

Conversations in Ethics:

Transforming Moral Distress to Moral Resilience: One of Our Toughest Pediatric Cases

**April 19, 2019
12:00 p.m. – 1:00 p.m.
Baptist Hospital
5 MCVI**



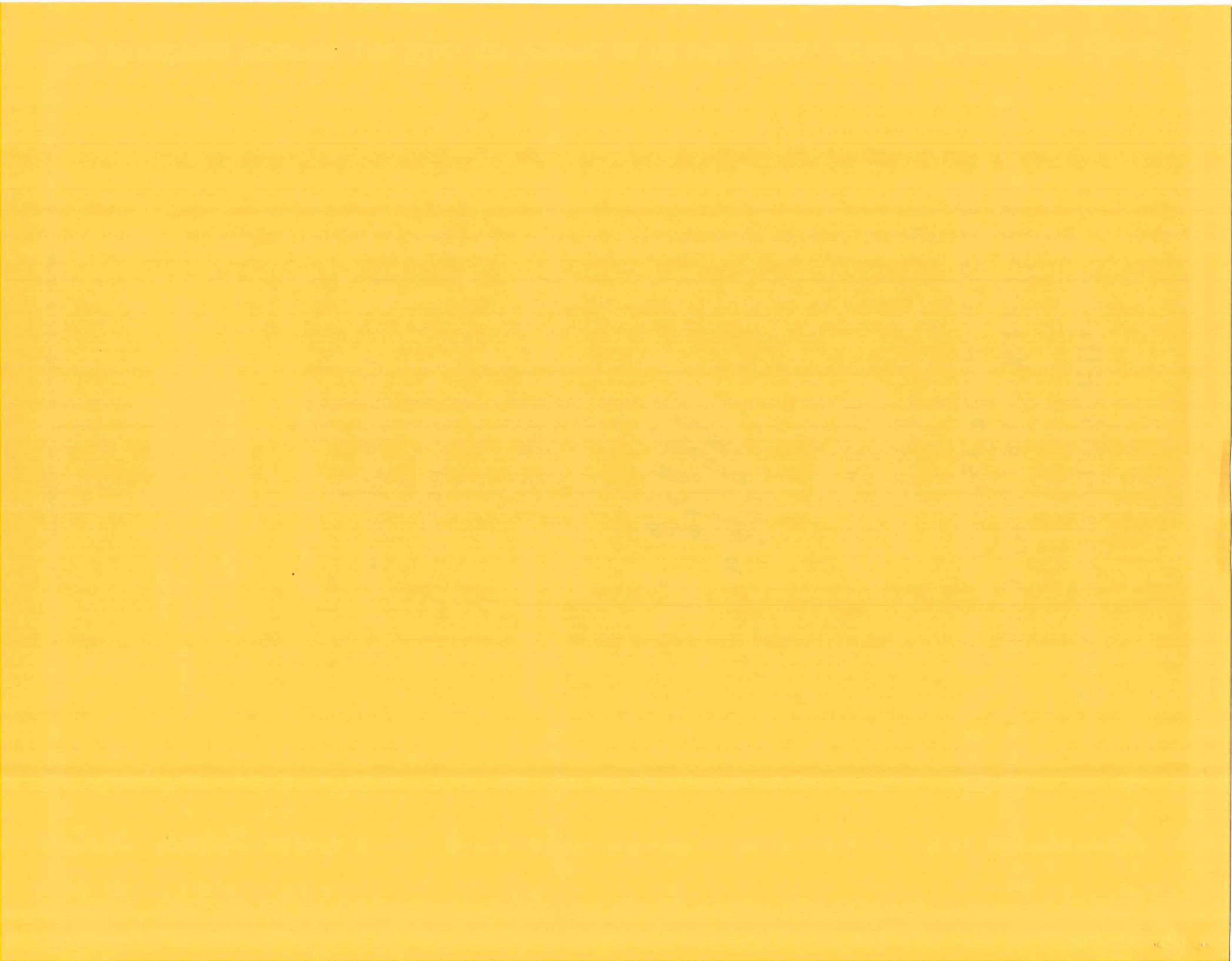
**Video-conferenced to:
Mariners Hospital Executive Conf. Rm., Doctors Hospital Valencia Side A, West
Kendall Hospital Cl. 4 & 5 and Live Webcast**

Speakers:

**Susan Chalfin, Ph.D.
&
Rose Allen, DNP**

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Baptist Health South Florida**



Transforming Moral Distress to Moral Resilience: One of Our Toughest Pediatric Cases


Susan Chalfin, PhD
&
Rose Allen, DNP, MSM/HM, RN, CHPN

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Objectives

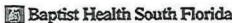
At the completion of this education conference, participants will be better able to:

- Describe the ethical challenges and moral distress experienced by healthcare professionals while caring for complex, pediatric patients at the end of life
- Define and understand the concept of moral resilience
- Utilize effective strategies to cultivate moral resilience in clinical practice and to manage moral distress

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Disclaimer

This case presentation is based on an actual ethics consultation case. However, to remain in compliance with HIPAA Privacy Rules, the content has been modified

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American Academy of Pediatrics Brain Death Guidelines

> Determination of brain death
 –clinical diagnosis based on
 absence of neurological
 functions with a known
 irreversible cause of coma

> Ages: > 30 days to 18 years
 old the following is required:

- > Two examinations including
 apnea testing with each
 examination
- > Observation period of 12-hours
 apart
- > Ancillary studies –i.e. blood
 flow, are not required

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Pediatric Ethics Case

Ethics consult requested by: The palliative care ARNP 4 days post admission

Ethical Dilemma: The child's father, would not accept the diagnosis of brain death following 2 separate physician's examination with apnea testing and an additional ancillary blood flow study, showing no flow to the brain.

Relevant Medical & Social History: This was a toddler who drowned in the bath tub at home. Fire rescue was called and she was brought to hospital in full arrest, requiring intubation with ventilator support and other life prolonging interventions, including vasopressors.

Relevant Social History: The child lived at home with her parents and older maternal sister. She was the only child for the father. Father had history of depression and anxiety. Parents were not married; dated for a short while prior to mother's pregnancy.

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Pediatric Case (cont.)


Summary of Events Over 2-weeks:

- > Ethics team met with parents – wanted to explore 2nd opinion for brain dead diagnosis
 - > Family had international ties with other physicians
 - > Angry at family/staff discussion about organ donation – would never consent to donation
- > The father continued with outbursts of aggressive behavior including threats towards physicians, nurses, and even towards the child's mother. He refused to have the maternal grandparents visit the child
- > He would not provide feedback from the second opinions; was requesting additional EEG and another blood flow study, which was not granted
- > Hospital security were present in the unit and Metro-Dade police were called more than once
- > Daily huddles - Staff were updated daily, supported, given scripts on what to say so everyone remained a cohesive team

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Pediatric Case (cont.)

- By day-11 the healthcare team, ethics, and the leadership team met and decisions were made to wean off vasopressors which were not serving a purpose for the brain dead child
- On day-14 vasopressors were stopped and the child had asystolic arrest within 3-hours
- Father's behavior escalated. Police and hospital security were again called with a large presence
- The parents and their family were allowed quiet time separately in the room, (1-hour each family group), after the asystolic arrest
- The father was then escorted by the police out of the hospital with a restraining order
- Entry into the unit was changed from open access to card access for safety reasons
- Follow up debriefing session held 1-week later for the staff to include psychology support

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What Were the Morally Distressing Challenges?


- For the MD
- For the Nurse
- For the Case Manager

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Definition of Moral Distress

- Moral distress is a phenomenon that occurs when healthcare professionals cannot carry out what they believe to be the ethically appropriate actions because of various constraints
- If not addressed – moral residue, crescendo effects, dissatisfaction, burnout, leaving job and leaving profession

Hamric, A.B., Davis, W.S., Childress, M.D. (2006)

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BNSF Study on Nurses' Experiences with Moral Distress - Topical
 BNSF Moral Distress Questionnaire (MDQ) - Final Factor Professional Summary
 Differences Between Disciplines
 Most Common Source of Moral Distress

	RN (N=20)		MD (N=12)		SWCM (N=27)		ARNP (N=7)		RT (N=20)	
	Mean (SD)	Rank	Mean (SD)	Rank	Mean (SD)	Rank	Mean (SD)	Rank	Mean (SD)	Rank
Compliance with provider orders for legal concerns (medication, blood, and transfusions)	4.85(5.13)	1	4.02(4.81)	4	1.44(2.50)	10	6.33(6.13)	3	7.20(6.10)	1
Follow the family's wishes to continue life support when thought to have no hope in the patient's future	4.87(4.80)	2	4.54(4.11)	2	4.33(5.75)	3	11.14(7.80)	2	6.70(5.52)	2
Watch patient care suffer because of a lack of provider confidence	4.53(5.59)	3	4.77(4.83)	1	4.74(4.73)	2	3.02(2.23)	8	2.60(4.69)	7
Provide to other patients care that is not from administrative demands to reduce cost	4.13(5.53)	4	3.87(4.32)	5	5.22(6.03)	1	2.23(4.39)	10	4.10(6.03)	11
Deliver medical care knowing when they may possibly fail	4.0(4.33)	5	4.15(3.89)	3	2.30(3.14)	5	11.77(7.52)	1	5.95(4.95)	3
Witness health care providers giving "false hope" to the patient and family	3.27(4.17)	8	2.72(3.25)	10	3.15(3.31)	4	3.57(3.15)	7	3.00(6.01)	5
Follow the team's treatment plan for a patient with a long patient care episode (days)	2.81(3.52)	9	1.77(2.85)	12	1.52(1.88)	8	5.71(5.09)	4	1.10(1.51)	13
Compliance with provider orders for patient care that is not to be provided (medication)	1.97(3.63)	11	2.05(3.13)	9	1.66(2.50)	9	4.00(3.83)	5	4.47(4.67)	4
Work with issues and ethical dilemmas/procedures that are not in compliance with patient care practice	3.48(4.88)	6	3.22(3.99)	8	2.04(2.54)	6	5.29(4.30)	5	3.70(4.91)	6

Moral Distress Suffering

COMMON RESPONSES TO SUFFERING*

	PHYSICAL	EMOTIONAL
Fatigue	Persistent physical ailments	Anger
Dullness	Headaches	Fear
Lethargy	Gastrointestinal disturbances	Guilt
Hyperactivity	Impaired sleep	Emotional outbursts
Weight gain	Impaired mental processes, such as forgetfulness	Sorrow
Weight loss		Depressed
Susceptibility to illness		Cynical
		Grief-stricken
		Anxiety
		Hurt
		Frustration
	BEHAVIORAL	SPIRITUAL
Addictive behavior	Apathy	Loss of meaning
Alcohol, drugs, gambling, food, etc.	Indifference	Crisis of faith
Controlling behaviors	Avoidance	Loss of control
The need to be "right," inflexibility, rigidity	Erosion of relationships	Loss of self-worth
Offender behavior	Agitation	Disrupted religious practices
Taking aggression out on others who often have less authority	Shaming others	Disconnection with people, work, community
Boundary violations	Victim behaviors	
*Disengagement with patients, families	Feeling powerless to change one's situation	
*Inappropriate or disengagement in patient care situations	Depersonalization	
	Treating patients as non-persons	
	Feelings of being unable to act according to one's conscience	
	Crying due to work-related issues	

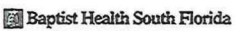
Moral Distress

HOW TO COPE AND RISE ABOVE MORAL DISTRESS UNDER THESE CIRCUMSTANCES?

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Resilience (APA, 2018)

- The ability to “adapt well over time to life-changing situations and stressful conditions”.
- “Being resilient does not mean that a person doesn’t experience difficulty or distress.”

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Moral Resilience


- “the ability and willingness to speak and take right and good action in the face of an adversity that is moral/ethical in nature”. (Lachman, 2016)



Moral Resilience

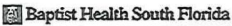
“Capacity of a person to sustain, restore or deepen their integrity in response to moral complexity, confusion, distress or setbacks.”

Rushton, 2016

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Factors that Contribute to Moral Resiliency

- Organization
- Team
- Individual

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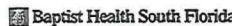
Organization Factors

- Promoting a culture of ethical practice
 - Policies and Procedures
 - Administrative Support
 - Ethics Committee
 - Risk Management
 - Mental Health Resources
 - Safety and Security Resources
 - Staff Training and Education
 - Community Resources

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Team Factors

- Good communication and problem solving skills
- Making realistic plans and take steps to carry them out
- Positive and supportive team relationships
- Use of debriefing

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
Individual Factors

- Self awareness
 - A realistic and positive view of yourself and confidence in your strengths and abilities
- Assertiveness/Self-assurance
- Self-regulation (the capacity to manage strong feelings and impulses)
 - Flexibility
 - Maintaining a hopeful outlook
 - Keep things in perspective
- Self-care
- Relationships with family and friends

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Individual Factors (cont.)

- Ethical competence
- Commitment to transformational learning
- Commitment to a culture of ethical practice
- Ability to find meaning in the midst of despair

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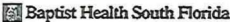
Personal Testimonies of Moral Resilience

- *Physician*.....
- *Nurse*.....
- *Case Manager*.....

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Summary and Conclusions

- Moral distress arises from ethically challenging medical cases, such as this case of pediatric brain death with father's mental health issues, parental conflict, and father's difficulty accepting his daughter's death.
- Moral distress occurs when healthcare professionals cannot carry out what they believe to be the ethically appropriate actions because of various constraints. If not addressed – moral residue, crescendo effects, dissatisfaction, burnout, leaving job and leaving profession can result.
- Organization, team, and individual strategies that build moral resilience help to reduce moral distress and sustain professional integrity.
- Organizations that promote an ethical culture, good communication and supportive growth oriented teamwork, and highly qualified, emotionally healthy, and resilient medical staff are critical to successful patient care.


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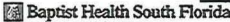
Questions and Discussion

Acknowledgement

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References

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