

**Between a Rock and a Hard Place: When Healthcare Providers Experience
Moral Distress**

Report on the World Café Exercise

Carmen Webber

Provincial Health Ethics Network

April 2009

Summary

The College and Association of Registered Nurses of Alberta (CARNA) and the Provincial Health Ethics Network (PHEN) hosted two joint conferences in 2008 to create a dialogue around moral distress experienced by healthcare providers. This report presents the findings from the World Café exercise conducted at the Edmonton conference in September of 2008.

Causes of Moral Distress

Two broad categories of situations and/or factors cause healthcare professionals who participated in this exercise to experience considerable moral distress: resource allocation and difficulties in professional and inter-professional relationships. Chronic short-staffing, lack of available beds, and challenges associated with mentorship and training cause particular distress in the workplace. Short-staffing often leads to greater workloads for nurses, placing additional stressors on them, such as mandatory overtime and difficulty getting approval for time off for personal matters or vacation. Staff is at risk of burning out and patient safety might be compromised in a chronically short-staffed environment.

Participants said that support and resources dedicated to mentorship are lacking. Taking on students, while at the same time maintaining a regular workload, is difficult and many nurses experience fatigue. Nurses recognize that mentorship is essential in socializing new staff and providing them with the necessary hands-on preparation for clinical work. They would like more formalized mentorship programs to give students the skills to better assume responsibilities on the job when they become RNs. “Nursing cannibalism” was a commonly used metaphor that describes how experienced nurses sometimes treat new nurses. Instead of nurturing and mentoring those new to the profession, experienced nurses can at times make it difficult for them.

Both intra- and interdisciplinary bullying occur in the workplace. Lack of respect and validation for nurses’ work perhaps intensifies the territorial behaviour already experienced in the workplace, and contributes to nurses feeling powerless. Many nurses believe that they are also not supported or heard by management. Repeated requests for assistance are sometimes never addressed, reinforcing the position that nurses have no collective voice. Poor communication at all levels is a precipitating factor in many of the difficulties experienced in professional and inter-professional relationships.

Recommended Changes to Address Moral Distress

Participants offered a number of suggestions for creating more supportive work environments, key among them are time and process for debriefing and relationship-building, good communication and strong leadership. Nurses want positive, productive work environments and they want to be engaged in decision-making in some capacity.

Debriefing is essential in a quality work environment. Nurses need time and defined debriefing processes to develop relationships with their colleagues and to care for themselves. Both formal and informal opportunities to resolve moral distress must be more easily accessible to staff. Time restraints in their work usually restrict nurses from accessing this support and, with time, further promote feelings of disengagement from nursing and their peers.

Strong leadership is needed to facilitate open, transparent communication, and respect between the health professions and management. Of particular concern is the culture of non-reporting. Nurses face a dilemma when they observe inadequacies in colleagues’ practice. They believe that no one is listening or taking action at the managerial level but at the same time they worry about the consequences of reporting a peer for poor care. Participants would like management to eliminate the intimidation of reporting, which would

allow them to express concerns with no consequences or judgement, thereby helping to ensure quality care and maintenance of high professional standards.

Between a Rock and a Hard Place: When Healthcare Providers Experience Moral Distress

Introduction and Methods

The College and Association of Registered Nurses of Alberta (CARNA) and the Provincial Health Ethics Network (PHEN)¹ hosted a joint conference in Calgary in May 2008, the theme of which was *Between a Rock and a Hard Place: When Healthcare Providers Experience Moral Distress*. A second conference was held in Edmonton in September 2008 due to demand. CARNA and PHEN introduced a World Café exercise to the agenda of the Edmonton conference as a means to create dialogue around moral distress among participants. Moral distress was defined as knowing what the right thing to do is, but not being able to do it because of institutional, systemic or other barriers.

The purpose of the World Café was to generate feedback from members which could be disseminated to appropriate stakeholders to highlight the challenges faced by healthcare professionals in their practice settings and to propose potential strategies to address them. This report is based on qualitative analysis of the feedback from the discussions surrounding the conference theme.

Through a series of rotating small group discussions, participants engaged in conversations about three open-ended questions on the topic of moral distress. One facilitator was present at each round table discussion and used the following guiding questions to engage participants in the exercise:

- Identify situations in your own practice or work in which you experienced moral distress and how you addressed them?
- What three factors contribute most to moral distress in your workplace?
- What are some changes that could be made to your workplace that might help address moral distress?

Facilitators selected recorders who wrote the groups' comments on paper as the discussion proceeded. A staff person with CARNA reviewed the feedback from the approximately 50 groups (350 participants) and identified 26 broad themes that appeared to fit the data related to the kinds of situations that cause moral distress in participants' workplaces, and how they address them.

A PHEN staff member further refined the initial 26 themes by qualitatively coding the comments. She grouped the recorded comments under themes using constant comparison as she did so and 29 themes finally emerged. The method of constant comparison involves checking new data against existing themes and revising as necessary to ensure that data are connected to concepts represented by the themes.² Because questions 1 and 2 elicited very similar responses from the participants, they were analysed together. Themes related to the situations and/or factors that cause moral distress, and the recommended changes to help address this issue, were separated into four very broad organizing categories, including: *resource allocation, professional and inter-professional relationships, patient and family care, and policy and practice*.

¹ *Opinions expressed in the World Café Report are those of the conference participants and do not represent the position of CARNA or PHEN.

² For more explanation of constant comparison, see Bryman (2004). *Social research methods*. New York: Oxford University Press. (p. 403)

All themes include a brief narrative about the comments that emerged, including examples to highlight common findings. Example quotes included in the report are exactly as written in the notes from the World Café exercise.

While the majority of conference participants were nurses, it should be noted that a number of other health care providers – from physicians, occupational therapists, physiotherapists, social workers, pharmacists and others were also present and provided their input.

Findings

What situations and/or factors contribute most to moral distress in your workplace?

Resource Allocation

Among the most commonly cited situations that cause moral distress among health care providers is the perceived lack of appropriate human and material resources. High patient acuity, compounded with fewer resources, leads to unmanageable workloads, little to no lag time on shifts, and being unable to provide the quality of care that care providers would like. More experienced care providers reported that they are unable to maintain standards of care that they were previously able to meet earlier in their careers. The notes broke down into four themes that reflect these factors, which are listed below.

- Short staffing
- Challenges to mentorship and training
- Appropriate or best treatment and equipment not available
- Inequitable access to resources

Short staffing

Short staffing due to difficulties in recruitment and retainment, time constraints, workload, and staffing logistics were high on the list of concerns expressed by participants. They are particularly challenged by short staffing, which contribute to greater workloads, causing them to miss breaks, be unable to get days off for personal matters, and having to work mandatory overtime. Many participants expressed concern for patient safety and staff burnout resulting from chronic short staffing. They described how staffing challenges not only creates a disconnect between the ideal and actual provision of care, but actually leads to their inability to provide quality care. Examples of their comments are:

“High demands – patient load increased; no breaks.”

“Being aware of staff working up to 20 days in a row.”

“Seeing poor nursing care due to lack of resources & workload.”

Challenges to appropriate mentorship and training

Participants described a range of challenges related to mentorship and training. Senior staff finds it difficult to mentor new staff, both new graduates and those who are trained overseas, because they feel that they are not supported to do so. Preceptors’ workloads are not reduced making, it difficult to take on

mentorship duties and keep up with their work, which leads to fatigue. Some participants said that mentors and instructors are in a difficult position given the staffing situation, and they claimed that instructors are forced to pass unfit students and practitioners to try and get more professionals out working.

Participants noted that many new nurses are ill-prepared for some aspects of practice because they lack appropriate hands-on training. Casual employees also encounter difficulties in their practice because they may not be familiar with the systems, procedures or clients; participants thought these problems were due to a lack of resources for training.

Still another dimension to this theme is the rigidity of practice regime on nursing units. New nurses may try to practice according to policy and procedures but it is not always supported because the senior staff “doesn’t do it that way.” Student nurses come with new ideas but they are socialized by the staff. If senior staff does not nurture a culture of acceptance of new ideas and new ways of practicing, opportunities for mentorship and learning are lost. In this way the culture of the unit may lend itself to moral distress. Some illustrative comments are:

“These new recruits are expected to perform beyond what they’re capable & they require appropriate preceptorship. Supports are not there for them.”

“Putting young people into situation and have no mentoring.”

“Lack of incentives for staff, e.g. professional development.”

Appropriate or best treatment and equipment not available

Bed availability, patients in inappropriate settings or level of care, patients being discharged before they are ready or have the necessary supports in place, and general lack of resources fall within this theme. Participants cited many examples of situations that cause them distress related to not being able to provide the best treatment, whether it was because patients were in an inappropriate care setting, or because there were simply not enough beds. Examples include:

“Bed shortages / allocation imbalances.”

“Patients having no help at home when they are discharged.”

“Not equipped with the necessary tools to work (technology, financial).”

“People living at risk; would like the individual to move but has no capacity in the system to assist them.”

Inequitable access to resources

Participants recognized that inequities in the distribution of resources occur in the system, which forces them to find creative solutions to ensure that patients get appropriate care. One example of perceived inequity in access to resources is the situations in which families and individuals may not meet eligibility criteria for services from publicly-funded organizations, many of which have greater sophistication and ability to raise funds and solicit donations than non-profit organizations. Participants noted that there are large groups of people whom are not served by publicly-funded organizations and the responsibility lies

with non-profit organizations to try and serve these individuals with little, if any, public funding. Some comments about inequity are:

“Lack of resources especially when advocating for equal access to health care for older patients (justice).”

“Staff’s moral distress seems (to be due to) inequitable funding to access for the First Nations population.”

“Inequitable resources for (discharge) depending on insurance, WCB-Solution.”

Professional and Interprofessional Relationships

Challenges in relationships between nurses, physicians and managers rank highly among distressing situations faced by participants in their workplaces. As a result of these sometimes strained relationships care providers feel disenfranchised and that they are not valued or respected for their knowledge and skills. Physician – nurse relationships are especially difficult, particularly in the differing approach to, and assessment of patient care. There was a strong feeling among participants that nursing does not have a voice. The notes broke down into six themes that reflect these frustrations:

- No time or appropriate structures in place for debriefing, problem solving, relationship-building
- Challenging team dynamics, poor communication
- Bullying, territorial behaviour in the workplace
- Perception that managers and administrators are not addressing the problems presented to them
- Nurses feel disengaged, detached from work, and powerless
- Little recognition of the difficulties facing managers

No time or appropriate structures in place for debriefing, problem solving, relationship-building

With such compressed work schedules in fast-paced environments, participants said that there is no time to debrief and reflect on their work, making it difficult to connect with colleagues. As one participant said, “Health care is about relationships, but we’re not allowed to build them.” Where structures are in place for support it often takes too long to access and participants noted the need for easy access to critical incident debriefing to help the whole team soon after a difficult situation. Problems are discussed in the break room but are rarely acted upon because staff are always dealing with the urgent – not necessarily the important – so they cannot move on to solving problems. As a result, problems reoccur immediately. The following are additional related comments:

“No time for problem solving.”

“Lack of time to deal with the moral distress. Walls build up, people become numb, outlets become unhealthy.”

“Insufficient debriefing access.”

Challenging team dynamics, poor communication

Poor communication or lack of communication between shifts and between health care professionals causes distress in the workplace. Lack of continuity and poor communication as a result of changing teams was mentioned as a frustration. Participants, many of them nurses, said that physicians tend to control decisions resulting in the inability of groups of health professionals to function as a team. Other challenges to team dynamics and communication include personality differences, different belief systems, resistance to new ideas, and different values and ideals. Examples of comments related to team dynamics and communication are:

“Criticism between silos – lack of communication / intolerance of appreciating individual program issues.”

“Very little attention given to helping & supporting team development from a interdisciplinary perspective.”

“Trying to work collaboratively with other professionals.”

“Not feeling support from other medical professionals. Supposed to be working as a team.”

Bullying, territorial behaviour in the workplace

Both intra- and interdisciplinary bullying occur in the workplace. Participants said some incidents of bullying occur as a result of “turf wars,” “territorialism,” or “power struggles” between disciplines. The most commonly cited form of bullying is what participants called “nursing cannibalism,” whereby nurses “eat their young” instead of nurture and mentor those new to the profession. Participants recognized the situation was due to lack of support and emphasis on mentorship and relationship-building.

Perceived lack of respect for nurses from medical professionals and the public causes particular distress. Lack of respect from medical professionals is attributed to territoriality to some degree. In some cases, physicians do not see others’ expertise as a resource but rather a threat. For example, participants shared that in some workplaces physicians take offense if calls are made to the Ethics Committee for consultation. Standards to guide ethical decision-making, as well as support for and recognition of ethics committees, were suggested as an area for improvement.

Examples of bullying comments are:

“Staff bullying – professional level bullying.”

“Value of the ‘nurse’ (clinical) not seen by other professionals / team members – disregard & importance of the nurse not being valued.”

“Staff Conflicts – HCA’s vs. students – pecking order. Territorial behavior.”

Perception that managers and administrators are not addressing the problems presented to them

There are several reasons that participants think that managers and administrators are not effectively addressing the problems of which they are made aware. A common perception is that managers follow upper management needs and are thus not adequate leaders for front-line staff. Non-medical personnel in management positions, who may not understand the skills required for and challenges of nursing, is seen

as problematic; participants think that without this knowledge managers cannot understand what an appropriate workload is, for example.

Lack of support, intimidation from authority figures, the perception that nurses are not being heard by management, and unclear channels through which to voice concerns were commonly cited reasons that contribute to the perception that managers and administrators are not listening to staff. Participants revealed that corporate bullying exists in health care, which contributes to a fear of reporting, thus reinforcing the perception that management is not amenable to suggestions or feedback from front line staff. Some examples of comments are:

“Unable to vent concerns due to attitudes. Very paternalistic. No opportunity to speak.”

“Overpowering from management – ‘My way or the highway.’”

“Not being heard by management.”

Nurses feel disengaged, detached from work, and powerless

As a result of feeling disrespected as professionals and not being heard by management, among other issues, many nurse participants reported a sense of powerlessness, with the feeling of disengagement from the profession a common consequence. Apathy was commonly used to describe how some participants' nurse colleagues felt about their work. Participants in one group stated that the feeling of powerlessness among nurses is promoted to some extent by their own mentality, telling themselves that “I’m just the nurse.” The organizational hierarchy to which many participants referred causes them to feel caught in the middle and unable to affect change. Examples that illustrate nurses' feelings of powerless and disengagement are:

“Sense of hopelessness derived from feeling like they (the nurses) are not being heard. Unable to affect because of the hierarchy.”

“Apathy / hopelessness create a suffocating negative environment.”

“Can’t leave work feeling like you’re finished & did a good job! Nobody cares about quality not being there anymore. New nurses seem to be able to readily detach themselves from this (not all of course).”

Little recognition of the difficulties facing managers

Some participants recognized the challenges managers are faced with in their roles. Managers feel the pressure of having to answer to upper management and being accountable to the staff they lead. Some participants felt that there was little to no mentorship for managers, and they are in fact leaving their jobs because they have no support from upper management.

Managers also experience moral distress over trying to support nurses within constraints; they want to do more to support nurses but feel they cannot because of budget limitations, described by one group as the “Rob Peter to pay Paul” syndrome. Some other morally distressing situations facing managers are:

“Distress of having to give pink slips – treating people as objects.”

“How do I mediate peace between staff and students?”

“Middle manager caught between upper managers & front-line workers.”

Patient and Family Care

Challenges related to providing care and support to patients and their families cause moral distress among health professionals. This broad category includes some themes that reflect mild frustrations in the workplace, whereas other themes reflect situations that participants found to be deeply distressing. For example, patient non-compliance is frustrating to staff because they are aware that beds will not be available to “others that may need them more urgently”. Rather more distressing are very complex cases, and cases in which care was directed by the threat of legal action. The notes broke down into six themes that reflect distressing situations that arise when providing care:

- Educating and supporting families
- Care directed by threat of legal action
- Distress caused by difficult or complex cases
- Differences in interprofessional care
- False sense of autonomy for patients, especially among the elderly
- Documentation, charting methods take away from patient care

Educating and supporting patients and families

Unrealistic expectations from family members, and the “everyday” with patients and their families, which involves providing them with resources and advocating on their behalf, can be distressing to health care providers because of the increased time spent with families in an already resource-challenged environment. Extra time spent with families exposes staff to family distress, adding to their emotional burden.

Participants also noted that respecting differences in patients’ cultures and traditions can cause them moral distress when providing support to them and their families. For example, how women are regarded in other cultures can impose personally challenging situations on female nurses, if their own values do not align with those of the patient’s. Examples of comments are:

“Distress with families – long term & expect things / tasks to be done a certain way; depending on the shift.”

“How to approach the families when “enough is enough” (there is nothing left to do) for the patient.”

Care directed by threat of legal action

In some cases participants experienced moral distress when the care they provided to patients was directed by the threat of legal action. Some participants suggested that physicians’ approach to care is more influenced by the fear of legalities than other health professionals. New, inexperienced nurses may also be influenced by the threat of legal repercussions to a greater degree than more experienced nurses because they are scared. Participants said that health professionals might even provide treatments even if they do not agree with them to decrease the chance of legal consequences. In many cases health professionals could anticipate the outcome of a given course of treatment. However, families sometimes want treatment and “heroic” measures “at all cost” and will go to court to keep aggressive care in place. Examples of comments that reflect these concerns are:

“ICU patient, end stage care; family going to court to keep aggressive care.”

“Care was directed by legal threats & implications of some family members. Risk of unit / staff being viewed / portrayed as prejudice.”

“Physical / verbal threats from family members towards staff ‘to keep Mom alive or else.’”

Distress caused by difficult or complex cases

Difficult and/or complex cases, including situations in which inappropriate or unnecessary procedures were administered, cause a high degree of moral distress among nurses. They offered many examples of cases involving unnecessary suffering of patients, disagreement between family members themselves, and between family and health professionals. Some examples are:

“Pain management – seeing patient die in pain with limited pain medication. Fear of addiction, hesitant of pain medication.”

“Dilemma of testing 98 yr old for sample test. Although diagnosis already made, it was for practice for medical students.”

Differences in interprofessional care

Team dynamics affect clinical decision-making and participants provided many specific examples where the approach to care was different among team members. The resulting moral distress that participants experienced, and in some cases the resulting injury to patients due to different approaches to care, was significant. Some participants said that in cases where they disagreed with physician orders they received no support from management, or felt uncomfortable voicing their concerns during conferences. Examples of comments include:

“Dr. ’s wanting to ‘save life’ when quality of life isn’t there.”

“Dr. was unwilling to explore other treatment options. Nurses felt as though they did not have a voice; charge nurse felt uncomfortable voicing concern to Dr. and team members during conferences.”

“Physician sees one medical problem in pt, does not see whole picture, physician does assessments / treatments for specific problem and not whole patient. Physicians ‘medical practice’ and fear of lawsuits rather than ‘total patient care.’”

False sense of autonomy for patients

Moral distress caused by discrepant physician opinions, and family and patient wishes, can be very upsetting. In some cases, participants felt that patients’ wishes were not carried out due to pressure from family members or because a physician’s opinion was given more weight than the patient’s stated wishes. Some participants were particularly concerned about protecting the wishes of elderly patients, for example:

“Elderly resident, diabetic on 5 insulin injections per day (plus glucose testing) decided to accept just 2 injections per day. Staff required to work around patient choice. Physicians initially reluctant to change orders until informed by nurse those only 2 injections given.”

“Personal written directive ignored by Physicians and engaging family to go against patient wishes.”

Documentation, charting methods take away from patient care

Some participants said that the amount and kind of documentation required in their work is overwhelming. Specifically, computers used for charting and recording assessments can make nurses' practice difficult as they can be cumbersome. Participants pointed out that some of these technologies, specifically charting and assessment software, might interfere with independent decision-making and guide their practice to some extent. Comments related to this theme are:

“In past, the Dr. used to write an order and the requisitions would print out. Now technology is more directive & guiding practice. Have to do the computer work and the paperwork now.”

“Homecare perspective – computers!... Too much time involved – required follow up, with outcomes to manage assessment. Too many man-hours on a computer taking time away from patient care / time.”

Policy & Practice

Participants noted several situations in which conflicts between policies and practice, and areas requiring clearer policies, can create challenges in the workplace. A paucity of organizational policies that would help protect health professionals from burnout, and help build relationships, also causes moral distress. On a broader scale, the economic situation in Alberta, changing political agendas and the moving target of health care can cause moral distress in the workplace. The notes broke down into three themes that reflect participants' frustration with organizational and broader government policies:

- Perception that policies are at centre, not patients
- Lack of performance evaluation policies
- Provincial vision of healthcare

Perception that policies are at centre, not patients

Participants perceived that organizational policies, not patients, are ultimately at the centre in the current health care climate. With a health care culture that follows a business model there is a feeling of a lack of humanity, or “policies before people.” Participants said that they feel tied by the policies of the greater system and are distressed by political wrangling where care has not been given as it should have been. Many said that there are too many rules and policies, the “extreme nature of bureaucracy,” that prevent them from getting decisions and seeing change. Examples of comments that illustrate this theme are:

“Bureaucracy- Protecting reputations.”

“Accreditation / care plan / image more important than the ‘care’ given.”

“No negotiation or flexibility in interpreting policies.”

Lack of performance evaluation policies

Staff under performance, unsafe practice and mistakes affecting quality of patient care is distressing to health professionals. Participants reported feeling a great deal of moral distress caused by observing unsafe practices, “incompetence” of other health professionals, and the number of nurses that have repeated medication mistakes. There are reportedly few, if any, structures in place for performance evaluation and the sentiment among participants is that “no one is listening or taking action at (the) managerial level.” As well, there is a culture of non-reporting in some organizations because political corrections have created a code of silence.

“Lack of confidence in other health care team members.”

“Observing poor care – what do you do (e.g.: med errors).”

“Dilemmas when a person reports inadequacies and others don’t perform to your level of care.”

Provincial vision of healthcare

The recent amalgamation of the former health regions into Alberta Health Services has caused a great deal of uncertainty among health professionals. They also believe that the business agenda of private healthcare has some momentum. Furthermore, it is an agenda that “has a different moral compass than public services”. Moral distress is caused by the tension between the political agenda of privatization and the public calling to serve. Examples of comments include:

“No clear articulated vision.”

“Business people on new board – including insurance. How will that help those trying to keep it public – money driven?”

“Appointed health authority – political.”

What changes could be made to your workplace that might help to address moral distress?

Resource Allocation

For those participants who experienced moral distress because of a lack of human and material resources, increased resources (e.g. staff, mentors, beds, and budgets) is an evident solution to alleviate moral distress in the workplace. Many of the suggested changes related to training and skill development involve investing in mentorship to improve the clinical skills, confidence and retention of staff. Another theme that came through strongly in the notes is that participants want workload, staffing, time off and vacation issues to be acknowledged. Other than increasing staff, beds, and budgets, three unique themes emerged from the notes:

- Opportunities for career development, training and mentorship
- Flexibility in workload, time off and vacation
- Utilize all members on multidisciplinary teams

Opportunities for mentorship, training and career development

In general, participants thought that there is not enough support for new staff. They very clearly value mentorship because they believe a learning culture is an essential component of a quality workplace. Many participants believe that students are not adequately prepared for clinical work upon graduation and formal mentorship programs might help support that transition while filling in the gaps in knowledge/experience.

Experienced nurses would also like opportunities for career development and continuing education. As one participant noted “change is as good as a rest.” If nurses are given the opportunity to move to other aspects of career development this could energize them, adding to their longevity in nursing. Granting sabbatical time to take courses and creating opportunities for nurses to participate in research on units are two ideas for supporting nurses to develop their skills. Some comments related to this theme are:

“Hire a ‘mentor’ for every patient care unit. Pilot at (hospital) – all 4 medical units based in this hospital-call it the ‘(former health region) Regional Nursing Affairs pilot.’”

“Improve the amount of clinical time that student nurses receive so they are better prepared to deal with patient care with workloads when they graduate.”

“Provide education to increase skills / competence.”

Flexibility in workload, time off and vacation

Participants want their workloads to be addressed such that they might have a more acceptable balance of work and time off. There is significant stress imposed on nurses and their families over the issue of mandatory overtime. They wonder if they should quit because they need to take care of their families, or whether they should stay at work because they need the extra income. Some staff spoke of having worked for many years and still being ineligible for time off and vacation. Examples of ideas around time off and vacation arrangements include:

“Reward staff for low or no absenteeism (e.g. no sick time used in 6 months or year, some sort of reward like time off, vacation).”

“Making sure vacation time is granted and someone be able to take it. Giving blocks of vacation & not granting some in the middle.”

Another suggestion to improve the quality of nurses’ work life is to provide childcare in the hospitals, which has the added possible benefit of attracting new staff to the profession. Staff members who perform shift work have an especially difficult time finding childcare. Family/work balance is very important to nurses, and working arrangements with some measure of flexibility would be looked on favourably if they allowed nurses to spend more time with their families. Examples of such arrangements include:

“Flexibility in hours: permanent shifts / weekend etc., self-scheduling, job sharing.”

“Coordinate shifts of spouses whenever possible to increase family time.”

Utilize all members on multidisciplinary teams

A few participants observed that some multidisciplinary team members, social workers for example, are the “catch all (people).” They suggested that all team members need to be used to their full capacity to alleviate the burden on any one given team member. Examples of comments are:

“Use all members on multidisciplinary teams to their full capacity, i.e. chaplain, ethics, social work, psych help.”

“Engaging chaplains to deal with issues that need buffer.”

Professional and Interprofessional Relationships

Improved communication at all levels ranked highly among participants’ suggestions for changes to their workplaces. Participants said that just naming the issue would be an important first step in addressing moral distress. De-stigmatizing moral distress involves bringing awareness to the problem and taking steps to encourage dialogue. Strong leadership is essential in facilitating improved communication and relationships. In particular, participants said that leadership must take a strong position on bullying in the workplace and that policies are necessary to address this problem. Five themes related to addressing the challenges of professional and interprofessional relationships emerged from the notes:

- “Good” communication-Open, transparent dialogue
- Designated time and process for debriefing and problem-solving
- Strong leadership
- Care for the caregiver
- Improved access to and endorsement of clinical ethics committees

Good communication & open, transparent dialogue

Open communication between disciplines within the hospital hierarchy is perceived as a necessary condition for improving relationships. Participants emphasized transparent communication with staff at all levels, but especially between management and front line staff to promote connection with, and

understanding of front line challenges. They also suggested that conflict resolution and communication skill development for staff would help to promote open dialogue.

Good communication requires sharing of information. Being able to report without fear of reprimand, consequence or judgment is central to transparent communication. Participants want the “intimidation (resulting from) reporting a peer for poor care, or (a medical) error, or unsafe practice” to be eliminated. There is a code of silence among caregivers, which is damaging to relationships, but it can put patients at risk if unsafe practices are not reported. Participants emphasized that when they have bad days they must still maintain a very high standard, professionally. Reporting needs to be upheld as part of the high professional standards and staff need to be respected when they do report abuses. Examples of comments related to promoting quality communication include:

“Protecting the whistle blower.”

“Communication with all team members – more time, give as much information as possible to all levels of employees.”

“Interpersonal relationships & communication strategies.”

Designated time and process for debriefing and problem-solving

It is important that nurses have the time to reflect, connect with each other and develop relationships. Participants said that they have no time to talk to their peers at work because they are always too busy or short staffed. They expressed a strong need for appropriate time and process dedicated to debriefing. Participants recommended easier access to debriefing, especially at the end of a shift. Having a designated person to go to for immediate concerns would also make it easier for nurses to participate in debriefing. They also suggested that management implement both formal and informal debriefing, with a mix of both being the most effective way to address staff needs. Informal opportunities to debrief could be made part of the work day. Participants did not offer specific suggestions as to how debriefing could be incorporated into the workday but they did suggest that informal sessions could be structured using a team-building approach whereby the atmosphere is relaxed, casual, and food is provided. More formal debriefing could be mandatory, offered regularly, and in a structured format. These sessions should be offered in a confidential, professional setting. Some participants’ comments related to this theme are:

“There has to be time in the work day for debriefing / discussions of distressing situations & circumstances.”

“Easier access to debriefing, i.e. not having to come in on a day off.”

“No time to actually talk to other peers at work. Always too busy or too short staffed. No time to ‘debrief’ at end of shift.”

Strong leadership

Nurses would like managers and administrators to show strong leadership and support, especially in promoting respect and anti-bullying in the workplace. As with moral distress, nurses see naming the issue as an important first step in addressing bullying in the workplace. At the minimum, managers need to help facilitate relationship-building to strengthen interdisciplinary bonds. The next level of action might involve more a more formal approach to deal with this issue by developing anti-bullying policies. It is not known whether participants were unaware of such organizational policies, or whether they thought that

the existing policies were inadequate. Yet another step in taking action is to enact specific legislation against bullying. Again, it is not known whether participants thought that legislation in the area of harassment and bullying is nonexistent or whether legislation is, in their opinion, inadequate for their particular concerns in healthcare organizations.

Participants indicated that they would like their managers to be more accessible. According to participants, good managers are those who are visible to the staff on unit, not just “going to meetings.” Participants also suggested that by being visible they can be more effective at encouraging and modeling respectful communication. One of the most prominent themes that emerged from this World Café exercise is that nurses feel like they do not have a voice and are left out of decision-making. When they request assistance from management their concerns are not necessarily met with action, but rather with “canned answers” in an attempt to placate them. Nurses feel strongly that their voices are not heard, they are not being offered the support they need, and in some cases, are victims of “corporate bullying” by management. Examples of suggestions related to creating strong leadership and taking action against bullying include:

“Create leaders who understand how to lead & inspire to model open, respectful conversation, ‘no blaming’. Finding common ground ‘win, win’.”

“Workplaces need to adopt “no harassment / no abuse” policies; not only for pt., and to staff, but from staff to staff.”

“Legislative (exact legislation) against / actions; against bullying / harassment.”

Care for the caregiver

The theme ‘care for the caregiver’ is related to strong management but came out distinctly in the comments. Participants desire a work culture that attends to the needs of staff, promotes care for each other, and goes beyond the exchange of service for remuneration and benefits. Camaraderie is very important among nurses, and simple gestures, such as offering praise and demonstrating appreciation for each other, are often not initiated if they are not socialized or supported. Nurses recognize a need for focussing on relationships with peers and doing work to bridge the gap between professions, thereby nurturing respect. Team-building exercises and getting together outside of work for socializing and recreation, where there is no discussion of work, are suggested relationship-fostering activities. Some examples of participants’ comments are:

“Staff needs to care for each other.”

“Nurses be sure to kinder and more patient with each other.”

“Supportive environment – recognize who does things well, support the ones who struggle or need more help with procedures, knowledge, abilities.”

Improved access to and endorsement of clinical ethics committees

A number of participants said they would appreciate easier access to clinical ethics committees. It is reportedly difficult to access ethics support, with too many levels of management between nurses and the ethics committees. Some health care professionals are not aware if their organization has an ethics committee, or how to access it if there is a one. Nurses would like this resource to be endorsed more

formally, as colleagues of theirs do not always value the support and expertise an ethics committee offers. Examples of comments related to ethics committees and access are:

“No knowledge of “if” we have an ethics committee and if there is, how do I access it?”

“Allowing anyone to access Ethics Committee.”

“Strong formal Ethics Committee process.”

Patient and Family Care

There were a few broad suggestions as to how challenges associated with patient and family care could be resolved. Participants said that more discussions with patients and their families, especially regarding end-of-life care, are important. Similarly, they would like to see more open discussions and transparency, such that patients and their families can make fully informed decisions.

One specific solution to a perceived problem is changing the time of rounds and working with physicians so that they appreciate that coming onto the units at a shift change is especially difficult. With regards to using computers for documentation, nurses suggested that data entry staff be employed to take the responsibility off of nurses, freeing up more time for direct patient care.

Policy & Practice

At the level of the organization, nurses suggested policies and practices that would allow them to have a greater impact on decision-making. Participants also looked more broadly at civic responsibility for health, suggesting that the public needs to be informed and vote on the issues. They also suggested that people need to take action at the individual level and must be encouraged to become “responsible for their own health.” Two themes related to policy and practice were identified:

- Policies and practices that would allow RNs to have more impact on decision-making
- Broad initiatives that encourage society to take responsibility for health

Policies and practices that would allow RNs to have more impact on decision-making

Participants thought it was very important to shift policies and practice to involve staff in decision-making. They suggested a few ways that they could provide input to affect systemic change. Several participants said that they would like to be asked for feedback by means of a needs assessment survey or a “two cent” box to allow for creativity. Others said that performance evaluations would help show their strengths and weaknesses. Exit interviews are still another way for staff to have influence over change. Some comments related to this theme are:

“Obtain staff input & accept input to make changes.”

“Evaluation of processes / changes by asking front-line staff.”

Broader initiatives that encourage society to take responsibility for health

There was some discussion around public education initiatives to encourage people to take personal responsibility for their health. Considering the already strained health system, participants thought that society should take some responsibility in caring for their family members; it is not just health care providers that should provide care. Furthermore, these system limitations need to be clearly articulated to the public to help establish reasonable societal expectations of the system and health professionals.

Participants also saw the benefit of public information initiatives to educate people about having personal directives before illness or early on in the course of diagnoses and illness. Examples of their comments include:

“Family and client participation in care of patients. It’s not just the health care providers that should take care. Address changes in public expectations & acuity of patients.”

“Less rigidity in ideas – maybe an incentive to give families \$5,000 if they can find a way to help loved one at home and not at hospital.”

Conclusion

Moral distress occurs as a result of the tension between knowing what the right thing to do is but not being able to do it because of institutional, systemic or other barriers. Often the barriers make it difficult or impossible for health care providers to provide the level care that they would like. They also encounter barriers that prevent them from working in quality work environments that are supportive of relationship-building, promote respect and encourage open communication and good relationships. In particular, nurses feel strongly that they are not heard, due in some part to a lack of respect for their knowledge and skills. They want their collective voice to be valued and to be invited to engage in genuine dialogue working toward the goal of creating quality practice environments.