Chapter 20

Managing Compassion Fatigue, Burnout, and Moral Distress

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Jana is a registered nurse (RN) working in a hemodialysis unit. She has been there for 15 years and takes pride in knowing all of her patient's special needs and idiosyncrasies. She looks forward to going to work and enjoys most of the patients and families she works with. In the past 2 years, however, the volume of work on the unit has dramatically increased. There are fewer nurses on the floor, and as a result, Jana has to monitor more patients than before. She spends most of her time rushing from one bed to the next, checking on patients' dialyzers and vitals.

Recently, she had to spoon-feed lunch to two of her patients, which took a great deal of time, and she had to frequently interrupt what she was doing to respond to alarm bells. One of the patients she was feeding was experiencing difficulty swallowing, and Jana found herself becoming very impatient with the patient's slowness in eating her meal. Later, on her way home, Jana felt very guilty about this and regretted being so irritable with this lovely elderly patient.

Over the past 2 decades, the healthcare system in the United States has been in a state of flux: We have experienced numerous budgetary cutbacks that, in turn, have led to a reduction in staffing, more hospital mergers (Small & Small, 2011), and a decrease in resources to care for patients:

> During the 5 years ending December 31, 2009, there were at least 278 hospital mergers covering 639 hospitals with 108,711 beds. This represents 11% of the American Hospital Association estimate of the 944,277 total staffed hospital beds in the United States. (Small & Small, 2011, p. 3)

Nurses all over North America report that they are being asked to do more with less (Duxbury, Higgins & Lyons, 2010) and are having to care for a larger number of sicker patients who require

more complex care than in the past (American Hospital Association, 2012; Canada Census, 2011; Schoen et al., 2011; U.S. Census Bureau, 2010).

In acute-care settings, family members are now more involved in decisions about the care of their loved ones. This can present new challenges for nurses and physicians around sharing decision-making, communication, and control. In addition, as a result of more family presence at the bed-side, healthcare workers must not only provide care and support to their patients but also offer comfort and bear witness to traumatized and, at times, highly distressed family members (Egging et al., 2011).

Nurses are now having to meet the multiple and sometimes competing demands of those to whom they are accountable: their employer, supervisor, physician colleagues, professional association, patients and their families, the public at large, the government, and, in instances when things go wrong, the media and judicial courts. In the midst of this complex and evolving landscape, higher expectations have been set to improve quality of patient care by focusing on "safety, effectiveness, timeliness, efficiency, equity and patient-centeredness" (Institute of Medicine [IOM], 2001). The requirement to provide patient-centered care, in particular, highlights the ongoing tension that nurses face: They must provide top-quality care to patients while contending with insufficient resources and work overload, just as Jana faced in the vignette at the beginning of this chapter. Without adequate resources, nurses are placed in an untenable situation in which they are at increased risk of developing stress-related illnesses—which paradoxically jeopardizes quality patient care.

Is it possible to offer high-quality patient-centered care while preserving the health of staff? Rising rates of sick leave, workplace grievances, complaints from patients and families, and lowered work satisfaction among hospital staff have fueled an interest in gaining a better understanding of the forms of occupational stress that can affect healthcare workers, particularly nurses. Burnout, compassion fatigue, and moral distress are distinct but inter-related concepts that refer to the various ways in which the work affects care providers (Mathieu, 2012). The first step in developing an effective strategy to ensure that nurses can provide high-quality care while staying healthy is to understand the complex consequences of work overload and repeated exposure to patients and families in pain and in distress.

Research in the fields of compassion fatigue and burnout in healthcare workers has grown tremendously in the past decade—we now have access to new data to assist us in recommending best practices to support staff in their rewarding but challenging work. In this chapter, we will discuss the relationship between compassion fatigue, burnout, and moral distress and offer strategies at both the individual and organizational level which will help prevent and/or mitigate their effects and ultimately support nurses in being able to provide high-quality patient-centered care. We will also discuss the concept of "role overload," provide a self-assessment tool for the warning signs of compassion fatigue, discuss the impact of compassion fatigue and burnout on patient-centered care, suggest strategies for developing and maintaining an ethical climate in the workplace, and provide an action plan for self-care for individuals, teams, and organizations.

We would like to invite you to go back and read the story of Nurse Jana from the introduction. Then consider the following questions:

- What were your thoughts and reactions to this story?

- Has a similar experience ever happened to you? If so, how did you feel?

- In your work setting, are there any resources and/or strategies in place that Jana could use to address her challenge?

- What would you have done in her shoes?

Burnout

Bernard works as a nurse in a long-term care facility that primarily cares for patients with Alzheimer's disease and other types of dementia. A new owner recently purchased the facility, and the climate at work has changed drastically: Staff members have lost control over their shift schedules, their workload has increased significantly, and the unit manager seems punitive and intimidating. There are rumors that the new owner will be cutting those who don't seem to be "pulling their weight." Bernard enjoys caring for the patients, but feels stressed and anxious about the workplace climate. With his new shift schedule, he is also struggling to balance home and work life and feels like he is "walking on eggshells" whenever the manager is near him.

The concept of burnout is not new to healthcare. It was first mentioned in the late 1970s and early 1980s by psychologists Herbert Freudenberger (1980) and Christina Maslach (1978, 1982), who were studying the effects of professional exhaustion. Since that time, the term burnout "has been widely used to describe the physical and emotional exhaustion that workers can experience when they have low job satisfaction and feel powerless and overwhelmed at work" (Mathieu, 2012, p. 10). Burnout can affect non-healthcare workers as well: Being employed in a high-stress, low-reward factory or a frenetic law office can lead to burnout just as easily as working in a challenging hospital ward.

In 2006, Statistics Canada published their first National Survey of the Work and Health of Nurses. They found that "close to one-fifth of nurses reported that their mental health had made their workload difficult to handle during the previous month" (para. 37). In the year preceding the study, more than half of the nurses surveyed had taken time off work because of a physical illness, and 10% had been away for mental health reasons. Access to EAP (employee assistance program) was a shocking 80%, which is more than twice as high as EAP use by the total employed population (Mathieu, 2012).

Burnout in Physicians Affects Patient Care

Numerous global studies involving nearly every medical and surgical specialty indicate that approximately 1 of every 3 physicians is experiencing burnout at any given time—in this case, burnout being defined as "emotional exhaustion" "depersonalization" and "low personal accomplishment" (Shanafelt, 2009, p. 1338). Dr. Tait Shanafelt, one of the leaders in physician wellness research in the United States, recently published a series of findings that compares U.S. physician health with the overall American population. In this 2012 study, Shanafelt and colleagues (2012) found that 45% of physicians experienced symptoms of burnout with differences depending on the medical specialty: "[...] the highest rates among physicians [were] at the front line of care access (family medicine, general internal medicine, and emergency medicine)" (p. 1377). Shanafelt then juxtaposed the findings against the general population and found that physicians were more likely to experience burnout than the average American citizen: "Compared with [...] US adults, physicians were more likely to have symptoms of burnout (37.9% vs 27.8%) and to be dissatisfied with work-life balance (40.2% vs 23.2%)" (p. 1377).

This study, as well as a prior 2009 paper by Shanafelt, both indicate that burnout has a direct impact on the quality of care delivered by physicians and on the relationship between physicians and their patients. Strikingly, Shanafelt (2009) also found that it affected treatment compliance:

> Physicians' degree of burnout and professional satisfaction are related to physician empathy and compassion, prescribing habits, referral practices, professionalism, and the likelihood of making medical errors. Physician burnout also appears to influence patient adherence to recommended therapy, the degree of trust and confidence patients have in their physician, and patients' satisfaction with their medical care. (p. 1338)

Although it was not a finding of the Shanafelt studies, it is not difficult to imagine that burnout in physicians will in turn contribute to increased stress among nurses.

The Challenge of Increased Interaction With Family Members

Although it has been shown to be beneficial to most patients (Egging et al., 2011), the push for more family presence 24/7 in acute-care settings and their involvement in patient care (The Joint Commission, 2010) can pose challenges to nursing staff. Some families are extremely vocal and strong advocates for their loved ones, which can be challenging when nurses are struggling with role overload and time compression. Unfortunately, when resources are limited, one of the first casualties is quality communication between staff and family members (Azoulay et al., 2000; Heyland et al., 2002).

Addressing burnout in healthcare workers is clearly a crucial aspect of improving patient-centered care, but we also need to gain a better understanding of two other threats to the delivery of quality patient-centered care: compassion fatigue and moral distress.

You are now invited to go back and re-read Bernard's story. Then consider the following questions:

- *Did you have any thoughts about or reactions to this story?*

- *Have you ever worked (or do you currently work) in an environment where burnout is present for you? Is it present in your colleagues? What key features stand out for you?*

- *What options, if any, do you feel that Bernard has at this time?*

- *Have you ever been physically assaulted or verbally abused on the job? Were you surprised by the incidence rates of abuse reported in this section?*

Role Overload

To combat compassion fatigue and burnout, agency administrators and therapists may also wish to ask themselves "How many cases are too many?" (Killian, 2008, p. 42)

Hurried and stressed physicians order tests or referrals and prescribe medicines in an attempt to appease and give the illusion of high quality care. (Rickert, 2012, para. 16)

Although employees of all walks of life can experience *work* overload, which can be defined as having too much work to do in a certain span of time, *role* overload specifically refers to the accumulation of too many competing duties. A 2010 study commissioned by the Workplace Safety and Insurance Board of Ontario revealed that 60% of healthcare workers were suffering from "role overload," which they defined as "having too many responsibilities and too little time in which to attend to them" (Duxbury et al., p. 2). Nurses sometimes refer to it as "having too many hats to wear." In their report, the authors paint a picture of healthcare workers struggling to juggle all the demands on their time and energy:

[Role] overload at work is caused by a lack of time (too many commitments, time constraints, and unrealistic work deadlines and work expectations), multiple competing priorities, a lack of help and support, understaffing, an inability to control the situation, and a non-supportive organizational culture. [Role] overload at home is related to expectations at work, a lack of time, competing demands and priorities, a lack of help and support, life cycle stage (eldercare, children at a difficult age) and an inability to control the situation. (Duxbury et al., 2010, p. 3)

The study found a direct correlation between role overload and poor outcomes, including "negative emotions, [...] poorer physical and mental health, increased work-life conflict, poorer relationships at work and at home, greater intent to turnover, increased absenteeism, greater use of EAP, and lower commitment and productivity" (Duxbury & Higgins, 2013, p. 3). The investigators also found that healthcare workers were in poorer physical and mental health than staff surveyed in other sectors of the population: In healthcare, "59% report high levels of stress and 36% report high levels of depressed mood and [...] one in five are in poor physical health" (Duxbury & Higgins, 2013, p. 56).

> **NOTE**
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> An additional phenomenon that can amplify the stress of role overload is unpredictability. In a 2007 study, Krichbaum and colleagues referred to "complexity compression" which they defined as "what nurses experience when expected to assume additional, unplanned responsibilities while simultaneously conducting their multiple responsibilities in a condensed time frame" (p. 86).

In addition to role overload, nurses report regular workplace violence. A 2008 position statement from the Registered Nurses' Association of Ontario (RNAO) stated that "nurses are three times more likely to experience violence than any other professional group" (RNAO, 2008). The Statistics Canada National Survey of the Work and Health of Nurses, mentioned earlier, found that "... [O]ne-third of all nurses had been physically assaulted in the past year" (Statistics Canada, 2006, para. 35). A national survey carried out in 2006 by the American Association of Critical-Care Nurses showed that 64.6% of their respondents had experienced verbal abuse in the past year (from various sources such as patients, family members, other nurses, and physicians) and 22.2% had been physically abused at least once, primarily by patients (Ulrich et al., 2006). One recent study on verbal abuse in the workplace among registered nurses in the U.S. found that "about 49% experienced verbal abuse from nurse colleagues at least once during the past 3 months" (Budin, Brewer, Chao, & Kovner, 2013, p. 4).

> **Warning Signs of Burnout**
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> - *Feeling hopeless and discouraged in dealing with work*
> - *Feeling like your efforts at work do not make a difference*
> - *Not feeling connected to others at work*
> - *Feeling trapped by your job as a nurse*
> - *Often feeling worn out because of your job as a nurse*
> - *Often feeling overwhelmed because your caseload seems endless*

- *Feeling bogged down by the system*
- *Feeling that you are no longer a very caring person*

Source: Adapted from the Professional Quality of Life—Proqol Self-Test (Stamm, n.d.)

Compassion Fatigue

Amina is a student nurse on placement in a busy emergency department. She is job-shadowing Louise, a seasoned ED nurse with more than 20 years of experience in the field. They are called to attend to a patient who has been sexually assaulted during a party following a local college football game. "Here we go," says Louise, "Another drunk girl who is going to cry in our ED because she can't remember who she went home with." Amina is shocked by Louise's comments and by her lack of empathy toward the patient.

What Is Compassion Fatigue?

The term *compassion fatigue* is a more recent concept than burnout. It was first mentioned in the literature in the early 1990s. Carla Joinson referred to "compassion fatigue" in a 1992 paper exploring the impact of work-related stress among emergency room nurses. Subsequently, psychologists such as Dr. Charles Figley (1995) found that helping professionals of all stripes such as nurses, social workers, physicians, and child welfare workers were exhibiting symptoms of profound emotional exhaustion, poor work engagement, hopelessness, and a decrease in feelings of empathy and compassion toward patients. In addition, professionals who worked in high-trauma situations (such as child welfare workers and emergency department nurses) were showing symptoms similar to post-traumatic stress disorder (PTSD) without ever having been in the line of fire themselves.

Unlike burnout, which is related to challenges within the work environment such as role overload, lack of control, and lack of reward, this new form of work-related stress was connected to the empathic engagement between the healthcare provider and the patient. This gave rise to a new field of research and the creation of new terminology as experts began to try and better understand this complex form of burnout that seemed to affect only caregivers and helping professionals rather than the general public.

As discussed in detail in Mathieu's 2012 book *The Compassion Fatigue Workbook*, compassion fatigue refers to the profound emotional and physical exhaustion that a caregiver or helping professional can experience over time. Unlike burnout, which can happen to anyone who is struggling with unsatisfactory workplace conditions, compassion fatigue is specific to being in a caregiving relationship.

> Compassion fatigue refers to the gradual erosion of all the things that keep us connected to others in our caregiver role: our empathy, our hope, and of course our compassion—not only for others but also for ourselves. When we are suffering from compassion fatigue, we start seeing changes in our personal and professional lives: We can become dispirited and increasingly bitter at work; we may contribute to a toxic work environment; we are more prone to clinical errors; we may violate patient boundaries and lose a respectful stance towards our patients. We become short-tempered toward our loved ones and feel constant guilt or resentment at the never-ending demands on our personal time. (Mathieu, 2012, p. 8-9)

As previously mentioned, in acute-care settings, families now participate increasingly in decision-making and are more frequently present at the bedside. As a result, nurses may be exposed to more traumatic details and may, at times, develop a deeper understanding of the suffering of patients and families as they bear witness to the grief and distress around them. For example, one pediatric cancer ward recently expressed difficulty retaining their recreational staff for more than 1 to 2 years. The causes of the attrition varied, but one frequently stated reason was the staff's inability to cope with the pain and suffering of the families and children with terminal cancer (B. Muskat & A. Robertson, personal communication, 2013).

Mathieu (2012) quotes the following incidence rates:

> Depending on the studies, between 40 to 85% of helping professionals were found to have compassion fatigue and/or high rates of traumatic symptoms. For example, a ... study carried out by Abendroth and Flannery in 2006 among Florida hospice nurses found that 79% of them had moderate to high rates of compassion fatigue and 83% of those who did not have debriefing/support after a patient's death, had symptoms of compassion fatigue. (p. 34)

Mathieu (2012) continues:

> The level of compassion fatigue that a helper experiences can ebb and flow from one day to the next, and even very healthy helpers with optimal work/life balance and self-care strategies can experience a higher than normal level of compassion fatigue when they are overloaded, are working with a lot of traumatic content or find their case load suddenly heavy with patients and families who are all chronically in crisis. (p. 9)

Compassion fatigue is a normal consequence of prolonged exposure to difficult stories and individuals in pain and in crisis. It is not a disease or a mental illness. The warning signs can vary from person to person depending on several factors such as your personality, coping style, prior life history, current life circumstances, the quality of social support that is available to you at work and at home, and the quality of training you have received (Gentry, 2002; Pearlman & Saakvitne, 1995).

Self-Assessment—Warning Signs of Compassion Fatigue

The following self-assessment is not intended to be a diagnostic test, but rather an exercise in "taking stock," to help you identify what areas in your life are currently contributing to making you more vulnerable to developing compassion fatigue. We invite you to take the test when you have some time to reflect on your current home and work situation, and when it is done, to take a step back and look at the overall picture: Are there areas that need more attention than others? Would it be possible for you to change some of your coping styles, to get access to more training, or to ask some colleagues to create a support group at work or outside of work?

What Is Your Coping Style?

When you are overwhelmed with difficult stories from work do you frequently...

❑ *Have several stiff alcoholic drinks or use drugs to numb out when you get home*

❑ *Watch hours of television until you fall asleep in front of the set*

❑ *Spend hours surfing the Web*

❑ *Numb yourself with overwork*

❑ *Binge on sugary, salty, or fatty foods*

❑ *Shop even though you can't afford it*

❑ *Gamble online or in a casino*

How often do you...

❑ *Exercise or meditate*

❑ *Play with children*

❑ *Play with pets*

❑ *Find someone to debrief*

❑ *Journal*

Personality

❑ *Are you a very sensitive person? Do you take on other people's suffering?*

❑ *Is your volunteer job exactly the same as your day job?*

❑ *Do you ever get a break from being in a caregiver role?*

❑ *Were you a caregiver in your personal life long before you became a nurse?*

❑ *Do you have a hard time delegating? Saying no?*

Prior Life History

☐ Do you have a history of trauma, abuse, neglect and/or domestic violence in your personal life?

☐ Do you have a history of drug or alcohol abuse, compulsive gambling, or other addictions?

☐ Do you have a history of depression or an anxiety disorder?

☐ Have you ever been physically assaulted on the job?

Current Life Circumstances

☐ Are you currently going through a divorce or separation?

☐ Are you currently caregiving for a person in your own family (a child, spouse, or other relative with a long-term illness or disability)?

☐ Are you currently dealing with financial difficulties?

☐ Are you currently struggling with an addiction?

☐ Are you currently suffering from clinical depression or an anxiety disorder?

Quality of Social Support

☐ Do you have access to good emotional support at home or among your friendships?

☐ Do you have access to someone who can help you with daily chores at home (errands, cleaning, cooking, home repairs, finances, etc.)?

☐ Do you have access to good emotional support at work?

Training

☐ Do you feel that you are adequately trained to care for the patients on your current caseload?

☐ Do you have access to regular professional development to learn new techniques and stay on top of your nursing skills?

☐ Is there any training you wish you could receive at this time? What kind of training is it? Write it down here:

Supervision

☐ Do you have access to good quality supervision and debriefing at work?

☐ If you do not have access to good quality supervision and debriefing at work, is it something you can access outside of work?

The goal of this self-assessment is not to tally up your check marks in order to get a score. Rather, we invite you to take a look at the themes that emerged from your inventory. Where do you need to focus your energy? What is working well for you at the moment? If you are comfortable doing so, this is an exercise you may want to do with a close friend or colleague, so you can discuss your results and reactions to the self-assessment. If you find yourself overwhelmed by your responses, you may want to contact a mental health practitioner to discuss your feelings and reactions.

The Impact of Compassion Fatigue and Burnout on Patient-Centered Care

In her 2009 book *Trauma Stewardship*, Laura van Dernoot Lipsky, a Seattle-based social worker with many years of experience working in hospital emergency departments, reflects on one frequent consequence of compassion fatigue in healthcare staff—minimization and desensitization to other peoples' suffering:

> We may start out being moved by each person's story, but over time it may take more and more intense or horrific expressions of suffering to deeply move us. We may consider less extreme experiences of trauma as less "real" and therefore less deserving of our time and support. ... Minimizing is not triaging and it is not prioritizing. This coping strategy is at its worst when you've witnessed so much that you begin to downplay anything that doesn't fall into the most extreme category of hardship. Although you may still be able to nod and do active listening and feign true empathy, internally you are thinking something like, "I cannot believe this conversation is taking 20 minutes of my time. There wasn't even a weapon involved." (van Dernoot Lipsky & Burke, 2009, pp. 78-79)

Anyone who works in a trauma unit or a similar high-stress setting for any length of time will be familiar with this phenomenon, and a certain amount of desensitization is not, in and of itself, necessarily a bad thing—we cannot perform effectively as healthcare workers if we are reeling at every patient's story. The problem arises when our detachment starts interfering with our empathy and with the quality of care we offer patients and their families. There are, unfortunately, too many stories of poor bedside manners in hospitals, of patients and families being ignored or treated disrespectfully by staff who have lost their compassion and become numb to human suffering.

But rather than laying the blame on individual helping professionals, recent research clearly demonstrates that the problem also lies at a systems level; therefore, our solutions must not solely focus on the individual but must also address the organization as a whole. Given this, one key element at the organizational level that needs to be addressed is the issue of how institutions can foster an ethical work environment that will support patients and staff alike.

An "Ethical Climate"

The concept of an "ethical climate" first emerged in the business literature approximately 50 years ago (Schluter, Winch, Holzhauser, & Henderson, 2008). Since that time, the concept has expanded into the healthcare domain, and an *ethical climate* can be described as the organizational conditions and practices that affect how ethical patient care issues are discussed and decided (Hart, 2005). Lützén and Kvist (2012) propose that "a safe environment that supports ethical action and allows messy ethical questions to be raised and discussed is absolutely essential to a morally habitable healthcare environment" (p. 36).

According to Olson, five conditions need to be met in order for staff to engage in ethical reflection. Staff should (Olson, 1998, p. 346):

- Have the right to relevant information and be free to express what needs to be said about an issue (power)

- Be free to disagree with one another in order to increase their understanding of an issue (trust)

- Be included in the decision-making process if they have a stake in the outcome of the decision (inclusion)

- Be allowed to take different positions on issues or to change their views (role flexibility)

- Be encouraged to ask questions, participate in decision-making, and have access to the information necessary to make informed decisions (inquiry)

Research has shown that a restrictive ethical climate is related to moral distress and is a factor in nurses leaving their positions and profession (Hart, 2005). However, factors such as ethics education; control over the practice environment; and improvements in workload, staffing, and resources have been demonstrated to be related to nurses staying in their positions (Austin, Bergum, & Goldberg, 2003; Corley, Minick, Elswick, & Jacobs, 2005; Hart, 2005; Pauly, Varcoe, Storch, & Newton, 2009).

Moral Distress

Melinda, a 22-year-old with a history of congenital heart disease and multiple comorbidities, recently underwent a valve repair and was subsequently admitted to the CVICU with a diagnosis of sepsis. Melinda's father, a recent immigrant from Greece with limited English language skills, refused to leave his daughter's bedside, despite urging from the unit staff. Within 2 days of her admission, Melinda's status rapidly deteriorated, and she went into cardiac arrest. Nancy, the nurse caring for Melinda, had previously questioned the attending physician about the patient's code status, feeling she should not be resuscitated, but the physician disagreed. Consequently, Nancy initiated CPR while the father pleaded with her not to hurt his daughter.

Melinda eventually died in the early morning hours, and the father's cries of anguish could be heard throughout the unit. This was the fourth death in the unit within a week. Nancy felt she had failed both the patient and her father that night. She believed she had caused the patient and her father undue suffering by administering CPR that she felt to be futile. In addition, she felt she was not able to provide the degree of support to Melinda's father that he needed, in part due to being short staffed in the unit, but also because she did not have access late at night to interpretive services to address the language barrier or to pastoral care services to support his spiritual needs. As days passed, Nancy described feeling an overwhelming sense of guilt and failure for not meeting her standard of care and found herself to be tearful and unable to rid herself of the sound of the father's anguished cries for his daughter.

Andrew Jameton (1984), a professor of Philosophy and Ethics in Public Health at the University of Nebraska Medical Center, is credited with first coining the term "moral distress" in 1984 in a book on nursing ethics. In it he states, "[M]oral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). According to Epstein & Delgado (2010), moral distress involves a threat to one's *moral integrity*, which is defined as "the sense of wholeness and self-worth that comes from having clearly defined values that are congruent with one's actions and perceptions" (p. 3).

What Is Moral Distress?

The American Association of Critical-Care Nurses (AACN) defines moral distress as "[something that] occurs when you know the ethically appropriate action to take, but are unable to act upon it [and when] you act in a manner contrary to your personal and professional values, which undermines your integrity and authenticity" (AACN, n.d., p. 1). The Canadian Nurses Association (CNA) *Code of Ethics for Registered Nurses* defines moral distress as arising

> in situations where nurses know or believe they know the right thing to do, but for various reasons (including fear or circumstances beyond their control) do not or cannot take the right action or prevent a particular harm. When values and commitments are compromised in this way, nurses' identity and integrity as moral agents are affected and they feel moral distress. (CNA, 2008, p. 6)

Three Causes of Moral Distress

The research literature defines three root causes of moral distress (Hamric, Borchers, & Epstein, 2012):

- Problematic clinical situations
- Internal constraints
- External constraints

Examples of problematic clinical situations include aggressive treatment that is considered futile, working with providers who do not have the required level of competence, inadequate informed consent, inadequate pain relief, using resources inappropriately, disregard for patient's wishes, lack of truth-telling, and providing false hope to patients and families (Corley, 2002; Hamric et al., 2012; Pauly et al., 2009).

Internal constraints include personal characteristics of the healthcare professional that limit his or her ability to affect the situation, for example, a lack of assertiveness or confidence, perceived powerlessness, an error in judgment, lack of understanding the full situation or of alternative treatment options, socialization to follow orders, fear of losing one's job, or anxiety about creating conflict (Hamric et al., 2012; Hamric, Davis, & Childress, 2006; Wilkinson, 1987).

External constraints include the broader organizational and contextual constraints, such as hierarchies and power imbalances within the healthcare system, lack of collaboration, lack of resources, pressures to cut costs, inadequate team communication, policies that conflict with patient care needs, following family wishes regarding patient care for fear of litigation, tolerance within team of disruptive and/or abusive behavior, and a negative ethical climate (Elpern, Covert, & Kleinpell, 2005; Epstein & Hamric, 2009; Gutierrez, 2005; Hamric et al., 2012; Kälvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Ludwick & Silva, 2003; Papathanassoglou et al., 2012; Zuzelo, 2007).

Reflection Activity

You are now invited to go back and reread Nancy's story with patient Melinda. Then consider the following questions:

- *Did you have any thoughts about or reactions to this story?*
- *Can you identify the problematic clinical situation?*
- *What internal constraints were present, in your opinion?*
- *What external constraints were present, in your opinion?*
- *If Nancy worked in your workplace, what resources would she have available to address her moral distress during and after the event?*
- *In terms of managing your own moral distress, is there a resource you wish was available to you at your workplace, but currently isn't?*
- *Can you think of one or two outside sources of support to help you manage this stressor? (You may wish to read on and return to this question once you have completed this section.)*

The negative effects of moral distress have been well established and include both psychological and physical effects (Pauly, Varcoe, & Storch, 2012). The psychological reactions often involve

feelings of frustration, sadness, isolation, guilt, anxiety, tearfulness, depression, nightmares, helplessness, powerlessness, and anger (Elpern et al., 2005; Wilkinson, 1987). The experience of moral distress increases the risk of poor coping, low self-esteem, loss of personal integrity, and avoidance or withdrawal from patients (Epstein & Delgado, 2010).

Physical responses include sweating, trembling, headaches, gastrointestinal upset, and insomnia. The effects on the workplace include lack of trust, poor collaboration, poor pain management, health professional burnout, and high turnover rates (Austin et al., 2003; Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005; Corley, et al., 2005; Elpern, et al., 2005; Gutierrez, 2005; Hamric, 2000; Hamric & Blackhall, 2007; Jameton, 1993; Meltzer & Huckabay, 2004; Nathaniel, 2006; Sundin-Huard & Fahy, 1999; Wilkinson, 1987).

Studies have also highlighted the powerful lingering effects of moral distress, termed "moral residue" by Webster and Baylis (2000). In organizations where moral distress is unaddressed, the moral residue builds over time in what is referred to as a "crescendo effect" (Epstein & Hamric, 2009). As noted by Epstein & Hamric (2009), there are three potential consequences of moral distress and moral residue:

- The first consequence is that nurses may become desensitized to the moral aspects of care and see their disregard of their ethical obligations as normal.

- Second, nurses may engage in different ways of conscientiously objecting to an ethically challenging situation, which may be either productive (e.g., calling an ethics consult) or disruptive (e.g., documenting a disagreement in a patient's chart) (Epstein & Delgado, 2010).

- The third consequence is burnout.

Research shows a correlation between moral distress and burnout (Epstein & Delgado, 2010; Meltzer & Huckabay, 2004) with some studies identifying moral distress as a reason nurses choose to leave their position or even their profession (Corley, 1995; Hamric & Blackhall, 2007).

Wendy Austin, in the Faculty of Nursing and the John Dossetor Health Ethics Centre at the University of Alberta, argues that healthcare restructuring and cutbacks are demoralizing. She believes the shift to a corporate model of healthcare and the streamlining of services places health professionals at greater risk of being in conflict with their ethical obligation to those in their care. According to Austin (2012):

> [H]ealth care practice needs to be grounded in a capacity for compassion and empathy, as evident in standards of practice and codes of ethics. Such grounding allows - for humane response to the availability of unprecedented advances in biotechnology treatment, for genuine dialogue and the raising of difficult, necessary ethical questions and for the mutual support of health professionals themselves. If healthcare environments are not understood as moral communities but rather as simulated market places, then the healthcare professionals' moral agency is diminished and their vulnerability to moral distress is exacerbated. (p. 27)

> ### The 4As—An Approach to Address and Reduce Moral Distress
>
> - *Ask:* Review the definition and symptoms of moral distress and ask yourself whether what you are feeling is moral distress. Are your colleagues exhibiting signs of moral distress as well?
>
> - *Affirm:* Affirm your feelings about the issue. What aspect of your moral integrity is being threatened? What role could you (and should you) play?
>
> - *Assess:* Begin to put some facts together. What is the source of your moral distress? What do you think is the "right," action and why is it so? What is being done currently and why? Who are the players in this situation? Are you ready to act?
>
> - *Act:* Create a plan for action and implement it. Think about potential pitfalls and strategies to get around these pitfalls.
>
> *Source: AACN, 2005, n.d; Rushton, 2006.*

The Connection Between Compassion Fatigue and Moral Distress

To date, there is limited research that explores how these types of occupational stressors are interrelated. Evidence exists to demonstrate the validity of each as distinct concepts, but what is not known is the role each may play in the development of the other (Sabo, 2011). What is known, however, is that moral distress is the result of a "perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action" (Epstein & Hamric, 2009, p. 331). It is this challenge to one's personal and professional values and moral integrity that distinguishes moral distress from psychological distress and compassion fatigue (Epstein & Hamric, 2009). Psychological distress describes emotional reactions to situations, but does not necessarily involve a violation of core values and obligations (Epstein & Hamric, 2009; McCarthy & Deady, 2008).

Strategies for Creating a Positive Ethical Climate

Several authors have discussed strategies for addressing moral distress (Austin et al., 2005; Badger & O'Connor, 2006; Bell & Breslin, 2008; Corley et al., 2005; Epstein & Hamric, 2009; Hamric et al., 2006; Hamric & Blackhall, 2007; Hart, 2005; McDaniel, 1997; Olson, 1998; Papathanassoglou et al., 2012; Pauly et al., 2009; Pauly et al., 2012).

Their suggestions for creating a positive ethical climate are compiled here:

- Speak up: Identify the problem, gather the facts, and voice your opinion.
- Be deliberate: Know whom you need to speak with and know what you need to speak about.

- Be accountable: Sometimes our actions are not quite right. Be ready to acknowledge this and accept the consequences.

- Build support networks: Align yourself with colleagues who support you. Speak with one authoritative voice. Foster caring colleagues and a zero-tolerance policy on lateral violence.

- Focus on changes in the work environment: Focusing on the environment is more productive than focusing on one individual patient. Similar problems tend to re-occur. It's not usually the patient that needs changing, but the system.

- Participate in moral distress education: Attend forums and discussions about moral distress. Learn all you can.

- Make it interdisciplinary: Multiple views are needed to determine the common causes of moral distress in your unit. Target those. Facilitate open interdisciplinary communication.

- Develop policies: Develop policies to encourage open discussion, interdisciplinary collaboration, and the initiation of ethics consults.

- Design a workshop: Train staff to recognize moral distress, identify barriers to change, and create a plan for action.

- Make sure everyone knows how to utilize the hospital Ethics Committee.

- Provide an opportunity for those less powerful to be heard.

- Seek out effective role models for novice nurses.

- Provide an adequate orientation for new staff.

- Establish an environment that supports professional autonomy.

- Consider ethics rounds.

- Self-reflection may help people develop the courage needed to change circumstances that they view as morally wrong.

- Make use of well-established ethical decision-making frameworks to facilitate dialogue and balanced application of various relevant values among stakeholders.

- Support caring for self.

Source: Adapted in part from Epstein & Delgado, 2010, p. 7

Reducing Compassion Fatigue and Burnout— What Works?

Mathieu (2012) discusses strategies to reduce compassion fatigue and burnout. In summary, research in the field shows that the following key strategies reduce compassion fatigue and burnout in healthcare professionals:

- Strong social support both at home and at work (Bober & Regehr, 2005; Killian, 2008)
- More control over work schedule (Duxbury et al., 2010; Killian, 2008)
- Rebalancing caseload and workload reduction (Bober & Regehr, 2005; Killian, 2008)
- Timely access to good quality debriefing and supervision (Killian, 2008; Saakvitne & Pearlman, 1996)
- Reduced number of hours spent working directly with traumatized individuals (Bober & Regehr, 2005)
- Access to regular professional development and ongoing training (Killian, 2008)
- Increased self-awareness through mindfulness meditation and narrative work such as journaling (Cohen-Katz et al., 2005; Kearney, Weininger, Vachon, Harrison, & Mount, 2009; Shapiro, Brown, & Biegel, 2007)
- Good self-care (Gentry, 2002; Saakvitne & Pearlman, 1996)
- Improved work/life balance
- High job satisfaction
- Access to counseling and/or coaching as needed
- Increased recognition of the work done by nurses (Saakvitne & Pearlman, 1996)

Duxbury, Higgins, and Lyons' 2010 study also found that most of the strategies used by healthcare workers to manage overload were self-initiated and few of them came from the hospital offering flexibility and support: "It appears that supportive management, being prepared emotionally, having a plan, setting priorities and having a good support team and access to help are the best ways to cope" (p. 2). Budin et al. (2013) recently showed that nurses working at magnet hospitals were less likely to report verbal abuse by colleagues.

Strategies to reduce compassion fatigue, burnout, and moral distress and to improve quality patient care need to be implemented at all levels simultaneously (Saakvitne & Pearlman, 1996):

- Individually (nurses deciding to improve their self-care and work-life balance)
- Professionally (nurses accessing additional training, championing positive team engagement, choosing not to participate in gossip or lateral violence at work)
- Organizationally (hospitals providing adequate staffing, access to good quality supervision, and ongoing education and training)
- With the system as a whole (recognizing that person-centered care, which includes the health of the caregivers, is a priority to ensure high-quality patient care; more funding being provided to healthcare and social services; improved salaries and working conditions for healthcare professionals)

Individual Strategies

The advantage of individual strategies is that they can be implemented by the healthcare practitioner at any time, no matter *where* they work, with *whom* they work or how healthy or toxic their workplace is. Individual strategies begin with the self through a process called self-awareness, through the practice of mindfulness, and finally by identifying one's own early warning signals of burnout and compassion fatigue.

Develop Self-Awareness

As explained in *The Compassion Fatigue Workbook*:

> Self-awareness means being in tune with your stress signals. Do you have a good sense of how your body communicates to you when it is overwhelmed? Do you get sick as soon as you go on vacation, develop hives, or get a migraine when you are stressed? Many of us live in a state of permanent overload and are dimly aware of it. What happens when you feel angry? Do you explode or do you swallow your rage? Where in your body do you feel your anger? (Mathieu, 2012, p. 81)

Self-awareness also means being aware of our current feelings and behaviors, understanding the choices we make, being aware of the reasons why we act or react the way we do and how this is connected to our past history, perhaps, or a trauma we experienced. Do you live in a constant state of overwhelm? Many healthcare workers, when pressed, will admit that they have become "hooked" on stress and tend to live in crisis mode most of the time.

In her book *Trauma Stewardship*, Laura van Dernoot Lipsky addresses the risk of living in a constant state of tension and urgency: "When we keep ourselves numbed out on adrenaline or overworking or cynicism, we don't have an accurate internal gauge of ourselves and our needs" (van Dernoot Lipsky & Burke, 2009, p. 110). The best way to develop self-awareness is to practice mindfulness, which is our second strategy for individuals in healthcare.

Practice Mindfulness

Mindfulness is an ancient Buddhist practice that invites participants to meditate while being in the present moment, without judgment. Mindfulness-Based Stress Reduction (MBSR) is a mind-body approach that was originally developed by Jon Kabat-Zinn in the late 1970s and was popularized by the publication of his book *Full Catastrophe Living* (1990) and by a very successful stress-reduction program taught by Kabat-Zinn and colleagues at the University of Massachusetts Medical Center (Kabat-Zinn, 1982). MBSR has become extremely popular since: Many hospitals and mental health services provide MBSR training to their staff and patients alike.

Among many health benefits, MBSR has been found to effectively reduce relapse in depression and help chronic-pain patients manage their symptoms (Kabat-Zinn, 1982; Teasdale, Segal & Williams, 1995). Additional work exploring the effectiveness of MBSR in reducing compassion fatigue has shown some very positive results: "One study of clinical nurses found that MBSR

helped to significantly reduce symptoms of compassion fatigue [...and] helped subjects be calmer and more grounded during their rounds and interactions with patients and colleagues" (Cohen-Katz, et al., 2005 as cited in Mathieu, 2012, p. 123). In 2005, a randomized control trial exploring the effectiveness of MBSR in reducing stress in healthcare professionals found that "those who participated in the MBSR intervention reported decreased perceived stress and greater self-compassion when compared with controls" (Shapiro, Astin, Bishop & Cordova, 2005, p. 170).

Develop an Early Warning System

Compassion fatigue and burnout are cumulative effects of working in high-stress, high-volume workplaces, but they do not manifest themselves in the same way in each person. The best strategy is for each helping professional to get to know his or her own warning signs. If we were to place your stress and overload symptoms on a continuum from green to yellow to red (green being when you are least symptomatic, red being when you are close to stress leave, for example), what would your yellow zone look like? What would be your main behavioral, emotional, and physical symptoms (Mathieu, 2012)?

Examples of Self-Care Activities

- *Participate in non–work related hobbies where you are not in a helping role*
- *Exercise regularly*
- *Eat healthy, nourishing foods during your shifts*
- *Have a transition ritual to leave work behind when you get home*
- *Spend time with friends and family who are not in your field, without talking shop*
- *Have access to regular debriefing or counseling, as needed*
- *Journal, meditate, connect with nature*
- *Read non–work related books during your downtime*
- *Spend time with pets*

Professional Strategies

Professional strategies are tools that each healthcare professional can use to enhance their resiliency such as ensuring that their clinical skills are well-honed and up-to-date; developing healthy boundaries; enhancing presence; and finally, assessing one's interaction with work colleagues to avoid toxicity and gossip and instead foster positive professional connections.

Identify Areas of Work Where You Need Additional Training

When hospitals and other healthcare agencies have to compress budgets, one of the first areas affected is often education and training; staff report no longer having access to as many continuing education programs as they did in the past, or departments find themselves unable to fund backfill while nurses are away at training courses, and, as a result, requests for educational leave are denied (Gentry, 2002). One of the very first studies on treating compassion fatigue identified "skill acquisition" as one of the five key pillars of wellness for helping professionals (Gentry, Baranowsky, & Dunning, 1997). In another later paper, J. Eric Gentry refers to situations in which staff is "working beyond levels of competency" and explains that this is often a result of role overload and lack of training (Gentry, 2002, p. 49).

You are invited to ask yourself the following questions:

- Are there areas of your work that are new to you, and where you feel unskilled and worried about your lack of training and/or experience?

- Are there areas of your work where you feel rusty? Are there techniques you have not used in a long time, and do you feel that you would benefit from some additional training/practice?

- Have you been "volunteered" to perform some clinical techniques that are outside your scope of practice without having access to further training?

Practice "Exquisite Empathy"

Richard Harrison and Marv Westwood, two psychologists in the field of compassion fatigue, have coined a beautiful term to describe our ultimate goal: *exquisite empathy*. They define exquisite empathy as a key characteristic of highly resilient helping professionals.

The key features of these helpers are that they experience, in their work with patients, "highly present, sensitively attuned, well-boundaried, heartfelt empathic engagement" (Harrison & Westwood, 2009, p. 213). Harrison and Westwood explain that these are practitioners who are "invigorated rather than depleted by their intimate professional connections with traumatized clients" (p. 213) Another way to put this: On the continuum between feeling completely numb and desensitized at one end of the spectrum and being devastated and weeping at every patient story at the other end, there is this "sweet spot" in the middle that allows helping professionals to care "just the right amount" while remaining grounded and present for our patients.

The challenge is that our compassion, although it may have been at an optimal level when we started working in the field, is constantly challenged by workplace burnout, competing demands on our time, and a sometimes less than ideal organizational context.

Connect with Colleagues on Your Team

In a 2008 study, York University researcher Kyle Killian found that social support at work was "the most significant factor associated with higher scores on compassion satisfaction" (p. 40).

Compassion satisfaction is defined by Beth Stamm as the "pleasure you derive from being able to do your work well" (Stamm, n.d., para. 1).

Unfortunately, one of the first casualties of burnout and compassion fatigue is workplace collegiality. Ample data on what is often referred to as lateral violence demonstrates that nurses, in particular, tend to be very hard on each other when they are stressed and overloaded; in an atmosphere of role overload, staff members in a hospital often turn on each other and develop what has been called a "poverty mentality" (Sheridan-Leos, 2008; Stanley, Martin, Michel, Welton, & Nemeth, 2007).

As a strategy, we recommend that you identify the most positive staff members on your team and foster constructive alliances with them: Take lunch breaks together and embrace a "no-gossip" policy. Encourage staff members to have open discussions about their yellow zones of compassion fatigue and burnout, and share strategies on the best ways that your colleagues can support you when you are in the yellow zone.

Beware of Getting Stuck in a Negative Spiral

Mathieu (2012) discusses strategies to manage negativity in the workplace: "When a workplace is toxic, several things happen: The atmosphere becomes one of mistrust (with the suspicion often directed at upper management). Many of us get locked into a negative frame of mind" (pp. 71–72).

Laura van Dernoot Lipsky (2009) has written about the dangers of gossip and negativity in the workplace:

> We become convinced that others are responsible for our well-being and that we lack the personal agency to transform our circumstances. This notion has less to do with our physical surroundings than with our internal states. We may believe that we deserve better pay, safer work environments, more respect, adequate time away from work, and greater resources, and this all may be true, [...but] we can succumb to a belief that we have no capacity to influence any outcome. (p. 93)

You are invited to take an honest look at your current attitude toward work and office gossip, and see whether you are surrounding yourself with colleagues who are likely in the red zone, and who promote cynicism and negative talk.

Examples of Professional Strategies for the Team

- *Avoid office gossip.*
- *Form positive strategic alliances: Identify your colleagues who are still in the green or light yellow zone and spend more time with them.*

- *Advocate for change in a constructive manner: Use business language to make your case (e.g., showing that compassion fatigue and burnout lead to increased rates of sick leave and attrition—retention statistics may have more sway with senior leadership than speaking about how staff is feeling about the workload).*

- *Join or form a wellness committee.*

- *Invite a few colleagues to participate in a lunch sharing program where each person makes lunches for everyone in the group one day a week and then receives a meal from a different person during the rest of the week.*

Organizational Strategies

Research demonstrates that rates of burnout and compassion fatigue are lowered when staff perceives that their organization is supportive (Bober & Regehr, 2005; Duxbury & Higgins, 2012; Killian, 2008). Over the past 2 decades, work-life balance specialists Duxbury and Higgins have carried out several extensive surveys on employee work-life balance, caregiver duties, and role overload, interviewing more than 100,000 subjects since 1991. Their latest reports, released in 2012–2013, present a shocking decline in the quality of work-life balance among their survey sample: At this present time, only 23% of their subjects say that they are satisfied with their work-life balance compared to 46% in 1991; 57% reported high levels of stress; and 40% said that were experiencing role overload, which is defined as "a type of role conflict that results from excessive demands on the time and energy supply of an individual such that satisfactory performance is improbable" (Duxbury & Higgins, 2012, p. 7).

They also found that employees who cannot balance work and home tend to miss more work, have lower productivity, and be heavier users of employee benefits than those who are coping well (Duxbury & Higgins, 2012; Duxbury & Higgins, 2013).

What can organizations do? Duxbury and Higgins (2012) offer concrete recommendations for organizations, and name "3 key determinants of employee mental health, work-life balance and absenteeism":

- "Being able to vary arrival and departure times"
- "Arrang[ing] work schedule to accommodate family demands"
- "Being able to interrupt work day to deal with personal matters and then return to work" (p. 12)

They also demonstrate that what makes the biggest difference is the quality of management—"who you work for vs where you work"—and recommend that managers be offered the training they need with enough time to "grow into their role" (Duxbury & Higgins, 2012, p. 12).

Conclusion

It is a gray and cold Tuesday in the middle of the Minnesota winter, and Jana is working at her usual fast pace in the dialysis unit, trying to keep on top of the call bells and beeping monitors. One of her patients, Mr. Simmons, who has been coming three times a week for 12 years, was recently admitted as an inpatient for end stage renal failure, and doctors gave him a few days left to live. He is receiving dialysis nonetheless as per his and his wife's wishes. At some point during her busy day, Jana notices that this man's vitals are fading fast. The physician comes and declares there is nothing left to be done except to keep him comfortable. His dialyzer is unplugged, and his wife is called to his side.

Jana is upset that the doctor has not ordered for this patient to be wheeled to a more discreet space for his last moments on earth. There he is, dying in a noisy, brightly lit unit among 30 other patients. All that Jana can do is pull the curtain around Mr. Simmons and ask the family visiting the patient beside him to be quieter, given the circumstances. Mrs. Simmons is left alone sitting next to her husband holding his hand. After about an hour, when Mr. Simmons has breathed his last breath, Jana pops her head in briefly and asks whether there is anyone she can call for Mrs. Simmons. She also asks her, as per protocol, to fill out the required forms for the removal of the body. At the end of her shift, Jana feels exhausted and sad. This isn't what she would want for her loved ones.

Reflection Activity

- *What are your thoughts about and reactions to this story?*

- *Based on what you have read in this chapter, please identify three resources that Jana could harness in helping her manage this stressful situation:*

    a. *Personal:*

    b. *Professional:*

    c. *Organizational:*

In his 2012 blog article "Patient-Centered Care: What It Means and How to Get There," James Rickert writes, "[P]atient-centered care is a method of care that relies upon effective communication, empathy, and a feeling of partnership between doctor and patient to improve patient care outcomes and satisfaction, to lessen patient symptoms, and to reduce unnecessary costs." It stands to reason that nurses, many of whom are suffering from some level of work-related exhaustion and are working with depleted physicians and other allied health professionals, may find that their effective communication skills with families and patients erode over time. We believe that patient safety and quality of care can be improved by providing units with adequate staffing, reducing role overload, providing staff with regular educational training on complex

issues (such as psychiatric illnesses and the impact of trauma on patient and family behaviors), and by addressing other factors related to burnout, compassion fatigue, and moral distress.

It is clear that if we are going to successfully navigate the upcoming surging demographic tide of aging patients while delivering high-quality care, healthcare workers need more support, better working conditions, and better training. True patient-centered care cannot be implemented without taking the full organizational picture into account. We cannot expect nurses to provide high-quality care without supplying them with the tools necessary to do their work in a way that is sustainable for both individual helping professionals and institutions as a whole.

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