

Moral distress is often defined as knowing what you feel must be done, yet not being able to do it. When situational requirements contradict our individual moral compass, the tension between our desires and the actual actions and/or inability to act can create moral distress. For example, restrictions on visitation despite the value of social interaction is an example at the forefront of the current pandemic. Moral distress responses and intensity in a similar situation can vary from person to person.

As hospice and palliative care professionals, we are involved with complex decision-making. When the treatment plan differs from our core values, we may experience moral distress as an uncomfortable feeling such as fear, anger, doubt, anxiety, shame, etc. It can decrease motivation and compassion as well as contribute to lower quality of care and decreased job satisfaction. It manifests differently for each person, based on levels of self-awareness and ability to access internal and external resiliency factors (Jaskela, Guichon, Page, & Mitchell, 2018).

Examples of moral distress in hospice and palliative care:

- ◆ Changes in how care is provided as a result of the pandemic such as restricted visitors, limited contact, necessity to wear personal protective equipment.
- ◆ Restrictions to protect community health that come into conflict with individual needs.
- ◆ Situations that contradict expected natural order such as severe/terminal childhood illnesses.
- ◆ Patient continuing to receive aggressive treatment when he or she is unlikely to have a positive outcome.
- ◆ Disagreement between patient and family members related to goals of care and preferences.
- ◆ Patient or family goals of care contradicting professional opinion of best course of treatment or families not wanting to discuss goals of care/end of life arrangements.
- ◆ Interventions such as palliative sedation utilization and voluntarily stopping eating or drinking.

Being able **to address moral** distress requires a willingness to explore difficult issues as well as finding ways to address them on a personal level. In 2004, the American Association of Critical-Care Nurses published *the 4A's to Rise Above Moral Distress* to help clinicians recognize and address moral distress. They are Ask, Affirm, Assess and Act.

The 4 A's

	What does it mean?	What can it look like?
ASK	Moral distress can be physical, emotional, behavioral or spiritual. Recognize your baseline and notice if something has changed.	Determine what suffering looks like and what baseline is; questions to consider: Am I suffering? What does suffering look like? What does wellness look like?
AFFIRM	Recognize, name and accept the moral distress. Determine how to take responsibility for own well-being.	Reaching out to others for validation and support, verbalizing what is upsetting you, connecting to internal and external resources for support.
ASSESS	Identify the source of the distress.	Is the distress connected to an individual event or series of events? policy related? missing support/ resources? Things that our outside of our control? our role?
ACT	Create a plan to process or address the moral distress. If possible, address underlying contributing factors.	Some actions include: discussion and consultation with others, validation with peers, self-care efforts, exploration of your morals and their role on your practice, clarifying your role and what aspects are or are not within your ability to influence.

Moral Residue and the Crescendo Effect (Epstein and Hamric, 2009)

Lingering feelings after the event are referred to as moral residue. It can impact thoughts and actions after the issue or event causing moral distress is over. Moral residue is difficult to characterize because it is not always the same, has varying intensity, and the lasting effects vary from situation to situation.

In times of a national health crisis such as a pandemic, there is not one isolated case, but many. The feelings of moral distress left after each case is the residue and can accumulate when they are not addressed and processed.

Both moral distress and moral residue can increase over time, leading to a newly established baseline after each event. This leads to an increasing reaction to moral distress from the previous event and although the event causing the distress has ended, the person does not necessarily return to their original baseline. The clinician continues to experience that distress to a degree which can become cumulative, especially in instances where similar issues prompting moral distress in a clinician are present such as end-of-life care. Instances where the clinician continually cannot provide ideal care due to circumstances and limitations exacerbate moral distress. This scenario is prevalent during the current pandemic.

The residue leaves us physically, emotionally and spiritually worn down. Over time this accumulation can have a cumulative effect on our perspective, our well-being, and our actions. The 4 As, intentional debriefing of challenging situations, and collective acknowledgement and support during instances of moral distress are key to mitigating moral distress impacts. Left unresolved, moral distress and residue can lead to ongoing limitations in ability to solve systemic problems, decreased empathy, compassion fatigue, burnout and vicarious work-related trauma.

Final Thoughts

Moral distress can affect everyone, including our patients, families, caregivers, and coworkers. At the time of this publication, the pandemic has heightened the distress experienced. If left unattended, moral distress (and moral residue) can complicate clinical practice and hasten burnout.

Resources

AACN Ethics WORKS Group. (2004). *The 4 A's to Rise Above Moral Distress*. Aliso Viejo, CA: American Association of Critical-Care Nurses. Retrieved from https://www.emergingrnleader.com/wp-content/uploads/2012/06/4As_to_Rise_Above_Moral_Distress.pdf

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Jaskela, S., Gicho, J., Page, S.A., & Mitchell, I. (2018). Social workers experience of moral distress. *Canadian Social Work Review*, 35(1), 91-108.

Daubman, BR., Black, L., & Goodman, A. (2020)., Recognizing Moral Distress in the COVID-19 Pandemic: Lessons From Global Disaster Response. *J. Hosp. Med*,11;696-698. Published Online First September 23, 2020. doi:10.12788/jhm.3499 Retrieved from: <https://www.journalofhospitalmedicine.com/jhospmed/article/228332/hospital-medicine/recognizing-moral-distress-covid-19-pandemic-lessons>

Nofziger, D.(2020 June 17). *Staff perspective: Moral distress, residue, and the crescendo effect- understanding the potential impact of the extended Covid 19 crisis*. Uniformed Services University Center for Deployment Psychology. Retrieved from <https://deploymentpsych.org/blog/staff-perspective-moral-distress-residue-and-crescendo-effect-understanding-potential-impact>

Turning Moral distress into Moral Resilience <http://www.ihl.org/communities/blogs/turning-moral-distress-into-moral-resilience-during-the-covid-19-pandemic>

Five clinical examples to look at types of moral distress and ways leadership can help address it
<https://www.ccm.org/content/early/2020/06/04/ccm.87a.ccc047>

List of suggestions for how to address Moral distress in hospital setting <https://www.aacn.org/blog/facing-moral-distress-during-the-covid-19-crisis>

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