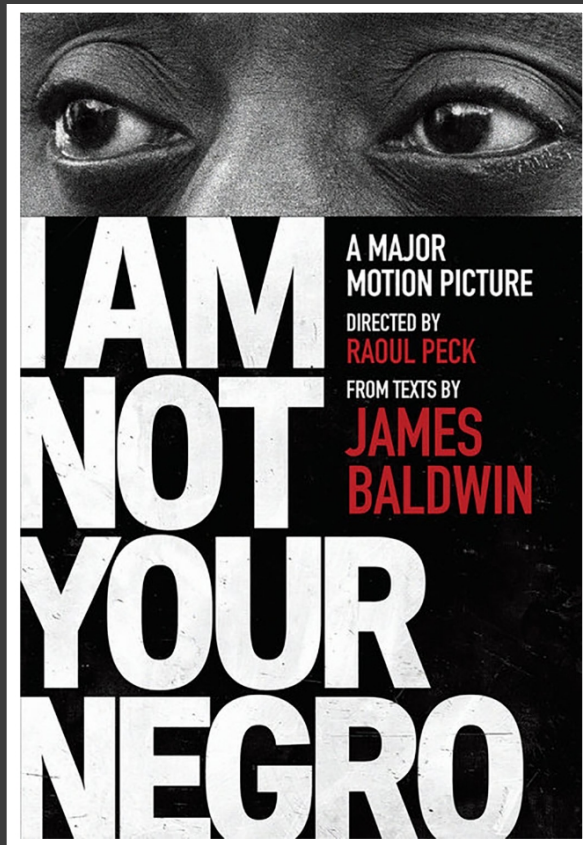
A numbness

Withdrawal

Not indifference

Not freedom from moral feelings, but absence of affects.

MORAL APATHY



“There are days in this country when you wonder what your role in this country is and your place in it. How precisely are you going to reconcile yourself to your situation here and how you are going to communicate to the vast, heedless, unthinking, cruel white majority that you are here? I am terrified at the moral apathy, the death of the heart, which is happening in my country. These people deluded themselves for so long that they really don’t think I’m human. I base this on their conduct, not on what they say. This means that they have become moral monsters.”

Roshi Joan Halifax referring to James Baldwin, *I Am Not Your Negro*.

- The **unmet obligations** and commitments that remain when we have to make hard choices and prioritize one value over another.
 - In every decision there are two competing obligations or commitments
 - Even when we make the best decisions all things considered there are still obligations and commitments that have been unmet.
- There is the **guilt or regret** in not meeting all commitments and obligations.
- Moral residue is the accumulation of unprocessed moral distress and the remaining consequence of moral distress.
- Clinicians and many of us in the greater landscape of our country are actually working with issues related to moral residue, sheltering alone or with a few others.

Roshi Joan Halifax, 2020

MORAL RESIDUE



Eric Ward

THE CHALLENGE: DURING & AFTER THE COVID-19 PANDEMIC

- Change in nursing education and the health care system.
- Burnout was already at high levels going into the pandemic. Now we have an opportunity, in the midst of this pandemic, to look at the healthcare culture that nurses find themselves.
 - From cumulative work demands and stress in a toxic workplace, and the loss of meaning, work that is too intense, too much work just undoes the individual
- Structural violence and systemic discrimination (PPE, ventilators)
- Institutional demands
- Missed appraisals of compassion

Roshi Joan Halifax



Jonathan J Castellon

THE CHALLENGE



The development of approaches within clinical training and practice that:

- Offer clinicians ongoing ways to work skillfully with the emotional and somatic dysregulation generated by moral distress.
- Among the strategies are techniques directed to cognitive, affective, attentional, and somatic awareness and self-regulation.
 - Including approaches derived from contemplative traditions used for stress reduction and resilience training.
 - Mindfulness emerges by purposefully paying attention to and not judging one's unfolding experience .

Carse, A., & Rushton, C. H. , 2017

MORAL DISTRESS ITSELF IS NOT THE ENEMY.

It can heighten awareness that an occasion might require, with careful moral consideration and prompt valuable reflection and action.

- Find new ways to support the effective moral agency of clinicians, at all levels of power and authority;
- To give courageous voice to, matters of conscience without fear of resistance, dismissal, or reprisal, and
- With realistic hope that their constructive protests and creative ideas will be heard and taken seriously.
- An urgent need for the design of innovative approaches that will support clinicians' ability to work constructively with the somatic and affective dimension of moral distress, and
- To learn skills that can foster moral resilience and enhance moral efficacy.

Carse, A., & Rushton, C. H. , 2017 , p.26

NURSING EDUCATION

The First Line of Defense

Ethics Education

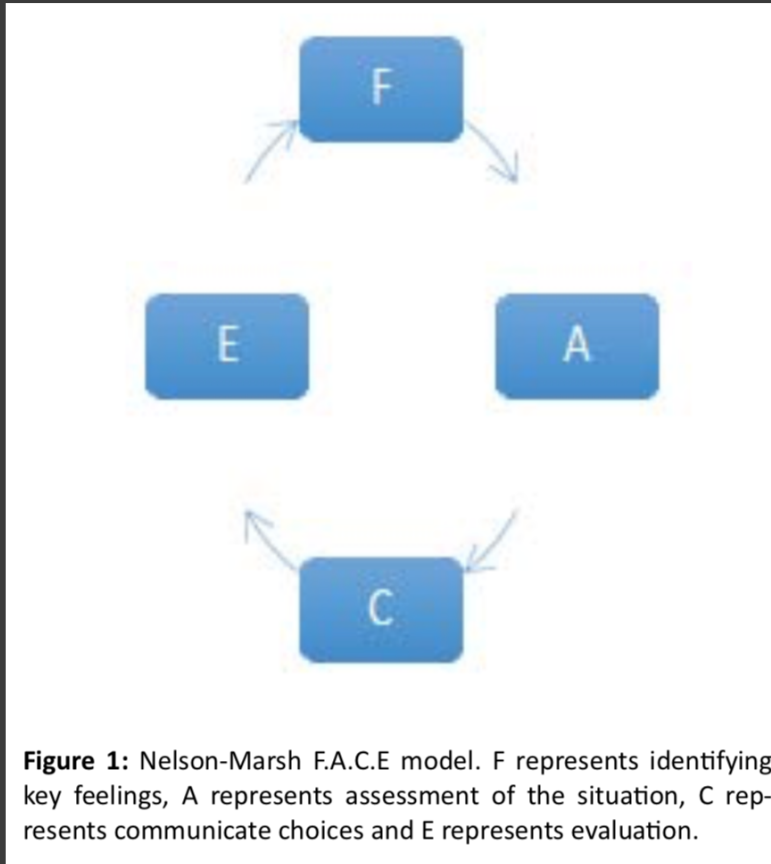
Resilience-building educational interventions/programs :

- Mindfulness strategies,
- communication techniques,
- spiritual well-being and cultivating hope,
- knowledge of ethical decision-making frameworks,
- nurturing moral sensitivity, and
- opportunities to rehearse and experience cumulative successes managing challenging ethical situations

Organizational Communication Skills:

Fear of reprisal can be broken down further into three dimensions: 1) fear of power and influence of another, 2) fear of potential relational harm after offending a superior, coworker, or subordinate, and 3) fear of engaging in conflict.

Krautscheid, L., 2019; Rushton, 2017



MORAL DISTRESS REEXAMINED

Building Moral Communities

“Feminist ethics, as an emancipatory approach, is committed to changing uneven distributions of power and privilege in everyday life, resulting in a blurry boundary between ethics and politics.”

How moral agents experience moral distress can account for who they are as professionals and demand an accounting from others.

Nurses are in a good position to bring others together to begin to create this kind of change in paradigm through dialogue and modifications in practice.

Accounting for and communicating values and responsibilities .

Repairing Damaged Moral Identities through the creation of “Counterstories”



Ben Athul

Notes Slide 27. Addressing moral distress through the Lens of feminist theory

-Moral distress is the response to constraints experienced by nurses to their moral identities, responsibilities, and relationships.

-Health professionals must get assistance in accounting for and communicating their values and responsibilities in situations of moral distress.

-Because identities are created narratively, they can be repaired narratively as well (Lindemann 2006).

-One source of moral distress is the result of the damage to nurses' moral identity as holistic care providers in circumstances in which their values are not supported by others in their institutions or the knowledge they possess is not recognized. Nelson (2001)

-creating "counterstories" to repair damaged identities and challenge dominant narratives.

Notes slide 27. Counterstories of their work as knowledgeable and trustworthy professionals to re- pair their damaged moral identities and to help lessen the occurrence of moral distress.

One source of moral distress is the result of the damage to nurses' moral identity as holistic care providers in circumstances in which their values are not supported by others in their institutions or the knowledge they possess is not recognized.

Nelson (2001) describes the importance of creating "counterstories" to repair damaged identities and challenge dominant narratives.

She describes the oppressive identity of nurses as consisting of overly "touchy-feely" portrayals of nurses that suggest stereotypes of women's inferiority. With these narratives, nurses are viewed as being capable of emotion, but not reason, and being able to be like mothers, but not of being scientific.

Counterstories are needed that portray nurses as skilled caregivers with serious responsibilities that require knowledge, skill, and virtue.

These also have the potential to portray nurses as powerful.

Create counterstories that can act as forms of resistance that place significance on nurses' power as opposed to their vulnerability

Final Notes: McCarthy and Deady (2008) raise concerns that an overemphasis upon nurses' moral distress is damaging to nurses, because it implies that nurses have little power to do anything about their distress or the situations that create it.

Focusing on the education of future health care professionals and ethicists underscores the relevance of professionals working together, as opposed to working in silos, to adjust their focus beyond the medical model to that of health equity and social justice (Frenk et al. 2010; Peter 2011; Sherwin 2011).

Questions



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