Literature Review

Reviewed by Jordan Bauer, RN, MS

Sheppard, Katherine N, Barbara G Runk, Ralitsa S Maduro, Monica Fancher, Andrea N Mayo, Donna D Wilmoth, Merri K Morgan, and Kathie S Zimbro. 2022. "Nursing Moral Distress and Intent to Leave Employment During the COVID-19 Pandemic." *Journal of Nursing Care Quality* 37 (1): 28-34. doi:10.1097/NCQ.0000000000000596.

This research study was performed by nurses and for nurses. It arose out of a concern that the increasing number of COVID-19 cases with limited resources to care for them in the healthcare system would harm nurses. Specifically, the authors suspected that an increase in moral distress among nurses would cause them to seek employment elsewhere. Moral distress, which is defined as a phenomenon that occurs when one knows the ethically correct action to take but is constrained from acting, has been shown to increase nurse turnover. This study claims to be the first to connect that datum with the COVID-19 pandemic and took place during the late summer months of 2020 when there was a particularly high incidence of COVID-19 occurring in healthcare systems across the country.

In short, their suspicions were confirmed. They identified two factors in moral distress that influence nurses in leaving their position: 1) poor patient care quality and safety; 2) work environment. On the one hand, nurses who expressed moral distress regarding patient care quality and safety were almost three times more likely to state they were considering leaving their position due to moral distress. For these, the moral distress arose from such things as witnessing violations of standards of practice or medical errors and not feeling sufficiently supported to report the violation. Other factors may have included taking care of patients that a nurse did not feel qualified to care for. On the other hand, and perhaps even more dramatically, nurses who expressed moral distress over issues with work environment were nine times more likely to state that they were considering leaving their position due to moral distress. Some of these influences in the work environment may have included working with a lack of resources or perceiving a lack of respect for patients. Additionally, poor work environment may have involved feeling pressured or required to do things that the nurse was not comfortable with or in the patients' best interest.

In their discussion and summary, these authors emphasize the importance of both minimizing moral distress where possible and helping nurses develop good coping strategies for moral distress. In their hospital system, the nurse executive took charge in engaging nurses for the sake of minimizing moral distress and helping them feel supported ethically. The nurse executive also tried to foster a sense of belongingness among the nursing staff. Regarding coping, the authors noted a shocking deficiency in nurse familiarity with ethics consultation and thus suggest greater ethics education on such resources. They also recommend ensuring that nurses are utilizing the employee assistance programs, such as

counseling, already in place for the sake of mental health. Apart from addressing these deficiencies, the study is weak in making suggestions for mitigating moral distress on a systemic level. However, it drives home the connection between the moral harm that is occurring among nurses with poor employee retention, particularly during COVID-19. The researchers in this study emphasize that nursing turnover presents a tremendous expense to the health care organization (recruiting, hiring, orienting, etc.) over several months. This makes keeping frontline nurses in place and in action a huge priority for maintaining the bottom line. For those who may not prioritize the moral health of nurses, this nurse-driven study advocates for greater attention to moral distress among nurses on the grounds of expense to the organization, as if to say, "Maybe this will get their attention."

Spilg, Edward G, Cynda H. Rushton, Jennifer L Phillips, Tetyana Kendzerska, Mysa Saad, Wendy Gifford, Mamta Gautam, et al. 2022. "The New Frontline: Exploring the Links Between Moral Distress, Moral Resilience and Mental Health in Healthcare Workers During the COVID-19 Pandemic." ***BMC Psychiatry*** **22 (19): 1-12. doi:10.1186/s12888-021-03637-w**

This study performed in Canada from April to September, 2020, stresses the point that healthcare organizations should do more to protect their most valuable assets, namely their employees. The study observes that health care workers will unavoidably face moral adversity in the workplace. Situations of moral conflict persist and are exacerbated by such tremendous triggers as the culmination of the COVID-19 pandemic. The study investigates the relationships between the moral resiliency, moral distress and mental health of health care workers in the midst of the pandemic. Moral distress, according to these authors, is described as the distress that comes from ethically judging and acting when the consequences seem to challenge one's own integrity. It comes from frequently making tough ethical choices like triaging patients in the context of limited resources or whether to follow directions that go against professional standards. Moral resiliency, on the other hand, is the ability to sustain or restore one's integrity in response to such adversity. The study hopes to demonstrate the protective potential of developing moral resilience against the onslaught of potentially morally distressing events that health care workers are exposed to.

There are four notable results from this study. First, health care workers who are exposed more frequently to COVID-19 patients have a correspondingly higher likelihood of experiencing moral distress, a trend that continues despite passing time and exposure. It does not just improve with time or experience. Secondly, health care workers with such frequent exposure are prone to higher moral distress if their moral resiliency is low. Third, there is a correlation between high moral resilience and better mental health outcomes. Finally, some populations (particularly males, those without current mental disorders, those who sleep well and those who experience high levels of support) are more prone to moral resilience than others.

Above all, this study demonstrates that moral resilience does temper the development of moral distress while being exposed to potentially morally distressing events (such

as frequently caring for COVID-19 patients). The authors acknowledge the need to reduce the frequency and intensity of exposure to COVID-19 patients on a systemic level, but they underscore the need to simultaneously cultivate healthcare workers' capacities of moral resilience. Moral adversity will occur, the researchers admit, but the healthcare system should acknowledge and confront the internal sources of distress by promoting self-regulatory skills such as mindfulness and inculcating moral efficacy, self-stewardship, and buoyancy among their health care workers. They should also develop a community of support and interconnection that honors individual integrity and values. In short, health care systems (and health care as a whole) need to train health care workers to deal with moral adversity in a confident and mutually supportive way. If it was not obvious before, COVID-19 has made this very clear: this is how we protect our greatest assets.

Jackson-Meyer, Kate. 2020. "Moral Distress in Health Care Professionals." ***Health Progress:*** **23-29.**

This article by Kate Jackson-Meyer offers a more comprehensive view of what moral distress is and how it impacts health care workers, both before and during the COVID-19 pandemic. She provides a very helpful overview of the development of the term. When first coined, moral distress applied to those who know the right thing to do but are constrained by the institution from doing so. Now, however, a broader definition of moral distress is called for which consists of negative self-directed emotions or attitudes in response to perceived involvement in situations one perceives to be morally undesirable. Admittedly, this definition includes almost all situations that stimulate moral discomfort and encompasses, to varying degrees, the vast majority of health care professionals during the COVID-19 pandemic. Yes, she suggests, the problem is that big. Somewhat presciently, Jackson-Meyer envisions that the moral effects of the pandemic on health care professionals will be long lasting (and she is writing in 2020).

Moral distress, Jackson-Meyer points out, is rooted in challenges to one's self-understanding as a moral being. Its effects occur in waves including initial distress, reactive distress and moral residue. Further, the effects are physical, emotional, behavioral, and spiritual. They may manifest as fatigue, anger, guilt, anxiety, depression, spiritual distress, loss of meaning. These effects may lead to burnout, and they clearly reveal the vulnerability of the healthcare professional and their need for considerable care.

How do we care for our health care professionals, particularly in light of the pandemic? Jackson-Meyer proposes a substantial and multi-layered approach for health care systems. Of note, she emphasizes the need to address three levels of moral distress: moral, psychological, and spiritual. Each level deserves its own interventions, calling for the involvement of ethicists, spiritual advisors, and mental health professionals. She also advocates for both immediate and long-term action plans rooted in ethical education, moral distress assessments, and ethical discussions. Some of her interventions include using the MMD-HP (Measure of Moral Distress for Health Care Professionals) assessment, practicing interdisciplinary moral health rounds, and offering ethics workshops and webinars. Further, Jackson-Meyer invites

further investigation into moral distress along the lines of Catholic morality, social teaching, and theology. In her view, there is work to be done on all fronts.

SYNTHESIS

As a hospice nurse in the early stages of the COVID-19 pandemic, I recall being hit with the enormity of potentially morally distressing events such as limiting visitors for dying patients. It is heartbreaking and it is personal. These three articles all demonstrate that health care organizations need to take serious action in addressing moral distress among health care workers during the COVID-19 pandemic. As nurse shortages now challenge health care systems, travel nurses are filling in gaps at a tremendous cost, and large sign-on bonuses are being used for recruitment. Now is the time to take an honest look at the real issues behind health care worker burnout. Money cannot fix it. Beyond mere concern for the bottom line or employees as our greatest assets, Jackson-Meyer admirably perceives health care workers as themselves worthy of the same compassion and care provided to patients. Her proposed interventions beautifully resemble acts of mercy. It is a matter of Christian charity. For me, as a nurse working in the field, her analysis and action plan ring true and re-enkindle in me a desire to engage with and care for my colleagues on the front lines with me.

Despite their different perspectives, all three articles point out the tragic inadequacies of the current health care environment in dealing with moral distress. Likewise, all three call for greater assessment, some level of systemic change, and the development of moral resiliency or coping among health care workers. Health care organizations need to start by assessing underlying levels of moral distress and daring to ask the difficult questions about whether their employees feel supported in ethical decision making. This is no small task. However, our health care workers, our colleagues or mission partners, are suffering from moral distress and feeling like they cannot do their jobs anymore. Attending to these wounds must be part of our Catholic mission.

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