A Systems Approach to Moral Distress in Long Term Care

Margaret Lemley
Duquesne University

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A SYSTEMS APPROACH TO MORAL DISTRESS IN LONG-TERM CARE

A Dissertation
Submitted to the McAnulty Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Healthcare Ethics

By
Margaret R. Lemley

December 2017
A SYSTEMS APPROACH TO MORAL DISTRESS IN LONG TERM CARE

By

Margaret R. Lemley

Approved October 12, 2017

Gerard Magill, PhD
The Vernon F. Gallagher Chair
Professor of Healthcare Ethics
(Dissertation Director)

Henk ten Have, MD, PhD
Director, Center for Health Care Ethics
Professor of Healthcare Ethics
(Committee Member)

Joris Gielen, Ph.D.
Assistant Professor
Center for Health care Ethics
(Committee Member)

Henk ten Have, MD, PhD
Director, Center for Health Care Ethics
Professor of Healthcare Ethics

James Swindal, PhD
Dean, McAnulty College and
Graduate School of Liberal Arts
ABSTRACT

A SYSTEMS APPROACH TO MORAL DISTRESS IN LONG TERM CARE

By
Margaret R. Lemley
December 2017

Dissertation Supervised by Gerard Magill, Ph.D.

This work attempts to answer the following question: can a systems approach serve as a positive way to address issues of moral distress within the long-term care setting? Building upon the existing literature, this dissertation argues that previous efforts to understand moral distress within the healthcare setting have been limiting in two important ways: First, much of the research related to moral distress in healthcare has focused almost exclusively on these issues within an acute care setting. Second, the efforts to identify and reduce incidents of moral distress have focused largely on the individual and his or her response to specific triggers. This dissertation shifts the perspective away from a strict focus on the acute care setting and explores moral distress within the long-term care setting. In addition, the argument here is expanded from looking solely at individual responses to specific triggers to a systems approach of identifying and reducing incidents of moral distress organizationally within the long-term care setting.
Three specific area of focus are explored and systems thinking applied to each: the culture of the organization, the organizational leadership, and methods of communication employed within the organization.
DEDICATION

This dissertation is dedicated to all of the remarkable, selfless staff, residents, family members, and volunteers alongside whom I have had the honor of working for more than twenty-five years. Your daily efforts to improve the quality of life for our vulnerable seniors have had a very positive influence on my life, and my hope is that the information offered in this dissertation can serve as a positive influence on yours as you continue to work.
ACKNOWLEDGEMENTS

I would like to acknowledge the support provided to me by my friends, family, and colleagues, as well as the residents, who have provided encouragement throughout this process.

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My heartfelt thanks to all of you.
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iv</td>
</tr>
<tr>
<td>DEDICATION</td>
<td>vi</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter 1: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>A. Organizational Culture and Moral Distress</td>
<td>5</td>
</tr>
<tr>
<td>1. Organizational Ethics</td>
<td>5</td>
</tr>
<tr>
<td>2. Integrated Ethics and Systems Thinking</td>
<td>7</td>
</tr>
<tr>
<td>3. Organizational Culture in Long Term Care</td>
<td>8</td>
</tr>
<tr>
<td>B. History and Causes of Moral Distress</td>
<td>10</td>
</tr>
<tr>
<td>1. The History of Moral Distress</td>
<td>10</td>
</tr>
<tr>
<td>2. Causes of Moral Distress within Long-term Care</td>
<td>13</td>
</tr>
<tr>
<td>3. The Crescendo Effect of Moral Distress</td>
<td>14</td>
</tr>
<tr>
<td>C. Leadership Styles for Addressing Moral Distress</td>
<td>17</td>
</tr>
<tr>
<td>1. Transformational Leadership</td>
<td>17</td>
</tr>
<tr>
<td>2. Servant Leadership</td>
<td>19</td>
</tr>
<tr>
<td>3. Appreciative Leadership</td>
<td>22</td>
</tr>
<tr>
<td>D. Effective Organizational Communication Methods</td>
<td>24</td>
</tr>
<tr>
<td>1. Appreciative Inquiry and Moral Distress: A Communication Change Agent</td>
<td>24</td>
</tr>
<tr>
<td>2. Appreciative Inquiry in Healthcare</td>
<td>27</td>
</tr>
<tr>
<td>3. Appreciative Inquiry and Conversational Capacity</td>
<td>28</td>
</tr>
<tr>
<td>E. Addressing Moral Distress with Empowerment</td>
<td>29</td>
</tr>
<tr>
<td>1. Organizational Leadership and Moral Discourse</td>
<td>30</td>
</tr>
<tr>
<td>2. Organizational Leadership and Moral Courage</td>
<td>31</td>
</tr>
<tr>
<td>3. Organizational Empowerment of Caregivers</td>
<td>32</td>
</tr>
<tr>
<td>F. End of Life Care and Moral Distress</td>
<td>34</td>
</tr>
<tr>
<td>1. The Role of Culture and Compassion at the End of Life</td>
<td>34</td>
</tr>
<tr>
<td>2. Leadership and Cultural Sensitivity</td>
<td>36</td>
</tr>
</tbody>
</table>
3. Communication and the Empowerment of Caregivers to Address Moral Distress ............................................................................................................. 37


G. Summary and Conclusion ................................................................................................. 39

Chapter 2: Implications of Organizational Culture ................................................................. 42

A. Organizational Ethics and the Role of Organizational Culture ..................... 42

1. 1995 Joint Commission Mandate and the Pioneer Network ......................... 43

2. Organizational Moral Agency/Responsibility ................................................. 45

3. Individual Moral Agency/Responsibility ......................................................... 47

4. Threats to Individual and Organizational Moral Agency ........................ 49

B. Integrated Ethics and Systems Thinking ................................................................. 57

1. The Veterans Administration Model .................................................................. 57

2. The Hidden Culture and the Competing Values Framework ......................... 60

3. Application of a Systems Approach to the IntegratedEthics® Model........ 62

4. Operationalizing the Mission, Vision, and Values of the Organization ..... 65

C. Organizational Culture in Long Term Care ......................................................... 66

1. Historical Perspective: Rewards vs. Punishments .......................................... 66

2. The Role of the Survey Process in Shaping Culture ....................................... 68

3. Moral Courage and the Goal of a Just Culture .............................................. 68

4. Application of Systems Thinking to Achieving Culture Change ................. 72

Chapter 3: Moral Distress ................................................................................................. 79

A. The History of Moral Distress ............................................................................... 79

1. Hans Seyle and Andrew Jameton ...................................................................... 80

2. The Ethics of the Ordinary: Differentiating Workplace Stress from Moral Distress ........................................................................................................ 84

3. Organizational and Individual Barriers Contributing to Moral Distress ........ 88

B. Causes of Moral Distress Within Long-Term Care ....................................... 91

1. How the Culture Affects Incidents of Moral Distress .................................... 93

2. Compassion Fatigue and Burnout .................................................................... 98

3. Theories of Accountability/Agency (Individual versus Organizational) ...... 101

C. The Crescendo Effect of Moral Distress ............................................................... 104
Chapter 4: Organizational Leadership Responsibility for Moral Distress

A. Transformational Leadership ............................................................................. 120
   1. The Role of Executive Leadership ................................................................. 122
   2. The Learning Culture and the Learning Leader .............................................. 125
   3. Moving from Self-Sacrifice to Self-Fulfillment .............................................. 128

B. Servant Leadership ........................................................................................... 129
   1. Servant Leadership Defined ........................................................................... 130
   2. The Essence of Moral Authority and Interdependency ................................... 136

C. Appreciative Leadership As an Expression of Servant Leadership and
   Transformational Leadership ............................................................................... 143
   1. Appreciative Leadership Defined ................................................................. 144
   2. Five Core Strategies of Appreciative Leadership: Inquiry, Inclusion,
      Inspiration, Integrity, and Illumination ......................................................... 149
   3. Facilitating Positive Change Within Individuals and the Organization .......... 151

D. Conclusion ....................................................................................................... 153

Chapter 5: Methods of Effective Communication ............................................. 159

A. Appreciative Inquiry and Moral Distress: A Communication Change Agent .... 159
   1. Appreciative Inquiry as a Philosophy and a Methodology .............................. 161
   2. Appreciative Inquiry and the Impact of Mental Models .................................. 166
   3. Developing and Practicing the Strength of One’s Own Voice ....................... 171

B. Appreciative Inquiry in Healthcare .................................................................. 174
   1. Paradigm Shift: Focusing on the Positive ..................................................... 174
   2. Application of the Lessons from the University of Virginia ......................... 176
   3. Humble Inquiry ............................................................................................. 181

C. Appreciative Inquiry and Conversational Capacity ......................................... 183
   1. The Paradox of Moral Courage ..................................................................... 186
2. Understanding and Supporting the Personal Ethical Threshold ................. 188
3. The Power of Imagination ..................................................................... 189
D. Conclusion ............................................................................................. 191
Chapter 6: Leadership Empowerment to Resolve Moral Distress ............... 197
A. Organizational Leadership and Moral Discourse: A Communication Change Agent ........................................................................................................... 198
  1. Methods of Effective Communication ........................................... 198
  2. Six Dimensions of Organizational Change – A Systems Approach ...... 202
  3. Conversational Capacity - Managing the Human Side of Healthcare .... 204
B. Organizational Leadership and Moral Courage ..................................... 207
  1. The Interdependency of Morale and Morality .................................. 207
  2. Competing Values Framework in Assessing Organizational Culture ...... 209
  3. Code of Ethics of the American College of Healthcare Executives ....... 213
C. Organizational Empowerment of Caregivers ......................................... 218
  1. Empowerment versus Persuasion ..................................................... 219
  2. Empowerment as Seen Through the Mission, Vision, and Values of the Organization ........................................................................................................... 221
  3. Empowerment and Job Satisfaction—Effect on Reducing Moral Distress .... 223
D. Conclusion ............................................................................................. 228
Chapter 7: Moral Distress in Long-Term Care at the End of Life ............... 234
A. The Role of Culture in Establishing the Quality of Life and the Quality of Death in Long-term Care ........................................................................................................... 234
  1. Defining Quality of Life in Long-Term Care ...................................... 237
  2. A Historical Perspective on End-of-life Care—Is There Such a Thing as a Good Death? ......................................................................................................................... 241
  3. The Role of Culture in Determining the Quality of End-of-Life Care ...... 245
B. Leadership Empowerment of Caregivers to Address Moral Distress ......... 248
  1. Family, Patients, and Staff—Views of the End of Life ....................... 248
  2. Stewardship, Servant Leadership, and the Sanctity of Human Life ...... 251
  3. Compassion and Suffering at the End of Life—Implications for Caregivers 254
C. Methods of Effective Communication in Providing End-of-life Care While Addressing Concerns to Reduce Moral Distress ................................................................. 258
1. Methods of Effective Communication at the End of Life: Verbal and Non-Verbal ................................................................. 258
2. Organizational Systems Supporting End-of-life Care......................... 260
3. Implementation of Positive Organizational Programs Designed to Reduce Moral Distress In End-Of-Life Care ......................................................... 262
D. Conclusion ........................................................................................... 265
Chapter 8: Conclusion ................................................................................... 270
Bibliography ................................................................................................ 276
Chapter 1: Introduction

Andrew Jameton is credited with developing the initial framework for the study of moral distress within the nursing profession in the 1980s. Much of his original work and the work of those who followed have centered on the individual practitioner and his or her response to specific triggers, both internal and external. Little research has attempted to apply the available understanding of moral distress to organizations, particularly in terms of applying systems thinking to the study of moral distress within the long-term care (LTC) setting.

The purpose of the current research is to develop a systems approach to addressing issues of moral distress within LTC, moving the focus away from the individual to the organization. Three specific areas will be analyzed as a means of providing an ethical justification for expanding the focus of moral distress from one that centers primarily on the individual to one that focuses on the operational systems within the organization. Current research regarding the culture, leadership, and methods of communication within the LTC setting will be reviewed. Application of these three operational areas will be integrated from a systems perspective, and the Strong Connections Law used to justify the thesis that efforts to identify and reduce incidents of moral distress in LTC must be understood in the larger context of systems thinking. This analysis departs from the existing research in shifting the focus away from the individual to the organization. In doing so, this dissertation expands the existing literature by applying systems thinking to the issue of moral distress within the LTC environment.

This dissertation will argue that previous efforts to understand moral distress within the healthcare setting have been too limited in focusing on individual responses to specific triggers. The inter-relationship between the culture of the organization, the leadership within the
organization, and the methods of communication used within that organization will be evaluated
in relation to their impact, both individually and collectively, in reducing moral distress.

Unlike the acute care setting, in which the majority of the research on the causes and
effects of moral distress have been conducted, the LTC setting provides a unique, somewhat
more controlled environment in which to evaluate the effectiveness of a systems approach to
addressing moral distress. In so doing, new avenues for addressing and reducing incidents of
moral distress will be identified. This expanded view will provide a framework for additional
research within the LTC setting that balances the responsibility of the organization with the
needs of the individual in confronting and reducing incidents of moral distress.

The thesis of the current study is the ethical justification of applying a systems approach
to issues of moral distress within LTC. Because moral distress has largely been understood as a
phenomenon of the individual, efforts to address and reduce incidents of moral distress have
focused almost entirely on the individual and his or her reaction to specific triggers. Building
upon the existing literature, the current study aims to expand the framework within which issues
of moral distress are evaluated. Specifically, this dissertation will argue that previous efforts to
understand moral distress within the healthcare setting have been limited in two very important
aspects: first, the majority of research related to moral distress in healthcare has focused almost
exclusively on issues of moral distress within the acute care setting and second, efforts to
identify and reduce incidents or moral distress have largely focused on the individual and on his
or her response to specific triggers.

The current study will shift the historical perspective surrounding issues of moral distress
away from the acute care setting to the LTC setting. In addition, this study will expand the
argument from looking solely at individual responses to specific triggers to a systems approach of identifying and reducing incidents of moral distress organizationally within the LTC setting.

In applying a systems approach to issues of moral distress in LTC, this dissertation will draw upon the Strong Connections Law to argue that within the LTC setting, three specific aspects of the organization can have a tremendous impact on reducing incidents of moral distress: 1) the culture of the organization, 2) the leadership within the organization and 3) the methods of communication employed within the organization. These three aspects will be reviewed from a systems perspective and will be shown to establish an environment where incidents of moral distress can be greatly reduced.

This argument will be made first by drawing on a review of the existing literature on both moral distress and systems thinking. This research will then be applied to a study of the culture, communication, and leadership within the LTC setting. The dissertation will conclude with the application of systems thinking to end-of-life decision making. The dissertation will demonstrate that when the culture, communication, and leadership of an organization are all viewed as one system, morally complex issues can be addressed in such a manner as to reduce the moral distress that often accompanies them.

In their article on the evolution of the concept of responsibility within bioethics, Turoldo and Barilan address a phenomenon within the healthcare setting whereby inaction towards a particular set of circumstances can often be viewed as fully morally laden as active action. This conflict between action and inaction helps to clarify the moral conflict faced by many who have chosen to work in the LTC environment. This moral conflict is often experienced in the complexity of having to choose one course of action over another, oftentimes with the chosen action being out of the control of the caregiver. This internal conflict is of particular concern
when addressing issues of moral distress. Andrew Jameton, who is believed to have coined the term “moral distress” in 1984, used this term to describe situations experienced primarily by critical care nurses. In these situations, the nurses felt they knew the morally acceptable course of action but were constrained from taking it owing to both internal and external factors over which they perceived they had no control.

Because moral distress has largely been understood as a phenomenon of the individual, efforts to address and reduce incidents of moral distress have focused almost entirely on the individual and his or her reaction to specific triggers. A great deal has been learned over these past 30 years relating to the potential triggers and/or causes of moral distress within the healthcare environment. Equally important research has taken place regarding the positive role that organizational ethics can play in approaching moral distress from a systems perspective within the organization.

Issues of control, communication, leadership and culture all interact with one another within the organization. Such interaction creates a work environment that can either be supportive of the caregiver or create organizational impediments that contribute to issues of moral distress. The next several chapters discuss how the application of a systems approach to issues of moral distress within LTC can be established to address and remediate issues of moral distress for caregivers within the LTC setting.

Systems thinking challenges healthcare teams to seek to understand the connections that exist within the organization and to expand their knowledge base as a result of these interconnections. Systems thinking allows teams to see beyond what may initially appear to be isolated or independent incidents. Recognizing these interconnections allows the leadership of the organization to better understand events and therefore influence them. The ability to
recognize these interconnections and use them for the benefit of the organization is one of the most valuable contributions that adopting a systems approach to addressing issues of moral distress can provide. In the current study, those interconnections refer to the culture of an organization, its leadership, and the methods of communication it uses. Understanding how each of these seemingly independent variables can positively affect a reduction in incidents of moral distress will be discussed in the chapters that follow.

A. Organizational Culture and Moral Distress

Chapter 2 discusses the organizational culture that underlies moral distress by considering the contribution of organizational ethics, the role of IntegratedEthics® in systems thinking, and the importance of organizational culture in LTC.

1. Organizational Ethics

The ability of an organization to remain true to its mission, vision, and values is an essential component of an ethical organization. The role of the healthcare organization as a moral agent helps to shape the context within which individual moral agents execute their own moral beliefs. This fact was recognized by the Joint Commission on the Accreditation of Hospitals (now known simply as the Joint Commission) in their 1995 mandate. This mandate called for the inclusion of an Organizational Ethics Program as part of the on-going requirements for accreditation of healthcare organizations. In their 1995 addition to their regulatory standards, the Joint Commission provided the following definition of organizational ethics: “those aspects of the operation of the Health Care Organization that have to do with the ‘ethical responsibility’ of the organization itself ‘to conduct business and patient care practices in an honest, decent and proper manner.’”
In specifically identifying the organization itself as an agent with ethical responsibility, the Joint Commission forced a dialogue concerning the role of moral agency and what role it would play as both individuals working within the organization and one moral agent operating as a single organization. It is this latter role, that of the organization as an agent with ethical responsibility, that helps to move the discussion surrounding issues of moral distress away from the individual and toward the organization as well as to a systems approach for addressing and minimizing such distress.

Professionals working in a healthcare organization, such as the LTC environment currently being addressed, understand with a doubt that they must be accountable for their actions. What becomes an important consideration when discussing the role of organizational ethics—and, by extension, a systems approach to organizational ethics—is the impact that organizational factors can have, both positive and negative, on an individual’s ability to exercise his or her individual moral agency. One of the first acknowledgments that must be made when attempting to address issues of moral distress within LTC is the central role that the organization itself can play in supporting the individual moral agency of each of its employees. Of particular relevance in support of the need for a systematic approach to identifying and operationalizing ethical practices throughout the organization is the knowledge that individuals will behave in ways that they would normally repudiate if they believe that a legitimate authority (in this case the organization) accepts responsibility for the effects of their conduct. While individual employees may initially take comfort in knowing that they are acting in a manner consistent with organizational practices, it will be demonstrated that acting against one’s own conscience will, over time, create a moral residue consistent with repeated and long standing issues of moral distress.
Although the integrity of all those working within the organization is essential to the ethical functioning of that organization, the establishment of their integrity has as much to do with the impact that each individual can have on the organization as it does with the impact that the organization can have on the choices individuals make in carrying out their responsibilities. Cathleen Kaveny has suggested a category of agency that seeks to bridge the standard concept of individual moral agency with the social structures of which these individuals are a part. Kaveny proposes that individual moral agents are “networked agents: and as such their actions need to be understood in a broader context that includes the social structures that contribute to just and unjust societies.” In suggesting a type of networked agent, Kaveny has touched upon the concept of aggregated agency. While Kaveny is applying this concept to issues of formal and material cooperation within the Catholic Church, the concept is readily transferrable to the complexities that exist within the healthcare setting. Determinations of organizational moral agency and the application of systemic measures that both strengthen the moral agency of the individual and recognize the influence of organizational practices on the overall ethical operation of the organization will be shown to support the current argument: that individual experiences of moral distress must be addressed through a system-wide effort that addresses both individual responsibility and organizational moral agency.

2. Integrated Ethics and Systems Thinking

Peter Senge’s foundational work on management practices and systems thinking, *The Fifth Discipline*, describes the systems that exist within organizations as being bound by invisible fabrics of interrelated actions. Such is definitely the case within healthcare organizations where hundreds of interrelated yet often separate functions contribute to the overall effectiveness of the organization.
The Veterans Health Administration is one of the largest integrated health systems in the United States, operating more than 1,500 care sites with close to 6 million patients yearly. During a 5-year period which began in 2003, the VA worked to develop a program titled IntegratedEthics®, which focused on three key areas in their operation: ethics consultation, preventive ethics, and ethical leadership. Although the VA has come under scrutiny in recent years for what have been described as unethical business practices, one aspect of their program, preventive ethics, has positive applications to the current discussion regarding the development of a systems approach to issues of moral distress within LTC. The preventive ethics component of the VA IntegratedEthics® model calls on the organization to reflect critically on the institutional factors that are known to influence patient care, and to reform policies determined to undermine the ethical care of patients. The preventive ethics approach seeks to identify barriers that might impede the care that is given and to address quality gaps in a proactive, systems-oriented manner. This approach offers a framework that could be utilized within the LTC setting as it attempts to address issues throughout the health system that can have a negative impact on the patient and in the case of issues of moral distress, on the caregiver as well.

3. Organizational Culture in Long-Term Care

While the accumulated virtues of an individual are evident in one’s character, the accumulated virtues of an organization become evident within its culture. In establishing the desired culture within a healthcare organization, one that empowers caregivers and supports ethical decision making, several factors have been determined to be critical success factors. The first and perhaps most important is the need to have a clear understanding of how policies and procedures are operationalized within the organization. Specifically, it is essential to confirm that internal practices are consistent with the stated policies and procedures throughout the
organization. In the absence of this standardization or systemization, a hidden culture can develop that is detrimental both to the individual and to the organization.

In the absence of a focused approach to the development and ongoing support of the organization’s culture, a so-called hidden culture can become the predominant means of behavior within that organization. The organizational culture that is established and operationalized can work to enhance the ethical practices of those who are employed within it, or it can have the opposite effect of pressuring employees to achieve high performance standards by any means possible, including unethical means. Research studies suggest that it can be difficult for individuals to act in accordance with accepted ethical norms and professional standards in the face of serious organizational barriers. These barriers are particularly harmful when employees believe that they are pressured into acting in a manner that is inconsistent with their personal values or that they are prevented from carrying out what they know to be the right course of action. These constraints, if left unaddressed, can lead healthcare practitioners to feel voiceless, powerless and unable to provide the care to their patients that they believe they deserve. These constraints can often lead to experiences of moral distress, resulting in burnout and a desire to leave their chosen profession.

The LTC environment represents a particularly challenging environment in relation to practices that could lead to moral distress, owing in large part to the historical practice of operating from a standpoint of offering rewards or punishments for actions thought to be positive or negative from the viewpoint of the organization. Eugene Litwak describes the care that is provided to residents in a nursing home as detached, impersonal, and rule-governed. While great strides have been made in the intervening 29 years since Litwak’s book was first published, the fact remains that nursing homes are governed by hundreds of regulations which can limit the
ability of staff to act independently and in a manner that they believe is in the best interest of their patient.

The establishment of a culture is one of the ways that an organization can preserve its integrity over time and can differentiate itself in establishing its own identity. The culture in many ways comes to define the organization. How an organization comes to imagine its future will, in part, determine the behavior within the organization and how well that organization has equipped itself to address issues of moral distress. Seeking to integrate the values of the organization with the individual values of its members can have a very positive impact on the experience of moral distress within the organization.

B. History and Causes of Moral Distress

Chapter 3 provides an historical perspective on moral distress and traces the possible causes of such distress within the healthcare setting. The negative effects of long-term exposure to moral distress will be reviewed specifically as it relates to current research regarding the crescendo effect of moral distress and the applicability of the Yerkes Dodson Law to issues arising from the build-up of moral residue over time.

1. The History of Moral Distress

In tracing the emergence of the awareness of moral distress and its impact on both healthcare practitioners and the organizations in which they work, two distinct areas of influence become evident. The first began in 1936 with the groundbreaking work of Hans Selye wherein he identified aspects of stress and worked on helping people to understand it. In his early work on stress, Selye differentiated between a negative form of stress, which he termed distress, and a positive type of stress, which he termed eustress. Although differing methodologies have been applied to the issue of stress, depending on the discipline under review, there is general
agreement that certain stressors can elicit responses in individuals that can have negative impact over time on both their health and wellbeing.

The second influence began with a series of lectures in the 1960s, which focused on the concerns of the medical community over ethical issues that were resulting from the period of explosive growth in medicine and technology. It is difficult to appreciate the evolution of the awareness of moral distress within healthcare without first establishing the context within which this phenomenon emerged within the field of bioethics. What began as the untroubled conscience of early physicians grew into issues of conscience that remain today. We see, for example, Dr. Michael DeBakey expressing concerns about the ethical implications of heart transplantation, as well as the title of the first conference held to address ethical issues within medicine, “Great Issues of Conscience in Modern Medicine.” Thus, the concerns surrounding the ethical implications of medical practice have become a central feature in modern medicine.

In many ways, although without formal recognition, the history of bioethics parallels the history of the emergence and awareness of moral distress as one of the unintended consequences of all of the positive, innovative medical advances over approximately the past 70 years. The early bioethicists recognized that the great challenge facing the medical profession would be to learn how to use the new breakthroughs positively without surrendering some part of their own and their patients’ humanity. Questions of personal conscience and individual values were becoming intertwined with medical possibilities that began to bring into question long held values surrounding quality of life and end-of-life decision making. This moral ambiguity surrounding the ethical dilemmas faced by physicians and other healthcare practitioners required expertise beyond the medical community and soon included religious scholars, philosophers,
social workers, and educators, all of them collaborating to establish an ethical framework and normative methods of ethical decision making.

This struggle remains today in the everyday ethical decisions being made by healthcare practitioners at all levels of the organization. Moral distress can be seen as a consequence of the effort made by individuals to preserve their moral integrity when seemingly forced to act against their own moral convictions. The advances made by early bioethics were later adopted within the LTC setting with the implementation of ethics committees, personnel trained and devoted to spiritual care, and departments of social work to address the psycho-social needs of the residents.

One of the first efforts to develop a model to measure moral distress is found in the work of Mary Corley with her development of the Moral Distress Scale. In response to the growing concern for the impact of moral distress on both the individual practitioner and the healthcare organization, Corley and her colleagues developed and tested a means of differentiating what is believed to be normal job-related stress from the often more consequential effects of moral distress. The original moral distress scale, consisting of 32 questions, was given to a sample of 214 nurses working in hospitals across the United States. The results were determined to be both valid and reliable while acknowledging the need for further testing with a larger sample size.

Of significance to the current discussion of moral distress, its causes and possible remedies are the questions that Corley and her associates developed as a means of quantifying the amount of moral distress and the actions of the nurses experiencing such distress. Sample questions included asking nurses to rate the frequency of specific situations thought to lead to incidents of moral distress. These questions dealt with such matters as how often the nurse was asked to follow a family’s request not to discuss death with a dying patient who asks about dying, how often they had been asked to follow a physician’s order not to tell a patients the truth...
when they asked for the truth about their condition, or how often they had not intervened when observing another employee not respecting a patient’s dignity. In this instance, while the findings of the study substantiated earlier findings related to the impact of moral distress on the healthcare practitioner, the current study added a great deal to the working knowledge of moral distress. Knowledge was greatly expanded because of the depth of the questions asked and the insight that the responses brought to the overall awareness of the impact of moral distress on the everyday work environments of the healthcare practitioners. While these findings related to nurses’ responses to moral distress in the acute care setting, more recent findings support the premise of the current discussion that these results are readily transferrable to the LTC setting for reasons discussed below.

2. Causes of Moral Distress within Long-term Care

Because moral distress is a phenomenon of the individual versus the situation, identification of the possible causes of such distress will naturally vary among individuals. While the individual nature of the experience of moral distress is not in question, an understanding of the causes must be sought not only individual by individual but also organizationally. The most widely referenced sources of moral distress identified within the nursing profession relate to the nurse’s belief that harm is being done to the patient in the form of unaddressed pain and suffering, medical prolongation of dying without adequate discussions concerning end of life choices, inadequate staffing, and the effect of cost containment and resource allocation. It is unfortunate that each of these known causes of moral distress are known challenges within the LTC environment, supporting the thesis of the current study that issues of moral distress can be successfully addressed only if done so on a system-wide basis.
From an organizational perspective, the methods of communication used, the leadership of the organization, and the culture that is developed will all be shown in later chapters to affect positively the effectiveness of addressing issues of moral distress. Though the causes of moral distress can be numerous and widely varied, there is widespread agreement as to the psychological manifestations that result. These include feelings of frustration, anger, guilt, anxiety, withdrawal and self-blame. One of the most important mechanisms that an individual can possess in addressing issues of moral distress is thought to be developing and practicing the strength of one’s own voice. Using one’s own voice helps to build the moral competence that enables moral courage and acting in harmony with one’s own conscience.

It is interesting to note, in relation to the desire to know the strength of one’s own voice, the various meanings/derivations of the word conscience. The conscience, derived from the Latin word for the conscious knowledge of guilt, is thought to hold the human sense of right and wrong. The Hindus define conscience as the “knowing voice of the soul, while the Hebrews associated the meaning of the word with the heart. Each of these meanings, while somewhat different, point to an innate sense of what a person deems to be morally right and helps to support the notion that moral distress is in fact a phenomenon within the individual that must be addressed not only by the individual but also, in a supportive way, by the institutional practices of the organization.

3. The Crescendo Effect of Moral Distress

Since Andrew Jameton first introduced the term moral distress, several theories have been put forth in an attempt to explain this phenomenon and to develop methodologies that might lessen the negative impact of moral distress on health professionals and the institution. One concern has remained constant within each of these theories. That concern relates to how
best to differentiate the role of the individual in taking responsibility for addressing his/her own distress balanced against the responsibility of the organization in taking steps to reduce such distress.

The goal of the current study is to demonstrate that the only effective way to confront issues of moral distress is from a total systems perspective, by looking at the culture, the communication, and the leadership within an organization, using a holistic approach to confront this serious phenomenon. This approach, however, is not meant to absolve the individual practitioner from accepting responsibility for participating actively in all activities intended to address such issues. It is interesting to note that research into individual practitioners’ apparent participation in their own moral distress appears to be related to a gradual reduction in the ability or the desire of that individual to differentiate between moral and immoral acts as a result of the prevalence of moral distress in everyday practice.

John Abott Worthley supports this theory in referring to the “ethics of the ordinary.” Worthley posits that although a considerable amount of research has been applied to the moral challenges resulting from the on-going technological advances in medicine, little attention has been paid to the everyday ethical challenges confronted by the healthcare practitioner. As these everyday ethical dilemmas become more and more commonplace, the level of acceptance of these ethical challenges begin to be accepted as the status quo. This theory is further supported by Cathleen Kaveny, who speaks about the danger involved for individuals’ sense of right and wrong when participating in repeated immoral/evil acts. Over time, individuals’ capacity to identify and follow through on good choices is diminished.

It is not until or unless the individual practitioner reaches what Elizabeth Epstein termed a crescendo that the build-up of previous incidents or moral distress becomes unmanageable for
the practitioner. Epstein’s theory of a crescendo effect builds from Jameton’s original work regarding moral distress in which he identified two specific aspects or components of the distress experienced by the practitioner. The initial distress according to Jameton occurs as the situation unfolds. This is followed by a reactive distress, thought to be the lingering distress experienced by the individual once the situation has been addressed. This lingering distress is now termed moral residue. Epstein collaborated with Anne Hamric in 2009 to develop a theory of moral distress that built upon Epstein’s earlier work and identified a continuum of moral distress—beginning with the initial distress and continuing as repeated incidents of moral distress build up over time, which they termed moral residue, and ending with a crescendo effect or breaking point for the practitioner.

Webster and Bayless present a descriptive definition of their concept of moral residue as that which each of us carry with us from times in our lives when, in the face of an ethically or morally challenging situation, we either seriously compromised ourselves or allowed ourselves to be compromised. It is this residue that can prove to be the most physically and emotionally paralyzing to the individual and which, if allowed to permeate an organization can have equally devastating consequences to the organization.

While the crescendo effect is thought to play a significant role with anyone experiencing moral distress, the environment within LTC appears to be particularly suited to repeated incidents leading to a build-up of moral residue. Specifically, chronic short-staffing, conflicts, and lack of proper education regarding end-of-life decision making and low reimbursement rates that can affect the quality of care that is given all add to the moral distress experienced by practitioners in the LTC environment.
Additional examples of morally distressing events that are known to occur during the routine practice of providing care include miscommunication on the part of the medical team, both among themselves and with the patient; missed opportunities for meaningful conversations concerning end-of-life decision making, feelings of powerlessness on the part of the healthcare practitioner, and value-driven conflicts regarding appropriate treatment options.

C. Leadership Styles for Addressing Moral Distress

Chapter 4 identifies three particular styles of executive leadership, each thought to bring a positive framework to addressing issues of moral distress and success for the organization. The three leadership styles that will be reviewed are transformational leader, servant leader, and appreciative leader. When applying the leadership techniques found in each of these three styles to the goal of reducing incidents of moral distress across the organization, one particular attribute will be identified in common among all three. Each of these leadership styles incorporates within them the goal of shifting the existing paradigm of leadership from having the “power over someone” to empowering those being led with the “power to.” This important shift of authority will be shown as a critical element in how executive leaders can contribute to reducing moral distress within their organizations.

1. Transformational Leadership

Executive leadership within healthcare organizations has become increasingly more complex over the past quarter century. Multi-organizational health systems, rapid technological and medical breakthroughs, resource allocation concerns and an ever diversified workforce requires the oversight of equally strong, educated, diverse leaders and leadership teams able to address these challenges successfully. Leaders in healthcare today are often forced to navigate between competing and often seemingly mutually exclusive goals; the care needs of the patients,
the financial constraints of the insurance companies and the daily responsibilities of providing a workplace that supports all of these competing priorities.

These competing demands appear to indicate the need for strong management skills on the part of those who choose to lead these organizations. While this is no doubt the case, it would be incorrect to use the terms management and leadership as one and the same. While both skills will be shown as being equally important, particularly in relation to efforts to reduce moral distress, management of the organization, on the one hand, refers to the systems that are developed within the organization to insure the smooth and consistent application of policies and procedures within the organization. Leadership, on the other hand, corresponds more closely with managing and motivating the people within that organization. Executive healthcare leadership must have both the management skills necessary to organize and control institutional functions while at the same time having the courage and principled relationships to lead people successfully. Chapter 4 focuses on the role of the leader and the influence that the leader can have in bringing both the systems and the people into alignment.

The ability to influence others positively to achieve specific behaviors and desired results is one of the most important roles of the executive leader. The effectiveness of leaders in being able to influence others will depend largely upon their ability to develop a culture within the organization that represents the values and mission of that organization. Contrary to those who believe that a leader must know everything about the organization and must be personally competent in all areas of the organization is the differing perspective that the primary responsibility of the leader is to bring people together around a common goal in a manner that is consistent with the mission and values of that organization. Their expertise may lie not in the
technicalities of any given position, but in being able to understand what is required of each individual to make him or her successful and, in turn, make the business successful.

In addition, the role of executive leadership requires that leaders be prepared at all times to protect their organizations from issues that diminish trust within the organization. These potential threats to trust include employee perceptions that leaders are concerned only with their own success, dishonesty, and inconsistent messaging. Executive leadership requires that the leader understands his responsibility to all those he is serving, the patient or resident, the board and the employees. Two of the most effective ways to achieve the goals of transformational leadership are through the practice of servant leadership and appreciative leadership.

2. Servant Leadership

The term servant leadership is attributed to Robert Greenleaf from an essay he wrote in 1970 titled “The Servant as Leader.” Servant leadership is now in its 4th decade as a recognized leadership style, and its applicability to present-day leadership struggles appears no less relevant today than it was at Greenleaf’s first writing. Particularly related to the challenges faced by leaders in the LTC setting, servant leadership speaks to the needs of the care teams working within LTC and to the necessity for proactively addressing concerns by the staff that are now recognized as leading to moral distress. For Greenleaf, the best test of whether or not someone could be identified as a servant leader is to question whether or not those being served by the leader grow as individuals in the process of providing the care or services required of their positions. Two questions can be asked which will help to determine the answer: Are those being led motivated and appreciated in such a way that they become wiser, more autonomous and more like themselves in the course of being led? Are they likely, in turn, to become servant leaders themselves? The tenants of servant leadership can be found in the discussion in Chapter 6
concerning the empowerment of employees within their job settings. It highlights the core
distinction between having power over someone or something versus granting the power to
someone or something.

Larry Spears, former CEO of the Robert K. Greenleaf Center and noted author on servant
leadership, has identified what he believes are ten characteristics of the servant leader that are
critical to both the development and long term effectiveness of the servant leader. They are as
follows. **Listening** is highlighted by both a keen ability and desire to listen attentively to others
as well as seeking regular periods of reflection that allow for a deep understanding of one’s own
voice. **Empathy** is evidenced by an ability to assume only good intentions from co-workers and
to seek always to understand the view of another, even when those views differ from one’s own.
**Healing** is evidenced by great strength in the ability to heal both one’s self and one’s relationship
to others. **Awareness** includes a strong self-awareness that awakens leaders to their environment
and allows for a holistic approach to understanding a given issue. **Persuasion** is evident when
servant leaders seek to persuade rather than use their authority to achieve a desired result.
Servant leaders are known for their ability to seek and reach consensus within a group.
**Conceptualization** is evidenced by reaching beyond the day-to-day demands of one’s position; a
servant leader seeks to be aware of the bigger picture and works to achieve greater goals
consistent with the mission, vision, and values that have been established for the organization;
**Foresight** is evidenced by the ability of the servant leader to learn from the past and to use it to
predict and understand the consequences of any future actions or inactions.

In the current discussion about reducing the experience of moral distress, a great deal has
been learned from past failures in learning how best to understand and address such issues.
Servant leaders successfully position themselves to build upon past failures and to learn from
their shortcomings. Much of the current progress being made in successfully addressing issues of moral distress has come about as the result of lessons learned from previous misguided approaches. Stewardship reflects one of the main characteristics of servant leadership: specifically, the leader is working in service to another and is responding to those needs as part of supporting and developing that individual. Commitment to the Growth of People is seen in the ability of the servant leader to nurture each person both personally and professionally. This is demonstrated by inclusion of employees in decision making and valuing both the individual and the group contributions of those within the institution. Giving voice to each individual enhances the self-worth of each one and expands his or her ability and willingness to contribute to the organization. Building Community is observed in servant leaders as they seek to build community within the organization. In doing this, the servant leader is establishing an environment that is supportive of individual efforts and recognizes the strength of establishing common goals through shared values and clear vision.

Each one of the ten characteristics of the servant leader supports the goal of addressing moral distress on a system-wide basis within a culture that is supportive and clearly works within the framework of the established mission, vision, and values of the organization. Sipe and Frick provide what they have termed the “seven pillars of servant-leadership,” which while similar in many respects, includes additional attributes that would prove to be particularly beneficial in the LTC setting. These include the need for the leader to be a person of character, put people first, be a skilled communicator, be a compassionate collaborator, have foresight, be a systems thinker, and lead with moral authority. Each of these attributes helps to position such leaders as worthy of respect, inspiring the confidence and trust of those they oversee.
One final approach to leadership styles, which shares many characteristics with that of
the servant leader, is found in what is termed *appreciative leadership*. This leadership style
flows from a larger management approach termed *appreciative inquiry*. A discussion of the
positive role that appreciative inquiry can play in addressing issues of moral distress is found in
Chapter 5. One aspect of appreciative inquiry is the importance that this communication method
places on the role of the leader within the organization.

3. **Appreciative Leadership**

Building upon many of the same core features as servant leadership, appreciative
leadership positions leaders (both formal and informal) to establish the needed relationships with
their co-workers in an environment that builds trusts, strengthens existing relationships, and
allows all involved to reach their individual potential. The result over time is the establishment
of a culture that truly reflects the mission, vision, and goals of the organization. Alignment of
the mission, vision, and goals of the organization with the day-to-day operations of the
organization can have a positive effect on reducing the experience of moral distress for those
who work there. For effective implementation of the methods used in appreciative leadership,
those who seek to practice it must first acknowledge that their organizations are living and
continuously changing human creations.

Appreciative leadership is defined largely by five core strategies, each of which focuses
on the relationship that exists between leaders and followers, as well as the relationship among
followers. Each of the five key strategies that define appreciative leadership seeks to develop the
positive potential within each individual for the benefit of both the individual and the
organization. The five strategies are inquiry, illumination, inclusion, inspiration, and integrity.
• **Inquiry.** The executive leader who seeks input from his team members in an open and honest manner signals to his team that he values their input and that he will draw upon their input when decisions are made.

• **Illumination.** The appreciative leader seeks to draw out the individual strengths of those on his team for the purpose of strengthening their confidence in their own abilities and supporting and identifying strengths in other.

• **Inclusion.** Perhaps as much as any of the five strategies involved in appreciative leadership, inclusion is critically important when cultivating an environment that seeks to minimize issues of moral distress. By including every level of the organization in decisions that will ultimately affect the members, leaders are signaling their desire to understand the impact that various organizational decisions will have on the attitudes relating to their work.

• **Inspiration.** Providing inspiration to an organization can be one of the most beneficial contributions that an appreciative leader can make to the organization. By inspiring their employees, leaders set into motion a force larger than any one individual as all team members build on the ideas and expertise of those with whom they work. Together, the creative spirit in individuals creates a synergy that moves the organization beyond the contributions of the individual to include the contributions of all members.

• **Integrity.** Although integrity is often defined in a negative context, specifically by referring its lack in a given situation, when leaders exhibit integrity in their daily work, they send a positive message to their followers. Leaders who act with integrity are letting members of the organization know that they will be acting honestly in their dealings with others and that they are setting an expectation that others will act with the same level of
integrity. The level of contributions among all employees has been found to improve when they witness this level of accountability.

Just as servant leaders seek to understand fully and to serve those they lead, appreciative leaders seek to provide strategies as a means of letting people know that they are an important part of the organization and are valued for who they are. The appreciative leader seeks to clarify where the organization is heading and the role that the individual plays in achieving the goals of the organization. Finally, the appreciative leader sets expectations for performance in an environment that encourages achievement of both individual and organizational goals. When one seeks to develop a leadership style that creates a culture which minimizes moral distress, the characteristics of the servant leader combined with the strategies of the appreciative leader offers the greatest opportunity to address such issues successfully.

D. Effective Organizational Communication Methods

Chapter 5 reviews specific methods of effective communication within the organization. The provision of healthcare is often viewed from a perspective of deficits and limitations with all staff being trained to focus on the negative and on what is wrong or could go wrong in any given situation. Given this view of leadership and organizational oversight, recent research into the most essential attributes of leadership has shown that a leader’s ability to build trust among employees is highly important, appreciating the contributions made by employees at all levels of the organization. One of the most promising ways to accomplish these goals system wide is through appreciative inquiry.

1. Appreciative Inquiry and Moral Distress: A Communication Change Agent

Based on the premise that human systems grow in the direction of their deepest and most frequent inquiries, it is understandable that within the LTC environment the most frequent
inquiries are often rooted in problems and shortcomings relating to the care provided. Appreciative inquiry provides a means of understanding the operation from another perspective, a positive perspective that seeks to focus on what is being done correctly and positively within the organization and to build upon those accomplishments. Developed in the mid-1980s by David Cooperrider and his associates at Case Western Reserve University, appreciative inquiry challenged the common problem-based approach, encouraging inquiries that would reflect what is working well within the organization and building upon that.

Appreciative inquiry seeks to focus on building upon strengths in order to eliminate those operations that may be carried out poorly. Because appreciative inquiry allows the focus to shift to the positive, it brings the positive mental models to the surface to be employed for more creative approaches to issues within the organization. Whitney and Trosten-Bloom identify the following concepts or assumptions as foundational to appreciative inquiry:

- People individually and collectively have unique gifts, skills and contributions to bring to life.
- Organizations are human social systems, sources of unlimited relational capacity, created and lived in language.
- The images we hold of the future are socially created and, when articulated, serve to guide individual and collective actions.
- Through human communication – inquiry and dialogue – people can shift their attention and action away from problem analysis to lift up worthy ideals and productive possibilities for the future.

Focusing on what is being done correctly within the organization, combined with a desire to understand fully the mental models within which both the individual and the organization
must operate, help to support a system-wide approach when applied to issues of moral distress. Developing an understanding of the concept of mental models is one of the most important factors to consider when seeking information that will help to clarify one’s own perception of moral distress. The impact that such models have on the way each individual views a particular set of circumstances determines to a large degree what might trigger experiences of moral distress for a given individual. Senge describes mental models as “deeply ingrained assumptions, generalizations, or even pictures or images that influence how we understand the world and how we take actions. Very often we are not consciously aware of our mental models or the effects they have on our behavior.”

Both the significance and the impact of mental models on the experience of moral distress cannot be understated, as mental models help to explain why the experience of moral distress is so individualized and why it can only be addressed systemically throughout the organization. This notion is contrary to previous approaches that attempt to identify the potential for moral distress by isolating specific incidents thought to trigger such distress for large numbers of individuals within the organization. Understanding the role of mental models becomes a shared responsibility between the individual healthcare practitioner and the organization. Just as individuals have mental models or sets of assumptions upon which they make their decisions, organizations develop their own sets of mental models based on the workgroups that exist within the organization. The assumptions of the work group come to define shared beliefs and ultimately cause the group to act in certain ways. The organization must strive to seek out this information from its employees, who must be willing to share their own views if actions are to be taken to address issues that may lead to moral distress. Understanding the impact that mental models can have on individual employees’ perceptions of
their workplace has been shown to influence an organizations’ ability to embrace the tenants of appreciative inquiry.

2. Appreciative Inquiry in Healthcare

The healthcare environment is well suited to benefiting from the techniques of appreciative inquiry, given the relational aspect and active listening approaches that help to define it. The following provides two examples of the successful implementation of appreciative inquiry in helping to address two very different concerns in a hospital setting.

The first example is taken from the University of Virginia Medical Center, which in 2007 was confronted with its house staff training program’s being placed on probation by the Accreditation Council for Graduate Medical Education. The effects of loss of full accreditation had the potential to greatly reduce the stature of the school and the reputation of the hospital. The medical center turned to the appreciative inquiry process in an attempt to better understand what the school had previously excelled in and to seek solutions that would allow them to build upon their strengths. The school regained its full accreditation, and in the process the administrators learned that the appreciative inquiry process had increased employee engagement, improved communication across departments, and improved the sense of psychological safety, which is critical to creating an environment of trust. Building upon the lessons learned during this process, additional departments began to use appreciative inquiry when confronted with operational challenges that might previously been addressed from a more negative perspective.

The second example is taken from a study undertaken by Dewar and Nolan, which sought to develop a compassionate relationship model of care that could be implemented in an acute care hospital serving older adults. The appreciative inquiry model was used in this study to develop a model for caring conversations between the caregiver and the patient. Questions were
developed to draw out positive feedback from the patients and would assist the caregivers in strengthening the relationship with the patient and creating opportunities for caring conversations. The survey included such questions as “What matters to you most whilst you are in hospital?” “Tell me something that will help us to care for you here?” “What things have worked well for you here?”

The lessons learned from the problems at the University of Virginia and the study on creating compassionate relationships in an acute care setting support the use of appreciative inquiry as one means of enhancing the quality of conversations that might lead to positive change within the organization.

3. Appreciative Inquiry and Conversational Capacity

In his book *Conversational Capacity*, Craig Weber puts forth the notion that despite the amount of knowledge and expertise that a given team may have regarding their subject matter, the team will be ineffective and inefficient if it is lacking in what he terms “conversational capacity.” The foundation for this capacity is rooted in psychological safety and in the ability not only to ask questions but also to ask them correctly, as described in discussing the methods used with appreciative inquiry. Conversational capacity seeks to have conversations about difficult subject matter in a non-defensive balanced manner.

Certainly, given the personal nature of issues involving the experience of moral distress, the need for the ability to raise issues of concern effectively is critical in helping to confront such issues. While the systems approach to addressing and resolving moral distress within the organization is paramount in addressing such distress, responsibility must be shared with the individual practitioner. These practitioners must seek to understand themselves well enough to
appreciate what might act as a trigger in producing moral distress within themselves and work with the organization to address such triggers.

Craig Weber has identified several triggers, including how much we care about the issue, what our status is within the organization, the level of expertise we may have in a given subject, and the perceived risk of speaking up versus the perceived risk of not speaking up. Despite policies that are consistent with the operating goals and the mission of the organization, the responsibility lies mostly with healthcare practitioners to both stand up and speak up for themselves in situations that they believe are inconsistent with their own moral beliefs. The role of organizational leadership in cultivating a non-threatening/non-judgmental environment that permits effective conversations about concerns is essential for ultimately reducing the experience of moral distress across the organization.

E. Addressing Moral Distress with Empowerment

Chapter 6 reviews current research surrounding empowerment. Whether one is empowered by someone else to act or whether they empower themselves to act independently from some other authority, empowerment is thought to be a process whereby individuals gain mastery over their own lives. The control that results from this empowerment can play a significant role in reducing the feelings of powerlessness so indicative of moral distress. In an organizational setting, such empowerment can be established only within an environment of trust and within operating systems that support these efforts.

This goal strongly emphasizes the need for operating systems that are clear, concise, and consistent with the established mission, vision, and values of the organization. The effective use of empowerment within an organization helps to support the thesis of the current study by
demonstrating the appropriate balance between the individual and the organization in helping to reduce incidents of moral distress.

1. Organizational Leadership and Moral Discourse

One of the basic elements of empowerment is the opportunity that it creates to bring about positive outcomes for both the individual as well as the organization. Consistent with the findings of Edgar Schein discussed above, Kuokkanen, Leino-Kilpi, and Katajisto found that in order for nurses to have any real impact on their work and their decision making capacity, empowerment must be evident at the lowest level of the organization, not merely in the more senior positions within the organization. In order to do this, the environment, and ultimately the culture of the organization, must support team-oriented decision making, values that are integrated throughout the organization, and sufficient resources for education and training to support the goal of developing an empowered workforce.

If organizational culture is to have a significant impact on establishing an environment where issues of moral distress are lessened, such must begin with the leader’s ability to create an environment of psychological safety for every employee at all levels of the organization. While this may be one of the most difficult responsibilities of organizational leaders, there are eight readily identifiable means of establishing psychological safety within the organization. The following eight guidelines are being presented in relation to the goal of identifying and reducing moral distress within the organization by first establishing a workplace in which employees do not feel threatened when bringing concerns regarding moral distress to their supervisors. They include the following:

1. Leaders must establish a compelling positive vision to show that they have a primary goal of addressing and reducing incidents of moral distress system-wide.
2. **Formal training/education** must be provided on moral distress, its causes, and steps to be taken organizationally to reduce it.

3. **Employees must be involved** in the solution at all levels of the organization.

4. **Informal training of groups or teams** of individuals should be carried out to address specific concerns of those individuals.

5. **Trained coaches should be available** to provide feedback to employees as they work through the changes necessary to achieve more open communication.

6. **Positive role models** must be identified within the organization that can model desired behavior and demonstrate that it is safe to express opinions and offer improved ways of addressing concerns.

7. **Support groups** should be provided to those who desire reinforcement of the new communication methods.

8. **Systems and structures** must be developed that are consistent with the desired changes.

2. **Organizational Leadership and Moral Courage**

The presence or absence of moral courage in the workplace can serve as an indication of the potential for moral distress, with the degree of moral courage having an inverse relationship to the degree of moral distress experienced. Rushworth Kidder offers an interesting observation regarding the relationship between the role of individual moral courage and the responsibility of the organization to foster moral courage. Kidder puts forth the notion that although organizations seek individuals who have moral courage, organizations must strive to create the type of culture and environments where moral courage is not needed. The practice of appreciative inquiry discussed above provides a strong foundation that not only supports the ability of an employee to express moral courage but also, when used effectively, reduces the
need for moral courage on the part of the employee when bringing issues of concern to those in power.

The organization has an opportunity to provide an environment that reduces the likelihood that moral distress will be experienced by their employees. To do so, the organization must avail itself of the most current research relating to issues of moral distress and implement those practices that have proven successful. For example, current research suggests that when nurses believe they are working in a constructive work culture that generates high levels of work satisfaction, lower levels of moral distress are noted. Nurses who believe that they have a good relationship with peers, patients, managers, physicians, and hospital personnel have also been observed as experiencing less moral distress. Contrary to these positive steps are findings indicating that if nurses work in organizations without policies in place to guide ethical practice or mechanisms for addressing complex conflicts with physicians, they will experience more moral distress. Adopting the method of appreciative inquiry within the LTC setting would provide the support that is so vitally needed in preventing and addressing issues of moral distress.

3. Organizational Empowerment of Caregivers

One of the ways that an organization can integrate its operations in a manner that allows individual employees to feel valued, respected, and trusted is by empowering employees at all levels of the organization to make decisions on behalf of the organization that are consistent with its culture, mission, vision, and values. At the core of empowerment within the organization is a relationship that is cultivated between leaders and followers based on mutual honesty. In the hospital environment, researchers have found that distinct dimensions of empowerment are evident. These are characterized as behavioral, verbal, and outcome bound. Behavioral
empowerment refers to the sense of control that employees have over their work environment as a result of their actions. Verbal empowerment refers to the perceived ability of employees to express their opinions. This empowerment would be tied to the degree of psychological safety felt by the employee. Outcome empowerment refers to the degree to which employees believe they can influence the outcome of decisions that are made. Just as with the need to operationalize the mission, vision, and values of the organization when approaching issues of moral distress from a systems perspective, the need to fully understand and capture the true meaning and goal of empowerment is essential if it is to become a positive factor in addressing and reducing incidents or moral distress system wide.

Just as both the culture and leaders’ methods of communication have been demonstrated as playing a critical role in helping to minimize the effect of moral distress within the organization, the role of leadership in empowering employees is equally critical. For this, leaders must be aware of their central role in articulating a moral vision, understanding the needs of the employees, and helping to support ongoing efforts to increase the self-awareness and self-confidence of each employee. In doing so, leaders will help to increase employees’ understanding of their own moral identity. Each of these factors contributes to the feeling of psychological empowerment so critical to addressing and reducing issues of moral distress in the workplace.

If we consider that one of the main goals of the current study is to expand the argument regarding the causes of moral distress to include both the individual and the system in which that individual works, empowerment can be seen as the bridge that connects the individual with the organization in identifying and reducing incidents of moral distress. Although empowerment can often elicit notions of a hierarchical organization, when appropriately handled by a skilled
leader, empowerment can be mutually beneficial to both the organization and the individual. Ethical leaders will work to create both the culture and the communication methods necessary to support the moral development of their employees, permitting the appropriate balance between the independent actions of the employees and the leadership skills necessary to foster such empowerment.

**F. End of Life Care and Moral Distress**

Chapter 7 focuses on the research in the previous chapters concerning moral distress as applied to LTC at the end of life. The care provided to patients at the end of life is frequently acknowledged as being ethically complex. End of-life care is often seen as fragmented, marked by poor communication among the care providers and a lack of consensus regarding the plan of care. The treatment decisions that are made regarding end of life can affect the patient, the family members or others close to the patient, and the caregivers providing the care. In the case of the caregivers, issues of moral distress can arise when the caregiver thinks the treatment decisions are morally wrong or when health professionals feel forced into following end-of-life policies that they believe are causing harm to the patient. Specific responses to reducing moral distress when providing care at the end of life will be discussed from a systems perspective. The impact of the culture on end-of-life care, the role of leadership in supporting cultural sensitivity, and the methods of communication used will be shown to have a positive impact on acknowledging and reducing incidents of moral distress when addressed systematically throughout the organization.

**1. The Role of Culture and Compassion at the End of Life**

Although great strides have been made in attempting to challenge the contemporary thinking that people go to nursing homes to die, it is true that those working in nursing homes are
confronted with death on what might be regarded as a somewhat routine basis. A 2010 study conducted by the Brown University Center for Gerontology and Healthcare Research found that approximately one in two Americans 85 years of age and older die in nursing homes. Issues surrounding end-of-life decision making can often lead to disagreements among the staff regarding issues of respect for resident autonomy and those that surround the quality of life and quality of care for the patient. How an organization comes to address the dying process from a systems perspective can play an important role in helping to reduce the experience of moral distress for caregivers. How to maintain the dignity of each patient in what becomes an often-repeated event is critical to maintaining the humanity of all those involved in providing care, including the healthcare practitioner whose job it is to provide support and comfort for the dying resident.

Unlike the acute care setting, where patients and their caregivers may not have the time necessary to establish a relationship, residents in LTC communities often have lengths of stays extending for a number of years. During that time, relationships develop that are beneficial to both the patient and the caregiver. These relationships, however, make it much for painful for caregivers when each of the people they have befriended pass away. The need to provide compassionate care at the end of life is an essential component both for the patient and for the caregiver. Immanuel Kant presented a specific notion of compassion when he expressed his belief that while it may not be our duty to feel compassion, it is our duty to nurture the capacity in us to feel it. When we confront issues of moral distress, this duty to nurture the capacity for compassion becomes a shared responsibility on the part of the organization with the caregiver. It is addressed through a system-wide acknowledgement of the importance of the leadership of the organization, the culture that is supported, and the methods of communication modeled
throughout the organization. Compassion, just as experiences of moral distress, is individualized, requiring strength and courage on the part of the caregiver. In seeking to connect with their patients as human beings, caregivers expose themselves to a degree of vulnerability which, if not recognized and supported, can lead to experiences of moral distress over time. Institutional support in the form of ethics education and mechanisms for follow-up discussions regarding care that was viewed by the caregiver as being ethically challenging can help to establish a culture that provides support for the caregiver and compassionate care for the patient.

2. Leadership and Cultural Sensitivity

One strategy to reduce the amount of moral distress experienced by healthcare providers who participate in end-of-life care is to provide support and advocacy for those experiencing the symptoms of moral distress. Active listening, in a non-biased environment can prove to be beneficial to both the individual and the organization. Education offered on an interdisciplinary basis and collegial practices are two strategies that can be initiated to reduce moral distress. Open collegiality and models of shared practice can help to establish a sense of shared responsibility and minimize feelings of moral distress. This shared responsibility is particularly helpful when supporting end-of-life decision making because it helps to provide support and to share the burden of repeated involvement in end of life care.

An organization whose mission, vision, and values are aligned with its operating policies and expectations of employees at all levels of the organization is well positioned to enhance the moral character of the organization and, in so doing, to minimize the experience of moral distress for employees. Though issues such as moral ambiguity, lack of moral discussions within the organization, lack of ethics education for the workforce, and a diffusion of responsibility among employees all serve to perpetuate incidences of moral distress, proactive measures to address
these issues have been found to effectively reduce such distress. The cultural values of the healthcare organization should be evidenced within it through shared values, ones that lead to action, and in creating an environment where all those interacting with the organization feel safe in bringing their issues forward for discussion.

3. Communication and the Empowerment of Caregivers to Address Moral Distress

One means of identifying whether or not a given circumstance might lead to or has led to moral distress was developed by the American Association of Critical Care Nurses. The method, called “The 4 A’s,” is an effort to empower employees to take control over their own situations and work to reduce their own moral distress. The association recommends that healthcare practitioners first ASK themselves if what they are feeling is consistent with the definition of moral distress, as discussed in Chapter 3. If moral distress is a concern, they recommend that practitioners AFFIRM their own feelings on the issue to determine what aspect of their moral integrity is being threatened, ASSESS what is believed to be the correct course of action, and ACT by developing a plan to address the source of the distress. The “4 A’s” (ASK, AFFIRM, ASSESS and ACT) empower the practitioner to take corrective action, first by acknowledging that the circumstances being confronted could lead to moral distress, and then followed by the support in actions to relieve such distress.

While this approach places a great deal of responsibility on the individual practitioner, if all other systems are in place within the organization (a supportive culture, respect of each employee reinforced by strong leadership, and methods of communication that are open and non-threatening), the 4A’s approach might prove to be a valuable method for combating the negative effects of moral distress. Conversely, if the systems are not in place for appropriate support of a
practitioners who use the 4 A’s, they may experience additional distress from not being heard and/or valued.

4. Systemic Measures for Reducing Moral Distress in End-of-life Care

It is hopeful that proven methods do exist which can have a positive impact on reducing incidents of moral distress for the caregiver. One such system-wide approach with the ability to be readily transferred to the LTC setting is the Moral Distress Consult Service (MDCS). This service, which was first developed and implemented at Virginia Commonwealth University Hospital, functions in much the same manner as the ethics consultation service. One distinction of the MDCS is that it focuses exclusively on issues that have resulted in morally distressed staff versus the more common approach of addressing more general ethical dilemmas resulting from clinical cases. The primary purpose of the MDCA is to minimize and ultimately prevent the crescendo effect by proactively addressing morally complex issues. Building relationships is a critically important element within an organization that is often neglected or underestimated. Efforts to bring people together to address common challenges, such as those found throughout the LTC environment, can serve as a strong indicator to employees that the organization has a desire to address individual issues of moral distress.

A second approach, and one of the most effective means for addressing and ideally preventing issues of moral distress and which succeeds system wide, was developed by the Schwartz Center for Compassionate Care in Boston, MA. Established in 1995 at the bequest of a Boston healthcare attorney with terminal cancer, the Schwartz center was established with one goal in mind: “to promote compassionate care so that patients and their caregivers relate to one another in a way that provides hope to the patient, support to the caregivers and sustenance to the healing process.”
One of the hallmarks of the Schwartz Center is their advocacy and promotion of what they term Schwartz Center Rounds. These rounds are of particular importance in the current discussion regarding end-of-life care and moral distress as they provide an opportunity for healthcare providers to meet at a regularly scheduled time to discuss social and emotional issues they are experiencing in caring for their patients. The Schwartz Center Rounds provide an excellent example of a system-wide initiative as these discussions involve trust on the part of the administration in sharing what may have been errors in medical judgment, trust, and empowerment of the employees who have the courage to share their emotional turmoil, and systems that support the free exchange of confidential information for the purpose of minimizing the emotional distress of the caregiver. In addition, the sessions provide an opportunity for learning that results from receiving feedback on other courses of action that might have been possible and might have produced more positive outcomes.

G. Summary and Conclusion

Chapter 8 provides a summary for and conclusion of the current study. Moral distress having been understood mostly as a phenomenon of the individual, efforts to address and reduce incidents of moral distress have focused almost entirely on the individual and on his or her reaction to specific triggers. The current study attempted to shift the focus away from the individual and to consider efforts to address moral distress from a systems perspective by considering the impact of three specific operational factors within the LTC setting. These include the culture of the organization, its leadership, and the organizational methods of communication. The ethical problems that can arise in a healthcare environment are inextricably linked to the environments in which they arise. The ethical dilemmas that result cannot be
viewed as random failures but must be identified as unintended consequences in the systems in which they occur.

This study uses a systems approach known as holism to emphasize the idea that the whole of the organization is greater than the sum of its parts. The Strong Connections Law is applied to the interconnectedness of three distinct aspects of the LTC environment: the culture, the leadership, and the methods of communication that help to define the organization. Of particular importance in the current study is the argument that in order to reduce incidents of moral distress within the LTC environment, both the organization and the individual must play equal roles in addressing both the causes and possible mechanisms to reduce such distress. In this instance that method is a systems approach which focuses on operational improvements related to organizational culture, leadership, and communication.

Additionally, the important role of the correct use of empowerment both organizationally and individually has been revealed as a key factor in understanding the critical connection made between these three factors. Though in LTC there is a history of acknowledging the importance of inter-departmental communication, this study attempts to enhance that notion, seeking not only coordination between departments but also a recognition of the need to understand how each of the areas contributes to the proper functioning of the whole. Whereas LTC providers are accustomed to looking at the organization from a multi-disciplinary perspective, applying a systems approach to addressing issues of moral distress allows for the integration of the culture, leadership, and the methods of communication within the organization all to be directed toward a specific goal. The result of this integration is the ability to reduce incidents of moral distress systemically throughout the organization.
The true answer to reducing the experience of moral distress experienced by caregivers does not rest solely with either the caregiver or the organization. To address issues of moral distress effectively, solutions must be achieved through a joint effort between the organization and the caregiver. The result of such efforts will be improved quality of care for the patient and an emotionally stronger, more engaged healthcare team.
Chapter 2: Implications of Organizational Culture

The culture that exists within an organization serves to represent the values and beliefs of the organization itself. Given this fact, the culture within the organization can serve as either a positive reflection of the work being conducted, or it can serve to discredit the organization if the values and practices within that organization are not representative of their stated mission, vision, and values.¹

A. Organizational Ethics and the Role of Organizational Culture

As one of the three main factors identified as having the potential to have a positive effect on the experience of moral distress within an organization, understanding the culture of an organization becomes a critical component to implementing a systems approach effectively for reducing moral distress. Organizational ethics can be thought of as an organization’s desire first to define and understand their mission and core values, and then to seek ways of ensuring that the operational aspects of their business are consistent with their stated values. When conflicts arise the ethical organization will seek to find ways to bring these values back into alignment both for individual employees and for the organization itself.²

In his 1951 book, The Changing Culture of a Factory: A Study of Authority and Participation in an Industrial Setting, Elliott Jaques describes organizational culture as something that develops around a set of mutually agreed upon standards and practices. Over time these practices come to define the organization and exert a degree of control over those working in the organization in terms of acceptable and unacceptable behaviors.³ Jaques’ definition is important to the current discussion as it begins to touch on the oftentimes unwritten understanding of those within an organization to act within certain acceptable patterns of behavior. In addition, Jaques’ representation of the culture of an organization causes one to view
the organization as a whole—despite the number of independent departments or numbers of employees within that organization. If one then agrees that organizations do develop a culture that comes to define both the organization itself and the individuals who work there, taken one step further, the organization then shares responsibility with the workforce within it to operate in an ethical manner. It is this shared responsibility that helps to substantiate the premise of the current paper, which seeks to demonstrate that both the causes of and reductions in the incidents of moral distress should be viewed as a shared responsibility between the individual and the organization and that such incidents can be shaped by the culture that is established within the organization.

The recognition of the shared responsibility that exists between the organization itself and the individuals within that organization helps to illustrate the fact that both the individual and the organization share in the development and sustainability of the culture that comes to define them. An individual may initially express his or her own moral agency; then, ultimately, networked agents will each contribute to the culture and ethical practices that come to define the organization.\(^4\)

1. **1995 Joint Commission Mandate and the Pioneer Network**

Recognition of the importance within a healthcare organization of the role of individual moral agents and the broader role of the organization itself in acting as a moral agent was highlighted by the Joint Commission on the Accreditation of Hospitals in 1995. At that time, the commission established a requirement for all healthcare organizations seeking to be accredited by that body to include an organizational ethics program as part of the requirements for accreditation.\(^5\) The significance of this requirement cannot be understated in relation to the goals of reducing incidents of moral distress within the organization as it established ethical
responsibility not only on the individual working within the organization but also on the
organization itself in the manner it conducts business and provides care. In addition, though not
specifically addressed within the mandate, it has had significant implications for the
development and on-going importance of the role of leadership within the organization and the
culture that comes to define the organization. Both patients and society in general have now
come to agree that the provision of healthcare must be seen as a moral enterprise and that it is the
responsibility of all those involved; the individual practitioner as well as the organization itself to
ensure that ethical practices form the foundation of the provision of care that follows.

While the 1995 mandate by the Joint Commission on the Accreditation of Hospitals
marked a significant milestone in addressing both individual and organizational ethical
responsibility for the care and operation within the acute care setting, similar work began in 1997
with the first meetings of what would become known as the Pioneer Network within long-term
care (LTC) organizations. The Nursing Home Pioneers, as they were originally labeled, was
made up of practitioners within the LTC environment who recognized the long overdue need for
significant improvements to the care that was being provided to the residents of LTC
communities as well as for the staff seeking to provide that care. What was realized by this
group of professionals was that the changes necessary would require not only changes to
particular policies and procedures but also, and more fundamentally, changes in the attitudes and
behaviors that had come to define nursing home care. In short, what was needed was a change in
the overall culture of these organizations. The result was what became known as the Culture
Change Initiative, the goal of which remains to establish caring communities where staff are
empowered to care for residents and where residents are encouraged to remain as independent as
possible, with the quality of life of the resident becoming the main focus of all staff members.
The Pioneer Network was begun as a grass roots effort by “pioneers” within the industry who were disheartened by what they viewed as inadequate and often detached care of residents in an environment marked by high turnover of staff and detachment from the outside world. In their own words the “Network’s vision is to create in America a culture of aging that is life-affirming, satisfying, humane and meaningful.”¹⁰ Consistent with the premise of the current study, those involved in the culture change movement recognized the need for systemic change within the LTC environment and sought to achieve those changes through their work to change both individual and societal attitudes towards aging through education and policy reforms.¹¹ Additional reference will be made to the on-going work of the Pioneer Network in relation to treatment at the end of life as well as their focus on making systemic changes to the system in order to realize true culture change.

2. Organizational Moral Agency/Responsibility

Although the mechanism for judging the moral agency of an organization may differ from the criteria used to assess an individual healthcare provider, the organization must accomplish on an aggregate basis what the individual accomplishes through his or her own dealings with an individual patient or the public.¹² It is interesting to note that management researchers maintain that corporations elicit, perhaps unintentionally, unethical behavior by employees. A majority of managers surveyed believed that organizational pressures, not character flaws with individual employees, led people in their organizations to act unethically.¹³ The organizations themselves and the way that they encourage or discourage ethical or unethical practices become the primary influence on the moral identity of their employees.¹⁴ The degree to which the organization itself encourages or discourages ethical or unethical practices, whether
consciously or unconsciously, helps to form the culture of that organization and the way it is viewed, both internally by its own employees and externally to those that it serves.

Steven Pearson, et al. have described three interrelated yet distinct dimensions that they have identified as comprising organizational ethics. From their perspective, organizational ethics includes an inspirational component often found in the mission, vision, and values of the organization. In their view, organizational ethics is the result of 1) a deliberative or analytical component, which is looked to as a means of identifying ethical challenges within the organization and 2) management processes that can be developed and implemented, and which will be integrated throughout the organization and will help to establish the ethical culture of the organization itself.\(^\text{15}\) Taken one step further, it is not difficult to accept the notion that organizational identities can in fact influence individual moral identities. This concept serves to elevate the importance that the organization itself can have on the moral character of the individuals working there.\(^\text{16}\)

Allen Buchanan has described bureaucratic organizations as characterized by a “complex web of principal/agent relationships” where the agents perform tasks on behalf of the organization as directed by top management.\(^\text{17}\) While this characterization may in fact provide an accurate representation of healthcare organizations in the past, a model put forth by Karl Weick appears to apply more accurately to the workings within healthcare organizations today. Weick describes healthcare organizations as open systems that are created by and interact with changing sets of agents. He suggests that organizations are constantly reinventing themselves as they adjust to changing interrelationships and to the changing environments in which they find themselves. Weick’s characterization allows for a broader understanding of the organizations as an entity that can be deemed as acting as a moral agent in its dealings both internally and
externally, and more appropriately reflects the continually changing environments within healthcare.\textsuperscript{18}

3. Individual Moral Agency/Responsibility

A professional working in a healthcare organization exercises individual responsibility through moral agency. A professional must answer for his or her actions.\textsuperscript{19} What becomes an important consideration when discussing the role of organizational ethics is the impact that organizational factors can have both positively and negatively on an individual’s ability to exercise moral agency. An important factor to consider when attempting to understand the role of individual moral agency is the recognition of the role that the organization can play in facilitating the individual moral agency each of its employees.\textsuperscript{20} Research suggests that individuals will behave in a manner contrary to their own beliefs if they believe that a legitimate authority—for example, a supervisor or boss—is accepting the responsibility for their actions.\textsuperscript{21} In the healthcare setting this may take the form of following a policy even if that policy is felt to contradict the individuals’ personal beliefs or is contrary to what they believe to be the correct course of action.

Recent research regarding moral agency suggests that it should be viewed as more than isolated individuals acting in rational ways to deal with ethical problems. Rather, moral agency can be better understood as individuals acting in a sphere of interconnectedness with one another. This expanded view acknowledges the interrelationships and interdependencies that exist for all practitioners within their own organization based on the culture and context of their work environment.\textsuperscript{22} The ability to interact openly with other members of the healthcare team in an environment that is psychologically safe and that is supported by the organization reduces the likelihood that moral distress will come to permeate the employees of that organization.\textsuperscript{23}
relationship that exists between the individual employee and the organization becomes symbiotic as both the employee and the organization influence the behavior of the other.24

As referenced in Chapter 1, Cathleen Kaveny has proposed a theory of agency that seeks to combine individual moral agency with that of the social structures or organization of which the individual is a part. Kaveny puts forth the concept of “networked agents” and argues that individual actions should be viewed within a much broader framework that includes the context within which the individual agents function.25 Kutz has suggested a similar framework regarding the role of individual moral agency in relation to complicity in terms of what he terms “I-We” problems. Kutz explains that although the individual agent, “the I,” might participate in a harm caused by something that “We” do, the “I” is not personally accountable for the harm caused because of the insignificance of the individual contribution.26 Central to this argument is the understanding that issues surrounding the association of an individual agent with harms mediated by other agents comprise the domain of complicity.27 The principle of complicity will be discussed in further detail as it relates to threats to individual and organizational moral agency.

Finally, Dennis Thompson speaks of the difficulty in clearly distinguishing between the role of individual moral agency and that of organizational moral agency as the “problem of many hands.” Specifically, he suggests that because many people contribute in numerous ways to the decisions and policies that are made within an organization, it may be difficult if not impossible to determine who is morally responsible for those decisions and policies.28

Organizational ethics, when implemented effectively, provides the framework for the establishment of institutional moral agency, including the establishment of the culture as well as guidelines outlining the treatment of employees and all those with whom it interacts.29 It is in
this area of moral agency and individual versus organizational accountability that any understanding of moral distress, its causes, and its remedies becomes more complex. On the one hand, individuals must be held accountable for their particular actions with the organization based on the responsibilities of their position. Conversely, organizations must be responsible to each employee for establishing and fostering an ethical climate whereby the collective activities of all employees are responsible for the consistent operation of the organization and alignment with organizational mission and values.\textsuperscript{30} The mechanism for achieving this balance is the established culture that has been allowed to permeate the organization.

4. Threats to Individual and Organizational Moral Agency

Research studies suggest that it can be difficult for individuals to act in accordance with accepted ethical norms and professional standards in the face of serious organizational barriers.\textsuperscript{31} These barriers could be related to a hidden culture within the organization that works against compliance with written and formalized policies and procedures; the barriers could exist due to a disconnect between the written mission, vision, and values of the organization and its internal policies, or they may be the result of the absence of a just culture within the organization. Each of these barriers increases the likelihood for serious issues to develop relating to conflicts of interest, conflicts of conscience, moral ambiguity, and moral disengagement. Complicity with unethical practices can be the result of both intentional and unintentional cooperation with wrongdoing.\textsuperscript{32} Managers who understand the specific ethical challenges within each area of their organization are in a better position to eliminate the specific barriers being faced by their employees.\textsuperscript{33} Whether intentional or unintentional, the involvement of employees in unethical practices can lead to incidents of moral distress as a result of employees’ acting in a manner that is contrary to their own moral belief systems. Specific examples of what is meant by
organizational complicity are provided below in a discussion of what is meant by conflicts of interest, conflicts of conscience, moral ambiguity, and moral disengagement.

Organizational complicity encompasses both the acts of individual moral agents and those of the organization acting as a moral agent. In the medical environment as in life itself, good can often be intertwined with evil. Changes in both medicine and society over the past several years have resulted in a morally pluralistic society, both culturally and ethnically. With this diversity has come a blurring of the lines between what actions may be deemed morally permitted and those that are not. This fact will be shown to be one of the main sources contributing to moral distress within LTC, particularly in relation to decisions regarding end-of-life care. This issue will be explored in detail in Chapter 7.

Within the healthcare environment these beliefs can translate into complicit acts with physicians cooperating either formally or materially in wrongdoing. Unfortunately, examples of such complicity are prevalent in the medical community and include such practices as fraudulently completing insurance forms so that a patient will receive needed care, a physician working within a managed care system who perhaps unwillingly cooperates in causing harm to a patient while adhering to policies designed to save money, or physicians who cooperate with a hospital policy that they believe is wrong to avoid the loss of income or censure to themselves for speaking up.

What these examples help to demonstrate is the complexity of the issues surrounding complicity in the healthcare setting. While these examples are intended to highlight the fact that the intentions of the physician in addressing the needs of his patient may in fact be appropriate, the act itself remains unethical and in some cases illegal. Other acts of cooperation focus more directly on the complicity that directly benefits the physician himself or the organization for
which he works. These examples will be discussed below relating to conflicts of interest and conflicts of conscience in matters of complicity and cooperation.

Organizational cover-ups provide an additional example of complicit acts that are both intentional and potentially costly to the organization. In situations where the organization may be publicly embarrassed, the tendency on the part of the organization may be to refrain from any public chastisement in order to protect both its internal and external reputation.\(^{36}\) While this may serve the short term goal of protecting the organization from embarrassment, the longer term implications of participating in such complicity can affect the culture and ethical integrity of the organization.

As referenced above in the discussion involving individual moral agency, Kutz offers an explanation of accountability that helps to explain the interrelationship of the individual moral agent with that of the organization in what is termed the complicity principle. This principle explains that the individuals are accountable for what others do when they intentionally participate in the wrong they cause and that individuals are accountable for the harm that is caused together with others, independent of the actual difference one individual makes.\(^{37}\)

In the examples provided above, employees who are aware of fraudulent insurance practices or of specific policies that call for limiting care that is based on financial considerations is complicit in these acts, though perhaps never actively participating in such acts themselves. Factors such as the structure of the organizations and the availability of information can be used to affect the degree of complicity that individual employees acknowledge in an organizational setting.\(^{38}\)

The current paper examines the need for an integrated, systematic approach to addressing and ideally preventing issues of complicity and cooperation in wrongdoing that may contribute
to the experience of moral distress among employees. This issue is often not one of needing to identify one large single cause but thousands of small causes, each of which may be insignificant when taken individually but that become decisive when taken together.\textsuperscript{39} It is possible that in an organizational environment, the collective sum of the decisions and actions that take place are worse than its parts, the individual actions of its members.\textsuperscript{40} Because negative effects of complicit acts are felt throughout the organization, only system-wide approaches to addressing such acts will prove successful.

Specific acts of complicity and/or cooperation with wrongdoing are seen within the healthcare organization in practices that are deemed as representing conflicts of interest and conflicts of conscience for both the individual and the organization. Often these conflicts are the unintended result of a complex web of financial arrangements between healthcare practitioners and the industry itself.\textsuperscript{41} As one more example of the expansion of ethical dilemmas that originally defined bioethics, conflicts of interest within the healthcare organization were once thought to relate to a limited number of physicians and should therefore be addressed privately by them. As the role of the healthcare provider has expanded, so also have the opportunities for potential conflicts of interest to emerge, which have proven to pose a much more serious threat to the organization than was once imagined.\textsuperscript{42}

Specific examples of conflicts of interest that have been noted within the healthcare industry relate largely to inappropriate financial ties that exist between physicians and the broader healthcare industry, such as for-profit research facilities, the misuse of professional journals to highlight a drug or medical device that the writer/physician has a financial interest in its marketing, and the awareness of possible financial ties between a physician and the pharmaceutical company making the medications that are being prescribed by the physician.\textsuperscript{43} In
worst-case scenarios, these conflicts of interest have been found to influence the care that is being provided to the patient, with the physician choosing to promote his or her own interests over those of the patient in determining treatment decisions. These examples help to support the need, which was identified by the Joint Commission in 1995, for an organized, systematic method of establishing and mentoring organizational ethics practices within healthcare.

It is unfortunate that many of the issues involving conflicts of interest and conflicts of conscience relate to the impact of money on the provision of care, both for the individual provider as well as the institution’s need to be profitable. Serious ethical concerns are raised by the difficulties that emerge as a result of the difficult ethical choices that must be made, which require a balance between the economic viability of healthcare as a business and the quality of healthcare that is demanded. In recent years, concerns regarding the impact to patient care resulting from physician compensation and incentive structures have become more and more widespread. Two different methods of physician compensation, capitation of fees and fee for service, each pose the potential to affect the care that is given. The first involves the concern of providing as little care as possible and the second, the concern of providing unnecessary services for the purpose of generating as much revenue as possible from each patient treated.

It is interesting to note that as concerns surrounding conflicts of interest have increased, regulatory mechanisms have been put into place to prohibit physicians from referring patients for tests or medications to companies or products in which they have a financial interest. In addition, practice guidelines and utilization review committees have been established for the purpose of monitoring the clinical choices that are being made to insure that the decisions made are in the best interest of the patient, not solely in the financial best interest of the physician or health system. Ultimately, however, the organization must educate the staff on the
organization’s commitment to moral decision making, including their requirements for profitability and the moral duties that extend beyond that profitability.\textsuperscript{48}

Conflicts of conscience are generally associated more with individual providers and their moral agency versus determinations of the conscience of the organization. However, when viewed from an organizational ethics perspective, the responsibility for addressing those conflicts of conscience must be shared equally between individuals and the systems in which they work. Addressing conflicts of conscience must be seen as a shared responsibility if the organization is to respect the integrity of the individual while at the same time upholding the mission and values that define it.

The involvement of the legal system in matters generally thought to be the domain of medicine has placed additional moral burdens on the shoulders of medical providers who were torn between their personal moral beliefs relating to specific medical procedures and those that were becoming legalized within society. Specifically in relation to the landmark Roe v. Wade Supreme Court decision legalizing abortion, physicians began to express serious concern about their right to refuse to perform procedures or treatments that they believed to be immoral.\textsuperscript{49} Because it is not always feasible for physicians to work in organizations, such as Catholic health systems, which share their moral and religious beliefs, ethics clauses began to emerge as one means of protecting individual providers from having to perform procedures or treatments that they finds morally objectionable.\textsuperscript{50} Mechanisms must be put into place largely through the culture that is developed and the policies and procedures that are implemented to convey a message to the individual employee of an organization’s commitment to honor employees’ personal moral beliefs in the performance of their duties. This practice will have the additional
benefit of building trust between the employee and the organization, and it can effectively reduce incidents of moral distress in the workplace.

Discussion has taken place regarding the role of conscience clauses in healthcare that ask whether or not it is a reasonable expectation of the healthcare organization to have to make allowances for the moral beliefs of their employees or whether it should be required of the employees to draw a distinction between their personal moral lives and their morals at work. Essentially what is being asked is whether or not it is morally acceptable to permit physicians to exercise their own moral agency when making judgments about what types of procedures they will agree to perform. Fortunately, the consensus today acknowledges that it is an unrealistic expectation for medical professionals to restrict their strongly held personal beliefs to their private lives. Edmund Pellegrino, for example, has suggested that because nearly all clinical decisions require value judgments of one type or another, it is not reasonable to expect physicians to have to subrogate their own moral integrity in honoring the wishes of the patients simply because of the profession they have chosen.\textsuperscript{51}

Lessons learned as a result of the revelations regarding the unspeakable cruelty to human subjects of scientific research at the hands of physicians lends further support for permitting the role of individual conscience to guide physicians. Experiments such as those conducted at Tuskegee, Willowbrook, and the Nazi concentration camps during World War II clearly provide evidence that organizations need both to adhere to strong ethical practices and, equally important, to support ethical decision making process by their employees as a cross check of organizational practices.\textsuperscript{52} In appropriately addressing issues surrounding conflicts of conscience by individual practitioners within the healthcare organization, the organization has
acknowledged its desire to support the beliefs of morally serious physicians and healthcare professionals.\textsuperscript{53}

Conscience clauses do not, however, provide protection to the organization itself that may wish not to provide certain services that are not consistent with their stated mission and values. A specific example relates to a New York State Court of Appeals ruling that requires all employers who choose to provide their employees with insurance coverage that regularly covers the cost of prescription drugs must also cover the cost of contraceptive medications. An exception to this requirement was given to non-profit organizations that could prove that the beliefs of the organization are religious in nature and that the organization primarily employs people who share those beliefs.\textsuperscript{54} Additionally, changes relating to coverage issues are being modified as a result of the Patient Protection and Affordable Care Act (ACA).\textsuperscript{55}

Whether referencing individual moral agency or collective agency, the inability to properly discern ethically justifiable actions can prove debilitating for a number of reasons. The inability to delineate between right and wrong decision making has been equated to a fog of moral uncertainty that surrounds the decision-making process.\textsuperscript{56} Whether such lack of clarity stems from ambiguity because of unclear standards or from an attempt to disengage oneself or one’s organization from behavior otherwise recognized as unethical, Bandura has suggested several possible reasons for such disengagement. These include moral justification, euphemistic labeling, advantageous comparison, displacement of responsibility, diffusion of responsibility, disregard or distortion of consequences, and dehumanization.\textsuperscript{57} Each of these specific means of actively allowing a moral agent to disengage or disassociate him/herself from the situation represents a threat not only to individuals but also to the healthcare system in which they work.
Such disengagement can serve to justify complicity with those acts and cooperation in practices known to be unethical. Whether intentional or unintentional, repeatedly reinforcing the notion that those in charge are not able to exercise independent moral judgment begins to insulate them from external accountability for the consequences of many of their decisions. Because individuals form the basis for acceptable norms within the organization, methods of accountability need to focus on what individuals can do to address and mitigate collective harms. A healthcare organization itself must actively seek to support the integrity and moral agency of each of its employees as a means of reducing the moral ambiguity and disengagement of employees that can have such devastating effects.

**B. Integrated Ethics and Systems Thinking**

1. **The Veterans Administration Model**

IntegratedEthics®, a model developed by an interdisciplinary team within the Veterans Health Administration over a 5-year period from 2005–2008, is often described by the brief tagline “improving ethics quality in healthcare.” Representatives from bioethics, medicine, nursing, public administration, business, education, communications, and social sciences were called upon to develop a systemic model that could be used to address organizational ethics issues in the 21st century. The IntegratedEthics® model systematically prioritizes, promotes, measures, and improves performance relating to ethics in much the same manner as other organizational imperatives are addressed.

The Veterans Health Administration is the largest integrated health system in the United States, serving close to 6 million patients yearly. Given the enormity of the health system, the need to provide clear guidance regarding expectations for ethics quality throughout the system is critical to the overall success of the organization. Because ethics and quality care are now
known to go hand in hand in the provision of care, the IntegratedEthics® model seeks to improve the manner in which ethical issues are addressed with the knowledge that in doing so, the quality of care provided will also improve.

It is interesting to note that despite all of their efforts towards achieving ethical practices, findings from an independent accounting audit conducted in 2006 noted certain deficiencies in accounting practices that were thought to be the result of ethical issues and culture. The audit identified concerns with a culture that valued making the numbers over ethical practices. While it was not proven that the quality of care suffered as a result of these practices, the ethics quality of the organization was called into question. The audit raised concerns about the rules-based culture that appeared to be operating within the VA at the time of the study, as well as the employees’ perception that ethical practice was not valued within the health system.

Although the VA used this knowledge in the development of their IntegratedEthics® program, further evidence of ethical issues that pointed to systemic issues within the VA surfaced in 2009 that once again pointed to a culture within the health system that did not value ethical practices. Although the IntegratedEthics® program had been implemented throughout all of the VA’s 153 medical centers and 21 regional networks by early 2008, its impact for improving the ethics quality within the system had not yet been realized in 2009. The 2009 study was designed to test and validate the content of the IntegratedEthics® program. Findings from the survey indicated that within the VA at that time, clinicians felt that they had little or no input into priority setting and resource allocation. As a result, these clinicians were feeling disenfranchised by the organization. In addition, there was a disparity in priority setting, wherein clinicians identified resource allocation as an important ethical concern while ethics committee chairpersons identified end-of-life issues. Perhaps not surprising when viewed with
the knowledge available today was the lesson learned from the study, which identified the importance of fully understanding the needs and perspectives of individual stakeholders across the organization, which may have been a precursor to the troubles that surfaced in more recent times.

In a second study concerning the ethics of resource allocation within the VA, both managers and clinicians reported their belief that the institution was ineffective in identifying and resolving ethical issues related to resource allocation and pointed to a lack of education as the cause of the ineffectiveness.  

It is clear that the goals of the IntegratedEthics® model and of the Veteran’s Administration were well intentioned and clearly designed with honorable goals in mind. One might question why in 2014, 11 years after the implementation of the IntegratedEthics® program, Eric Shinseki, the Secretary for Veterans Affairs, was forced to resign amid reports of falsification of patient records relating to the wait times of patients in nearly 40 VA medical centers for which he accepted responsibility. This scandal was all the more difficult to understand given the great strides that had been made within the VA in providing superior quality of care over the past 15 years. It is interesting to note that in a comprehensive report mandated by Congress in response to the revelations—led by representatives of the Mitre Corporation, analysts from the Rand Corporation, McKinsey and Company, the Institute of Medicine, and Grant Thorton—found the VA Health System to be suffering from bureaucracy and leadership challenges that, if left unchecked, would ultimately leave the VA with unsustainable capital costs and not well positioned to succeed in the transformation recommended by the assessment team. Of particular relevance to the current study is the recommendation that the leadership of the VA take a deliberate approach to transforming the
culture within the health system, particularly related to improving communication between the local facilities and the administrative headquarters. Finally, in an article written by three practicing physicians within the VA system, all three point to the negative impact of the accumulation of rules and regulations being imposed at the national level that adversely affect the ability of the providers to render the necessary care. Consistent with the findings of the 2009 task force, the 2014 scandal/crisis within the VA cited a demoralized workface as one of the casualties of a lack of leadership within the health system.

Clearly, the challenges currently being faced both within the VA and outside by Congress and the public indicate a strong disconnect between what was thought to be the care being provided and what was actually being provided. One reason for this and one that is central to the current study is the presence of a so-called hidden culture, which is discussed below.

2. The Hidden Culture and the Competing Values Framework

The importance of organizational culture began to be recognized as a significant factor in organizational effectiveness during the 1980s with the impact of organizational culture becoming more and more significant to issues leading to moral distress. One of the most dominant frameworks for assessing organizational culture is known as the competing values framework. This framework was developed as a means of identifying the core values and assumptions of any given culture in relation to the effectiveness of those approaches in reaching the goals of the organization. The competing values framework identifies four specific types of cultures within organizations. These include: the hierarchy or control culture, the market culture, the clan or collaborative culture and the adhocracy or create culture.

In identifying which of these four culture types is most supportive of reducing the likelihood of moral distress, the answer is dependent on the values of the organization in
question and how those values are operationalized by the employees working there. Separate from the determination of which of the four culture types might be found in a given organization is a specific characteristic relating to how well the core business of the organization can be accomplished in a manner that does not make bravery or moral courage essential in the day-to-day operations of the organization.\textsuperscript{77} Such an organizational culture would be free from intimidation, one in which the employees would not be fearful of expressing their concerns about what they personally find morally stressful or ethically questionable.

Organizational cultures are thought to exist on three different levels relating to the degree of visibility of the culture to those observing it.\textsuperscript{78} The first level, known by the description “artifacts,” relates to the visible processes of the organization, observed behavior and organizational processes. The second level, that of espoused beliefs and values, provides a guide or normative framework that members of the organization can use to address situations of uncertainty or ethically challenging decisions. This second level is particularly important for staff as they struggle to understand morally correct actions in any given situation. When the espoused beliefs and values of the organization are not evidenced in the everyday behavior of the employees of the organization, instances of moral distress will likely increase. The third level of culture refers to basic underlying assumptions, which can become so internalized by the members of the organization that they no longer recognize these assumptions as having an impact on their decision making and daily operations.\textsuperscript{79} In addition, the elements of the culture must evolve with the changing circumstances of the organization.

Within a healthcare organization, the evolving culture may relate to the cultural diversity of the employees; rapid advancements in medical technologies, which threaten old beliefs and require new operating systems; or societal changes that move the culture in different directions.\textsuperscript{80}
Managing the evolving culture is one of the primary tasks of the organization’s leadership and one of the most significant ways that the organization can insure that the new practices are consistent with the values of the organization and will not have a negative effect by increasing moral distress for its employees.

Employees within the LTC setting must confront an historically negative perception of their work on the part of the society as a whole. By acknowledging the many challenges involved in elderly care and in seeking to change the culture that has surrounded this care for so many years, it is hoped that the strides being made by such groups as the Pioneer Network will bring about needed changes within LTC which will over time reduce the incidents of moral distress for residents, families, and staff members.\(^8^1\)

Finally, it should be noted that often there is a difference between how policies are taught and intended to be executed versus the way that they are actually operationalized within the health system. This difference has been termed the “hidden culture.” This hidden culture is thought to represent the difference between what is sacred, or officially sanctioned, and what is profane, or how things are actually done.\(^8^2\) The existence of a hidden culture can signal a disconnect between the management of a healthcare organization and the individual employees. This lack of cohesiveness between stated policies and procedures and the reality of how things are done can contribute to instances of moral distress for the staff. Fortunately, however, individuals generally do not engage in harmful and unethical conduct until they have justified to themselves the morality of their actions.\(^8^3\)

3. Application of a Systems Approach to the IntegratedEthics® Model

The awareness of a hidden culture may help to explain the apparent disconnect that existed within the Veterans Administration, particularly in light of the widespread recognition
that the VA had received for their program. One of the greatest attributes of the program was the fact that it did attempt to apply an integrated or systems approach to achieving ethics quality throughout the organization. It is interesting for purposes of the current study to attempt to understand what factors may have been present that ultimately undermined years of work and study and brought the entire Veterans Health System under such scrutiny. One way of doing this is to begin to understand the foundations of systems thinking when applied to a large health system such as the VA and to the LTC setting, the focus of the current study.

As a starting point for a discussion of the application of a systems approach to issues of moral distress within LTC relative to the discussion above regarding the VA, it is important to distinguish between two different types of systems: hard systems and soft systems. The second is to understand the difference (operationally) between a multidisciplinary approach and a systems approach when addressing operational issues such as moral distress within the organization.

In his book *Systems Thinking, Systems Practice*, Peter Checkland seeks to explain the difference between hard systems and soft systems by differentiating between the problems that each attempts to solve. At a very fundamental level, the distinction often made between hard and soft systems thinking categorizes hard systems as those that apply to well-defined, often technical problems. Soft systems approaches are often thought of in terms of less well-defined, complex situations involving human beings and their unique responses to varying situations. This distinction is critical to the current study of seeking to apply a systems approach to moral distress in that it accommodates differing responses to the same stimuli and supports one of the most important aspects of moral distress: that the experience of moral distress is a function of the individuals and their responses to specific triggers while also acknowledging the necessity of
expanding the common understanding to include the impact of organizational factors, such as the leadership of, communication within, and culture of the organization.\textsuperscript{86}

One of the main goals in applying systems thinking to reduce incidents of moral distress within LTC is the notion that by seeking to find the connections that exist between what might initially appear to be independent departments or functions, moral distress can be addressed more broadly and understood in the larger context of the overall organization.\textsuperscript{87} This idea is sometimes understood in terms of the modularity of the system. Modular design allows for the various parts of the organization to operate as independent systems, yet to be aware of and capable of supporting the requirements of the whole.\textsuperscript{88} In relation to the current study, while the culture, communication, and leadership of the organization could be viewed as three distinct components of the organization, under the concept of modularity, the three can be seen as supporting the requirements of the whole and are interdependent on one another for the successful operation of the whole.

Given the promise of the Veterans Administration IntegratedEthics® model, what becomes evident when applying a systems approach to finding out what began to unravel is the awareness that although it was thought to provide several components that would make up the whole (ethics quality, preventive ethics, and ethics consultation), the organization itself was not in fact able to integrate each of these complex areas as part of a functioning whole. Therefore, although the IntegratedEthics® model does provide valuable insights into how a complex organization such as that might function better, it no longer provides a model to be replicated in the current study.
4. Operationalizing the Mission, Vision, and Values of the Organization

Frequently, the mission, vision and values statements of an organization act as a first impression of what can be expected in any association with that organization. Whether to a prospective employee, a patient entering a hospital for a procedure, or a vendor, the mission statement can establish a set of expectations for all those who choose to become involved with it. In order to establish responsibility in organization, one must consider the values, motives and choices of those involved in policy formation.\(^89\) A strong indication of these motives can be found in the mission statement of the organization.

Core commitments by the organization, publicly stated and internalized by the employees of that organization, can serve to express outwardly the organization’s commitment to values such as equality, respect, quality and stewardship.\(^90\) The mission statement should serve both to inspire ethical behavior and to provide direction for desired standards of conduct.\(^91\)

While this positive internalization of the values of the organization can serve to strengthen the organizational ethics component of the operation, it is equally important to recognize the positive impact that immediate corrective actions can have when lapses do occur. If the organization is found not to have lived up to the commitments made in their mission statement, if they acknowledge these lapses and immediately move to take corrective actions, studies indicate that they may in fact gain greater ethical commitment from their employees. If however, employees and/or the public have experiences that are inconsistent with the stated mission of the organization, such as a failure to achieve the ethical alignment in the implementation of the values expressed in the mission statement, negative consequences can result, including moral cynicism, dampening of morale, and ultimately a reduction in the quality of the care provided by a demoralized workforce.\(^92\)
Of particular importance in being able to implement the organizations’ mission, vision, and values statement as a means to improve ethics quality throughout the organization is the need to integrate the mission and values statement properly into the organizational culture. An example of the impact of a properly aligned mission fully integrated into all aspects of an organization is provided by the Holy Cross Health System in South Bend, Indiana. Their efforts to educate their employees internally of the fact that every service rendered, every encounter with the outside community, and every dollar budgeted is an expression of their fidelity to the mission of that organization. The hospital reported that their efforts to align their stated mission entirely with their overall operation resulted in greater individual responsibility towards the mission and greater overall success for the organization.93

C. Organizational Culture in Long Term Care

1. Historical Perspective: Rewards vs. Punishments

As addressed briefly in Chapter 1, in his 1985 book which focused on the care of the elderly, Eugene Litwick found that the delivery of care in the nursing home could be characterized as detached, impersonal, hierarchical, and rule governed.94 How these practices affect the day-to-day operations within an LTC organization can have an impact on the incidence of moral distress within the organization.

Mark Latham, the Healthcare Administrator at Pleasant View Nursing Home in Concord, New Hampshire, describes the impact on the staff of a heavily regulated environment when he states simply that his team works better when they are measuring quality rather than measuring and operating from a framework of fear based on receiving a deficiency when they know they are attempting to address the needs or wishes of a given resident.95 Questions that must be answered if providers are to learn to balance the regulations with their desire to successfully
address the needs of the residents is why the regulations have been put into place and what can be done to increase the trust between not only the surveyors but also the public at large.

In looking at the most appropriate manner in which to address accidents and/or errors within the healthcare setting, Runciman, Merry, and Walton have drawn on the research of Perrow, Reason, and Rasmussen to argue that of all complex systems, healthcare is perhaps the most complex as it deals with the human, rather than the technical, aspects of a system. Thus, the blame or root cause of a specific accident, deficient practice, or error within the healthcare setting should be addressed from a systems-based approach rather than a person-based approach.\(^{96}\) As is characteristic of many systems, but particularly within healthcare, the interconnections within the system function through a flow of information and determine to a large extent how the system operates.\(^{97}\)

Kohn offers an insightful argument concerning the effect that a system of rewards and punishments can have on the employees within an organization when he argues that the use of rewards and/or punishment to elicit specific behaviors is really one and the same approach. According to Kohn, both systems rely on manipulative behaviors on the part of the organization that will, over time, lead to employees’ feeling controlled and in the worst cases, punished.\(^{98}\) The negative implications of a system where rewards and punishments are used in an effort to control behavior will be further discussed in Chapter 6. This chapter discusses the positive impact of leadership empowerment, particularly relating to efforts to increase employee morale and individual moral agency. In stark contrast to a system that develops out of a negative context, efforts to support the empowerment of each employee will be seen as the most productive means of encouraging and motivating employees.\(^{99}\)
2. **The Role of the Survey Process in Shaping Culture**

It may be difficult to comprehend that the very process that has been put into place to ensure the quality of care in LTC organizations is a process that oftentimes brings with it the most stress, and ultimately moral distress, for those seeking to provide such care. Frequently, operational decisions are made within the nursing home out of fear of the survey process rather than what might be in the best interest of the residents. Some have argued that it is not the regulations themselves that need to be reformed but rather, and more important, the need to change the regulatory culture in which the regulators oversee the nursing homes.

LTC communities, like most other healthcare operations, are regulated by several different entities, each with the stated goal of helping to provide quality oversight to the organization. This oversight is provided by several different agencies including federal and state licensing agencies (i.e., the Centers for Medicare and Medicaid), state and local governments, professional boards and associations, as well as private, not-for-profit entities that provide a mechanism for specific certifications. It is unfortunate that many of the regulations are implemented as a means of addressing care issues in the 15% of nursing homes nationwide that have consistently failed to meet the regulatory standards relating to quality of care. These poorly performing nursing homes serve to perpetuate the view of the larger society that all nursing homes provide bad care and that the overall culture within LTC is one of neglect and abuse, making it all the more difficult for well-run, caring nursing homes to continue on their path of culture change, resident-centered care, and employee empowerment.

3. **Moral Courage and the Goal of a Just Culture**

The presence or absence of moral courage within both the individual and the organization determines to a large extent whether issues of moral distress will in fact lead to a build-up of
moral residue and experiences of moral distress, which will be discussed in greater detail in the following chapter. In relation to the current discussion regarding the possible need for moral courage in relation to overcoming incidents of moral distress within the culture of an organization, it is important to understand that moral distress is thought to be the result of one of two factors: either internal (within the individual employee) or external (as a result of organizational constraints). The moral courage required to address the experience of moral distress appropriately must also be sought by addressing moral courage both within the individual and within the organization.\(^{104}\) Courage, like the experience of moral distress, is an intensely personal matter. Courage requires a great deal from individuals who exhibit it; they must know what they believe in, be clear on the mission of their life, and have a clear vision of the values that define their actions.\(^{105}\)

In their recently published (2013) guidelines regarding decisions on life-sustaining treatment and care near the end of life, the Hastings Center writes of the difficulty experienced by both healthcare professionals and society in confronting the ethical concerns that surround end-of-life decision making. They stress the importance of informing these decisions based on ethical norms and legal rights and from goals of care that follow from these rights.\(^{106}\) Doing so, in their judgment, requires courage on the part of all those involved in the decision-making process. Understanding the differences between moral courage and the more common uses of the word “courage” is critical to understanding how to successfully address and reduce issues of moral distress.

Perhaps the most fundamental definition of “moral courage” is simply “the courage to be moral.” Agreement as to what it actually means to “be moral” may not be universally agreed upon; however, generally, acting morally refers to adherence to five core moral values: honesty,
respect, responsibility, fairness, and compassion. While courage is a virtue that is respected in and of itself, moral courage is most closely associated with courage in the service of others and is therefore seen to be relatively free of self-interest.

The presence or absence of moral courage in the workplace can serve as an indication of the opportunity for moral distress, with the degree of moral courage needed having an inverse relationship with the degree of moral distress experienced. Rushworth Kidder provides an interesting observation of the relationship between the role of individual moral courage and the responsibility of the organization to foster moral courage. In his book, titled *Moral Courage*, Kidder puts forth the notion that although organizations seek individuals who have moral courage, organizations must strive to create the type of culture and environments where moral courage is not needed. If an organization has truly aligned its mission, vision, and values with those of its employees, moral courage should not be necessary in carrying out everyday responsibilities. This symbiotic relationship will be explored below, first through a discussion of how moral courage is evidenced in the individual, followed by how it is evidenced within the organization.

Each of us is thought to have a personal ethical threshold (PET) that represents what it takes for us to cross our own moral line in a way that violates our own standards and values. As each individual assesses any given situation that requires action, there are four attributes within the individual that help move the person from moral contemplation to action. These are one’s experience, one’s character, one’s faith in something beyond oneself, and one’s intuition. For a healthcare practitioner, each of these attributes can be either supported or negatively affected by the culture and environment in which they work. In confronting issues that are deemed to have moral consequences, one complicating factor that must be addressed is
the fact that moral arguments can in fact often be made on both sides of a given issue. In referencing the need for compromise, former President Kennedy has been quoted as saying in regard to moral arguments, that there is seldom an issue that exists where all of the angels are on one side of the argument.¹¹²

When this sentiment is applied to issues that may contribute to moral distress, a healthcare worker is often placed in the difficult situation of believing they must make a choice between what they believe is a right or wrong approach and may not in fact be knowledgeable about all of the factors involved. These decisions can become even more challenging when faced with two ethically sounds courses of action, both of which can be ethically justified but one of which is inconsistent with the personal values of the practitioner.

Perhaps one of the most important concepts in helping to understand/explain how moral courage is evidenced within an organization is that provided by Alasdair MacIntyre, who puts forth the idea that in effect no practice, either good or bad, can be sustained over time within an organization without the actor’s being supported by the institution.¹¹³ Whether publicly expressing their values through their mission statement or more privately embracing moral behaviors in the workplace, the employees feel the impact of what is embraced by the organization and what is condemned.

The organization has an opportunity to provide an environment that reduces the likelihood that moral distress will have a negative impact on the practitioner and on the organization as a whole. The organization must avail itself of the most current research relating to issues of moral distress and implementing proven actions to reduce its presence. For example, current research suggests what when nurses believe that they are working in a constructive work culture that generates high levels of ethics work satisfaction, lower levels of moral distress are
noted. Nurses who believe that they have a good relationship with peers, patients, managers, physicians, and hospital personnel have also been noted to experience less moral distress. Contrary to these positive steps are findings indicating that nurses who work in organizations that do not have policies in place to guide ethical practice and do not have mechanisms for addressing complex physician conflicts will experience more moral distress.\textsuperscript{114}

Moral courage is vitally important in organizations that have dysfunctional policies and cultures that no longer support the goals of the organization.\textsuperscript{115} Creating an environment and a culture where individuals feel secure enough to bring up ethical dilemmas for the purpose of discussion and resolution will help to reduce the individual experience of moral distress and will reinforce the mission, vision and values that form the culture of the organization.\textsuperscript{116}


Before discussing the “how to” of achieving culture change, it is important to point out that not all healthcare organizations require that a change in culture take place in order to accomplish a certain goal for the organization. The culture change proposed in this paper centers mainly on the need to address the culture of the organization as one of three main components (in addition to the leadership within the organization and the methods of communication utilized) if one is to seek to apply a systems approach to reducing incidents of moral distress. The main focus of the current discussion is to recognize that the culture of the organization comes not only to define the core values of the organization but also to influence and ultimately define the values of the individuals who work there; thus, the organizational culture can be regarded as one of the three main areas that can influence a reduction in the experience of moral distress within the organization.\textsuperscript{117}
When first assessing the possible need to change the culture of an organization, Edgar Schein suggests that the first step needs to be to build on the strengths of the current culture rather than focusing on the weaknesses of the culture.\textsuperscript{118} This observation is consistent with the method of communication and leadership discussed in Chapter 5 of this paper, which refers to the merits of employing a technique termed “appreciative inquiry” when one is seeking to bring about change within an organization from a positive and affirming perspective. In addition, Schein, a leading researcher in the field of organizational change, stresses that one cannot create a new culture without first understanding all of the factors that led to the development of the existing culture.\textsuperscript{119} This understanding, which can come about only via a thorough assessment of all of the systems operating within the organization, is consistent with the concepts discussed previously, which relate to understanding the differences between hard and soft systems and the need within healthcare to understand the complexities of the human element as it relates to applying a systems approach to problem solving.\textsuperscript{120}

Ultimately to achieve culture change within the LTC setting, the changes must be comprehensive and must encompass the whole organization in a complementary and inclusive manner.\textsuperscript{121} Relating specifically to seeking to reduce the experience of moral distress within the organization, there must be systemic changes in the three main areas of focus in this paper: the culture, the communication, and the leadership of the organization.

\begin{itemize}
\item \textsuperscript{2} Steven Pearson, James Savin and Ezekiel Emanuel, \textit{No Margin, No Mission} (New York: Oxford University Press, 2003), 157–151.
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K. Walshe, “Regulating Nursing Homes: Are We Learning from Experience?” Health Affairs 20, no. 6 (2001): 128–144.

Audrey Weiner and Judah Ronch, eds., Culture Change in Long Term Care (Binghamton, NY: Hayworth, 2003), 374–379.

Audrey Weiner and Judah Ronch eds., Culture Change in Long Term Care (Binghamton, NY: Hayworth, 2003), 32–35.


Catarina Gronlund, Vera Dalqvist and Anna Soderberg, “Feeling Trapped and Being Torn, 6–8.


120 Peter Checkland, Systems Thinking, Systems Practice (West Sussex, UK: John Wiley & Sons, 2005), A3–A15.

121 Audrey Weiner and Judah Ronch eds., Culture Change in Long Term Care (Binghamton, NY: Hayworth, 2003), 302–305.
Chapter 3: Moral Distress

The term “moral distress” was first used in 1984 by Andrew Jameton to describe situations wherein nurses feel they know the morally acceptable course of action but are constrained from following it; this concept is particularly applicable to nurses working in critical care. Jameton attributed this phenomena to both internal and external factors over which the nurses perceived they had no control. ¹ Because the experience of moral distress has historically been attributed to individual responses to certain stressors, initial research into the causes of and possible remedies for moral distress have focused almost entirely on the individual. More recent research has expanded this framework to include the interrelationship of individuals with their organizations, seeking interventions that include both individuals and the institutions where they practice. ²

A. The History of Moral Distress

Within the healthcare organization, moral distress has been found to exist at all levels including at the individual, patient, team, and system level and can affect the entire organization.³ Understanding these interrelationships is essential to successfully addressing issues of moral distress across the organization. The success of the organization and of the efforts of its individual members rests in the effectiveness of the group performance and is guided by the collective intentionality of its members.⁴ Efforts to support a common vision for the organization can only be achieved through systemic efforts to educate, communicate, lead and create a culture whereby everyday ethical issues, such as the issue of moral distress are acknowledged and addressed. The current chapter addresses the need for education on the topic
of moral distress by providing the history, the possible causes and the ramifications to the individual and the organization if moral distress is not addressed throughout the organization.

1. Hans Seyle and Andrew Jameton

Although differing methodologies have been applied to the issue of stress, there is general agreement that certain stressors may elicit responses in individuals that can, over time, have a negative impact on their health and general well-being. Selye used the term “stress” to represent a set of physical and psychological responses to adverse conditions or influences. In his early definition of stress, Selye differentiated between a negative form of stress, which he termed “distress,” and a positive type of stress, which he called “eustress” (see Section C of this chapter for a discussion of the latter).

Though Selye’s research on stress marked the beginning of an approach to studying stress-related illnesses (referred to as General Adaption Syndrome (GAS)), recent research into work-related stress has questioned the comprehensiveness of his initial theory in terms of offering a full explanation for the overall processes involved in responding to stress. Specifically, Selye’s account of stress contained no recognition of the environmental factors now thought to be a critical component in current theories on stress, and it did not treat the importance and relevance of the interaction between the environment and the individual response.

Stress within the workplace poses a costly threat to both the employee and the organization because of lost time, talent, and disengagement from work. It has been estimated that over 60% of all workplace absences in the United Kingdom can be attributed to stress, and in 2000, the total cost of occupational stress in the United States was estimated at between 200 and 300 billion dollars per year. Understanding the different types and presumed causes of stress is an important and necessary aspect for isolating moral distress as a unique type of
workplace stress affecting both the individual and the organization. Unlike research focused specifically on workplace stress, research into the causes of moral distress must be understood from two perspectives: first, the moral and ethical perspective and, second, the stress perspective.  

Todaro-Franceschi suggests that moral distress is not a new phenomenon and that it has been a part of nursing culture for a very long time. While the phenomenon itself may not be new, as Todaro-Franceschi suggests, it was not until Jameton called attention to it in 1984, by coining the term “moral distress,” that research and study began to explore it. Since then, a few theories have developed, which will be discussed later in this chapter. One of these, from Epstein and Hamric, is called the “crescendo effect.” Briefly, Epstein and Hamric believe moral distress to be defined by the presence of constraints. These are identified as either internal or specific to the individual—such as a lack of assertiveness or perceived powerlessness—or external: those caused by the institution, such as policies and priorities that conflict with the needs of the patients; by hierarchies within the healthcare system; or by inadequate staffing.  

Moral distress was first introduced as a concept that applied to the nursing profession, but today, its application has expanded to include workers in many different fields, both within healthcare and outside of it. It is interesting to note that some researchers believe that moral distress itself within the healthcare setting stems largely from an inappropriate application of practices in healthcare that have originated in other industries. As one example, healthcare administrators have attempted to apply management practices that are effective within business and engineering. Doing so has led to increased incidents of moral distress because of the application of cost-saving measures, specifically those relating to reductions in staffing and in the number of healthcare practitioners needed to provide excellent care. Within the health
professions, moral distress is now being recognized as a phenomenon that confronts all those involved in providing care. Individuals and healthcare organizations alike are attempting to address questions concerning the perceived rightness or wrongness of treatment decisions, even though they feel powerless to influence change regarding morally wrong actions.\textsuperscript{13}

In his 1984 definition of moral distress, Jameton focused primarily on institutional constraints, which he thought prevented agents from carrying out their perceived right course of action. In these situations, according to Jameton, the individual knows the right thing to do but is prevented from doing it because of perceived constraints.\textsuperscript{14} These constraints, whether internal or external to the individual, are a very significant aspect of providing healthcare; and, if left unaddressed, they can lead to healthcare practitioners’ feeling like voiceless, powerless employees, unable to provide the care that they feel patients deserve.

Whereas nurses have historically been the focus of much of the research about moral distress in healthcare, doctors have been shown to experience it as well for many of the same reasons as those reported by nurses. For example, physicians working in hemodialysis care have been found to suffer from what is called “a troubled conscience,” which, researchers allege, developed when the physicians were faced with conflicting demands, feeling trapped in irresolution and having to prioritize because of time constraints and conflicting demands. The doctors experienced many of the same reactions as the nurses, including feeling isolated, devalued, and not respected and affirmed for the decisions they made.\textsuperscript{15} As discussed in Chapter 1, it was the troubled conscience of the medical community resulting from a period of unprecedented growth in medicine and technology during the 1960s that established a framework for the emerging field of bioethics.\textsuperscript{16} These issues of conscience remain today, contributing to what is now termed “moral distress.”
For the healthcare practitioner of the 21st century, concerns have begun to shift from how to provide the best care, to how best to minimize harm in the provision of that care. While the causes may be many—including unsafe systems, insufficient staffing, and financial constraints—the result for practitioners is often a loss of compassion towards their patients, a loss of passion in their profession, and experiences of moral distress, ultimately leading to burnout and a desire to leave the profession. Practitioners’ negative feelings are thought to stem from one of two sources. First, the practitioner may know the right course of action but may feel constrained from doing it for fear of repercussions; and, second, the practitioner may recognize that something is wrong but not be confident of what it is. In the latter situation, emotions are thought to play a significant role in preventing such individuals from being able to think clearly and sort out objectively the ethical implications of their actions, leaving them paralyzed and unable to take the most appropriate action to benefit the patient and/or themselves.

A second important factor that was initially identified by Jameton related to two specific aspects or components of the distress: 1) initial distress, which occurs as the situation unfolds, and 2) reactive distress, which is thought to be the distress that lingers, even after the problematic situation has been addressed. This lingering distress is now termed “moral residue.” Epstein and Hamric have shown that this moral residue leads to a crescendo or breaking point for the practitioner after repeated occurrences of an initial distress.

Research over the past several years has attempted to assess, for healthcare practitioners, the impact of structural factors, specifically relating to organizational and institutional supports that could reduce instances of moral distress. Research conducted by Kalvemark et al. is particularly relevant to the current thesis, as it differs from Jameton’s definition by arguing that moral distress can result from the very fact that healthcare practitioners must make a choice
between the rules of the organization and their consciences. According to the research, although these practitioners did “act” in a way that followed their conscience, they continued to experience moral distress as a result of not being able to represent the interests of all stakeholders adequately, as well as the individual values of those involved.\textsuperscript{22}

2. The Ethics of the Ordinary: Differentiating Workplace Stress from Moral Distress

Luthringer addresses the challenges faced by healthcare practitioners in the course of their everyday roles by suggesting that the everyday ethical challenges faced by healthcare practitioners, precisely those which have the greatest impact on a patient’s wellbeing, can be the most difficult to resolve.\textsuperscript{23} Building upon the work of Luthringer, Worthley argues that the common everyday challenges confronted by healthcare practitioners have as yet remained largely unaddressed in favor of the more macro bioethical issues resulting from the advanced technological age.\textsuperscript{24} Austin discusses concerns similar to Worthley’s, suggesting that bioethics today deals too much with theoretical or high profile cases and is hence too far removed from the everyday ethical issues facing practitioners.\textsuperscript{25} While hospitals have established ethics committees to address ethical dilemmas, the more practical issues of needed supplies, bandages, and enough staff to care properly for the patients are often left unaddressed.\textsuperscript{26}

Examples of morally distressing events that are known to occur during routine care provision include miscommunication among members of the medical team as well as between them and the patient, missed opportunities for meaningful conversations concerning end-of-life decisions, feelings of powerlessness in healthcare practitioners, and value-driven conflicts regarding appropriate treatment options.\textsuperscript{27} The resulting impact on patients, staff, and the organization can be quite detrimental. The American Institute of Stress estimates that the cost to
U.S. businesses from stress-related incidents—such as lost productivity, increased workers’ compensation claims, turnover, and health care costs—may be between $200 and $300 billion dollars per year.28

In writing about the survivor personality, Siebert offers the idea that stress is not something that can be easily categorized. Rather, he suggests that stress is simply an internal “feeling” on the part of the individual owing to strain from something that is causing discomfort.29 Almost daily, nurses are faced with an on-going conflict between what nursing could ideally be and what it is in reality.30 Thus, the complexities of providing the best care to the patients can be lost in an effort to address what are perceived to be larger moral dilemmas. This situation is clarified if one attempts to define exactly what is meant by the word “care” in a clinical setting. Too often, care provision is thought of as one-dimensional: the caregiver provides care to the patient or resident. Absent from this description, however, is a more complete understanding of the various phases that must define the provision of care.

Tronto identifies four phases in care, each phase signaling a step in the caring process: 1) caring about someone or something, 2) taking care of someone or something as a process, 3) the act of caregiving, and 4) care receiving.31 While the first three phases of care are self-explanatory, the fourth phase, care receiving, can have the most impact on how caregivers ultimately feel about the care they provide. If a mutually respectful and supportive relationship can be established between the care provider and the care receiver, both parties will benefit from the care given and the incidence of moral distress experienced by the caregiver will be reduced. How unfortunate, yet how telling, are words from Greenlee, Assistant Secretary for Aging, who notes that staff in long-term care facilities have long desired to be praised for spending time with residents rather than being reprimanded for their lack of time management and for spending too
much time with one resident.\textsuperscript{32} Such a situation means that staff members in these communities are not able to provide a truly holistic approach to residents’ care, leading over time to issues of moral distress.

Though it is true that moral distress may be considered a type or form of occupational stress, the reverse is not true; not all occupational stress is moral distress. Thus, differences in the types of occupational stress are relevant to the current discussion because they further help to explain the complexity surrounding any understanding of stress in the workplace and to distinguish moral distress as a specific type of stress.

LeFevre, Matheny, and Kolt suggest three specific tenets that they believe are characteristic of stress: 1) there are only two types of stress, positive (termed eustress) and negative (termed distress); 2) stressors are most easily identified by certain characteristics, such as how much control individuals believe they have over a stressor, whether the stressor is seen in a positive or negative light by the individual, and the timing and source of the stress; and finally, as is consistent with the literature concerning moral distress, whether the stress is perceived as positive or negative rests solely within the individual’s perception of that stress.\textsuperscript{33}

Researchers have suggested several different theories in an effort to explain occupational stress, its source, and possible mechanisms for addressing it. Two such theories that relate to those ideas for explaining moral distress are reviewed here, as each shares some commonality with the theories being discussed and specifically relating to moral distress.

The \textit{person-environment fit theory} expands the notion that stress cannot simply be defined in terms of the individual or the environment but by the degree of mismatch or misfit between the two. This misfit can be the result of a disconnection between individuals and their environment; a disconnect between how individuals perceive themselves in relation to the environment; or a
combination of the two, which considers the demands of the job and the ability of the individual
to meet those demands, as well as how well the environment/organization is able to meet the
psychological and physiological requirements of the individual. The fit theory incorporates
two of the most important elements relating to the experience of moral distress by focusing on
both the individual response and the impact of outside influences, such as the work environment
and the ability of the organization to meet the needs of the individual adequately within that
environment.

The second theory of occupational stress that corresponds to theories of moral distress is
put forth by Spector and is called the control theory of occupational stress. This theory suggests
that the perception of stress is centered within the individuals involved according to their
perception of the degree of control that they believe they have over their work environment.
This perceived control can range from complete control—that is, having total autonomy, with
complete control over their schedule and their workload—to feelings that they have no personal
control over these same variables. While the earlier research relating to causes of moral
distress is consistent with the control theory of occupational stress, the fit theory offers a more
complete understanding of the role that both the environment and the individual response have in
the experience of occupational stress and, by extension, moral distress.

A final observation in comparing occupational stress and the more specific moral distress
is that a moral component is present, which is thought to cause the stress. Even in the
workplace, stress is generally categorized as moral distress when the stressor itself has been
determined to be ethical in nature, posing an ethical dilemma for the individual experiencing it.
Generally, only the experience of moral distress has been found to involve a compromise of
one’s core values or perceived moral obligation.
3. Organizational and Individual Barriers Contributing to Moral Distress

Organizational barriers that may contribute to the experience of moral distress can be thought of in two categories: environmental and administrative. Although often interconnected, the environmental and administrative barriers are both components of what are more broadly defined as organizational barriers, but they represent distinct aspects from an institutional perspective that can affect the practitioner in either a positive or negative way.

Perhaps one of the best examples of an environmental barrier that has been recognized and corrected where possible relates to the physical environment of nursing homes. Interestingly enough, over fifty years ago, Cumming and Cumming wrote about the therapeutic effect that an environment can have on both patients and staff, and noted that grim physical structures did nothing to improve the well-being of either the patients or the caregivers themselves.38

One effort to create a therapeutic environment within the nursing home was developed by Bill Thomas and his wife, Jude, in the 1990s. As a physician working in nursing homes, Thomas was struck by the same lack of any plant, animal, or even human interaction that would enrich the lives of both the residents/patients and the staff. Thomas and his wife developed what is now known and widely embraced as the “The Eden Alternative.” This philosophy requires each community that adopts this process to commit to following a comprehensive 10-stage process which are the principles of the Eden Alternative, as follows:

1) The three plagues of loneliness, helplessness and boredom account for the bulk of suffering among our elders.

2) An Elder-centered community commits to creating a Human Habitat where life revolves around close and continuing contact with plants, animals and children. It is these relationships that provide the young and old alike with a pathway to a life worth living.
3) Loving companionship is the antidote to loneliness. Elders deserve easy access to human and animal companionship.

4) An Elder-centered community creates opportunity to give as well as receive care. This is the antidote to helplessness.

5) An Elder-centered community imbues daily life with variety and spontaneity by creating an environment in which unexpected and unpredictable interactions and happenings can take place. This is the antidote to boredom.

6) Meaningless activity corrodes the human spirit. The opportunity to do things that we find meaningful is essential to human health.

7) Medical treatment should be the servant of genuine human caring, never its master.

8) An Elder-centered community honors its Elders by de-emphasizing top-down bureaucratic authority, seeking instead to place the maximum possible decision-making authority into the hands of the Elders or into the hands of those closest to them.

9) Creating an Elder-centered community is a never-ending process. Human growth must never be separated from human life.

10) Wise leadership is the lifeblood of any struggle against the three plagues. For it, there can be no substitute. 39

In adopting the principles of the Eden Alternative, as stated above, the organization itself commits to humanizing the work environment to the benefit of both the residents and the staff. It should be further noted that by placing the emphasis on the care that is given, by de-emphasizing a top-down bureaucratic authority and in their words, “by acknowledging the simple truth that human growth must never be separated from human life,” Thomas and his wife have designed a
framework that has the added benefit of addressing many of the organizational practices thought to reduce incidents of moral distress within the workplace.\textsuperscript{40}

Administratively, organizations have many resources at their disposal that could serve to break down any barriers thought to contribute to incidents of moral distress. Research indicates, however, that although the current practices within healthcare require increasing expertise on the part of practitioners, many healthcare organizations lack standardized policies, systems, and structures designed to support the practitioner in making increasingly complex decisions regarding care.\textsuperscript{41}

Kalvemark et al. sought to break down the causes of moral distress into their component parts—specifically, to separate the moral or ethical aspect of the distress from the actual stress or stressor leading to the distress. Kalvemark et al. conducted their study using focus groups from the clinical departments cardiology, hematology, and pharmacy, which are all at the same location in Sweden (Uppsala/Stockholm) and which have from five to seven practitioners in each group. The focus groups were asked specific questions regarding their experience of stress, and even more specific questions about what leads them to experience ethical or moral distress. The answers were categorized and summarized as follows: 1) lack of resources, including insufficient staff, insufficient availability of beds, and lack of time to devote to patients due to administrative responsibilities; 2) difficulty in complying with rules and regulations owing to the constraints noted above; 3) conflicts of interest resulting from conflicts in values and hierarchy; 4) economic constraints relating to not being able to provide the optimal care because of the cost of the medicine (respondents explained further by saying that if the best medicine were to be given, some other service would have to be cut to make up the cost of the medication); 5) justifying breaking the rules in order to act in what they believe is the best interest of the patient;
6) strained professional relations among doctors and the nurses if and when nurses question physicians’ orders because they do not share the same values regarding end-of-life decision making; and 7) lack of support structures within the organization for providing meaningful discussions when ethical dilemmas do arise that could lead to experiences of moral distress.\textsuperscript{42}

These findings are relevant to the current thesis in that they help to separate those causes that are related to the individual from those that can be controlled or reduced by the organization. In attempting to isolate the organization and its impact on the individual, nurses have been implicated in blaming “the system” for the constraints within which they work, defining the system as being comprised of the bureaucracy or the organization itself, the insurance companies, and even more broadly, the entire American healthcare system.\textsuperscript{43} In their 1986 research, Yarling and McElmurry created a term for this phenomena, “hospitalonian captivity,” which they used to refer to the restrictions that are put on the healthcare provider causing them to feel powerless and voiceless.\textsuperscript{44} Not being able to identify and label a specific source of the stress can in itself make efforts to reduce the stress much more difficult. Often the causes of the moral distress rest in more than one place and may in fact result from a combination of organizational, environmental and individual barriers. As noted by Kalvemark et al., while it is true that doctors, nurses and other staff members do not always agree on what each believes constitutes a moral issue, differing views regarding commitment to the patient versus commitment to the organization can further complicate agreement as to what each believes is the morally appropriate course of action.\textsuperscript{45}

B. Causes of Moral Distress Within Long-Term Care

Despite the fact that considerable research has been done on the possible causes of moral distress among acute care nurses, very little of it has specifically addressed the unique challenges
leading to moral distress among nurses and other healthcare practitioners in long-term care.\textsuperscript{46} Bill Thomas, co-founder of the Eden Alternative, as outlined above, described what he perceived as the most daunting challenges facing those involved in providing services within long-term care. In addition to the concerns noted with the physical environment of the nursing home, Thomas describes a system that is plagued by decreasing public funding for reimbursement rates in Medicare and Medicaid, a workforce suffering from chronic staffing shortages and low morale, scarcity of a skilled labor force, increased expectations of family members, increased frequency of litigation stemming from perceived or realized quality of care issues, and unmet expectations.\textsuperscript{47} Against this backdrop it is not difficult to understand that those providing care are faced with difficult moral challenges that can and often do lead to experiences of moral distress.

One might ask whether or not there are differences in the experience of moral distress within healthcare according to the care settings where the individual practitioners work. For this current study, it is important to distinguish what characteristics of long-term care might influence the incidence of moral distress among the staff. Edwards, McClement, and Read attempted to clarify those differences in their 2012 study of nurses’ initial response to moral distress, specifically within the long-term care setting. In their interviews with fifteen registered nurses on two separate occasions, Edwards et al. found that the nurses reported three specific themes regarding their initial response to moral distress within their work environment. While each of the nurses reported taking some type of action to address the perceived moral conflict, the action was dependent on several differing contextual factors, including what values were in conflict, whether the conflict was between colleagues (i.e., nurse to nurse), whether the conflict arose as a
result of a value conflict with a physician, and whether or not a relationship had pre-existed between the nurse and the individual with whom there was conflict.48

One interesting observation that differentiated nurses in long-term care from those in other settings, such as acute care, is the difference in staffing levels. Long Term Care (LTC) nurses reported having few if any other licensed nurses available to discuss their ethical concerns with during the course of their shift.49 As will be demonstrated later in this paper, the support of other colleagues and team members when faced with issues that could lead to moral distress is an essential factor in helping to address and work through ethical issues as they occur. In the LTC setting, there can often be only one RN on duty at any given time, which limits nurses’ ability to have a meaningful dialogue with a colleague at the time of an incident.50

A second issue that helps to explain incidents of moral distress within LTC is the personal relationship that develops over time between the patient/resident and the caregiver. Although it does not reduce the professional connection that can develop in other healthcare settings, LTC does, as the name implies, provide care to someone, generally over an extended time, with relationships developing that are both intimate and personalized.51 Unfortunately, despite the personal relationship that exists between the caregiver and the resident, over 90% of the nation’s nursing homes were found to have too few workers to take care of residents properly.52 As has been discussed previously, short or inadequate staffing has been found to be one of the leading causes of moral distress among workers.

1. How the Culture Affects Incidents of Moral Distress

Expanding on the discussion in Chapter 2, which focuses on the implications of organizational culture, this chapter looks specifically at the issue of moral distress and the impact that the many aspects of culture, both within and outside of the organization, have on the
experience of moral distress. In addition to the impact of organizational culture discussed in Chapter 2, this discussion includes the impact of the culture within the society at large towards LTC and the impact on the organization of the multi-cultural backgrounds of those choosing to work within an LTC setting on incidents of moral distress.

The discussion in Chapter 7, later in the dissertation, is particularly relevant here, as it seeks to apply a systems approach to potential moral distress relating to end-of-life care. Central to that discussion is the role that culture plays in providing and demanding quality care at the end of life and how the current societal culture has begun to demand and support the rights of individuals to participate in decisions regarding their own end-of-life care. While this cultural shift may at first glance seem obvious, it is helpful to look back, even within our own culture, at the evolution of this change and recognize that it parallels and is in response to changes within the society at large.

Outrage from society at large towards healthcare practices began with revelations concerning research on human subjects that came to light during the mid-twentieth century. In addition, concerns emerged over both the medical community’s use of technological advances in medicine and their unintended consequences, for which neither society in general nor the medical community was adequately prepared. Examples of these experiments include the Tuskegee Experiment, sponsored by the US Public Health Service from 1932-1972; the Willowbrook Hepatitis Study, which took place in 1965; and more recent revelations relating to Right-to-Die issues brought about by the technological advances of modern medicine. In each of these cases, the subjects of the experiments were thought to be vulnerable and in need of protection from society.
The Tuskegee Syphilis Study was conducted in the United States over a period of forty years, from 1932-1972. The study included over four hundred black men in Macon County, Alabama, who became the research subjects in a U.S. Public Health workers’ study concerning the long term effects of syphilis if left untreated. Although numerous ethical violations have been attributed to this study since it was made known, perhaps the most significant was the fact that although a treatment did exist for syphilis during the period of this study, it was deliberately withheld from the participants.\textsuperscript{54} Additionally, this study highlighted the need for informed consent, which has widespread relevance within healthcare today, particularly in relation to decision making at the end of life.

A second example involving a vulnerable population and a power imbalance was done at the Brooklyn Jewish Chronic Disease Hospital. In this instance, live cancer cells were injected into the bodies of twenty-two debilitated patients for the purpose of determining whether the previously established immune deficiency of cancer patients was caused by their cancer or by their debilitated condition. In this study, the vulnerability of the research subjects was thought to be exploited as a result of power imbalances stemming from the credentials of the lead researcher. Chester M. Southam was a distinguished physician-researcher at the Sloan-Kettering Institute for Cancer in New York City, and an assistant professor of medicine at Cornell University Medical College. Given his credentials, his methodology was not initially questioned by those who were aware of and in a position to judge his work.\textsuperscript{55} As more and more individuals became aware of the abuses, measures were instituted via regulatory processes to address and prevent future abuses.

In discussing emerging regulatory requirements and research ethics committees for human subject research, Volnei Garrafa provides a particularly valuable insight. Garrafa
suggests that the oversight measures did not represent the beginning of ethical questioning relating to clinical research but rather a recognition by society that ethical control over research activities like those involving human subjects cannot be left exclusively to the moral conscience of the researchers.\textsuperscript{56}

The role of society in identifying and rejecting morally unacceptable practices regarding research on human subjects directly parallels the public outrage and resulting regulatory interventions that will be discussed later here. They have characterized the LTC environment over the past few decades and have resulted in improvements in both the care provided and the culture created. Society in general has been directly involved in two attempts to change the culture and consequently help to reduce incidents of moral distress for the staff of LTC facilities. The first is the initiative to “untie the elderly,” and the second relates to initiatives in support of residents’ rights through the implementation of the Ombudsman program and the 1987 Budget Reconciliation Act.

In a 1989 symposium before the Special Committee on Aging/United States Senate, the committee agreed that the Federal Government would play a key role in supporting the establishment of restraint-free or restraint-reduced environments for nursing home patients. The committee based its recommendation on what they said was an overwhelming interest in support of this initiative. The Kendal Corporation of Kennett Square, Pennsylvania, was given special recognition for its efforts with this initiative.\textsuperscript{57} The Kendal Corporation has been given national recognition for never having used restraints in its operation. From the opening of its first community in 1973, Kendal was committed to honoring the dignity of the individual, no matter how ill or frail, and for supporting the independence and decision making of their residents.\textsuperscript{58} This philosophy led the way for other nursing homes and providers to follow in their footsteps.
Legislatively, OBRA ’87 and the Patient Self-Determination Act of 1990 signaled additional outside support both from within and outside of the industry for necessary reforms within the nursing home industry.\textsuperscript{59} The 1987 Omnibus Budget Reconciliation Act (OBRA 87) specifically focused on quality of life issues as part of the survey process. This was the first time that quality-of-life issues, as well as resident-rights issues, became a requirement for participation in the Medicare/Medicaid program in the history of nursing home regulation.\textsuperscript{60}

The LTC Ombudsman Program had its beginnings in the 1970s in response to growing public awareness of abuses within nursing homes and of the need to provide additional oversight over and above government regulation.\textsuperscript{61} The Ombudsman program remains an active partner in insuring quality care within nursing homes to this day. The Bush administration provides an interesting example in which the government sought support from the society at large to change the culture within nursing homes. A study completed by the Department of Health and Human Services found that it was not monetarily feasible for the government to require that nursing homes achieve a minimum patient-nursing staff ratio (estimated to be 8\% greater than what was budgeted at that time). In response, the Bush administration rather than mandating staffing levels, published the data on staffing levels in nursing homes and relied on the market demand created by an informed public to force nursing homes to increase their staffing levels voluntarily.\textsuperscript{62}

A second aspect of the LTC environment in particular and of healthcare in general relates to the multi-culturalism of both the healthcare providers and the patients/residents. Within LTC settings in the United States, both residents and staff represent an increasingly diverse population in terms of ethnicity, race, and (most important) differences in values as a result of the diversity.\textsuperscript{63} Thus, the idea has emerged in the literature that practitioners need to become
culturally competent, and two specific approaches have been suggested to fulfilling this need. The first is to use a fact-centered approach and the second, an attitude-centered approach. The former is the most familiar to anyone who is trying to learn about the values and practices of a culture that is unfamiliar to them. Although a factual approach can be an effective way to learn certain information about a given culture, it does not adequately account for the individual differences that come to define and shape one’s identity.

A more comprehensive approach to learning about individuals from a culture unlike one’s own is the attitude-centered approach. It calls on individuals to be open minded towards cultural differences and to seek to learn about the values (both cultural and personal) that come to define another person. This approach is thought to be a more positive, holistic method of truly learning about other cultures and other people. Although both approaches can be useful in learning generally about a given culture, the attitude-centered approach to cultural competence reduces the likelihood that an individual can be stereotyped based on pre-conceived notions of a given culture.

2. Compassion Fatigue and Burnout

Although research focused specifically on compassion fatigue and burnout within the LTC environment is limited in comparison to that for the acute care setting, some of the limited amount of valuable research that does exist is related in particular to burnout within LTC.

One such study, conducted by Bernice Kennedy and published in 2005, sought to answer the following questions: 1) whether there is a relationship between stress and burnout among the different educational levels of the staff (i.e., RNs, LPNs, and CNAs); 2) whether a relationship could be found between stress and burnout based on the different units where staff were working (i.e., memory support units, sub-acute, and rehab); and 3) whether there was any relationship
between the individual variables of the nurses—specifically relating to age, sex, race, marital status, and number of years they worked in the facility—and whether or not they had participated in stress management classes. Burnout is thought to be a syndrome that has symptoms similar to those that characterize moral distress: emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment.

With a sample size of approximately 25 RNs and LPNs, and 100 CNAs, Kennedy found that there was, in fact, a correlation between education level and the amount of burnout reported, with LPNs reporting the least amount of stress and burnout and CNAs reporting the most. In addition, incidents of stress were reported correlated to the acuity of the residents, with higher burnout and stress associated with the higher acuity patients. These findings are relevant to the current study, particularly when considered from the perspective of providing end-of-life care with the LTC setting. Kennedy’s findings will be discussed further in Chapter 7 when addressing the experience of moral distress in providing end-of-life care.

Forster suggests that compassion fatigue may, in fact, be best understood as a form of moral distress because many of the symptoms appear to be the same as or to overlap with those commonly associated with moral distress. Compassion fatigue is best described as a syndrome thought to develop when caregivers internalize the pain of those they are caring for. If compassion fatigue is not addressed, the symptoms can worsen and eventually lead to burnout similar to the symptoms of unaddressed moral distress. Unless caregivers can continuously find new ways to renew themselves, they will eventually lose the necessary energy for the position and ultimately the enthusiasm necessary to continue their work. Figley (1995) simplifies the notion of compassion fatigue by applying it to anyone who suffers as a result of their work in helping others.
What helps to differentiate compassion fatigue from burnout is the actual onset and severity of the symptoms. Compassion fatigue is generally characterized by a sudden onset of symptoms, whereas burnout is thought to build up over time as individuals gradually withdraw emotionally from those around them, eventually becoming either unable or unwilling to demonstrate empathy to those they are caring for.73 An interesting question posed in the literature, which currently remains unanswered, is whether or not burnout is contagious within an organization or work group. While there does not appear to be any supporting research to substantiate the claim that it is, research does indicate that certain factors within work environments appear to elicit a type of organizational level of burn-out not found in all work environments.74

An important factor that relates to the ability of the caregiver to address issues of compassion fatigue and burnout effectively is individuals’ levels of resiliency in responding to repeated incidents of workplace stress and/or moral distress. Whereas this characteristic must be developed within the individual, a great deal of research is currently underway that focuses on how individuals can strengthen their resiliency as well as how this particular ability helps to shield caregivers from the debilitating effects of compassion fatigue and burnout.75

Baranowsky and Gentry, both psychologists who work with individuals experiencing compassion fatigue, have developed a five-point approach to successfully managing compassion fatigue within the workplace. Their program includes the following: 1) improve resiliency skills by building on the support structures within our lives, such as relationship building with friends, family, and colleagues, so that when challenges do arise, support structures are in place to assist with overcoming the associated stress; 2) complete an internal assessment of what skills the individual may be lacking that contribute to an inability to respond to work demands in a
healthy way and seek additional training to overcome these deficits; 3) evaluate the circumstances that may be preventing individuals from properly caring for themselves in a way that permits them to have the energy and compassion to extend their care to others; 4) understand any internal personal conflicts that may be affecting their experience of fatigue; and 5) seek new ways to engage with others so that support will be provided when needed. These include support obtained from involvement with social, spiritual, and physical practices such as meditation, mindfulness training, and yoga.\textsuperscript{76}

3. Theories of Accountability/Agency (Individual versus Organizational)

It is difficult to expand on the concept of accountability without first acknowledging the role of individual agency. Bandura correctly identifies the role of agency as being connected to individual accountability when he explains the role of personal efficacy. According to Bandura, unless individuals believe that they can affect a given situation with their own actions, they will have little incentive to act in the face of difficulties. Each individual must believe in the power to effect change simply by individual actions.\textsuperscript{77} While most individuals understand their inherent responsibilities toward their employers in the workplace, it is often being answerable to oneself that causes issues with moral distress and helps to explain the impact of the distress as being a phenomenon of the individual rather than of the situation.

In expanding the discussion of individual and organizational moral agency begun in Chapter 2, this discussion looks at the impact on the employee of perceived power imbalances attributed to both the individual and the organization. The notion of professional power is a somewhat complex term because of the need to distinguish between implied power and actual power in the workplace. In addition, as will be discussed in Chapters 4 and 5, when attempting to address and reduce the experience of moral distress, the leadership of the organization must
move from a position of “power over” to “power to.” Professional power is thought of in terms of the influence one has over others simply because of the professional position that one holds.\textsuperscript{78}

Raven and Druglanshi have identified six power bases related to professional power and the use of such power in the work setting. These are coercive power, connective power, presumed expertise or skill, information power, reward power, and legitimacy or authority power.\textsuperscript{79} Each of these sources of power exists only to the extent that someone else has a need for what we have, whether information, a possible reward, benefit from the information they believe we hold, or simply respect given to a position. Whether people recognize the power they have in the work setting can affect how that power is exercised in that environment. This concept will be shown as critically important in the discussion of leadership techniques in Chapter 4, particularly in relation to servant leadership. Leaders must be aware of their own power, either real or perceived, if they are to channel it in a positive direction for the good of both the organization and the individual employee.\textsuperscript{80}

Of particular concern within LTC are the so-called “power differentials” that exist among staff at all levels of the organization.\textsuperscript{81} In a 2012 study, Newton et al. found that although nurses indicated their willingness to engage their superiors in dialogue concerning ethical issues, they deemed the conversations as “voicing to silence” because their concerns were actively silenced and not addressed.\textsuperscript{82} Such a lack of responsiveness over time can cause the powerlessness so often seen as a part of the experience of moral distress, and all of this becomes part of the culture of the organization. As the experience of moral distress becomes more entrenched in the organizational culture, the effectiveness of individual moral agency and accountability is reduced and both staff and patients suffer. Such power dynamics often adversely affect not only the
individual who experiences the moral distress but also the patient and the family members, who look to the caregivers for support and guidance.\textsuperscript{83}

A final consideration in reviewing the impact of a power differential on moral agency and, ultimately, healthcare practitioners’ accountability relates to the level of power that each person and/or organization holds over the other. Worthley describes three specific levels of power and their impact on both the “effect” one has on others as well as the “affect,” which relates to the manner in which power is exercised: macro power, or the power of the system itself; micro power, the power of the individual; and subtle micro power, which is thought to be unofficial, indirect, and individual in nature.\textsuperscript{84} Particularly relevant to the current discussion are macro/organizational power and subtle micro power. Each of these levels of power can affect the ability of individual healthcare workers to exercise their own moral agency when confronted with issues likely to contribute to moral distress, as well as the likelihood that they will do so. Wilbern helps to explain the importance of micro power when he speaks of the importance of attitudes and tone within the workplace, especially from those in positions of power.\textsuperscript{85} Even those individuals at the highest levels within the organization can use subtle micro power most effectively to assist those responsible for responding to and reducing incidents of moral distress by encouraging and supporting the individual agency of each employee.

An organization itself must be aware of how institutional values are implemented throughout the organization because any observed disconnection between values and implementation has been found to encourage employee lapses in ethics.\textsuperscript{86} It is essential for the organization to maintain operations consistent with its espoused mission, vision, and values, not only for the good of the organization but also for its employees and those it serves. Most critically, such an approach allows employees a successful alignment of their work environment
with their personal values and, in turn, helps to reduce incidents of moral distress. As noted previously, moral distress is more likely to occur where institutional policies and procedures are not consistent with the practitioners’ strongly held moral beliefs.  

C. The Crescendo Effect of Moral Distress

The research cited above supports the notion that the causes of moral distress can be equally attributed to individual responses to perceived stressors as well as practices within the organization that can elicit moral distress both within the individual and systemically throughout the organization. Applying a systems approach to addressing moral distress within the individual as well as the organization will be shown to be the most appropriate means of reducing such stress. Further, what becomes clear from the research to date is that measures taken to address moral distress within the individual prior to a build-up of moral residue will prove to be equally valuable to both the organization and the individual. In addition, the measures taken organizationally to prevent system residue within the organization will have an equally beneficial effect on the individual employee.

Within the scientific community, systems researchers apply the term “residue” to situations in the world that they have not yet been able to fully explain or bring under their control. Similarly, the need to control the build-up of moral residue that will, over time, lead to a crescendo is equally as challenging and requires a system wide approach to successfully addressing it. These concepts are further explained below.

1. Moral Distress and Moral Residue

In her 2010 article, Unruh refers to moral distress as “a living nightmare,” which aptly describes the on-going, daily trauma that incidents of moral distress in the workplace may cause. Whereas nightmares end when one is awake, incidents of moral distress, if left unaddressed, can
continue day after day with progressively more serious ramifications to both the healthcare practitioner and the patients/residents. One of the most serious effects of the constant moral distress for practitioners can be the dulling of moral sensitivity, which Chambliss calls a “routinization of the moral world.” In cases of routinization, nurses become desensitized to patients’ needs and no longer perceive how care or treatment decisions may be contrary to acceptable ethical standards.  

The crescendo effect model was first proposed by Epstein in 2007. Epstein initially worked on an empirical study of nurses and physicians in a neonatal intensive care unit and their experiences of moral distress. She later expanded upon her work when she collaborated with Hamric to include work that reflected several other disciplines and settings. 

The crescendo effect theory attempts to explain the relationship of repeated incidents of moral distress that lead to a build-up of moral residue, which ultimately leads to a crescendo or breaking-point. The evidence of this crescendo is sometimes seen outwardly as a numbing of moral sensitivity on the part of the healthcare practitioner, or a withdrawal from involvement in ethically challenging patient situations. Although Jameton did not specifically address or name a crescendo, his original theory which identified both an initial distress and a reactive distress helped to lay the foundation for this later expanded theory of the effect of the latent distress on the healthcare provider. This later reactive distress is now referred to as moral residue. The relationship over time of moral distress to a build-up of moral residue became the focus of the crescendo effect theory.  

The crescendo effect is best described as stemming from the residual distress that remains after a morally distressing situation has been resolved. Although moral distress and moral residue are often described together in the literature, the impact on the individual and on the
organization can be quite distinct and require different interventions to address. The original researchers credited with developing the crescendo effect theory identified what they believe are the most significant implications of their findings: 1) Given the negative effects of having reached a crescendo, every effort should be made by organizations and individual practitioners to identify and help to prevent the escalation to a crescendo in those who have repeated experiences of moral distress. Epstein and Hamric caution practitioners not to under-react when colleagues appear to have intense reactions to difficult cases as that may be a signal that moral distress is building to a crescendo level. 2) Repeated incidents of moral distress within a particular work environment may signal more serious systemic problems thought to center around issues of poor communication and feelings of powerlessness. 3) Leaders should be aware of the far-reaching organizational effects of moral distress by being alert to behaviors across the organization that could signal the presence of moral distress, even within departments that are not providing hands-on patient care.

Rambur, Vallett, Cohen, and Tarule offer a differing theoretical approach to the impact that moral stress can have on both the individual and the organization, which they call the “moral cascade.” Rambur, Vallett, Cohen, and Tarule broaden the approach to explaining incidents or moral distress by including the interaction of the moral identity of individuals with the values of the organization and the stated purpose of the organization.

Two significant attributes of the moral cascade theory help to differentiate it from the crescendo effect discussed above. The former can be perceived as expanding upon the relationship between moral distress and moral residue because it goes beyond this initial relationship to explore how the moral practices of individuals are influenced by and, in turn, influence the organization. Specifically, although moral distress is an experience of the
individual rather than an experience of the situation, significant aspects of the organization can either contribute to moral distress or help to minimize its effect, or channel the moral ambiguity to a positive end for both the individual and the organization.

The moral cascade theory begins to acknowledge the important role that an organization’s environment and culture can play in both establishing and maintaining a context in which one’s personal moral beliefs aligns with one’s ability to work in an environment that respects those beliefs. The moral cascade theory also helps to substantiate the notion that efforts to understand and address issues of moral distress must simultaneously include a more comprehensive understanding of the alignment of an organization’s mission, vision, and values and of how those values are operationalized throughout the organization. The alignment of an organization’s culture with its stated policies and goals can play a very positive role in helping both to identify situations that may contribute to moral distress and to provide opportunities to address those situations.

The work of Rambur, Vallett, Cohen, and Tarule on their moral cascade model contains strong parallels with that of Varcoe, Rodney, and McCormick. In many respects Rambur et al. appear to build on Varcoe et al.’s 2003 study in acknowledging the interconnectedness and context driven nature of moral action. As Rambur et al. were able to identify in their research, rather than studying people and their moral actions individually, they should be considered in relation to one another and to the entire network in which they work as a means of effectively addressing the possible issues of moral distress. These networked individuals (sometimes thought of as sub-cultures) can be found to both increase instances of moral distress as well as helping to resolve them.
One interesting aspect of the moral cascade theory relates to what Seyle has termed eustress, or positive stress, which was discussed previously. Of particular significance in discussing the moral cascade theory is the idea that not all morally challenging situations necessarily lead to moral distress; rather, it is possible to have initial distress lead to a type of eustress. If this positive stress can be acted upon and satisfactorily addressed, the buildup of moral residue can be minimized if not eliminated.99

2. The Yerkes Dodson Law

The idea that moral residue may lead to a crescendo has a parallel in what has become known as the Yerkes Dodson Law. This law posits that while there is an optimal level of stress that appears to increase both performance and efficiency, there is a point at which continued stress reduces both performance and efficiency. Although Yerkes and Dodson developed their theory in 1908, the premise of a threshold which, once experienced, brings negative consequences to the individual is consistent with current literature relating to the idea of a moral crescendo discussed above.100 The Yerkes Dodson law can also be seen as relevant to the moral cascade which recognizes a degree of positive stress (eustress) in its application.101

Further research on the effect of both positive and negative stress on the individual in a work setting is found in the work of Richard Lazarus, who is credited with developing the cognitive appraisal approach to stress. Though there are similarities to the work of Jameton and Selye, the cognitive appraisal approach posits that individuals can have different responses to the same stressors, depending on whether they appraise the stressor as positive or stressful.102 Further research from Lazarus and Folkman suggest that positive and negative responses to the same stressor can occur simultaneously within the individual, and any theory relating to stress or
emotion that focuses on only one of these responses (disequilibrium or arousal) is therefore incomplete.¹⁰³

This theory is supported by research carried out from Rose in a longitudinal study conducted on 201 male air traffic controllers. This study measured the amount of cortisol in the blood over a three-year period when compared with both their individual measurements of workload and objective assessments of workload. The study found that those with the highest amount of cortisol reported a higher degree of job satisfaction and engagement than those with lower levels, leading the researchers to conclude that eustress could be thought of as indicative of a healthy state of arousal which is most appropriately termed eustress, whereas distress was most closely associated with a negative psychological state.¹⁰⁴ These findings are important to the current discussion as they support the notion that it is not the stressor itself that produces the negative stress (or distress) but the combination of how the individual reacts to the stress, in this case the workload, and the situational context in which the stressor is experienced.

Consistent with this understanding is work by Le Fevre, Matheny, and Kolt, which disputes the original findings of the Yerkes Dodson Law and argues that no amount of “good” stress or eustress in the occupational stress research supports the theory that a moderate amount of stress or anxiety in the workplace leads to higher levels of performance.¹⁰⁵ One important finding, however, related to the concept of eustress was explored by Simmons and Nelson in a study that evaluated the relationship between eustress and the positive response to work demands and health. Their findings indicated that one’s response to work demands could be either positive or negative and could be positively influenced by interventions made by the organization. These included improved policies and procedures and an increased exposure to work, felt by employees, that allow them to be able to focus on the essential aspects of their jobs,
particularly patient care. Finally, their findings support the notion of not only reducing incidents of distress but also increasing the opportunity to increase experiences of eustress. Though it may be difficult to increase opportunities for eustress in the workplace, research does support the idea that an organization has a role to play in effectively responding to morally distressful situations by providing opportunities to discuss ethical conflicts as they occur and providing support and ethics education for the staff.

3. Parallel Applications of Systems Residue to Moral Residue

Pursuant to the discussion above about the impact of repeated incidents of moral distress on healthcare practitioner, which causes a build-up of moral residue, it is helpful to understand that a similar build-up of residue can be found within the system itself. Patricia Marck explains the concept of systemic residue using the framework of an ecological system. Drawing on the research of R.K. Barnhart and S. Steinmetz, Marck uses ecological restoration to demonstrate parallels to the interconnections within healthcare systems. She shows the negative effect of focusing too narrowly on any one specific issue without recognizing how each element within the organization affects all of the others.

Within an LTC organization, repeated incidents of low staffing, insufficient orientation of new employees, and a lack of awareness and/or concern related to financial cutbacks can be seen as systemic issues that might lead to systemic residue if left unaddressed by those with the ability and responsibility to address such issues. Repeated incidents of moral distress within the workplace are generally indicative of systemic problems within the organization including poor communication, lack of a collaborative work environment, and perceived powerlessness on the part of the staff to address these issues effectively.
As in the examples given earlier in relation to the Yerkes Dodson Law, a similar effect happens with systemic residue. Although a certain number of organizational efficiencies may in fact bring positive outcomes to the organization, repeated reductions in staff or other financial reductions can become too burdensome over time and unachievable, resulting in a weakening of the overall operation. Marck provides an example of such systemic residue, pointing out that often short-term efficiencies relating to reductions in staffing can ultimately contribute to increased overtime for the existing staff and, in the worst cases, to an increase in adverse outcomes for patients.110

In terms of similarities between moral residue and systems residue, an important parallel can be drawn between the need for resiliency in addressing and overcoming compassion fatigue, burnout, and moral distress and that same need within operating systems. From a systems perspective, resiliency can best be thought of as a system’s ability to recover quickly after being stretched or stressed in some way outside of its normal operating parameters. Whether in an organization or an individual, resiliency refers to the ability to restore, repair, or recover a normal state after some form of disturbance.111 Resiliency is a good indicator of a system’s ability to survive within a changing or variable environment, consistent with a practitioner’s need for resiliency as well in effectively facing issues of moral distress, compassion fatigue, and burnout.

For individual practitioners, several strategies have been suggested for improving one’s resiliency, including various forms of self-improvement such as developing self-awareness skills, participating in daily meditation and relaxation training, and mind-body awareness. The goal of each of these interventions is to strengthen the practitioner’s ability to respond when confronted with incidents that could lead to moral distress and ultimately a build-up of moral residue.112
Within organizations, resilience can be viewed as “a measure of the system’s ability to survive within a variable environment, while the opposite of resiliency is brittleness or rigidity.” Given all of the complexities surrounding care provision in the LTC environment, the need for resiliency in both the organization and the individual caregiver becomes self-evident. The strategies to support resilience will be further highlighted in relation to leadership practices, the methods of communication used within the organization, and the degree of empowerment experienced by the employees of the organization.

A second parallel between system residue and individual moral residue is that both must be approached with the understanding that changes made to one part of the system often have unintended consequences for other parts of the system. Over time, these unintended consequences can lead to a weakening of the entire system in the case of an organization and to a build-up of moral residue for the employee.

A final parallel between system residue and moral residue is the specific distinctions or classes of systems, which are categorized as natural systems, designed systems, and human activity systems. By definition, a natural system is best described as one untouched by human hands; it is not made, and its origins, found in the universe, cannot be other than they are. Observed natural systems have formed the basis for scientific research throughout the ages. The fact that the sun always rises in the east, the pattern and colors of rainbows, and the stars are all examples of natural systems that man cannot alter. Designed systems, on the other hand, are man-made and have been purposefully designed to meet some identified human activity need. In the case of designed systems, a human being could be designing either a physical entity or a more abstract system developed around a set of thoughts. In either case, the design is purposeful, in response to an identified need. Much of what one thinks of when considering
business systems can actually be categorized as demand systems designed to help address the business needs of the organization.\textsuperscript{115}

Social systems by contract become somewhat more complex to define and therefore more difficult in terms of drawing absolute conclusions. One prestigious account of social systems put forth by Tonnie identifies two types of social systems: first, a natural system which Tonnie termed “community,” which represents the strong ties among family members; and second, a society or association, which would characteristically be a rational connection of linked activities, such as that found in the workplace. Tonnie’s observations suggest that to understand a social system completely, one must consider the community aspect in combination with the societal or association aspect of the human condition under investigation.\textsuperscript{116}

In the current thesis, the significance of differentiating between the classes of systems is twofold: 1) to distinguish between the three types of systems in terms of the ability to modify or change them based on perceived human needs and 2) perhaps most important, to clarify that social systems are made up of components of both natural systems and demand systems. Given this blending, there will always be a human component to how stimuli—in this case, stressors thought to lead to moral distress—are perceived by the individual and how systemic efforts to overcome such distress must be addressed by drawing upon an understanding of the frameworks of both natural systems and demand systems.

Gary Filerman et al. point to the following characteristics as important for a social system: the system must have a purpose or goal, it must have shared values, boundaries within the system must be clearly understood, the required resources must be available, interactions must be positive and purposeful, the system must have the ability to change, and the outcomes or goals of the system should be understood by all of its members.\textsuperscript{117} Each of these characteristics
can be perceived as strengthening both the organizational system and the individual working within the system. Repeated failures in any one of these areas can have the effect over time of causing either system residue or moral residue, or both.

D. Conclusion

In providing an historical context to the research surrounding stress and moral distress, this chapter provides support to the current thesis; that although the experience of moral distress has historically focused on the individual and his/her responses to certain stressors, current research expands this notion and provides the ethical justification for supporting interventions designed to support efforts by both the individual and the organization in confronting and reducing incidents of moral distress. Because moral distress is known to be an experience of the individual versus an experience of the situation, the methods of addressing moral distress must be sufficiently broad to include interventions on several different levels, both for the individual and the organization.\(^{118}\) Although differing methodologies have been applied to the issue of stress, there is general agreement within the literature that certain stressors may elicit responses in individuals that can, over time, have a negative impact on the health and general well-being.\(^{119}\)

An important concept that helps to clarify the how the responsibility for reducing incidents of moral distress must be shared between the individual and the organization can be found in theories of accountability and agency; both on the part of the individual as well as the organization. Two important aspects relating to individual and organizational agency relate to power imbalances that have been found to exist within organizations. Within the healthcare organization, individual employees must first believe in their own power to effect change within their organization by their individual actions.\(^{120}\) In addition, the organization must seek to establish a culture that supports the power of the individual to do what he/she believes to be the
morally appropriate action versus a climate where the organization positions itself to have power over someone versus the empowerment to take necessary actions. The joint efforts of the employee and the organization working in partnership will be shown in the next several chapters to have the greatest positive impact on reducing incidents of moral distress. Specific leadership practices, methods of communication and employee empowerment will be identified that support both individual and organizational agency and result in effectively addressing issues of moral distress across the organization.

9 Vidette Todaro-Franceschi, Compassion Fatigue and Burnout in Nursing: Enhancing Professional Quality of Life (New York: Springer Publishing, 2013), 91–93.
18 Diana J. Mason, forward to Compassion Fatigue and Burnout in Nursing, Enhancing Professional Quality of Life, by Vidette Todaro-Franceschi (New York: Springer Publishing, 2013).
32 Kathy Greenlee, forward to Culture Change in Elder Care, by Judah Ronch and Audrey Weiner (Baltimore, MD: Health Professions Press).


51 Maria Vesperi, “Nursing Home Research Comes of Age: Toward and Ethnological Perspective on Long Term Care,” in *The Culture of Long Term Care*, ed. Maria Vesperi and Neil Henderson (London: Bergin & Garvey, 1995), 7–21.


68 Vidette Todaro-Franceschi, *Compassion Fatigue and Burnout in Nursing: Enhancing Professional Quality of Life* (New York: Springer Publishing, 2013), 111–120.
71 C. Joinson, “Coping with Compassion Fatigue,” *Nursing* 22 (1992): 116, 118-9, 120.
Chapter 4: Organizational Leadership Responsibility for Moral Distress

In applying a systems approach to moral distress in long-term care, the role of the leader and of the leadership practices within the organization is recognized as key in establishing a desired culture, along with methods of supporting communication within that culture.\(^1\) As the importance of strong leadership was increasingly acknowledged within organizations, researchers looked to general systems theory in recognizing that the principles applied in such fields as engineering, math, and physics were also true within living systems, such as families and larger institutions. The main premise of the general systems theory, which is critical when studying leaders and leadership, is the notion that an organization, however large and complicated, fundamentally functions as a unified whole and that changes in one part of the organization cause changes to the whole system as it tries to remain in balance.\(^2\) As discussed in Chapter 2, when applying a systems approach to moral distress, one is speaking of a soft systems approach, and as such, issues involving human beings and their unique responses are less well-defined.\(^3\)

This chapter explores the role of executive leadership and the impact that two specific leadership styles—transformational leadership and servant leadership—can have in positively influencing the entire healthcare organization by reducing incidents of moral distress.

A. Transformational Leadership

Given the constantly changing, complex, and multi-facility nature of today’s healthcare organizations, the need for strong executive leadership is unquestioned.\(^4\) An understanding of what is generally meant by the term “executive leadership” and the various types of leadership styles found to be the most effective within healthcare
organizations will be shown to have a significant positive impact on efforts to address and reduce incidents of moral distress within the organization. Given the demands placed on today’s executive leadership, both from within and outside of the organization, the role of the executive today is perhaps more challenging than at any other time in our history.  

Schein, one of the foremost influential scholars on the subject of leadership and culture within organizations, provides a simple but exact notion of what he believes is the most important issue for a leader to understand in order to lead an organization of any size or complexity successfully. According to Schein, the central focus of the leader should be seeking to understand the culture, both the hidden culture spoken about in Chapter 2 and the day-to-day culture that defines the organization. Once a leader has a thorough understanding of the culture of an organization, he can effectively address the obstacles that may be holding the organization back from achieving its goals. With this understanding comes the ability of that individual to become what is currently known as a “transformational leader,” a type of leader who is vital for bringing all aspects of the organization into an integrated operating system.

In helping to differentiate other types of leaders or leadership styles from that of the so-called transformational leader, Burns offers two types of leadership practices which he terms “transactional” and “transformative.” Transactional leadership, according to Burns, focuses on what might be considered basic goal-oriented tasks, without necessarily tying those goals or tasks into any higher moral motives or needs of those being led. By contract, transformational leadership moves beyond the extrinsic motives associated with transactional leadership, seeking to address the psychological
needs for autonomy and self-actualization, as well as the moral questions relating to righteousness, duty, and fulfillment of obligations. What follows in the discussion of executive leadership refers to the skills and abilities of the transformational leader and to the way these skills can be developed and enhanced.

1. The Role of Executive Leadership

Sergiovanni provides a comprehensive understanding of the need for and distinguishing characteristics of transformational leaders within school systems. While differences may exist between the management of a school and the management of a healthcare facility, Sergiovanni’s explanation of why transformational leadership is required in today’s world to ensure effective management practices is relevant to both. Sergiovanni explains the distinction between transactional leadership and transformative leadership with an analogy of how one views the mechanical workings of a clock. The transactional leader, according to Sergiovanni, views the workings of the clock from a position of control over and regulation of the master wheel, which in turn assures control over the entire clock. The transformational leader, however, approaches the clock in terms of its many parts and understands that the functioning of the clock is ultimately dependent on the independent actions of each of the mechanisms. In this analogy, Sergiovanni compares the approach of the transformational leader and the management of the school to the need for all the members of any team to perform at their optimum level based on their shared understanding of the goals and values of the organization.

This distinction is of particular importance within the healthcare environment as it acknowledges the need for the leaders to seek a shared purpose to their individual efforts, that they have an ability to respond to the human needs of those they are leading, as well
as the ability to clearly model the values that define the organization. At least one study has demonstrated that employees who work with a transformational leader find more meaning in and have more satisfaction with their jobs—certainly one of the goals of any leader seeking to reduce incidents of moral distress within the workplace.\textsuperscript{10}

Collins offers another view of transformational leaders, whom he refers to as “level 5 leaders” who seek to build up the organization and the people around them rather than seeking to highlight their own accomplishments. It is essential that transformational leaders continuously re-evaluate their own values and practices to ensure that they align with the values of the organization.\textsuperscript{11} This practice positions such leaders as role models to all those within the organization and provides clear direction relating to acceptable practices within the organization.

Given the complex and continuously changing environment that now defines healthcare organizations, one challenge of particular concern has been a lack of research into how executive level leaders are identified, developed, and evaluated within this industry.\textsuperscript{12} Collins suggests that one important factor when attempting to develop an executive leader is to consider an individual who has what he terms the “seed” within them to be a successful level 5 leader. In this case, Collins identified specific characteristics that characterize the level 5 leader and traits that the company could benefit from if they could train and develop people to exhibit these traits. A summary of those traits is listed below:

1) Such individuals should embody a mix of personal humility and professional will.
2) They prepare their successors for even greater success than what they have achieved.
3) They display modesty and are self-effacing and understated.

4) They are more concerned with the success of the company than their individual success or recognition.

5) They are resolved to do whatever it takes to make the company great, no matter how difficult those decisions might be.

6) They have been described as more plow horse than show horse.

7) They attribute success to factors other than themselves but accept responsibility when outcomes are not as successful as hoped.\(^{13}\)

Considering the specific parameters Collins outlines, the next step for any organization is to determine exactly what type of development program will be necessary if Collins’ standard for the level 5 leader is to be met.

Given the recognized importance of a transformational leader within the healthcare organization, it is encouraging to note that roughly half of US health systems have reported having an executive leadership development program (ELD) in place with another 12 percent reporting having a program under development.\(^{14}\) This statistic is encouraging because it acknowledges the importance of executive leadership within the organization, and it positions the organization to move toward a learning culture with learning leaders. Shah, Sterrett, Chesser, and Wilmore note an additional benefit of implementing an executive leadership development program. They note that effective on-going training and development programs are often listed as one of the top three reasons that employees accept and remain in their positions.\(^{15}\) As was noted in the previous chapter, in a study conducted by Kalvemark et al., insufficient staff was found to be one of the contributing factors to incidents of moral distress among staff.\(^{16}\) Thus,
any efforts made to reduce staff turn-over should be explored and implemented when possible.

2. The Learning Culture and the Learning Leader

Developing a culture where ongoing learning is supported and rewarded means that the leaders of the organization model the behavior they are seeking from their employees. Research indicates that only those organizations that learn how to identify employees who are both committed to the organization and possess a strong desire for continuous learning will be truly successful in the future. Developing an organizational culture that supports the ongoing learning of all employees to bring about the desired systemic changes necessary to address issues of moral distress requires both an unlearning of certain behaviors and new learning focused on systemic measures that will reduce moral distress. The process of unlearning and relearning becomes transformative for members of the organization and begins to establish the organization as having a learning culture. This description of a learning organization is consistent with Burkhardt and Spears’ description of the characteristics of Servant Leadership. They describe the learning organization “as one that is characterized by openness, freedom of expression, and a focused curiosity in which learning becomes practiced as both a central value and a core competency.”

The relevance of the connection between the learning leader and the learning organization to reducing incidents of moral distress is found in the need on the part of the leaders of the organization to provide access to ethics education system-wide to employees at every level of the organization as a means of increasing both awareness of moral distress issues and possible interventions to reduce such distress. Continuous
learning also plays a significant role in helping to bring about needed culture change within a long-term care environment as discussed in previous chapters. When both leaders and staff commit to continue acquisition of new knowledge and skills through on-going education both within and outside of the organization, they are signaling their openness to new ideas and perhaps new approaches to their work.\textsuperscript{21}

Schein has identified 10 characteristics that he believes must be present to establish an organization as a learning organization and a leader as a learning leader:

1. Leaders are proactive in their approach to identifying and rectifying problems.
2. The organization and all of its members should demonstrate a willingness to learn.
3. Leaders should believe in their employees and in their willingness to learn.
4. Leaders and their employees need to believe that the work environment can be managed effectively.
5. Leaders and their employees should be committed to seeking the truth about any potential barriers that might exist within the organization.
6. Everyone within the organization should be positive when looking to the future.
7. Communication among all levels within the organization must be open and honest.
8. There should be a commitment to cultural diversity.
9. A commitment to systems thinking should be present.
10. An on-going willingness is needed to reassess the organizational culture to insure that their practices remain consistent with their mission, vision, and values.\textsuperscript{22}
Each of these characteristics is consistent with previous discussions focusing on the importance of the culture in addressing moral distress as well as the need for an integrated approach throughout the organization to confront issues of moral distress on a systemic basis.23 As individual employees and the leadership within the organization begin to integrate each of these practices into their daily operations, both the individuals and the organization will have begun the process of moving from a position of self-sacrifice to one of self-fulfillment.

A second important aspect of creating a learning culture is for the executive leadership within the organization to create an environment of psychological safety for the employees that encourages on-going learning. Leaders can create such safety by working to develop their own skills in the following areas: they must be able to project a clear and compelling positive vision; they must provide support for themselves and their team members for on-going formal training; they must seek to provide individualized methods of training that are suited to the needs of the learner; informal training opportunities must be encouraged; consistent feedback must be provided to the employees; role models must be available for team members to look to for guidance; support groups must be established where team members can discuss what they are learning and have opportunities to question one another; and systems and structures must be put into place that support both the newly established learning culture as well as the commitment to on-going training as an accepted on-going responsibility of all members of the team.24 It should be emphasized that as an organization begins to develop its systems and practices to meet those required of a learning organization, an essential pre-
requisite for this learning is the creation of psychological safety both for the leadership of the organization and for all employees who work there.

3. Moving from Self-Sacrifice to Self-Fulfillment

“Leadership, it is said, is something that is bestowed on someone who is by nature a true servant.” These words by Robert Greenleaf call attention to the many servant leaders who have chosen to work within long-term care, and who, because of that choice, often bear the burden associated with their positions through their individual experiences of moral distress. Although a formal discussion of exactly what is meant by the term “servant leadership” will follow in Section B, it is important to the current discussion regarding executive leadership to appreciate the subtle change that can occur within individual leaders, which moves them from a mindset of self-sacrifice to one of self-fulfillment. This change within the leader brings with it a change within the organization that can positively affect the lives of all of those who live and work there. This is arguably the greatest gift that a leader can give to his or her employees—to model the transformation from viewing one’s position as one of self-sacrifice to one of self-fulfillment.

Many of the world’s greatest teachers, philosophers, scholars, and common men have written about the joy that comes from service to others whether or not the original intention of the service was to seek that fulfillment. St. Mother Teresa has been quoted as saying that “there is joy in transcending self to serve others;” St. Vincent de Paul is quoted as saying, “The highest form of worship is service to humanity;” and Albert Schweitzer is quoted as saying that “the purpose of human life is to serve and to show compassion and the will to help others.” The question is how a leader can begin to
model the behaviors that can bring about this fulfillment in others. The need for psychological safety is again stressed as a means of encouraging new and supportive behaviors within all of the staff. The need for psychological safety is also recognized as one of the main components in creating an environment in which issues of moral distress can be appropriately understood and addressed.  

In addressing the eight specific activities necessary to create the psychological safety spoken of by Schein, it should be noted that each of these activities is consistent with the previous discussions in Chapter 3 regarding the development of a culture that seeks to reduce incidents of moral distress. Specifically, moral distress is reduced by developing open communication of ideas, integrating the whole organization into systematic problem solving, and seeking positive role models through strong executive leadership. In addition, these findings are consistent with the leadership development programs being implemented throughout the United States that emphasize employee development and workforce improvements as well as continuous learning and education.  

B. Servant Leadership  

If one were to describe the attributes of the servant leader without formally providing an exact definition of the term, the following words might come to mind: listening, empathy, healing, awareness, persuasion, conceptualization, foresight, stewardship, commitment to the growth of people, and building community. These words, while not providing a formal definition of what is meant by servant leadership, do begin to provide insight into the attributes of the servant leader, particularly relating to
the leader looking outside of him or herself in both providing support and leadership to those being served and seeking that same support from those being led.

1. Servant Leadership Defined

Greenleaf first developed the term “servant-leadership” in 1970. Servant leadership is rooted in the belief that true leadership emerges first from a strong desire on the part of the individual to help and serve others. A keen observation which helps to define servant leadership is that made by Covey who has observed that the role of leadership itself is changing: it is moving from attempting to motivate and lead from the “outside in” to leading by inspiring others to look within themselves and to help to develop what is best within each individual. In describing the idea of service when referring to the servant leader, Vaill describes Greenleaf’s view of service as combining two components: the first is attitudinal, the second, behavioral. As these two attributes combine, servanthood is the result.

The idea of inspiring others to seek what is best within themselves is particularly important when confronting moral distress as it helps individuals to focus on their own beliefs and to define on a personal level what triggers incidents of moral distress. Greenleaf has characterized a loss of leadership as a failure on the part of the leader to foresee what should reasonably have been foreseen and as a failure to act on that knowledge when the ability and support are available to do so. In order to become a truly effective leader, according to Greenleaf, leaders must know themselves and must also seek to know others and the influence they have on other members of the organization, whether, positive, negative, or neutral. The leader, according to Greenleaf, must be in communication with all those involved in the operation. In a larger
institution, such as those that typically characterize healthcare institutions, the only way to ensure that such channels of communication remain viable is through systems designed specifically to maintain these open channels of communication. In doing so, the leader can achieve greater results for both the individual and the institution, as both will achieve greater success than they would individually. Several different paths are available to leaders as they seek to become true servant leaders.

Dr. Keith, CEO of the Greenleaf Center for Servant Leadership from 2007–2012, has identified seven key practices that he believes help to make servant leaders effective both personally and professionally. They are briefly described below:

1. Self-awareness – Servant leaders are aware of their own strengths and weaknesses and, because of this self-knowledge, they are able to identify the strengths and weaknesses of others. This knowledge allows them to encourage those they lead rather than simply judge them. In addition, servant leaders are aware of the impact that their words may have on others and seek always to honor their own words. In doing so, leaders gain the trust of those they are leading.

2. Listening - Servant leaders seek to understand the needs of those they serve by first listening to their concerns without trying simultaneously to resolve their issue. By listening first and acting second, the servant leader fully understands the concern before trying to resolve it. Because of the individual nature of experiences of moral distress, listening to an individual’s concern before attempting to resolve the concern can prove to be the most important step in the process as it allows for addressing the problem on both an individual and systemic level.
3. Changing the pyramid – The traditional structure of an organization is designed in a hierarchical manner with only a few individuals at the top making decisions on behalf of all of the employees in the organization. Servant leaders seek to serve those who in the more traditional leadership model would be serving them. By working to encourage, motivate, and value all members of the organization, the leader strengthens both the organization and the individual.

4. Developing your colleagues – Building upon the change in structure, servant leaders see as their primary mission the development of all employees within the organization. As the individual experiences growth both individually and professionally, the work environment improves, the customer is better served, and the organization benefits in ways that it might not otherwise experience.

5. Coaching, not controlling – In many respects, the practice of coaching versus controlling is an acknowledgement of the importance of addressing the power imbalances, discussed in Chapter 3, that frequently exists within all organizations, but particularly within a healthcare setting. As servant leaders work to develop their employees, they are at the same time deepening their relationship and developing the trust that is essential to building a strong team of dedicated employees who function within an environment of psychological safety. This safety provides the necessary foundation for a free flow of information regarding any concerns that either they or their supervisor might have. Where issues of moral distress arise, this relationship is critical to addressing and reducing such distress across the organization.
6. Unleashing the energy and intelligence of others – The importance of empowering employees to act independently will be fully discussed in Chapter 6 of this paper. Servant leadership recognizes the value of empowerment as one of the most important aspects that leaders can instill in their employees. A culture that empowers employees at all levels of the organization provides a strong signal to all employees that they are valued and trusted to act in what they believe is the best interest of the organization and in a manner that is consistent with what they know to be the mission, vision, and values of the organization.

7. Foresight – The ability to look to the future as a means of identifying the changing aspects of all organizations is perhaps the single thing that only the leader is in a position to accomplish within the organization. By taking responsibility for identifying and adapting to the changing aspects within the organization, the leader positions the organization to remain viable, and able to move into the future with a strong sense of direction that is consistent with the mission, vision, and values of the organization. While employees can generally understand the mission and values of the organization, most look to the leader to provide the vision for carrying out the mission successfully and adhering to the values that define the organization. Servant leaders who possess the foresight to be able to clearly inform employees of the current trends and the need for ongoing adaptation to remain competitive will receive the respect and loyalty of their employees.37

Sipe and Frick expanded on the work of Dr. Keith in outlining what they have termed the “Seven Pillars of Servant Leadership.” While there is some degree of overlap
in the two assessments, Sipe and Frick emphasize some important additions to the work of Greenleaf and Keith after much study on how they would define the term “servant leader.” The Seven Pillars of Servant Leadership, according to Sipe and Frick, are as follows: the servant leader 1) is a person of character; 2) puts other people first; 3) is a skilled communicator; 4) is a compassionate collaborator; 5) is possessed of foresight; 6) is a systems thinker; 5) and is able to lead with moral authority. Finally, Greenleaf makes the following two observations about the servant leader, which seem to be quite relevant when applied to leaders within the long-term care environment. First, no one leader can assume responsibility for the whole (in this case, the whole organization). All leaders can and must do is take responsibility for what they can do inwardly and how they deal with challenges as they present themselves. Second, the servant leader must work to “demythologize leadership,” to move it away from the idea that individuals can respect the position of leadership and not respect the person who holds that position. Respect, according to Greenleaf, can be granted only to persons, not positions, and to earn that respect, the servant leader must in all areas act with honesty and integrity. In so doing, those who follow will come to respect and support the leader and will make contributions to the organization that they might not otherwise feel inclined or encouraged to do. Acting with honesty and integrity allows leaders to act with moral authority, which can engender greater allegiance from their team than the power gained simply as a result of the position that is held.

Given all of the positive attributes associated with both the transformational leader and the servant leader, Graham identifies what she believes sets the practices of the servant leader apart from those typically classified as belonging to the
transformational leader. Graham seeks to develop a model of leadership that can both inspire and contain moral safeguards.\textsuperscript{41} In her study, Graham identified four types or classes of transformational leaders: 1) the charismatic leader, characterized by charismatic authority often emerging during periods of social and economic unrest and owing to the failure of traditional authorities (e.g., government) to meet the needs of the people; 2) personal celebrity charisma, often seen in popular sports figures, entertainers, or other high profile individuals; 3) transformational leaders with all of the attributes discussed above but who, according to Graham, owe their primary allegiance to the organization rather than to the individual; as a result, their moral authority could be called into question; 4) the servant leader who, in addition to all of the positive qualities attributed to the transformational leader, models moral behavior and serves others as well as being served by them.\textsuperscript{42} Because servant leaders seek to encourage those they lead to become autonomous moral agents, they work to improve not only the organization, but themselves as well.\textsuperscript{43} This proves to be one of the most significant and relevant aspects of servant leadership, particularly in relation to a leader’s efforts to address issues of moral distress within an organization.

Further substantiation of the subtle but significant difference between servant leadership and other forms of transformational leadership can be found in a study conducted by Liden, Wayne, Zhao, and Anderson.\textsuperscript{44} This study was designed to measure whether in fact servant leadership offers anything additional to leader behaviors in terms of serving the needs of followers and the larger community. It was determined that, consistent with Graham’s initial description as discussed above, servant leaders scored higher in the level of commitment from their followers as well as in overall
organizational commitment to the greater community. In addition, when tested for “behaving ethically,” servant leaders scored highest in this category, higher than scores for transformational methodologies. These results lend credence to the notion that ethical behavior and trust are now thought to hold a significant place in what defines a servant leader.45

2. The Essence of Moral Authority and Interdependency

Sergiovanni describes the connection between servant leadership and stewardship as very strong. Sergiovanni goes on to explain the central role that moral authority plays in successfully implementing both practicing servant leadership and understanding and appreciating the role of stewardship.46 Central to this connection is the concept of interdependency and its role in strengthening both the leader and the organization. In helping to explain the interconnectedness of servant leadership, stewardship, and moral authority, Covey has identified four dimensions of moral authority. First, the essence of moral authority (which he believes is synonymous with one’s conscience) is sacrifice. Conscience or moral authority, he argues, empowers people with the freedom to choose their own course without fear or intimidation. Second, conscience inspires one to become part of a cause worthy of commitment. In a healthcare environment, that cause can be pride in the care that is being provided, the values that define the organization, and commitment to a mission that is understood at all levels of the organization. Third, conscience teaches that the ends and the means are of equal importance and are in fact inseparable. Fourth, conscience expands one’s world to include those whose vision is aligned with one’s own and in so doing lightens the path for all. Benefits are reaped from
not only independent efforts but also the interdependence that is created when everyone shares the same mission and vision.\textsuperscript{47}

A second concept to explore fully is stewardship and its relationship to both servant leadership and moral authority/conscience. In the twenty-first century, stewardship is often thought of in terms of environmental stewardship—of preserving the natural resources for the generations who come after us. In much the same way, the use of the term “stewardship,” when applied to the current discussion, is meant to expand the notion of leadership to one that moves outside of individual boundaries and looks to the entire organization for insights and contributions to the mission. Stewardship calls on all members of the organization to center around a set of beliefs and values that allow each member to contribute and to choose service over individual self-interest, particularly the self-interest of the traditional leader.\textsuperscript{48}

Specifically in relation to an organizational setting, Block has identified four conditions that he believes are present in any organization governed by authentic service: 1) there is a balance of power at all levels of the organization; 2) there is a commitment to the larger community; 3) each member of the organization joins in defining the purpose and culture of the organization; 4) there is a balanced and equitable distribution of rewards.\textsuperscript{49} In reflecting on the organizational barriers that can contribute to incidents of moral distress, it is interesting to note that power imbalances, the impact of a hidden culture, and the negative impact of a system of rewards and punishments are often cited as obstacles to address. The model of servant leadership appears to address all of these obstacles.
The model of leadership that is created through servant leadership, stewardship, and the resulting moral authority gained from these practices addresses many of the concerns previously discussed and successfully reduces incidents of moral distress across the organization. As was noted in the previous chapter, healthcare workers frequently report feelings of isolation, disrespect, and lack of support in the decisions relating to patient care they must make daily. In addition, it is relevant to consider once again the observations of Thomas, co-founder of the Eden Alternative, who describes the nursing home environment as one plagued by decreasing public funding, a workforce suffering from chronic staffing shortages, scarcity of a skilled labor force, and perceived or actual quality-of-care issues. Given these recognized challenges within long-term care, practices that are encouraged through servant leadership and stewardship can serve to strengthen the working environment through the inclusiveness and the respect that these leadership methods develop throughout all aspects of the organization.

3. Systems Theory and the Interconnectedness Within Systems

It is interesting to note the degree of emphasis that Greenleaf placed on the role of systems when discussing his vision for servant leadership. It is not unusual when confronted with an operational issue to try to focus on that issue and to bring it to some degree of resolution. What a servant leader chooses to do is to expand that focus from only focusing “in” on the issue in question to focusing “out” and to considering the underlying patterns or systems of the whole organization. The problem is examined in its totality and, most important, the impact on the rest of the organization accounted for as changes (however positive) are made to individual components of the whole when possible solutions are considered. Greenleaf described what he believes is required of a
servant leader who seeks to think systematically. The requirements are as follows: that leaders be confident in the direction that they have chosen, even in the absence of specific goals, knowing that the ultimate goal will reveal itself as time goes on; that although servant leaders are aware of possible dangers in the choices that must be made, they are not paralyzed by them, choosing instead to see the positive in the world and the opportunities available; that servant leaders assume a world view and take a “big picture” approach to life, seeing connections in seemingly disconnected events; that servant leaders take personal responsibility in the decisions that are made and the direction that they chart. Leaders seek always to do their best with the resources available.\textsuperscript{53}

Senge describes the systems that exist within organizations as being bound by invisible fabrics of interrelated actions.\textsuperscript{54} This observation by Senge seems particularly true when considering the role of the executive leader and the management style thought to be best suited to adopting a systems approach to issues of moral distress within the organization. Consistent with the goals outlined above in describing the servant leader, Senge seeks to explain how the interrelationship between individuals and their organizations can come to benefit both in greater proportion than what either could accomplish singularly. He seeks to employ all members of the organization to their fullest potential and to create a shared vision for the future that expands both the motivation and sense of accomplishment on the part of the employee and more fully incorporates the goal of the individual with the goals of the organization.\textsuperscript{55}

When considering such interrelationships from a systems perspective, differing methodologies have been put forth to attempt to explain these connections. Two such methodologies are critical systems thinking (CST), also known as creative holism, and
total systems intervention. When confronting areas of weakness or inefficiencies within the organization, creative holism seeks to study the whole organization rather than focusing on individual parts and in so doing seeks remedies for addressing interdependencies and takes corrective action at each level of the organization and within each subsystem of the organization. Creative holism and total systems intervention both provide a framework for addressing moral distress across an entire organization by recognizing the potential interconnections that can lead to the distress and consequently providing system-wide interventions for reducing the distress. One of the most important arguments in the current thesis is the premise that to address issues of moral distress effectively within the long-term care setting, the leader must seek to understand all of the factors that may influence moral distress both individually and organizationally. While the current study seeks to highlight three main areas of the organization—the culture, the leadership, and the methods of communication—and their impact on experiences of moral distress, the underlying premise of the study supports the theories above in seeking to assess on a holistic basis all factors that may influence such distress.

Applying a systems approach to issues of moral distress is arguably one of the most important roles that leaders can assume within their organizations. Even before systems can be understood and applied to specific issues within the organization, a clear vision of the goal must be understood so that each member can fully participate and contribute to any solutions being sought. Gharajedaghi provides an example of the need for a clear vision. He recounts a story from Persian literature about a group of men who encounter an object while in complete darkness. The leader in this story is not able to help the men determine what that object might be, as he has no understanding of the
object himself. When a second individual arrives who is able to shine a light on the object, the object itself then becomes clear and the group can assess whether or not the object poses any risk to them and whether any action is required. The leader in this example was critical to focusing the members by shining a light on their particular quandary, and in so doing, he assisted the entire group in solving a problem that no one had been able to accomplish individually. A systems approach requires that the system be looked at and analyzed as a whole and forces the leader to recognize that the so-called “system” property no longer exists if any aspect of the system is changed in any way.

In the current application of a systems approach to incidents of moral distress, if any of the three main variables being reviewed (the culture, the leadership, or the methods of communication) are changed in any way the system itself changes for better or worse, but the impact of that change must be addressed holistically throughout the organization. Systems thinking is said to advance as people learn new ways of making a difference whether in their own lives or in their professional lives.

An important distinction that must be made when considering human systems and their possible interdependencies is the fact that, unlike all other naturally occurring and/or man-made systems, there is an element of self-consciousness. This self-consciousness of the human social system allows the human being to act freely and to choose his response to given stimuli or situations. This freedom of action and freedom of thought places a burden on leaders to motivate, educate, and lead all members of the organization in a manner that builds upon the existing interdependencies within the organization and strengthens the overall operation. This freedom of thought serves to distinguish between activities or systems that are meant merely to serve some purpose within a
greater whole from those that exist because of the deliberate choices of human beings.\textsuperscript{61} One of the main goals of systems thinking is to see beyond what appear to be isolated incidents and to recognize patterns and connections between seemingly isolated events. The role of the leader is to understand and recognize these seemingly isolated events and to channel all of the energies of the organization towards understanding these interconnections and strengthening them. Once these interconnections are understood, they can be controlled and in the case of moral distress reduced.\textsuperscript{62} Finally, the value that can be found in utilizing a systems approach to addressing the needs of the organization from a holistic viewpoint is the recognition that leading must be continuous over both the life of the organization and the life of the individual.\textsuperscript{63}

Similar to the systems approaches discussed above (CST, creative holism, and total systems intervention) is a systems methodology attributed to Vickers and called “appreciative systems.” The appreciative system is, according to Vickers, a means of examining a problem through an interconnected set of standards by which the individual both orders and ascribes value based on individual experiences and continuous learning.\textsuperscript{64} Of particular relevance to the current thesis is the notion—initially put forth by Vickers and later expanded upon by Checkland, the founder of Soft Systems Methodology, and his partner—that management is much more about relationships than it is about rational decision making of the type that characterizes hard system thinking.\textsuperscript{65} In highlighting the relational aspect of management and leadership, Vickers helped to draw attention to the individual responses that people may have based on their own life experiences, their values, and their cultural backgrounds, all factors that are known to influence how one perceives the experience of moral distress. The relational aspect of management and
leadership addressed by Vickers from a systems perspective will be further explored in Chapter 5 in a discussion of Peter Senge’s work on the impact of mental models and the impact of mental models on one’s perception of reality. According to Senge, systems thinking and the role of mental models are critically linked as one focuses on hidden assumptions and the other focuses on how to restructure those assumptions as a means of overcoming possible incorrect assumptions for the purpose of successfully correcting them or overcoming them.66

C. Appreciative Leadership As an Expression of Servant Leadership and Transformational Leadership

Leaders in the twenty-first century, particularly those leaders seeking to incorporate the wisdom found in the techniques of servant leadership and transformational leadership, are faced with several realities thought to define the challenges in any organization seeking to excel in today’s global economy. These trends include, first, a workforce constituted of younger workers who have come of age and are demanding different working environments from their leaders. Specifically, those new to the workforce want to be engaged and want to be heard. Second, organizations comprise diverse individuals—racially, ethnically, and culturally. The workforce seeks organizations representing that diversity, as well as leadership that is both collaborative and just. Third, institutions today must be flexible and able to respond to the changing demands of the global environment. Leadership is much more distributed across the organization with power no longer in the hands of only a few individuals. Fourth, solutions to organizational problems must be addressed in a holistic, sustainable manner and require both collaboration and appreciation of the individual differences of all
Maintaining the status quo is no longer viable for either sustainability or support for the mission of the organization. The command and control methods that had come to define leadership practices for decades have now been replaced by leadership practices like inclusiveness, dialogue among stakeholders, and participatory practices throughout all levels of the organization. Appreciative leadership, one leadership method thought to address the new demands facing executive leaders, is discussed below.

1. Appreciative Leadership Defined

Appreciative leadership is thought to comprise four distinct components or attributes: it is relational, positive, capable of turning potential into positive power, and possessed of a ripple effect on all members within the organization, making a positive difference in the world. Developed around the framework of appreciative inquiry (which is examined in detail in Chapter 5) appreciative leadership seeks to equate leadership with affirmation and to create an environment of organization-wide appreciation. Application of the principles of appreciative leadership to the long-term care setting specifically seeks to address and overcome the long history of rewards and punishments discussed in Chapter 2 and to move the conversation and the culture to one of appreciation, support, interconnectedness, and stewardship over both people and the organization. Whereas leadership practices that offer rewards and punishments are considered manipulative, those practices that define an appreciative approach seek to affirm and build upon the strengths that already exist within the organization. In a study of several healthcare organizations in the Chicago metropolitan area for determining the effectiveness of appreciative leadership in various healthcare settings, researchers found that appreciative
leaders were self-aware, open to new learning, and willing to change the way they viewed certain issues based on feedback they received from their teams. Practices so critical to the effective management of moral distress within long-term care are central to the leadership practices that now define appreciative leadership. These practices include eliminating silos within the organization and thus increasing communication, partnering with other departments to create operational synergies that would not otherwise exist, and developing business plans that serve to help each department minimize risks and strengthen the overall operation. At the core of appreciative leadership is the notion that there is more value to appreciating rather than judging in any given situation and to focus on developing strengths rather than on attempting to eliminate problems.

A second study particularly relevant to the current discussion was conducted at the University of West of Scotland and built upon a previous study that examined compassionate care practices by staff, families, and patients of older adults in an acute care setting. Designed around the tenets of appreciative leadership, the goal of the one-year study was to provide the support and tools necessary for staff to work together to develop a culture wherein staff are encouraged to build upon current practices in a supportive environment and in which all levels of the organization—personal, team and organization-wide—respond positively to stakeholders (staff, families, and patients). In stark contrast to the command-and-control (i.e., rewards-and-punishment) culture that has characterized many healthcare environments, this study sought to create an environment that encouraged leaders to develop relationships with their co-workers and patients that were nurturing, values based, and ultimately mutually beneficial. This program provided an opportunity for staff to engage actively in questioning one another for the
purpose of coming to appreciate differing perspectives on common issues. Interestingly, the facilitators of the study sought to do things differently rather than simply do different things, thus allowing them to build upon existing strengths and to identify and address areas of opportunity. The emphasis of the study focused on relationship building and appreciation of one another’s work with the goal of delivering excellent care. At the conclusion of the one-year program, staff reported increased self-awareness of their individual leadership capabilities; they reported learning new and effective methods of working with patients, families, and staff in a more cooperative, interdependent manner; and finally they reported developing new ways of building relationships which benefited them both personally and professionally. Finally, the authors wanted to stress the need for the organization to ensure that the organizational structure and systems were in place for supporting continued leadership development based on the appreciative leadership model. This study lends support to the current thesis by acknowledging the need to address issues system-wide and supporting the necessity for organizational structures to be fully equipped to do so continually.

Whitney, Trosten-Bloom, Cherney, and Fry outline what they believe is essential for leaders to know if they wish to use an appreciative leadership approach in developing and maintaining a strong, effective team: leaders must develop clear goals and a mechanism for measuring success, clarify areas of individual responsibilities and shared responsibilities, be clear that the work being conducted by the team members is carried out in a supportive manner and is relationship based, ensure that the procedures followed by the team are consistent and that information is shared freely by all team members, understand that the leader must be clear regarding how leadership is distributed
throughout the organization, clarify how will the team celebrate success, and be clear about how quality be measured and what standards will be used for measurement, and what methods of formal and/or informal communication the team will use. This summary demonstrates that many of the areas noted are consistent with the Scotland study discussed earlier, particularly regarding the effectiveness of creating a supportive, relationship-based environment in which to address operational areas. When employees are free to engage with one another for a common purpose without fear of retaliation, the outcomes prove to be beneficial to both the individual and the organization. Appreciative leadership is said to generate commitment as a result of inclusion.

Similar results were reported by Brooks concerning necessary operational improvements in a pediatric ward faced with high absentee rates, poor retention of staff, drug errors, and poor survey results. To confront these issues, Brooks implemented many of the appreciative leadership practices discussed above, including building the confidence of the staff, providing opportunities for creativity in addressing issues, believing that the goals could be met, and persisting with goals through the change process. As results became evident, Brooks reported that staff attributed much of the success to the fact that they were actively involved in determining the course of action, that they in fact now “owned the dream,” and that they were now proud of their work and of where they worked.

One of the most challenging aspects of working within any healthcare environment is facing the oftentimes negative perceptions of the industry. Healthcare has become entwined in language focused on deficits and limitations rather than on all of the positive achievements and caring professionals who devote their work to easing the pain
of others. Given this environment, the role of the leader, and in this case of the leader who espouses the tenants of appreciative leadership, is all the more critical to the success of the organization and to the individual employees within the organization. Cooperrider found that the appreciative leaders interviewed over the past 20+ years shared several common attributes or philosophies concerning their work. Appreciative leaders create their own reality; they are not brought down by the challenging circumstances in which they find themselves or their company. They approach their challenges with optimism, respect, and a positive intention to change things for the better. Appreciative leaders seek to expand the strengths and knowledge of all those they lead through a process of constant inquiry and in building upon the strengths, observations, and ideas offered throughout every level of the organization. Finally, appreciative leaders understand the positive impact of inclusion at every level and seek full participation from everyone within the organization, recognizing that both the individual and the organization grow and benefit from such inclusion. Greeny et al. sum up all of the qualities of the successful leader in one word: “influencer.” Their research on the commonality among successful leaders has led them to conclude that the most important skill of successful leaders is their ability to influence changes in the behavior of others—and, therefore, replace the term “leader” with “influencer.” While the terminology may be different, the link between the appreciative leader and the influencer rests in the positive interactions that these leaders bring to their organizations. Their willingness to devote time and interest to developing all members of their organization, in working towards common goals, and in being recognized for their individual and joint accomplishments all lend credibility to the title of appreciative leader.

Each of the five strategies discussed below are meant to provide a roadmap to the effective implementation of appreciative leadership. These strategies are designed to help energize the potential of each member of the team and to increase both individual and group performance. The five strategies and their importance in practicing the techniques of appreciative leadership are as follows:

1) **Inquiry:** The successful use of positive inquiry will be discussed more fully in Chapter 5; however, appreciative leaders conduct inquiries to gain feedback from employees about what is of most value to them in their work environment. The inquiry process is particularly helpful as leaders attempt to understand and address issues of moral distress because it allows for both individual and group feedback. The inquiry process sends a strong signal to the employees of the value that leaders place in them and acknowledges the contributions that they can make to the organization.

2) **Inclusion:** Inclusion helps all employees buy in to the overall success of the organization and strengthens the commitment to the mission, vision, and values of the organization. By developing the means of communication that seeks input from all stakeholders, appreciative leaders not only can more fully understand the priorities that may be important to them but also will deepen their understanding of what issues are important to employees representing all levels of the organization.
3) **Inspiration:** Appreciative leaders seek to provide the vision to those they serve and are successful in presenting that vision in a manner that is understood and embraced. Inspiration can be in the form of providing a clear vision or in harnessing the potential of the employees in helping to define the vision. In either case, the leaders are looked to for motivation and support in executing the vision.

4) **Integrity:** Often thought of as leading by example, appreciative leaders are viewed as role models of integrity in all aspects of the operation. By demanding a high degree of integrity from themselves, appreciative leaders can expect the same from their employees and vice versa. Where integrity is in question, effective leadership cannot be sustained.

5) **Illumination.** Illumination is meant to be a process whereby leaders help individuals clarify their own strengths in relation to the organization and seek to maximize those strengths for their own development and the good of the organization. When effectively implemented, the application of the 5 Core Strategies discussed above allows leaders and the organization to begin to develop a synergy throughout the organization and to break down the silos that can inhibit a free flow of information and ideas. This synergy serves to strengthen the overall operation and enhance the work experience of the employees. While each of the above core strategies was discussed in relation to appreciative leadership, it should be noted that they share many similarities with the strategies regarding the attributes of the servant leader discussed above and, specifically, those practices believed by Dr. Keith to define servant leadership.
One of the positive outcomes of embracing the five strategies of appreciative leadership discussed here is the impact that these strategies can have in strengthening the culture of inclusion within the entire organization. Rather than only a few leaders’ determining the future direction of the organization and seeking buy-in from the many, a new paradigm shift occurs and a collective voice is heard; this voice, which has been termed “full voice authoring,” refers to inclusiveness of input: being consulted and providing input into planning and decision making across the organization.90

3. Facilitating Positive Change Within Individuals and the Organization.

As has been demonstrated above, in the review of the work on executive leadership, servant leadership, and appreciative leadership, the most successful leaders look outside of themselves when seeking to strengthen their organizations and work to develop the unique skills that each employee brings to the organization. Drucker, a well-respected management consultant, describes the task of leadership as follows: “The task of leadership is to create an alignment of strengths that make people’s weaknesses irrelevant.”91

One means available to leaders seeking to align strengths and make weaknesses irrelevant is to develop their emotional intelligence within the organization. By developing the emotional intelligence of each member of the organization, the leader helps to create an atmosphere wherein people want to do and be their best, both for the organization and for themselves.92 Strengthening others through education, training, and mentoring opportunities allows leaders to strengthen themselves also by creating a virtuous cycle whereby both confidence and competence are developed within the leaders.
and those they are leading, thus allowing both to accomplish more than either may have thought possible when acting alone.  

For leaders in particular, certain competencies have been identified that have been found to strengthen emotional intelligence and help to improve individual leadership competencies, which may be categorized as personal competencies and social competencies. Personal competencies include the need for personal self-awareness and the need for an honest assessment of one’s own strengths and weaknesses. Once this self-assessment has been completed, the leader gains a strong sense of self and is in a position to reach out and encourage those he or she is leading. It is critical that the leader continues to adapt to changing situations and continues to improve oneself and one’s organization. This can be achieved by providing a consistent message and in honoring the values of the organization in each decision that is made. As trust is developed between the leader and those being led, the reciprocal relationship that develops will strengthen both individuals and will to exceptional results individually and collectively.

In seeking to develop skills thought to involve social competence, leaders must seek to improve their ability to fully understand and empathize with the needs of the other. This skill is essential when leaders seek to address issues of moral distress within an organization as it requires both the ability to understand the individual concerns of those who need help in addressing their own moral distress and, on a larger scale, to understand individual concerns from a systems perspective and their impact on the entire organization. Finally, from a social competence standpoint, the leader can act as a catalyst for change by strengthening individual relationships and clearly outlining and reinforcing a shared vision for the organization—which in the current discussion would
focus on efforts to reduce incidents of moral distress both individually and organizational. 95

Senge and his colleagues created a roadmap to successfully implementing sustained change within the organization. 96 According to Senge and his colleagues, one of the great disservices of many of the traditional leadership methodologies is the notion of the leader as a hero, positioning the leader as the only person capable of leading transformation within the organization. 97 Contrary to this leadership assumption are the practices discussed above, such as servant leadership and appreciative leadership, which emphasize the contributions of each member of the organization and seek to recognize the leadership capabilities at all levels of the organization. 98, 99 If, as Beckhard is credited with saying, “people do not resist change; people resist being changed,” the framework provided by both servant leadership and appreciative leadership provides support for individuals so that they can develop into their best selves with the goal, in this instance, of being better positioned to identify and reduce incidents of moral distress for themselves and their colleagues. 100

D. Conclusion

This chapter has focused on the vital role that the leadership of an organization can have on both individuals and organizations in addressing issues of moral distress. Two specific leadership styles; Transformational Leadership and Servant Leadership were highlighted as a means of demonstrating how the specific skill sets of each of these practices can be developed and successfully implemented to bring about positive change for the organization and the individual. The transformational leader seeks to address the human needs of employees by cultivating their need for autonomy and self-actualization,
as well as by addressing such moral questions as righteousness, duty and fulfillment of obligations.\textsuperscript{101} The transformational leader seeks to develop a shared purpose to their individual efforts and works to respond to the human needs of those they are leading.

Servant Leadership, a unique type of transformational leadership was developed in 1970 by Robert Greenleaf. Greenleaf believed that true leadership emerges first from a strong desire on the part of the individual to help and serve others.\textsuperscript{102,103} The importance of the practice of Servant Leadership on addressing incidents of moral distress is best seen through the goal of the Servant Leader to lead by inspiring others to look within themselves and to help to develop what is best within each individual.\textsuperscript{104} By inspiring others to look within themselves and to develop what is best within each individual, the Servant Leader develops in his/her followers the ability to believe in the strength of one’s own voice; an attribute that will be fully discussed in Chapter 5 and one that is crucial to successfully addressing issues of moral distress within the individual.

One final method of leadership that incorporates the positive attributes of both the transformational leader and the servant leader is a form of leadership known as appreciative leadership. The appreciative leader utilizes the method of communication known as appreciative inquiry to build upon the strengths of each individual as well as the strengths of the organization. At the core of appreciative leadership is the notion that there is more value in appreciating rather than judging in any given situation and therefore seeks to focus on developing strengths rather than attempting to eliminate problems.\textsuperscript{105} The appreciative leader utilizes the communication method known as Appreciative Inquiry to identify and develop these strengths. This method of communication will be reviewed in detail in the following chapter.


84 Marjorie Schiller, Bea Mah Holland and Deanna Riley, eds., *Appreciative Leaders, In the Eye of the Beholder* (Chagrin Falls, OH: Taos Institute, 2001), x–xii.

David Cooperrider forward to Marjorie Schiller, Bea Mah Holland and Deanna Riley eds., Appreciative Leaders, in the Eye of the Beholder (Chagrin Falls, OH: Taos Institute, 2001), ix–xiv.


Chapter 5: Methods of Effective Communication

After reviewing the impact that the culture and leadership can have on identifying and reducing incidents of moral distress throughout an organization, the final area under review addresses the role that effective communication can have in positively influencing both the individual and the organization. Effective communication expands the focus of moral distress, from centering primarily on individual responses to certain stressors to looking beyond the individual, and includes the role that the organization itself contributes to such incidents. This chapter will demonstrate that the methods of communication used within the organization cannot be overlooked as a central component of effectively addressing moral distress on an individual and organizational basis. The role of effective communication will be shown to play an integral part in acknowledging the interrelationship of the individual with the organization and the value in seeking systemic measures that can be applied organizationally to address the negative impact of moral distress.¹

A. Appreciative Inquiry and Moral Distress: A Communication Change Agent

One concept that will be referred to throughout this chapter that is relevant to each section pertaining to methods of effective communication is called “Conversational Intelligence.” Conversational Intelligence™ refers to a framework developed by Judith Glaser that is intended to help people appreciate and understand the positive and negative impact that everyday conversations can have on our relationships, as well as the way such conversations determine our ability to connect and engage with all those with whom we interact.² Of particular importance to the current thesis is the work that Glaser and her research team have conducted over the past 30 years relating to so called “reality gaps.” Glaser uses this term to acknowledge that individuals do not generally share the same reality in terms of life experiences,
culture, educational backgrounds, and family upbringing. These are but a few of the influences that, for each of us, have come to define our own reality.³ Similar to the concept of reality gaps is Peter Senge’s work with mental models. These, according to Senge, are deeply ingrained assumptions about the world that influence how we interpret the world around us. These assumptions may be conscious or unconscious, but the impact on how we process information and individuals’ resulting actions are now readily accepted as playing a significant role in our communications with one another.⁴ The research in support of each of these concepts will be referred to throughout this chapter as a means of helping to understand how individuals can interpret the same information or the same practices from totally different perspectives and how, as a result, the experience of moral distress can be individualized unless confronted systemically and purposefully throughout the organization.

A final important observation central to the current discussion is the significant role that questions can have in determining how receivers process information. Appreciative inquiry provides a methodology that appears to be well suited to the health care environment as it begins to shift the existing paradigm away from problems and shortcomings to one that focuses on what is being done correctly and positively, and building upon those accomplishments.⁵ As noted previously in this thesis, practitioners working within the health care environment are routinely confronted with morally distressing events in the provision of care. Such experiences include miscommunication on the part of the medical team between themselves and the patient, missed opportunities for meaningful conversations concerning end of life decision making, feelings of powerlessness on the part of the healthcare practitioners, and value driven conflicts regarding appropriate treatment options.⁶ The appreciative inquiry technique seeks to expand upon what
is positive in both a work environment and an individual’s personal life, and to focus on strengths rather than on perceived deficiencies.\(^7\)

Diana Whitney and Amanda Trosten-Bloom, two internationally respected authorities on the subject of appreciative inquiry, attribute the following beliefs to the foundation of Appreciative Inquiry:

- That people individually and collectively have unique gifts, skills, and contributions to bring to life.
- That organizations are human and social systems, sources of unlimited relational capacity, created and lived in language.
- That the images we hold of the future are socially created and, once articulated, serve to guide individual and collective actions.
- Through human communication—inquiry and dialogue—people can shift their attention and action away from problem analysis to lift up worthy ideals and productive possibilities for the future.\(^8\)

As can be seen from the list above, several of the attributes that have come to define appreciative inquiry are consistent with the attributes of both the servant leader and the appreciative leader, as discussed in the previous chapter. Specifically, these attributes are recognition of the unique gifts that each individual possesses, along with the recognition that organizations are made up of both human systems and social systems, and that through effective communication change is possible.

1. **Appreciative Inquiry as a Philosophy and a Methodology**

Appreciative inquiry (AI) was first developed in 1980 by a then doctoral student from Case Western Reserve University, David Cooperrider. who had agreed to assist a fellow
doctoral student researching physician leadership at the prestigious Cleveland Clinic. In the process of collecting data, he became fascinated by the stories that the physician leaders told of their greatest successes and of times when they recounted being their most productive, positive, and cooperative with one another.\(^9\) Cooperrider worked with Suresh Srivastva, his dissertation advisor, to review the data from the Cleveland Clinic and to analyze the data in a systematic manner while continuing to focus only on the positive accountings that the physicians recounted. What developed was a new method of analysis, which focused on the potential and possibilities for the future based on the successes of the past. Cooperrider and Srivastva termed their analysis “appreciative inquiry.” Impressed by the work of Cooperrider and Srivastva, the Board of the Cleveland Clinic requested a hospital-wide review employing the appreciative approach as a means of positive change at the Clinic. This assessment marked the first organizational analysis using the methods of AI and later became the subject of Cooperrider’s doctoral dissertation.\(^10\) Of particular relevance to the current thesis is that Cooperrider first developed the AI process within a healthcare environment and, over the next 25+ years, AI methodology met with much success in a number of organizational settings.\(^11\)

Cooperrider and Srivastva highlighted three main points in support of their method. First, they questioned the historical practice of simply attempting to solve problems within organizations rather than building on positive aspects of the operation. Second, they argued that organizations should be viewed as socially constructed and that, as such, they were limited only by the imagination of those who worked within them. Finally, they argued that the most effective method of change was the continual influx of new ideas and theories, and that their method of building upon previous successes and providing an environment where open communication was encouraged, made positive change possible.\(^12\) At the core of AI is the belief,
held by Cooperrider and Srivasta, that a problem-oriented view of inquiry is limiting and that it can reduce the possibility of generating new ideas and new theories that could address whatever challenges are being confronted. This positive approach to problem-solving will be demonstrated as particularly well-suited to the long-term care environment as it shifts the focus away from the historically negative rewards-and-punishment approach to one in which accomplishments are recognized and used as catalysts for further improvements that benefit the employees, the patients, and the organization as a whole.

Two examples within the long-term care setting that support the underlying assumptions of AI in approaching concerns from a positive framework can be found in the initiative to “untie the elderly” and in the 1987 Omnibus Budget Reconciliation Act (OBRA 1987), both of which were discussed in detail in Chapter 3 of this thesis. The initiative to move to a restraint free environment for nursing home residents was the result of a grassroots effort on the part of caregivers who recognized that although their patients were “safe” in restraints, their quality of life was diminished. Additionally, the effect of OBRA 87 and the 1990 Patient Self-Determination Act was to bring greater self-determination, dignity, and individual rights to residents of U.S. nursing homes. Improvements to the quality of life of nursing home residents in the United States would not have been possible without the foresight and imagination of those working in the nursing homes to continue to build upon current practices.

Because each application of AI is different based on the unique needs of the individuals or organizations using the technique, there are no absolutes for employing the AI method of inquiry. There are, however, four key phases of the process that have become the benchmark for implementation of the AI process. This process, known as the 4-D Cycle, comprises the following phases: Discovery, Dream, Design, and Destiny. The 4-D Cycle begins with what
Cooperrider, Whitney, and Stavros term the “positive core” of the organization, perhaps best described as that intangible which brings life or meaning to the organization. Though it is not always possible to define what is meant by the positive core, it is often seen and/or felt in such things as the values that have come to define the organization, the social capital that has been established, the distinct competencies that exist within the organization, and the organizational achievements and wisdom that are attributed to the organization.\(^\text{18}\) It is the positive core of the organization that comes to define it and that which is central to the successful implementation of the 4-D Cycle. An important aspect of AI that should be clarified before discussing the 4-D Cycle is that the practice of AI is meant to bring out or discover what gives life to an organization when it is at its best. Whitney and Trosten-Bloom stress that AI should not be thought of as a search for the positive versus the negative or the good versus the bad within an organization, but rather as a search, using the 4-D Cycle, for what energizes and inspires those within the organization to do and be their best as individuals and as employees.\(^\text{19}\)

As noted above, the 4-D Cycle includes four distinct phases: the discovery phase, the dream phase, the design phase, and the destiny phase. The discovery phase is designed to bring out times within the organization when there appears to be consensus that the organization was at its best. Looking back to Cooperrider’s experience at the Cleveland Clinic, the discovery phase would have been represented by the physicians’ recounting the times at the Clinic where they felt most alive, engaged, productive, and positive towards their work both individually and collectively as a team.\(^\text{20}\) During the discovery phase, questions are developed that attempt to bring out the positive core of the organization. The questions tend to be retrospective in terms of recounting times in the history of the organization that those being interviewed most value and wish to consider in terms of incorporating them into any potential changes. It could be thought
of as laying the groundwork for building upon those aspects of the organization that people feel most proud of and connected to.²¹

During the dream phase, as the name implies, participants and/or employees are challenged to imagine what “might be” for the organization if everyone could operate consistently drawing upon their positive core and building upon past successes and recognized strengths. Participants are asked to design the ideal organization as it relates to some identified element of the organization. For example, in relation to the current thesis, the element would be the experience of moral distress, and the design phase would ask participants to design the ideal organization that was equipped to address and/or eliminate the moral distress. Within the design phase, the element to be addressed is identified by developing a “provocative proposition.”²² The provocative proposition is developed with the goal of incorporating what was learned as a result of the previous two phases—discovery and dream—and builds upon the knowledge of the past and the dreams for the future. The destiny phase incorporates and evaluates all of the processes and systems within the organization in an effort to address successfully the ideas developed in the dream phase. The destiny phase can mark both the end of one 4-D Cycle and the beginning of the next as new ideas and methods are evaluated that can lead to another cycle of innovation and affirmative evaluations.²³

When considering the 4-D Cycle, we find one specific phenomenon that can have an impact on the ability of the participants to engage fully in each of the four phases—whether intentionally or subliminally—and that factor refers to Senge’s concept of mental models. Often, new insights, or “dreams,” fail to become functional owing to deeply held images and strongly held pre-conceived ideas that limit one’s thinking and prevent new ideas from taking shape.²⁴
The influence of these mental models using AI to confront issues of moral distress on a systemic basis across the organization is discussed below.

2. **Appreciative Inquiry and the Impact of Mental Models**

Perhaps the best explanation of why the same set of stimuli can cause moral distress in one individual and not elicit the same response in another is the impact that mental models can play in how each individual perceives their world. Because mental models are developed as a result of our previous experiences, mental models form the basis of how each of us processes and comes to understand the present. Mental models can be looked to as a means of understanding how two people can observe and experience the same event and interpret it differently.\(^{25}\) The application of an understanding of mental models to the issue of moral distress supports the premise of the current thesis by acknowledging that individuals can have different responses to the same stimuli. This fact allows one to expand the discussion of moral distress to include the interrelationship of individuals with their organizations and to seek interventions that include both individual and organizational remedies.\(^{26}\)

It is important to address the connection between the individual and the organization when assessing the impact of mental models on experiences of moral distress because a deeper understanding of mental models can provide an opportunity for a greater awareness of why individuals and organizations view both problems and opportunities in the manner that they do. From the perspective of individuals, an increased awareness of their own attitudes and thought processes can lead to greater ability to govern their actions and decisions.\(^{27}\) This greater understanding leads to better communication and the opportunity to successfully envision and change the future in a positive, productive manner.\(^{28}\) When considered in relation to the 4-D Cycle of AI discussed above, mental models can have a less positive impact on both the
individual and the organization because they can impede the ability to successfully participate in
the dream phase of AI. Whether consciously or unconsciously, mental models can prevent
people and organizations from imagining possibilities and, therefore, limit their ability to expand
their thought processes to include different approaches and reactions to events.29

In seeking to understand the possible impact of mental models on the successful
implementation of AI as a method to addresses moral distress, we soon find that the two cannot
easily be separated. While individual and organizational mental models may in fact contribute to
incidents of moral distress, working to understand and, when feasible, change these mental
models can serve to be a very effective means of successfully reducing such distress. A deeper
understanding of exactly how the methods of AI function helps us to clarify why the role of
mental models can be so useful in its implementation and in assisting in efforts to reduce
incidents of moral distress both individually and organizationally. Of particular note are what
Whitney and Trosten-Bloom have labeled the eight principles of AI. Each principle is built upon
three unique constructs: social constructionism, image theory, and grounded research. From
these flow the eight principles of AI.30

Social constructionism refers to a core belief that human communication can both create
and transform reality. While originally proposed by Peter Berger and Thomas Luckmann, it was
later expanded upon by founders of the Taos Institute, including Diana Whitney, Suresh
Srivastva, and David Cooperrider, in their work with AI. This includes the value of appreciative
interviews and the understanding of the importance of bringing all stakeholders together in order
to achieve sustained organizational change.31 Image theory, attributed to the works of Elise and
Kenneth Boulding32 and Frederik Polak,33 suggests that the images and dreams that individuals
have of the future influence their decisions and actions in the present. In effect, as people dream
of the future, they can in turn help to create it. This is an important concept when discussing AI as it reinforces the importance of the dream phase of the 4-D Cycle and gives a sense of empowerment to individuals and organizations in believing that they in fact can help to create their future. Finally, grounded research is employed as a means of studying the organization or culture in question by engaging the members of that organization in the research.\textsuperscript{34} An example of such grounded research is found in Cooperrider’s initial research at the Cleveland Clinic where he used the stories of the physicians to identify the strengths of the organization and to seek to build upon their recollections of a time when the clinic was operating at its best in terms of productivity, engagement among physicians, and alignment with the mission, vision, and values of the organization.

Flowing from these three constructs—social constructionism, image theory, and grounded research—are the following eight principles of AI: the constructionist principle, the simultaneity principle, the poetic principle, the anticipatory principle, the positive principle, the wholeness principle, the enactment principle, and the free choice principle.\textsuperscript{35} The following provides a brief summary of each of these principles.

1. The constructionist principle focuses on the importance that our method of human communication, specifically the words that are spoken, has on our ability to create reality and express individual creative power.

2. The simultaneity principle leads the way to one of the central tenants of AI. It holds that change begins immediately after a question is asked. Because positive questioning is fundamental to AI, the principle of simultaneity helps to support the notion that positive questions can lead to positive change.
3. The poetic principle is based on the premise that human systems, whether organizations or individuals, move in the direction of what they study. The poetic principle highlights the importance of continued focus on the positive, life-affirming aspects of both organizational life and personal life. This is accomplished by seeking to expand on the positive rather than the negative, on cooperation versus operating in silos, and on positive growth rather than failures.

4. The anticipatory principle refers to the idea that in effect individuals, as well as organizations, come to define their futures based on their ability to imagine their desired future. According to the Dutch sociologist Frederik Polak, images of the future influence the actions taken in the present and help to define the future we have imagined. Although some images are imagined visually, images are often described in narrative form and can therefore be communicated to others creating a shared vision.

5. The positive principle, based on the research surrounding AI and the use of positive questions, the 4-D Cycle, and the three constructs discussed above, posits that positive change can be achieved through positive questions and by directing attention to the positive core rather than using a problem-solving approach to address what is not working or areas needing improvement.

6. The wholeness principle refers to an approach of inclusivity and a desire to hear differing perspectives on the issue being addressed. Rather than attempting to seek common ground, the methods of AI seek to understand differing viewpoints and in so doing embrace those differences and become stronger as a result. In the case of addressing issues surrounding moral distress, it is critical to consider the various different perspectives of individuals and within an organization’s departments in order to address
the issues on a system wide basis. This approach provides a safe environment to express their individual concerns and to remain focused on the higher good and the positive core of both individuals and the organization as a whole.

7. The enactment principle focuses on the here and now and seeks to encourage people and organizations to live and work in the present in a manner that is desired for the future. Perhaps the best examples of the enactment principle are found in the guidance sometimes attributed Mahatma Gandhi, “Be the change you want to see,” and in the example set by Dr. Martin Luther King and his belief that the only way to change the world is to live the difference. The enactment principle calls on individuals and organizations not to wait for change to occur but to become the change that is needed.

8. The free-choice principle suggests that when individuals act of their own free will their contributions will be more genuine, and they will choose to participate based on their individual strengths, interests, values, hopes, and dreams. Free choice within the work setting is thought to build enthusiasm and commitment to the organization. The ability to provide free choice within the workplace will be further discussed in Chapter 6 when addressing the positive role that employee empowerment can have when confronting issues of moral distress.36

Each of the eight principles of AI focuses on the central role that communication plays in understanding oneself as well as communicating one’s views to others. The tenants of AI provide an excellent example of the joint efforts that can be made between the organization and the individual in identifying and successfully addressing any perceived gaps in the operation based on a positive, information based method of inquiry. Finally, it should be noted that the eight principles of AI described above, from Whitney and Trosten-Bloom, were an expansion on
the earlier work of David Cooperrider, Diana Whitney, and Jacqueline Starvos in detailing what they termed as “five principles of AI.” These included the constructionist principle, the principle of simultaneity, the poetic principle, the anticipatory principle, and the positive principle.37

It is important to review the discussion from Chapter 3 regarding the perceived or real power imbalances within the long-term care setting which have been determined to exist among staff at all levels of the organization.38 Of particular interest to the current discussion regarding AI is how the eight principles of AI can be used to address the historic power imbalances within long-term care and to give voice to all stakeholders of the organization. Recalling the 2012 study by Newton et al., which found that although nurses indicated their willingness to engage their superiors in dialogue concerning ethical issues, they deemed the conversations as “voicing to silence” because their concerns were actively silenced and not addressed.39 The eight principles of AI allow all voices to be heard and help to develop the skills and courage within individuals to call upon the strength of their own voice.

3. Developing and Practicing the Strength of One’s Own Voice

Following from the discussion above relating to the 4-D Cycle and the Eight Principles of AI is the need for developing and practicing the strength of one’s own voice. This raises the question as to how one might do that in a health care setting that is rules based and hierarchical in nature theoretically leaving little or no room for having one’s voice heard. The first step is to develop and clearly understand one’s own values. Organizations and individuals have a responsibility to identify, name, and clearly understand their core values if they are to succeed both personally, professionally, and organizationally.40 Such knowledge permits the individual and the organization to understand and forecast behaviors that may be expected, particularly in times of organizational and personal stress, which in turn allows them to respond more
effectively to and control such stress. Gus Lee addresses three different levels of core values, low, medium, and high, which he believes can be found in individuals as well as organizations.

Low core values, according to Lee, represent common habits which, to most people, would not be considered a value in the more positive sense of the word. Common examples of low core values include such things as ruthlessness, pride, racism, and egotism. While these may result in short term gains, they are not values that ultimately will bring success to the organization or the individual. Middle core values can be found in what are often referred to as best business practices. Generally thought of as positive, middle core values are found in such practices as having a customer focus, service, compassion, humility, and respect. The middle core values are those one would expect to see in a servant or appreciative leader. High core values, as defined by Lee, include three all-encompassing traits: integrity, courage, and character. If people conduct themselves with integrity, courage, and character, they can take comfort in the fact that they understand their own values and gain strength from listening to their own inner voice when confronted with moral decisions.41

While understanding one’s own values and those of the organization in which one works is a necessary first step to being able to practice the strength of one’s own voice, the next, perhaps equally difficult requirement, is being able to use that strength when confronted with difficult ethical challenges. Developing the strength to live the values that define the individual or the organization begins with individuals’ believing that they have the strength and power to overcome whatever ethical challenge confronts them.42 This concept is sometimes referred to as “the ability to speak truth to power,” and as such it requires not only the belief in oneself but also the need to practice and develop this skill over time and with different scenarios. Mary Gentile describes this as creating and practicing “value scripts,” so that when needed, these pre-rehearsed
scripts will be comfortable to draw upon and effective in addressing the ethical dilemma causing the distress. Of particular relevance to the current discussion of developing the strength of one’s own voice is the early work by Andrew Jameton on the causes of moral distress. Jameton used the term “moral distress” to describe situations primarily experienced by critical care nurses where they felt they knew the morally acceptable course of action but were constrained from taking action, owing to both internal and external factors over which they perceived they had no control.

Whether thought of as control, power, or moral courage, the ability to use the strength of one’s own voice must be developed so that, when needed, it can be employed to overcome a sense of victimization and called upon to address ethical dilemmas that might otherwise lead to experiences of moral distress. Using the methods of AI within the workplace provides an environment where such skills can be developed within a safe environment.

Practicing the strength of one’s own voice can be perceived in a negative light if the environment and culture of the workplace is not open to the communication methods characteristic of AI or is not under the leadership of a servant leader or appreciative leader. Individuals questioning given policies or practices within the workplace, such as those that might lead to moral distress, can, under certain conditions, be considered dissenters and misunderstood as not being supportive of the organization. Contrary to the negative connotations that can be associated with dissenters is the organization that recognizes the dignity of all individuals who work there and operates with an understanding of what each individual can contribute when allowed to express their own conscience and maintain their integrity both at work and personally. Mele describes the characteristics of this type of organization as having four distinct traits: the organization recognizes the whole person and his or her uniqueness and
capacity for personal growth; the organization respects each person as well as his or her individual human rights; the organization cares for those around them in a holistic manner, allowing for the growth of the individual as well as the organization; and everyone is managing for the common good rather than the good of particular interests.46

B. Appreciative Inquiry in Healthcare

While the goals of AI are not easily accomplished even within a health care environment, it is encouraging to note that the University of Virginia medical school provides an excellent example of using AI methods to address a serious operational issue facing the medical school.47 Their program and their use of AI—how the school approached the issue from an inclusive perspective, sought input from all stakeholders, and allowed for a safe environment for all views to be heard—is discussed below. The review begins with a discussion of examples of the successful efforts of several health care operations who were able to shift their operational focus from one rooted in negativity to one characterized by positive achievements.

1. Paradigm Shift: Focusing on the Positive

Chapter 2 focused on the impact that the culture within the long-term care setting can have on the experience of moral distress. It may be recalled that the culture within long-term care has been characterized as detached, impersonal, hierarchical, and rule governed.48 Mark Latham, the healthcare administrator of a nursing home in Concord, New Hampshire, describes the impact on the staff of what he views as a heavily regulated work environment. Latham states that his team works better when it is measuring quality rather than operating from a framework of fear, based on a system of deficiencies in care versus quality of care.49 Finally, Bill Thomas, the co-founder of the Eden Alternative, who is discussed in detail in Chapter 3, describes the culture within long-term care as plagued by decreasing public funding, a workforce suffering
from chronic staffing shortages and leading to low morale, scarcity of a skilled labor force, increased expectations of family members, increased frequency of litigation stemming from perceived or realized quality of care issues, and unmet expectations. Unfortunately, neither of these individuals describes an environment that could be considered positive or enriching for either the staff or the residents who live there. The healthcare environment is frequently described in terms of its limitations and deficits with those working within the health care setting trained to focus on problems and limitations. The question then becomes how to shift the focus from the negative to the positive aspects of long-term care and build upon all of those aspects that are known to enhance the quality of care provided and the supportive work environment for staff.

One such paradigm shift, which was highlighted in Chapter 2, is the work of the Pioneer Network, a grass roots effort by “pioneers” within the industry who were disheartened by what they viewed as inadequate, and often detached, care of residents. These long-term care industry professionals recognized the need for systemic change within the LTC environment and sought through their work to change both individual and societal attitudes towards aging through education and policy reforms. Of particular relevance to the current discussion regarding methods of effective communication are the lessons that can be learned from the efforts of those involved in the Pioneer Network, particularly their ability to acknowledge the legitimate issues surrounding the care of residents as well as deficiencies within the environment and then successfully build support for overcoming such issues by moving in a positive direction for change. This shift from focusing on the positive rather than the negative is achieved by first broadening the understanding of all that is positive within the work environment or the individual and seeking to build on those positive aspects. Those involved in the Pioneer
Network were able to achieve this. This same process can be applied to issues of moral distress by first acknowledging that such distress does exist and then using such communication methods as AI and humble inquiry to overcome such experiences. A second example that highlights the successful shift from a negative approach to a positive approach when addressing operational concerns achieved by employing AI communication methods is found in the efforts of the University of Virginia in 2007. These efforts were a response to having their house staff training program at the medical school placed on probation by the Accreditation Council for Graduate Medical Education.53

2. Application of the Lessons from the University of Virginia

When the University of Virginia’s house staff training program was placed on probation in 2007 by the Accreditation Council for Graduate Medical Education, the residency program, as well as the entire healthcare system, faced serious challenges, both to the reputation of the medical school and to the reputation of the healthcare system.54

As a result of the work carried out at the University of Virginia, those implementing the communication method of AI at the University identified practices that they believe allowed them to shift the culture from being focused on what was broken within the healthcare system to acknowledging all of the positive aspects of the operation. They believe that this was accomplished through the use of positive questions and the implementation of AI.55 Specifically, they identified the following practices as avenues that they believe can be used by any organization seeking to bring out the best in their people and their organization. They are as follows:

1) **Practice 1: The Flip** – When confronted with a concern or a complaint about some aspect of the organization, the leader who is tasked with addressing the concern can “flip” the
question to frame it in a more positive light. An example of such a question might be, “Can you tell me of a time when this was not an issue, when we were doing this well as an organization?” This allows the individual with the complaint to begin to work on solutions and to benefit from past achievements.

2) **Practice 2: Positive Gossip** – Shift the internal gossip from negative to positive by gossiping only about the accomplishments of fellow team members and not about the challenges or shortcomings of individuals or departments. By pulling away from the tendency within organizations to focus only on the negative, the positive energy gained from the recognition of what can be celebrated can become a force for positive change.

3) **Practice 3: Appreciative Check-In** – Begin each meeting by asking that someone recount a positive encounter that they had within the organization within the past week. Within the long-term care environment, this could be a positive encounter with a resident, family member, or a situation where a person observed someone going above and beyond to address a resident concern. By recalling a situation which highlights the best of the community, everyone can discuss more difficult situations from a more positive viewpoint and the likelihood of an agreed upon resolution is greatly improved.

4) **Practice 4: Sharing Stories that Inspire** – Perhaps the most important lesson learned from the work at the University of Virginia is the need to communicate. Ongoing discussion relating to areas of success can help to motivate employees through the more difficult times both personally and professionally. Looking back at the initial work of Cooperrider at the Cleveland Clinic, the success was achieved through focusing on what had worked in the past and what the doctors and nurses were the most proud of. Positive
stories help to shift the focus from what is not working to what people are the most proud of and what they want to achieve.

5) Practice 5: Cultivate Curiosity (Rather than Hasty Judgment) – Among all of the positive aspects included in working in a healthcare setting, one of the most negative, and possibly divisive, is the tendency to rush to judgment when attempting to address operational challenges or negative outcomes that reflect poorly on one department over another. In these situations, reflecting back on how positive questions can help to bring positive solutions to any given problem helps the team to focus on solutions that had worked in the past and moves them away from a strictly negative mindset—freeing them to be more creative and forward thinking in their approach and helping to achieve the desired results.

6) Practice 6: Foster Self-Reflection and Mindfulness – Successfully addressing issues of moral distress within the workplace has been acknowledged throughout this thesis as a joint responsibility between the individual and the organization. This need for self-reflection and mindfulness is yet another example of the importance of this joint effort. The individual is responsible for looking within him or herself and continuing to seek avenues for improvement, whether through education, physical fitness, or social interactions. The organization, likewise, must seek avenues for on-going improvement and enhancements to the operation. Both the organization and the individual share in creating the future they both desire.

7) Practice 7: Foster Community Using Improvable Pairs – Within the healthcare setting, it is not uncommon for silos to exist both within and between various departments. During the AI process, it has been found to be very productive to select individuals from
within the departments to question and interact with those individuals whom they
generally have little contact. For example, representatives from nursing may ask positive
questions of the Chief Financial Officer, or representatives from the Rehabilitation
Department may be asked to communicate with members of the Food Service team. In
using the AI questions, silos can be broken down as communication improves and
employees learn more about operations of departments other than their own.56

A final example of the successful use of AI communication methods within a healthcare
setting is found in the work of Scerri, Innes, and Scerri. Their work focuses on using the AI
method as a means of facilitating person-centered dementia care within acute care hospitals.57
Concerned about the quality of care provided to individuals suffering from dementia when
hospitalized in an acute care setting, these researchers sought to employ the AI method of
positive inquiry to understand from the staff what current practices were thought to have a
positive impact on the quality of care for individuals with dementia. Because the focus of the
inquiry was on developing improved strategies for supporting “person-centered care” (PCC) for
those with dementia, the study used the 4-D Cycle (discovery, dream, design and destiny) to
learn how best to support such efforts. These researchers identified a number of advantages to
employing the AI method. These included the ability of the staff to draw from their own best
practices in providing PCC, empowerment for the staff to initiate new activities as a result of
their discussions during the dream and design phases, and establishment of a strong foundation
during the process for ongoing interdisciplinary collaboration after the completion of the study.58

While the AI method does appear to provide a positive means of communication in an
organizational setting as evidenced in the studies above, it would be shortsighted not to highlight
also the arguments made by other scholars that call into question some of the core elements of this
process. Of particular concern to current practitioners of AI is the exclusive focus on the positive stories and experiences that AI draws from. This emphasis, critics believe, could limit other equally important conversations that may need to take place but which would be silenced in favor of only seeking positive stories. In addition, other critics note the lack of willingness on the part of AI followers to be open to other approaches to achieve change, citing them as deficit-oriented and focusing only on problems. Though there is concern regarding a perceived over-emphasis on the positive, AI is not intended to ignore the operational realities that often times signal the need for further investigation. AI is thought to be one method available to move the organization forward as it did with the three examples above. A second factor that raises concerns about the validity of the AI process stems from the apparent lack of any long-term studies that have sought answers to questions surrounding the AI method. These unanswered questions include but are not limited to how to determine when AI would be the most appropriate method of communication to address a change process, what organizational factors are thought to have the most influence on the success or failure of AI, and what, if any, are the qualifications necessary for those who facilitate the AI summits. Without concrete answers to these questions, critics feel that it is premature to accept all of the AI method’s recommendations wholeheartedly.

It is interesting to note that the goal of AI is thought to have evolved since it was first developed in the late 1980s and early 1990s, and that it has moved through four distinct phases, each building upon work from the previous stages. The four phases are marked by the changes and/or improvements that were designed as the work of AI became more and more relevant throughout the United States and eventually throughout the world. Beginning with the strengths-based approach that initially defined AI, the second phase initiated the use of the AI Summit, or whole system dialogue, and sought to incorporate stakeholders at every level of the organization,
stressing that all members have an important role to play in the success of the organization. The third phase, which came as a result of the events of September 11, 2001, is defined by the desire for sustainability and created what has become known as “Business as an Agent of World Benefit (BAWB).” Internationally, BAWB seeks to help solve global problems and improve social conditions through a whole systems approach. Finally, the fourth and current phase is defined by what is now termed “W-Holistic AI.” W-Holistic, as the name implies, seeks to connect all members of the organization with the life of the organization and provide meaning and purpose to each member, recognizing both the potential and contribution that each can have on the life of the community. The holistic approach that has come to define AI in Phase Four of its evolution is consistent with the premise of the current thesis, which draws upon systems theory to explain how what may initially appear to be isolated or independent incidents within an organization are, as described by Senge, bound by invisible fabrics of interrelated actions.

3. Humble Inquiry

Edgar Schein developed a second method of communication, which he called “humble inquiry,” that shares many of the goals of AI. Whereas AI focuses on questions that are designed to bring out the positive, drawing from past positive experiences, humble inquiry is relationship based and seeks to establish a trust level between people. The trust level permits each member to engage fully with the other and, in so doing, to improve their interpersonal communication skills, leading to a mutual respect and interdependence and thus establishing a mutually beneficial relationship. Humble inquiry builds upon a framework of mutual respect and acknowledges the fact that others may have information that can help address issues in areas other than their primary areas of responsibility, or perhaps who work in positions that are lower-ranking than those of the individual seeking their input. This desire to improve communication across
hierarchical boundaries was also seen as a positive characteristic of both the appreciative leader and the servant leader, and it seeks to address the power imbalances discussed previously. Eliminating the power imbalances and actively seeking to develop trust between employees through the inquiry process can help to break down barriers, and, in the case of addressing issues of moral distress, can bring about a greater understanding and appreciation of why specific policies or practices within the organization can affect various individuals differently. This knowledge can provide valuable insight to the organization in addressing these issues both individually and organizationally.

The significance of building trust as a means of improving the effectiveness of communication between two people cannot be overstated. Over a half-century ago, Albert Mehrabian identified three distinct ways that individuals convey information to one another when they are face-to-face in conversation. These are through words, through tone of voice, and through non-verbal communications, such as facial expressions and eye contact. He determined that individuals allocate only 7% of what they are hearing to the words that are spoken, 38% to the tone of voice being used, and 55% to the nonverbal behaviors. For communication to be effective, each of these three elements must be in balance. When they are not, the non-verbal communication becomes the overriding factor in how that information is processed by the listener. Consistent with the premise of humble inquiry is the research of Professor Uri Hasson of Princeton University. Through his research on brain activity during interactions between people, Dr. Hasson has determined that during successful communication the speaker and the listener share the same patterns of brain activity. However, when two people are not communicating at the same level, this neural coupling is significantly reduced. His research lends support to the notion that trust and rapport cannot be taken for granted during
conversations, and that for the communications to be effective for both parties, a level of trust, respect, and belief in the other must be present. In the absence of this trust, listeners will formulate their own understanding of the message based on factors other than the words that are spoken.68

Frederick Bird has identified what he considers to be seven characteristics of good conversations: the conversations are recognizable in that both the speaker and the listener are engaged and understand the message that is being conveyed; the speakers are attentive and not easily distracted; the conversations move forward reciprocally, with each party able to both initiate and provide information as well as respond to the information heard; the communications are rational, well thought out, and thought provoking; the communications are honest, as noted above by Schein, relating to the goals of humble inquiry; the speakers keep the promises they make, thus building trust; and the exchanges remain civil.69 How leaders and co-workers can improve their skills in developing trust and improving their communications is discussed below.

C. Appreciative Inquiry and Conversational Capacity

As a method of communication, AI seeks to use questions and dialogue to identify strengths and past successes of both individuals and organizations for the purpose of building upon them to plan and identify the most successful course in future decision making.70 An essential skill in drawing out this information is the ability to do two things—to ask the correct questions and to listen to what is being said. This ability develops in both parties an increased proficiency to listen and to appreciate the other person’s perspective on any given issue.71 As discussed previously, because moral distress is now known to be an experience of the individual versus an experience of the situation, methods of addressing the distress must be sufficiently broad to include interventions on several different levels, both for the individual and the
Institution. Allowing a free exchange of information helps to break down any potential misunderstandings and begins to build the trust necessary to confront such issues. One means of developing the skill of both asking the correct questions and in actively listening to the responses to those questions is what Weber calls “conversational capacity.” Weber defines conversational capacity as “the ability to have open, balanced, non-defensive dialogue about tough subjects and challenging circumstances.”

An interesting factor to consider when developing one’s conversational capacity is the role that symbolic communication can play in the ability to understand the message that someone is attempting to communicate. Symbolic communication is based on four key principles and is expressed or understood from four different modalities. First, the four key premises that must be appreciated if one is to benefit from the four modalities of symbolic communication are as follows: 1) communication is both literal and symbolic and both verbal and non-verbal; 2) symbolic messages can convey legitimate information; 3) symbolic messages may come from the unconscious mind; and 4) symbolic messages may bypass conscious censorship. The ability to integrate both the literal and symbolic meaning into a comprehensive understanding of what is intended within a given exchange of information can be processed through four different modalities. People may communicate through the use of a metaphor as in cases of using stories, figures of speech, or parables in an attempt to convey their message; they may communicate through music—in this case, meant to identify the voice, tone, volume, or speed used in the manner of communicating a message—therefore, music would represent all forms of auditory expression; the movements used during the communication, particularly relating to the facial gestures, posture that is taken, and the body language used when communicating a message; and the media that is drawn on to convey a message—pictures that may have been taken to lend
support to the message, drawings, or other visual aids thought to support the message that is being conveyed. The importance of developing an appreciation of the meanings contained within symbolic communication is particularly relevant when we seek to understand and minimize factors relating to moral distress. Often, individuals may not be able to communicate exactly why they are experiencing moral distress, thus making it almost impossible for the organization to address it. If the individual leaders or supervisors within an organization can learn the skills associated with identifying these symbolic clues in distress, the need for moral courage on the part of the employees to discuss their feelings of moral distress will be greatly reduced. In addition, individuals, both leaders and employees, must learn two-way communication skills, which are necessary to understand what steps could be taken to reduce the experience of moral distress.

Finally, Frederick Bird has suggested several ways of developing strong conversational skills on both an individual and organizational level, all of which would support efforts to better understand and address individual experiences of moral distress. These include encouraging individuals to speak up and to expand their discussions to center on moral decision making; to permit and encourage discussions, even when they address organizational dissent; and to support efforts to develop the abilities of the staff to participate and be attentive to operational conversations and to allow enough time for conversations to develop. Organizationally, these methods include making speaking up part of the job descriptions, seeking interactive activities designed to allow individuals to bring up sensitive topics; making time for ethics discussions across the organization; and establishing training programs designed to improve skills in conflict resolution.
1. The Paradox of Moral Courage

Chapter 2 discussed moral courage in the context of the need for a just culture within the organization. During that discussion an interesting argument from Rushworth Kidder was discussed. His argument posits that although organizations seek to hire individuals who possess day-to-day moral courage, the organizations themselves should be seeking to create the type of culture and environment where moral courage is not needed. Further, as noted previously, if an organization has truly aligned its mission, vision, and values with those of its employees, moral courage should not be a necessary requisite for carrying out everyday responsibilities. This paradox, between desiring employees who are thought to possess moral courage, while at the same time recognizing that if members of the organization—including leaders at all levels—are working in an environment that supports open communication, individual empowerment, and personal growth, the need for moral courage to bring issues to the forefront should no longer be necessary. This dichotomy is perhaps one of the more difficult dilemmas to reconcile when confronting issues of moral distress in the workplace. While the truth may lie somewhere in-between, it is difficult to minimize the important role that moral courage can play in helping individuals to navigate the often gray areas in life, both personally and professionally. Moral courage will be identified as a vital component in helping to formulate one’s own personal ethical threshold, as discussed in the following section.

In the context of the current discussions regarding issues of moral distress within long-term care and possible mechanisms to address such distress, one definition of moral courage put forth by Peterson and Seigleman seems to capture the essence of moral courage as it relates to this discussion. They speak of moral courage as that “which compels or allows an individual to do what he or she believes is right, despite fear of social or economic consequences.” For
purposes of the current discussion, two words in their definition are of critical importance and relevance: “compels” and “allows.” “Compels” refers to one’s own personal ethical threshold, which will be discussed in the next section of the paper. “Allows” refers to the ability of the organization to develop the leadership, the culture, and the methods of communication that permit individuals to express their views (both positive and negative) in an environment that is free from intimidation and retribution, thus eliminating the need for moral courage in the practice of their daily responsibilities. The expression of moral courage may in fact always be a pre-requisite when one feels compelled to speak out against something that seems unjust, unethical, or perhaps illegal. The distinction that Kidder referred to and that helps to explain the paradox of moral courage alludes to the latter reference of the organization’s allowing or creating an environment where such courage is not a necessary condition of speaking out. While it can sometimes be difficult to draw a distinction between acts of courage and acts of moral courage, an interesting distinction has been made that helps to highlight the difference from a practical standpoint. Acts of moral courage can be understood as acts that protect the tangible, whereas moral courage relates to protecting and standing up for intangibles, such as one’s values or virtues.  

This paradox highlights the joint responsibility that exists between the organization and the individual, and forces both to take responsibility for simultaneously supporting individuals and their expressions of moral courage while at the same time establishing a culture where this courage is not required. One way to meet both of these needs is through education on this subject. Though educators, scholars, and researchers do not agree 100% on whether or not a value such as moral courage can actually be taught, a consensus does exist among this group that people of all ages can benefit from instruction in what is agreed to be a core value. The
question then becomes how best to instruct individuals on developing their ability to draw upon moral courage. Three specific modes of learning/teaching have been found to be the most effective: 1) through discourse or discussion of moral courage, 2) through modeling and mentoring, 3) through practice and persistence. Drawing on the discussions regarding the leadership practices of servant leadership and appreciative leadership in the previous chapter, each of these modes of learning are methods characteristic of management practices used by those transformational leaders and are consistent with the skills necessary to develop moral courage in their employees.

2. Understanding and Supporting the Personal Ethical Threshold

The concept of the personal ethical threshold (PET) was highlighted in Chapter 2 in relation to the impact that the culture can have on people’s ability to live and act in accordance with their personal values. A related concept to the culture of an organization is that of the ethical climate of the organization. Whereas the ethical climate of the organization is one component in helping to define the organizational culture, the ethical climate encompasses two important facets that can affect ethical behavior: the shared perceptions of all those working in the organization as to their common understanding of what is meant by ethical behavior, and a common understanding of how deviations from ethical behavior will be addressed by the organization. Identifying what it would take for individuals to cross their own moral lines in a way that violates their individual moral standards is known as the personal ethical threshold (PET). The need to understand the boundaries of one’s own PET is a necessary prerequisite to communicate to others when an issue exceeds one’s personal threshold. With this self-understanding comes the ability to speak out when circumstances threaten to exceed the threshold and to allow one to act with moral courage to address the issue. Consistent with many
of the aspects of moral distress, experiences of reaching or exceeding one’s own PET can vary according to the issue in question. In relation to the PET, the likelihood of violating one’s own PET is based on two factors: situational pressure and the moral intensity of the event in question. In relation to experiences of moral distress, situational pressures had been thought to be the key driver of experiences of moral distress as individuals were confronted with feelings of distress or personal loss when faced with morally distressing events. Individuals experienced moral distress while attempting to adhere to their own values or, conversely, when they abandoned their own values in favor of perceived personal gain if they succumbed to the situational pressure. In addition, the moral intensity of the event can play an equally important role in compromising one’s PET. Compromising one’s own PET is best understood in relation to how one perceives the moral intensity of an event based on the importance or potential impact on others, while the situational pressure felt on a given issue relates exclusively to the impact on the individual. Individual impact can be experienced simultaneously as the event occurs, or later, as was discussed in Chapter 3, as a build-up of moral residue after repeated incidents of unresolved situational pressures leading to a crescendo. This is now identified as the crescendo effect.

3. The Power of Imagination

Srivastva and Saatcioglu have argued that imagination and dialogue are closely connected human processes that work in conjunction with one another. They contend that when given the proper attention and cultivation, the imagination can expand the thoughts and imaginations of both individuals and organizations. When imagination and dialogue are studied in conjunction with one another, knowledge is expanded, and a holistic approach to understanding develops. The result is an increased ability on the part of the organization to
understand the interrelations that exist within organizations, allowing them to better shape their lives and create their futures.\textsuperscript{88} Srivastva and Saatcioglu term the understanding of these interrelations as “imaginative knowing.” This imaginative knowing is thought to create new opportunities for the organization to grow and to embrace change as a necessary and desired aspect of that growth.\textsuperscript{89} In this sense, and consistent with the goals of AI, the individuals and the organization begin to live the questions they are seeking to answer with an appreciation of the fact that it is the on-going inquiry that permits growth as they seek never to settle for long-term answers to their current dilemmas but to approach each issue with an imaginative heart and an openness to the beauty in both life and work.\textsuperscript{90} This continuing questioning can lead to new imaginings and a continuing sequence of new approaches to the ever-increasing complexities challenging the individual and the organization.\textsuperscript{91}

The concept of imagination itself can have different interpretations, depending on how the term is being used and in what context it is being explained. One important distinction does exist, however, and that is between “imagination” and the somewhat more complex term “moral imagination.” Patricia Werhane offers perhaps the clearest definition of imagination as “[t]he ability to form mental images of real or unreal phenomena or events and to develop different scenarios or different perspectives on those phenomena or events.”\textsuperscript{92} As was discussed above, imagination plays a critical role in the 4-D Cycle of AI, particularly in the dream and design stages, unleashing the power of imagination to consider courses of action that might not otherwise be explored. Moral imagination, on the other hand, refers specifically to dilemmas that are thought to have a moral component. Werhane describes moral imagination in the following terms:

In managerial decision making, moral imagination entails perceiving norms, social roles, and relationships entwined in any situation. Developing moral imagination involves heightened
awareness of contextual moral dilemmas and their mental models, the ability to envision and evaluate new mental models that create new possibilities, and the capability to reframe the dilemma and create new solutions in ways that are novel, economically viable, and morally justifiable.93

Moral imagination is thought to have three distinct stages. Stage 1 requires an awareness of mental models and/or values that may influence how all stakeholders perceive a given situation. Stage 2 requires one to emotionally disengage from one’s own mental models and narrative so that the situation can be understood in an unbiased manner. Stage 3 develops more creative and/or value-driven solutions to the issue that may represent new thinking and new problem solving.94 As individuals and organizations move through the stages of developing their skills in the area of moral imagination, their ability to understand not only what might trigger their responses to moral distress but also, and perhaps more importantly for those in leadership positions, what triggers moral distress in those who report to them. As their knowledge and awareness increase, so also does their ability to address those triggers, particularly in the third stage of moral imagination when one is able to draw upon more creative and value-driven perspectives that may lead to new solutions.95 The ability to call upon moral imagination opens the possibility for re-thinking more traditional solutions to perceived moral dilemmas and to reframe mental models, thus allowing for a more deliberative, less reactive approach to addressing such dilemmas.96

D. Conclusion

This chapter has focused on the impact of effective communication specifically relating to the positive impact that the technique of AI can bring to both individuals and organizations. AI is based on affirmation and appreciation of those times when organizations and individuals
believe they were operating at their best and times that they are the most proud of. AI seeks to use current and past successes to imagine and design a successful future.\textsuperscript{97} Because health care environments have been historically defined in terms of deficits, the life-affirming approach of AI forces a paradigm shift, moving away from the negative approach of problems and limitations to one of identifying and building upon successes and dreams for the future.\textsuperscript{98/99}

The role of mental models and the impact of the PET were reviewed as a means of supporting the arguments made in this dissertation that individuals can react to the same set of stimuli differently based on such factors as their mental models and how they have come to understand their PET. Mental models are thought to form the basis for individual assumptions and points of view, and thus lead one to making assumptions about the nature and impact of a given situation on individual responses.\textsuperscript{100}

Finally, this chapter reviewed the critical role of the imagination in successfully employing the 4-D Cycle of AI particularly in relation to the dream and design phases of the cycle. In addition, this chapter critiqued and identified the role of moral imagination as a key element in being able to mentally rehearse different responses to morally challenging circumstances. These rehearsed responses enable individuals and organizations to alter their pre-conceived mental models, which allows responses that are more affirming and open to differing points of view.

Chapter 6 will continue the discussion regarding the role of effective communication and will focus on the important role that empowerment can play in overcoming the negative impact of moral distress on the individual and the organization.

\textsuperscript{2} Judith Glaser, \textit{Conversational Intelligence: How Great Leaders Build Trust and Get Extraordinary Results} (Brookline, MA: Bibliomotion, 2014), xiii–xxv.


Chapter 6: Leadership Empowerment to Resolve Moral Distress

Chapters 1–5 have focused on both the positive and negative aspects of three main areas that are thought to have a strong impact on the experience of moral distress: 1) the culture of an organization, 2) the leadership styles in it, and 3) the methods of communication used both to seek and to convey information. This chapter expands on the concept of empowerment touched upon in previous chapters; it will argue that if an organization can properly support and encourage empowerment at all levels, both the organization and the individuals who work there will become stronger and more self-reliant. In so doing, both will be better positioned to confront moral distress effectively and systemically throughout the organization. It will be demonstrated here that each of the three main components of this thesis plays a key role in building the trust and skill level necessary for empowerment to be effective in helping to reduce moral distress and to address morally challenging ethical dilemmas.

Chapter 3 of this thesis reviewed the impact of the so-called “power differentials” that may exist among staff at all levels of the LTC organization and the impact of the power differentials on incidents of moral distress.\(^1\) To summarize, the impact of the power dynamics has been found not only to have a negative impact on the staff but also to have a negative effect on the patient and family members who look to the caregivers for support and guidance.\(^2\) Chapter 4 began to address these power differentials by highlighting the distinction that exists between having power over someone and giving power to the individual, bringing out a person’s natural abilities so that both the individual and the organization benefit.\(^3\) It will be shown that the appropriate use of empowerment is a mechanism that can be effectively employed to allow both the individual employee and the organization to flourish.
A. Organizational Leadership and Moral Discourse: A Communication Change Agent

The executive leadership, the culture that is established within an organization, and the methods of communication used can have a positive role in reducing incidents of moral distress. The skillful use of individual and organizational empowerment will be shown as a vital component in tying each of these influences together for the benefit of both individual employees and the organization as a whole. Though over 70% of organizations surveyed indicated that they are employing some form of empowerment with their workforce, a lack of clarity prevails concerning how various organizations define and operationalize empowerment within their organizations. Peter Senge has described the systems that exist within an organization as being bound by invisible fabrics of interrelated actions. Those interrelated actions will be shown to form the foundation of an organization when the leadership, the culture, and the communication successfully embrace the appropriate use of empowerment. The following discussion clarifies what is meant by empowerment in relation to the long term care environment and the positive impact that empowerment can have in identifying and reducing incidents of moral distress.

1. Methods of Effective Communication

Engaging in a dialogue is said to require the free flow of meaning between two or more people. This may sound relatively easy, but in the workplace, achieving a free flow of information, particularly that with meaning for both parties, is not always as easily attainable as one might think. The reason for this may be as obvious as the question itself: the best mode of communication depends on both speakers’ contexts and the preferences of the persons attempting to communicate. It then becomes clear that one has to determine exactly what barriers exist for effective communication, depending on the audience to whom one is speaking.
Two barriers significant to discussions of moral distress are moral silence and moral deafness. Moral silence, on the one hand, refers to people’s inability or unwillingness to make their moral concerns known; moral deafness on the other hand, involves the inability or unwillingness to listen to someone else expressing moral concerns. Though these two concepts may be expressed differently on the individual versus the organizational level, preventing a free expression of moral concerns in the workplace is the result at both levels. Voicing moral concerns is thought to be a communicative activity that involves at least one other person. The ability to communicate moral concerns effectively (whether organizationally or individually) rests largely on the ability to express concerns in a clear, concise manner. Caution must be taken, as well, not to command another to adopt one’s own opinions; concerns must be expressed in a way that allows for reasonable debate and for the concerned persons to justify why they have moral concerns. This requirement helps to clarify the role of individual employees in both understanding their own morally laden views in a given circumstance and accepting responsibility for clearly making their superiors aware of the concern.

Moral deafness is characterized by a lack of attentiveness to the moral concerns being expressed by others. Such inattentiveness may or may not be intentional, but the result is an inability to engage in meaningful dialogue with those who are sharing their moral concerns. The ability to engage actively in the conversation and demonstrate true attentiveness involves four specific activities:

1) Listen and receive whatever information is being communicated.
2) Recognize patterns and meanings, making sense of what others are attempting to communicate.
3) Focus and distinguish what is really important from what is not.
4) Be ready not only to listen and comprehend but also to take an interest in the message. Moral deafness and moral blindness share strong similarities to the moral disengagement discussed previously in this thesis.

As discussed in Chapter 2, Bandura identified a third barrier to effective communication of moral concerns, which he termed moral disengagement. Bandura does not definitively confirm that such disengagement is a completely intentional act, but when it is sanctioned by the organization, it can result in a lessening of accountability and a reduction in the exercise of individual moral agency for both the individual and the organization.

How, then, does one overcome the tendencies toward moral silence, moral deafness, and moral disengagement and begin to listen and act on the information that is critical to addressing moral distress in the workplace effectively? One means suggested by David Gershon and Gail Straub involves developing the seven sources of personal power as follows: commitment, discipline, support system, inner guidance, lightness, love, and finding your own truth. In summarizing how these sources of personal power can positively affect the ability to address issues of moral distress successfully, both operationally and personally, Gershon and Straub make several observations. Commitment to any cause can requires a great deal on the part of the individual and/or the organization, but with it comes a sense of pride in the accomplishments that follow as well as a deeper understanding of the value in upholding and honoring the vision as one remains true to the commitments made. Discipline is a necessary pre-requisite for commitment because it ensures that both the individual and the organization are committed over time and under changing conditions. Interestingly, support systems provide strength to individuals versus organizations in a somewhat inverse proportion. Though the organization can provide a support system to the individual employee, the employees themselves can also offer a
support system to the organization by daily supporting its mission, vision, and values. Their support is then reinforced if the organization consistently honors those values. Inner guidance has been referred to in previous discussions concerning the importance of the power of one’s own voice as well as in the discussion of the importance of the personal ethical threshold in Chapter 5. Though it may seem that discussions regarding moral distress would not lend themselves to feelings of lightness, the need to maintain a light heart and openness to new ideas and approaches cannot be disputed. This ability can certainly reduce the moral deafness and silence that can inhibit efforts to overcome moral distress both organizationally and individually. Love refers to a form of self-love that places the individual on a road of continual self-discovery, compassion toward others, and continual renewal for both the individual and the organization. Arguably, viewing an organization from the standpoint of “love” may be difficult, but at least employees will feel positive toward an organization that is consistent with its stated mission, vision, and values and is therefore on the same path of continual self-discovery and renewal. Finding the truth, much like the need for understanding one’s own personal ethical threshold helps to both highlight and balance the responsibility for successfully addressing such issues as moral distress between the organization and the individual, as both are called upon to understand themselves and one another, and to make clear to one another how they to define their own truth.16

As individuals and organizations attempt to develop a work environment that supports open communications among all stakeholders, it is often necessary to change long-standing systems so that both parties can move forward. As discussed in Chapter 2 of this thesis, there is frequently a so-called “hidden culture” that can prevent both the organization and the individual from moving forward even when both appear to be open to changes that will improve existing
systems and allow a focused approach to reducing incidents of moral distress. A hidden culture can indicate a disconnect between the management of the organization and the individual employees. Robert Marshak, a recognized leader in organizational development, has researched the impact of a hidden culture on the ability of both the organization and the individual to navigate organizational change. Marshak has identified what he terms the “six dimensions of organizational change”: reasons, politics, inspirations, emotions, mindsets, and psychodynamics. While Marshak acknowledges the existence of what may be regarded as a hidden culture, he categorizes these unconscious dynamics as covert processes, which include mental models as well as the unconscious dynamics of both individuals and groups. How do each of these dimensions come to influence how the organization addresses change initiatives, and why is it that any type of change both personally and organizationally can prove to be so difficult? The next section discusses these questions.

2. Six Dimensions of Organizational Change – A Systems Approach

Marshak characterizes his model of organizational change in terms of “covert processes” stemming from two distinct origins: 1) rational or reason based arguments for change and 2) non-rational or emotional/human dynamics required to achieve organizational change. The first process can be best understood as data based as it relies almost exclusively on presenting a logical analysis of what needs to change within the organization. Leaders who employ a strictly rational or data-based approach proceed with the notion that once employees understand the rational basis behind seeking a specific change, their thoughts on the subject will be altered or enlightened, and the desired change will result. Unfortunately, this method of leading change, though prevalent, has not proven as effective as Marshak’s model, which is also supported by John Kotter and Dan Cohen. It has been proven that when leaders understand and
acknowledge the emotional components required in accepting and embracing organizational change and seek to address these aspects instead of relying exclusively on reason and analysis, change initiatives will be more widely accepted throughout the organization. The work of Kotter, Cohen, and Marshak addresses the importance of engaging both the heart and the head in helping to bring about desired changes within an organization.\textsuperscript{21} Accounting for the emotional aspects of individual responses to change allows individuals to understand better the proposed need for the change. It should be noted that this approach is consistent with Senge’s work on mental models, which allows for a change in mindset that can clear the way for accepting new ways of addressing long-standing issues.\textsuperscript{22} This approach is particularly well suited to addressing issues of moral distress within organizations as it opens the lines of communication between the leadership of the organization and the employees, begins to address any hidden culture that might prevent moving forward, and begins to build the trust necessary to establish psychological safety and mutual respect. It should also be noted that as leaders begin to address organizational issues in this manner, the necessary groundwork for establishing a culture of empowerment is being laid as a trust level is established, lines of communication enhanced, and a new culture developed.\textsuperscript{23} This way of proceeding may be thought of as a “systems approach” to problem solving, which Checkland defines as “an approach to a problem which takes a broad view, which tries to take all aspects into account, [and] which concentrates on interactions between the different parts of the problem.”\textsuperscript{24}

Seeking to understand how to communicate with the whole person—including both a rational, fact-based approach and a more emotional, feelings based approach—is consistent with the goal of applying a systems approach to moral distress and in identifying methods of effective communication as one aspect of that approach. Chapter 4 of this thesis discussed two specific
methodologies for addressing and building upon the interrelationships that exist within organizations for helping to address issues on a holistic basis. These two methodologies—critical systems thinking (CST), also known as creative holism, and total systems intervention—provide substantive examples of the positive impact that a systems approach can have in addressing the interdependencies that exist within an organization. If not addressed, these can systemically prevent the organization from successfully addressing such issues as moral distress at each level of the organization and with an equal focus on the individual and the organization.²⁵

The next step is for the leader to determine how best to use the research discussed above to move the organization toward successfully addressing issues of moral distress. This is arguably achieved through balancing both the organizational demands and data driven solutions with the undeniable need to keep firmly in mind that healthcare is a human endeavor and that it must be managed from a humanistic, holistic perspective.

3. Conversational Capacity - Managing the Human Side of Healthcare

While Marshak, Kotter, and Cohen are able to argue convincingly for the need to consider both the rational and emotional aspects of bringing about change within the organization, Jan Helge Solbakk applies a similar rationale to the individual and to the need to consider the non-theoretical aspects of moral decision making.²⁶ Solbakk argues for the importance of considering not only rational solutions for addressing issues of remainder and regret in moral conflicts (such as the subject of this thesis, moral distress) but also remedies that incorporate the emotional aspects of such solutions, characterized by feelings of the heart in addition to the head. In addressing the unresolved issues of remainder and regret, Solbakk is pointing to the residual nature of many moral conflicts and the internal conflicts that can remain with the individual even after an acceptable resolution to the conflict has been achieved.²⁷
acknowledging the need to broaden the discussion surrounding therapeutic doubt to consider both the rational and emotional aspects of the experience, Solbakk has helped to expand the roles and responsibilities of both leadership and the individual in addressing this issue. Further, this acknowledgement affirms the need for employees as individuals to confront issues of remainder and regret that may lead to moral distress while simultaneously not lessening the responsibility of the organization and its leadership for instituting policies, procedures, and practices that support such agency and provide the psychological safety for employees to perform their duties effectively. It is interesting to note that in a 2017 article written by Andrew Jameton, (who it should be recalled is credited with developing the initial definition of moral distress in 1984,) Jameton explained his original motivation and interest in moral distress as a means of better understanding and addressing the emotional side of moral problems faced by nurses he was instructing.\textsuperscript{28} Consistent with the works of Marshak, Kotter, Cohen and Solbakk, Jameton too sought to reconcile the emotional impact of moral decision making with the more theoretical aspects of such decision making and to better understand the role of emotions in arriving at those decisions.

A common perception is that emotion can interfere with rational thought, but a 1994 study by neurologist Antonio Damasio et al. suggests the contrary. In his research with individuals who had suffered brain damage that affected their ability to draw upon their feelings, he determined that they had also lost their ability for rational decision making, despite the fact that the individuals had otherwise normal intellectual function.\textsuperscript{29} This relationship caused Damasio to conclude that feeling emotions is a necessary condition to rational thought and decision making. In summarizing the work of Damasio, Rothschild writes that ”in order to make a rational decision, one must be able to feel the consequences of that decision in one’s own
body. According to Damasio, the decision needs to feel right to the individual, not merely be rationalized as right from a purely intellectual perspective. This need to balance one’s feelings with a more rational basis for certain actions forms the basis of what can later become feelings of regret, remainder, and moral distress. In a later study conducted in 2000, Damasio, Bechara and Damasio again explored the relationship between emotion and decision making. Though the main focus of their work was to determine the impact of certain neurological deficits in some neurological disorders, the connection made between emotions and rational decision making supports the argument that leaders need to address both the emotional and the rational basis for decisions if they wish to address moral issues from a holistic perspective and to communicate to their employees both the rational and emotional basis for decisions made within the organization. One of the main goals in creating and encouraging an empowered workforce is to provide a means of communication that is as open as possible by way of establishing mutual trust and respect. Given the research that demonstrates the benefit of managing both the emotional and rational aspects involved in communicating with a workforce, it is essential that leaders have the trust of their team members and that they are able to foster collaboration and facilitate relationships. It is interesting to note that the following four attributes have been found to be the most important in a leader from the perspective of followers: honest, forward-looking, competent, and inspiring. Kouzes and Posner found that over a 25-year period between 1987 and 2012, honesty was consistently rated as the number one attribute that employees most desired in their leaders, and this finding was consistent across countries, cultures, ethnicities, and organizational functions.
B. Organizational Leadership and Moral Courage

In reflecting on the discussion of moral courage outlined in Chapter 2 of this thesis, it is helpful to recall that a distinction was made between the word *courage* as commonly understood and the term *moral courage* as used in this thesis. Moral courage, it is said, is most closely associated with courage in the service of others and is therefore seen to be relatively free of self-interest. The current chapter seeks to review the dual aspects of what it means to empower someone else as well as what it actually means to “be empowered.” How methods of communication can enhance empowerment has been discussed above. The following discussion re-visits the role of culture and the impact of leadership and moral courage on successfully using empowerment as a tool to address and reduce incidents of moral distress. The connection between acting with moral courage and the corresponding increase in the morale of the workforce will be shown to have a positive role in addressing moral distress on both an individual and organizational basis.

1. The Interdependency of Morale and Morality

Though there is not complete agreement as to what it means to act “morally,” in general it can be characterized as adhering to five core moral values: honesty, respect, responsibility, fairness, and compassion. These same values can be seen as the necessary conditions for achieving a high level of morale within the workplace. It is interesting to note that although the morale within organizations has been recognized as an important workplace issue, the ability to conclusively define what actually makes up morale has proven to be difficult. Just as the experience of moral distress has been found to be dependent on both intrinsic factors experienced by the individual and extrinsic factors attributed to outside influences, such as the work environment, the level of morale within the organization has been found to be affected by those
same factors. For example, intrinsic factors experienced by the individual include “professional worth/respect, opportunity/skill development, work group relationships and patient care. Extrinsic factors have been found to be characterized by organizational structures, operational issues, leadership traits/management styles, communication and staffing.”38 This recognized relationship between intrinsic and extrinsic factors that relate to an organization’s morale is consistent with the premise of this thesis: that organizations must be reviewed from a total systems perspective for effectively addressing all factors that may influence moral distress, both individually and organizationally speaking. Given the operational impact of achieving a high degree of morale within the workforce, as well as the fact that such morale is built on the interdependence of individual and organizational moral responsibility, leaders of organizations need to be able to align the extrinsic factors involved in achieving a high degree of morale with the intrinsic factors known to affect employees on an individual level.

Hegney, Plank, and Parker provide great insight into a connection that has been revealed between morale and morality. In attempting to find remedies for a shortage of nurses in Australia, these authors developed a questionnaire to determine whether or not there was a connection between intrinsic and extrinsic work values and their impact on job satisfaction. A total of 2800 surveys were distributed to nurses in training, enrolled and registered nurses, in October 2001. The questionnaires were distributed across three sectors of the Queensland Nurses Union—public, private, and aged care—and results were made available for each sector individually.39 The aim of the study was to determine the effect of intrinsic and extrinsic work values upon job satisfaction and the intention to leave employment. However, an additional finding, which relates to the current discussion about the interdependence of morale and morality, revealed that where work stress is high, morale is low, and the intent to leave
employment is increased. Particularly relevant here are the results that relate specifically to nurses working in aged care. Compared to those working in the public and private sector, nurses in aged care reported their work as more “emotionally challenging,” more physically demanding, and more stressful than did nurses in either of the other two sectors. These nurses in the aged care sector also reported less collegial support and teamwork than those in the other two sectors. On a positive note, however, the nurses caring for the aged, unlike those in the public and private sectors, reported their belief that nursing is an extremely or quite high status career.

Though the study did not specifically address a possible connection between how one feels towards the importance of one’s job (i.e., status) and the stress that results from the importance placed on the role, it is possible that consistent with the understanding of the causes of moral distress, these nurses exhibit higher degrees of stress largely as a result of their internal struggles to provide care in a manner consistent with their values and their strong beliefs that their service is important and worthy. Finally, the nurses’ reported level of morale corresponded to their degree of autonomy and level of seniority.40

The studies discussed here have helped to substantiate the argument that there is indeed a connection between acting in a morally defensible manner and a corresponding positive impact on morale within an organization. This conclusion is supported by findings that feelings of professional worth and a belief in the importance of the work being done, the profession chosen, work group relationships, and quality patient care are all thought to relate to acting in a morally defensible manner and thus to correspond to high morale in the workplace.41

2. Competing Values Framework in Assessing Organizational Culture

Chapter 2 discussed one of the most dominant frameworks for assessing organizational culture, the competing values framework. The purpose of using this framework is to provide a
mechanism for identifying the core values and assumptions of an organization in relation to its effectiveness in achieving its stated goals. The discussion in Chapter 2 focused largely on the different types of cultures that can exist within an organization and the corresponding values that might result: that is, the hierarchy or control culture, the market culture, the clan or collaborative culture, and the adhocracy or create culture. The following discussion applies this information in exploring how the leadership of the organization can identify competing values within their organization and how they can take effective measures to bridge any value gaps that may exist between the organization and the individuals who work there.

If the organization is successful in integrating its values with those of the individual, both the moral agency of the organization and the morale of the staff will be strengthened. When values can be clearly identified and understood, a common bond can be established among all of the stakeholders (the organization, the employees, the residents, and family members), and a framework can be developed that allows for agreed-upon priorities and seeking a consensus around decision making that can positively affect all parties.

Burns describes three specific types of leadership values that are each attributed to specific leadership styles and that help to define the culture that is created as a result of these practices. These are as follows: 1) ethical virtues, which Burns describes as the Ten Commandments or rules of personal conduct; 2) ethical values, such as honesty, integrity, trustworthiness, and accountability; and 3) moral values such as liberty, justice, and community. While ethical values and ethical virtues are seen as culturally based, moral values are said to be more universally accepted and are looked upon as standards by which one can measure such things as character, policies, and programs. The UN Universal Declaration of Human Rights provides an example of a moral standard accepted by most nations of the world. On a much smaller scale, the moral values embraced by
the leadership of an organization come to define that organization and the individuals who work there if these values are consistent with the mission and vision of the organization and are successfully operationalized throughout the entire organization.

Zhu provides insight into the effect that ethical leadership can have on follower moral identity in his study of 335 organizational employees across thirteen different industries. Zhu’s study was developed to test the validity of whether ethical leadership behavior helps to develop follower moral identity and development and, further, what the influence of empowerment might be on such moral development. Zhu writes that “moral identity represents the degree to which a person identifies him/herself as a moral person. Moral identity determines when and why individuals behave in an ethical way and serve in the best interest of the collective, such as the organization, community or society.” The significance of strengthening the moral identity of individual employees centers on the relationship between a person’s strong sense of moral identity and the individual’s corresponding ability to evaluate what information is morally relevant to moral dilemmas before deciding on a specific course of action. This ability, in turn, allows employees to compare any dilemma with their own values to determine whether the action taken will be consistent with their own moral identity. Of particular relevance to the current thesis is the connection between leaders’ roles in developing the moral identity of employees through their own practices of ethical leadership and how this development can lead to strengthening both the individual and the organization and prepare both to address issues of moral distress individually and organizationally.

Chapter 5 discusses what Grenny et al. present as the qualities of a successful leader, which those authors summed them up in one word: “influencer.” Their research on common traits among successful leaders led them to conclude that the most important skill is the ability to
influence changes in the behavior of others—hence their assertion that the most appropriate term to define leaders is “influencer.”

The idea of the leader as influencer, mentor, or role model is a concept dating back at least as far as Aristotle, who is credited with saying that “morality is awakened in the individual only through the witness and conduct of a moral person.” In the work environment, it is the leader who is looked to as a role model and as the person who brings the values of the organization alive within the daily operation of the community. It is important to consider however, the argument of John Dewey that “while the idea of morality may begin with a set of culturally accepted goals and rules that are external to the individual, it is not until that individual freely chooses to accept those rules based on his/her own careful reflection and evaluation that they can be thought to be his/her own.” Dewey’s argument highlights the interplay between one’s personal ethical threshold and the responsibility of institutions and leaders to provide positive role models and to explain fully, by example, the mission, vision, and values of the organization for a holistic observance of the designated practices on every organizational level. Finally, it may be helpful to recall one of the most significant attributes of the servant leader discussed in previous chapters: they inspire others to look within themselves, bringing the best out of their followers by helping individuals to develop the strength of their own voices through positive mentoring from a selfless leader who is fully committed to both the individual and the organization.

A regard for the leader as mentor, influencer, or role model does not lessen individuals’ responsibility for their own moral behavior. Employees are accountable for understanding their own core values or core beliefs and being able to communicate those beliefs as appropriate to those they work with and for. Gershon and Straub discuss what they have identified as five
categories of core beliefs that can assist individuals in discovering their own beliefs: 1) the individual’s view of “self-responsibility and 2) of themselves in the form of “self-esteem, 3) a trust in someone or something greater than themselves—which they term as a “trust in the Universe, 4) whether or not they believe they have a “positive attitude, and 5) their ability to flow with change. 53 Individuals cannot successfully model an organization’s values to others without first having an understanding of and comfort level with their own core values and the impact of those beliefs on how they make decisions and carry out their responsibilities.

3. Code of Ethics of the American College of Healthcare Executives

The American College of Healthcare Executives (ACHE) has developed a code of ethics which is widely regarded as a guideline for ethical behavior within the healthcare industry. ACHE first published its code of ethics in 1941 and has continued to update and modify it to keep it relevant to the changing healthcare environment. It is important to note that this code of ethics, though intended to serve as a standard for professional behavior, also offers guidelines for individual behavior when associated with the role of the individual as a healthcare executive.54 The ACHE Code of Ethics is broken down into the following six categories that outline the scope of the healthcare executive’s responsibilities:

1. To the profession of healthcare management
2. To patients or others served
3. To the organization
4. To employees
5. To community and society
6. To report violations of the code.55
The ACHCE Code of Ethics has recently been augmented by updates to the American Medical Association’s Code of Medical Ethics (adopted in June 2016), which devotes eleven chapters, offered as “opinions,” to what are regarded as acceptable norms for the medical profession in their professional roles. These are opinions on patient-physician relationships; consent, communication, and decision making; privacy, confidentiality and medical records; genetic and reproductive medicine; caring for patients at the end of life; organ procurement and transplantation; research and innovation; physicians and the health of the community; professional self-regulation; inter-professional relationships; and financing and delivery of health care. In an article in the June, 2017 AMA Journal of Ethics, BJ Crigger identifies 4 specific opinions found in the AMA Code of Medical Ethics which he believes specifically attempt to address issues of moral distress within the health system. They are: 1.) Professionalism in Health Care Systems, 2.) Transparency, 3.) Exercise of Conscience and 4.) Contracts with Health Care Institutions. A brief summary of the significance of each of these 4 opinions in relation to efforts to reduce incidents of moral distress are as follows: Professionalism in Health Care Systems seeks to hold the leaders of healthcare organizations accountable for the policies they institute and the incentives they permit physicians to benefit from. The opinion also seeks to reinforce the primary role of the physician and their primary obligation as caring for their patients. Transparency calls upon both the institution and the individual physicians to maintain transparency in all of their institutional policies and practices and to identify any incentives that the physician may be receiving in an effort to disclose any information that has the potential to affect the care of the patient. The Exercise of Conscience seeks to support physicians who, in good conscience do not feel they can adhere to a specific institutional policy or policies. Contracts with Health Care Institutions seeks to provide guidance to physicians relating to
entering into contracts with institutions that could present a conflict of interest or compromise the physician’s ability to exercise independent professional judgment. Each of these Opinions seek to proactively address issues that could lead to moral distress and demonstrate a desire and awareness on the part of the American Medical Association to address moral distress from both an institutional and individual basis.

Of interest to the current discussion is the original code of ethics adopted by the American Medical Association in 1847, though comprehensive in its own right, mainly emphasized a balance of responsibility between physicians and their patients. For example, while Article I of the 1847 code outlined the duties of physicians to their patients, Article II outlined the obligations of patients to their physicians, furthering noting the obligations of physicians to the public and vice versa. The inclusion of responsibilities from patients and society toward the medical profession in the original code of ethics helps to demonstrate how the practice of medicine has evolved over the past 100+ years: it seems that, in the effort to address all of the complexities of providing care, the idea of shared responsibilities in medical care has somehow been lessened. More of the burden has been placed solely on care providers, and this shift has inevitably had implications in terms of moral distress for both caregivers and patients as the guidelines increasingly relate to specific ethical dilemmas instead of to the relationship, communication, and leadership aspects of care.

Finally, by way of contrast to the AMA and ACHE codes of ethics, the 1893 “Florence Nightingale Pledge” written as a token of esteem for the founder of modern nursing, is relatively simple. It is only seven lines in length, but the last sentence includes all that may be necessary to honor any code of ethics for nurses: “… and devote myself to the welfare of those committed to my care.” If nurses today could devote themselves 100% of the time to those committed to
their care, it is quite likely that incidents of moral distress would be reduced and the focus shifted to the patient rather than to the outside factors that require equal attention today. As noted previously in this thesis, contemporary nursing homes have been characterized as suffering from decreasing public funding, chronic staffing shortages that lead to low morale, increased expectations from family members, and increased frequency of litigation stemming from a perceived or realized lack in quality of care, and unmet expectations. Gini and Green highlight one of the most important truths about effective leadership: any leader who wishes to be truly effective must recognize that followers need to become reciprocally co-responsible for both individual and organizational successes, with each responsible to the other for the successful functioning of the whole. The codes of ethics discussed above allow for mutually agreed upon norms, thus allowing both the leaders and those who choose to follow them to understand the goals and expectations of their positions and to engage willingly in what should be a mutually beneficial relationship. Day, Minichiello, and Madison, in writing about nursing morale, support the need for such shared responsibility, which they term as shared ownership. It brings both the management and the employees, both leaders and followers, together in a shared purpose and joint recognition of the importance of each to the overall goals of the organization.

From an organizational perspective, a code of conduct can serve to highlight the guiding principles of the organization and can outline specific practices, those both expected and prohibited. New York’s Montefiore Medical Center provides an excellent example of a health care system that has developed a detailed institutional code of ethics. According to Montefiore, their institutional code of ethics reaches beyond the required standards, such as those from the Joint Commission, and seeks to quantify the ethical obligations of the institution as a health care provider. This comprehensive institutional approach incorporates all aspects of Montefiore’s
operations including patient care, medical education, clinical research, and community service as well as all aspects of the administrative functions that support these services including their volunteer services.\textsuperscript{65}

Montefiore has designed its institutional code of ethics by dividing the operational issues from the clinical issues so that both can be addressed in a comprehensive manner. From an operational standpoint, four specific categories are identified as follows, each with its own list of exactly how Montefiore achieves each specific objective:

1. Create an ethical organizational environment
2. Pursue a socially responsible agenda
3. Engage in responsible stewardship
4. Support fair marketing and communication practices. \textsuperscript{66}

In addition to the operational categories, Montefiore has identified the critical areas it believes relate most closely to the provision of care:

1. Close monitoring of the quality of care provided
2. Supporting ethical clinical decision making
3. Promoting multidisciplinary clinical consultation
4. Protecting patient privacy and confidentiality\textsuperscript{67}

By publicly stating its institutional ethics code, Montefiore provided a mechanism for all stakeholders—employees, patients, vendors, and volunteers—to gain insight into what the organization values and to what extent these values should be evident to all those who work at Montefiore, as well as all who receive services from them. This fact in itself can prove to be quite empowering as individuals begin to compare the values of the organization with their own.
Given the examples cited concerning the efforts made to codify certain norms of practice relating to ACHCE, the American Medical Association, and the American Nurses Association, one remaining question relates to what role the leadership of the organization can play in ensuring that those within their organizations honor these practices. One way to develop a framework for ensuring that these practices will be operationalized is working to empower everyone in the organization with the information, training, and resources they need to execute their responsibilities properly and to feel that their contributions are critical to the overall success of the organization. Empowerment, according to Ciulla, is ideally about giving people the “confidence, competence, freedom and resources to act on their own judgments.” Perhaps not coincidentally, these are the same traits that the servant leader seeks to instill in those he or she leads. The significant role that empowerment can play in the healthcare setting is reviewed in the following section.

C. Organizational Empowerment of Caregivers

Kuokkanen, Suominen, Harkonen, Kukkurainen, and Doran designed a study to test the effects of organizational change on work-related empowerment. For the study, a questionnaire given to registered nurses, practical nurses, and allied health professionals, excluding physicians and administrative personnel. The study was carried out over a three-year period with questionnaires given to 495 participants. The following factors were determined to have a positive effect on promoting an environment of empowerment within the work-place: 1) moral principles, 2) personal integrity, 3) expertise, 4) future-orientedness and 5) sociability. These results came from the fact that those nurses who participated reported a correlation between the factors thought to promote an environment of empowerment and their level of job satisfaction and motivation. With regard to these five categories, it is important to note that they represent...
a combination of factors indicating shared responsibility for both the organization/leadership and the individual for empowerment to be successful within the organization. Ultimately, the basis for the effective implementation of empowerment across the organization lies in the leader’s ability to believe in and trust those within the organization. These five factors that are thought to enhance empowerment all help to create an environment where trust and belief is shared between the leader and the employees, and where mutual respect becomes a part of the organizational culture. We turn next to a deeper exploration of the role of empowerment.

1. Empowerment versus Persuasion

The use of the term empowerment has been found to be somewhat contradictory based on the individual interpretation, experience, and perception of those seeking to understand its meaning. As a result, two distinct mindsets seem to have formed concerning empowerment within organizations: those in support of it see it as a legitimate vehicle to improve the quality of the working life for employees, whereas those who question its validity tend to view it as a management gimmick for shifting risk onto employees and requiring even more work from their employees, with or without the corresponding compensation generally associated with increased responsibility. This difference in perception may reflect the perceived or real power imbalances thought to exist within the long-term care setting. These power imbalances have been determined to exist among staff at all levels of the organization.

In many respects, this discussion of empowerment calls attention to the explorations in previous chapters on the role of the leader, specifically the servant leader, in helping to shift from a more historically autocratic method of leadership wherein the leader has “power over” his employees to one where the leader and all members of the team seek to create an environment that gives everyone the “power to” do what is necessary for bringing out the best in both the
individual and to the organization. “Power-over,” sometimes referred to as “coercive power,” is characteristic of a hierarchical form of leadership and is rooted in one person holding power over another in terms of having the ability or authority to punish, hire, or fire that individual. In a “power to” environment, generally characteristic of a collaborative work environment, power is sought from within all individuals in attempting to build upon their expertise and creativity for the benefit of both the individual and the organization. Kuokkanen and Katajisto have cautioned that any discussion of empowerment in the workplace must address issues of the power and how that power is used to motivate employees and improve patient outcomes. Empowerment is seen as being the most effective organizationally, not in terms of giving people power but rather as a means of successfully using the power that already exists within the individuals in the form of their experience, knowledge, and internal motivation to bring about a sense of ownership in helping to achieve the mission of the organization and to contribute to the vision and values that the mission is built upon. Empowerment relies on the mutual trust of all those involved in the process and builds upon this trust to the benefit of both parties. Finally, effective implementation of empowerment should provide the opportunity for individuals to gain control over their jobs, lives, and futures. In this sense, empowerment provides for a holistic approach to management that, when implemented systemically throughout the organization, can serve the best interests of both the individual and the organization. As employees gain control, their ability to speak up effectively becomes stronger and their belief in themselves and in the institution more productive.
2. Empowerment as Seen Through the Mission, Vision, and Values of the Organization

The ability to observe an empowered workforce from the outside often begins a perusal of the organization’s mission, vision, and values statements. As discussed in Chapter 2, these public statements can serve to express an organization’s commitment to the values it relies on for decision making and operating policies. These values can help to express the organization’s view regarding equality, respect, quality of care, and stewardship and to provide insight into how those values will be demonstrated throughout the organization.\textsuperscript{79} If an organization believes in the value of empowering its workforce, that commitment should be evident in their publicly expressed values. Mission statements on the other hand are intended to describe the purpose of the organization—why it is in the business and what it hopes to accomplish as a result of honoring that mission.\textsuperscript{80} The mission statement should serve both to inspire ethical behavior and to provide direction for desired standards of conduct.\textsuperscript{81} Examples of the mission statements of three different hospitals are provided below as a means of demonstrating how they each identify their own mission and purpose for their organizations:

\textit{Massachusetts General Hospital, Boston, MA}

Guided by the needs of our patients and their families, we aim to deliver the very best health care in a safe, compassionate environment, to advance that care through innovative research and education; and to improve the health and well-being of the diverse communities we serve.

\textit{Bon Secours Richmond Health System, Richmond, VA}

To bring compassion to healthcare and to be good help to those in need, especially who are poor and dying. As a System of caregivers, we commit ourselves to
help bring people and communities to health and wholeness as part of the healing ministry of Jesus Christ and the Catholic Church.

_Tenant Healthcare Corporation_

At Tenent, our business is health care. Our mission is to improve the quality of life of every patient who enters our doors. Our approach makes us unique and defines our future.82

Although brief, each of these mission statements provides insight into what anyone might expect to encounter should they utilize the services of one of these hospitals either as a patient, a visitor or an employee. Massachusetts General appears to focus on the needs of their patients and families in determining operational priorities and to do so in a safe and compassionate manner while placing education and research in the forefront of achieving their goal of improving the health and well-being of the diverse community that they serve. Bon Secours clarifies its mission of serving the poor and dying as part of their ministry of Jesus Christ and the Catholic Church, while Tenet Healthcare Corporation demonstrates in its mission statement that its “business” is health care and its mission is to improve the quality of life for every patient who enters the door. Its desire for future growth is based on the quality of care delivered.

If each of these mission statements is compared with the five factors identified by Kuokkanen et al. for creating an environment of empowerment within the workplace (moral principles, personal integrity, expertise, future orientation and sociability), the roots of an empowered workforce become evident. The desire to create such an environment can be inferred from each of the mission statements if one considers the words used to describe the mission of each organization: “compassionate environment,” “to bring compassion to healthcare,” and “to improve the quality of life of every patient.” Each institution appears to
approach its purpose systemically, referring to the goal of the organization and the fact that each seeks to do its work in a compassionate manner for the betterment of others.

3. Empowerment and Job Satisfaction—Effect on Reducing Moral Distress

Empowerment has been described by Kuokkanen et al. as a process of personal growth and development with job satisfaction and commitment to the organization as important elements that support nurse empowerment. Efforts to address moral distress can also be seen as a process of personal growth and development for the employees as they attempt to understand better their own values and the impact of mental models on their individual response to certain stressors. The connection between using empowerment as a tool to gain control over the workplace, as well as in one’s personal and professional life, parallels one’s need to take control of the issues known to lead to moral distress and helps to explain the goal of using empowerment techniques to overcome the challenges of moral distress in the workplace.

Before discussing the possible impact of empowerment in helping employees address issues of moral distress in the workplace, it is helpful to re-examine the general causes of and recommendations for addressing moral distress and then to explore creating a culture where empowerment can further support those recommendations. This thesis has argued that in order for moral distress to be addressed systemically in an organization, a collaborative effort must be made to focus on the culture, the leadership, and the methods of communication used to communicate the mission and values of the organization to all who work there. These same priorities will be shown as necessary if an organization is to use empowerment successfully as a tool for supporting initiatives to address moral distress.

Jameton’s 1984 definition of moral distress focused primarily on the institutional constraints believed to prevent medical personnel from acting according to what they perceive is
right when confronted with an ethical dilemma. The implication of this definition is that removal of these alleged constraints would free individuals to act in a manner consistent with their values and, thus, help to prevent the moral distress of having to act in a way that is inconsistent with their values. It should be noted, however, that later research contradicts or, perhaps more accurately, expands upon Jameton’s claim that individuals experience moral distress as a result of feeling pressured to act contrary to their values. Kalvemark et al. have attributed moral distress to practitioner’s being forced to choose between the rules of their organization and their conscience even when the choice they made was to follow their conscience. In this scenario, the moral distress is attributed to practitioners’ inability to represent the interests of all stakeholders—that is, to include both the organization and the patient. In addition, some researchers have given greater recognition to the interrelationship of individuals with their organizations and to seeking interventions that include both the individual and the institutions where they practice. Of particular significance to the current discussion is Jameton’s own thinking on the subject of moral distress. Though not all workplace stress can or should be considered moral distress, it is true that moral distress is the only form of stress that involves a compromise of one’s core values or perceived moral obligations.

As discussed in Chapter 3 of this thesis, some of the examples of morally distressing events that occur during routine provision of care and that are thought to contribute to incidents of moral distress include miscommunication among members of the medical team and/or between the medical team and the patient, missed opportunities for meaningful conversations concerning end-of-life decisions, feelings of powerlessness by healthcare practitioners, and value-driven conflicts regarding appropriate treatment options. Campbell, Ulrich, and Grady suggest expanding the understanding of what issues may lead to moral distress from those that
have formed the more widely accepted definitions of moral distress. Those definitions are generally attributed to Andrew Jameton, Epstein and Hamric, and Epstein and Delgado; and they include such concepts as knowing the morally right thing to do but being constrained from doing it owing to internal or external factors; an initial experience which, over time and with accumulated incidents of multiple experiences of distress, causes a build-up of moral residue; and the compromise of one’s moral integrity and/or core values.

Though these three explanations of moral distress offered by Jameton, Hamric, Epstein and Delgado are widely accepted in the literature, the expanded conception of the possible causes of moral distress as outlined by Campbell et al. is consistent with ideas presented by Worthley and Austin as well. Worthley argues that everyday challenges healthcare practitioners confront have as yet remained largely unaddressed in favor of the more macro bioethical issues resulting from our advanced technological age. Austin’s approach is similar to those of Worthley and Campbell et al. as well, as she argues that bioethics today is too far removed from the everyday ethical issues facing practitioners. In their proposed expanded definition of moral distress, Campbell, Ulrich and Grady include everyday situations that they believe can lead to moral distress. These include mild distress, delayed distress, moral dilemmas, bad moral luck, and distress by association. These, they believe, represent legitimate situations that may lead to the experience of moral distress. Finally, Fourie argues in support of broadening the definition of moral distress based on her contention that because moral distress can stem from a variety of morally troubling situations each representing some violation of one’s core moral values, it would be inappropriate and in many ways insufficient to single out just one factor to attribute the moral distress to. In this instance, Fourie was reacting to Jameton’s 1984 definition of moral distress as resulting from a constraint felt by the individual. Each of these expanded
definitions of moral distress may strengthen the argument for building empowerment into the fabric of the culture of healthcare organizations so that both the employees and the organization are properly equipped to address not only the severe ethical dilemmas with which they are confronted but also—and perhaps at least as important—to deal with everyday ethical challenges.

It should be noted that shifting to a culture of empowerment within a healthcare setting poses certain challenges as the organization moves away from the historic practices characteristic of a hierarchical culture. Blanchard, Carlos, and Randolph provide a comprehensive analysis of the stark differences that exist between a hierarchical culture and a culture of empowerment. Following is a summary of comparison of the distinctions between the two forms:99

<table>
<thead>
<tr>
<th>Hierarchical Culture</th>
<th>Culture of Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>Visioning</td>
</tr>
<tr>
<td>Command and control</td>
<td>Partnering for performance</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Self-monitoring</td>
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<tr>
<td>Individual responsiveness</td>
<td>Team responsibility</td>
</tr>
<tr>
<td>Pyramid structures</td>
<td>Cross-functional structures</td>
</tr>
<tr>
<td>Workflow processes</td>
<td>Projects</td>
</tr>
<tr>
<td>Managers</td>
<td>Coaches/team leaders</td>
</tr>
</tbody>
</table>
Employees                                Team members

Participative management               Self-directed teams

Do as you are told                      Own your job

Compliance                              Good judgment

These distinctions become all the more telling when one considers Litwick’s characterization of the delivery of care in nursing homes as discussed in Chapter 2: detached, impersonal, hierarchical, and rule governed. Any steps that the leadership of an organization takes in moving towards developing a culture of empowerment will be shown to parallel improvements in the level of staff job satisfaction: lines of communication are clarified, and employees are valued and supported in carrying out their responsibilities. It should be noted that three of the characteristics identified within a culture of empowerment—partnering for performance, team responsibility, and cross-functional structures—have specific relevance to addressing moral distress in the long-term care environment. Each of these practices helps to address concerns specifically identified in the research on moral distress as they relate to the long term-care environment.

Of particular relevance, are issues relating to the impact of staffing levels and the relatively few other licensed staff available to nurses with whom they can discuss ethical concerns during their shift. In the long-term care setting, it is not unusual to have only one registered nurse on duty during any given shift. This fact limits the nurses’ ability to have a meaningful discussion about an ethical concern at the time a decision must be made. The ability to feel connected to a team and to draw upon cross-functional structures would be a
valuable practice in helping to address moral concerns in a timely manner and with a skill level that might not otherwise be present to most individuals. In addition, however, the integral role of on-going professional education, career consciousness, and supportive organizational activities must continue to garner attention from leadership so that nurses are not merely provided an autonomous work environment but are truly empowered to exercise real influence and decision-making over their work environment.102

In addition, research by Day, Minichiello, and Madison supports the findings that when supportive professional relationships exist between nurses and the other medical staff, the nurses reported that their work was more meaningful, their professional knowledge and skills were used and appreciated, thoughts of quitting were greatly reduced, and a strong sense of community and work-group relationships was developed.103 Each of these factors can help to minimize the long-term effects of confronting the ethical dilemmas that have become so much a part of caregivers’ everyday work life. These findings are consistent with those of Blanchard, Carlos, and Randolph, who suggest that the three keys to empowerment are 1) to share accurate information with everyone, 2) to create autonomy through boundaries, and 3) to replace hierarchical thinking with self-managed teams.104

D. Conclusion

By way of summary, the main concepts of this thesis are the role of an organization’s culture, organizational leadership, and methods of communication in helping to address efforts to reduce moral distress systemically throughout an organization. In recalling Peter Senge’s observation that the systems existing within an organization are bound by invisible fabrics of interrelated actions, empowerment can be thought of as the thread that ties these three concepts
together.\textsuperscript{105} Thus, this chapter has focused on the positive role of empowerment in terms of achieving an organizational environment wherein moral distress is at a minimum.

Just as the culture, the leadership and the methods of communication within a healthcare organization must each be present and working interdependently to address moral distress throughout the system, the effectiveness of an empowered workforce is further dependent on the effective interplay of each of the four areas. Because of the individual differences in and perceptions of the way the term \textit{empowerment} is defined in the workplace, it is essential that the organization clarifies its own goals for the use of empowerment and that the evidence of this empowerment is seen in the culture, the leadership, and the communication methods employed.\textsuperscript{106}

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22 SENGÉ – MENTAL MODELS


73. Marie Edward, Susan Mc Clement, and Laurie Read, ‘Nurses’ Responses to Initial Moral Distress in Long-Term


Chapter 7: Moral Distress in Long-Term Care at the End of Life

A. The Role of Culture in Establishing the Quality of Life and the Quality of Death in Long-term Care

In a special report from 2005 by the Hastings Center, the authors note that “while death is inevitable, dying badly is not.” Though an exact definition of what it means to die badly is certainly subjective, research does support the notion that the end-of-life experience in U.S. nursing homes has been plagued by examples of poor pain control, low use of hospice services, inadequate advance care planning, and family dissatisfaction with the facility where a loved one has passed away. In reflecting on these examples, it becomes clear that the end-of-life experiences attributed to a so-called bad death have not necessarily occurred at the moment of the person’s passing but were rather a part of the individual’s life in the nursing home. Elizabeth Kubler-Ross perhaps expressed this the most clearly by saying, “If we could remember to treat the living well, we wouldn’t need to remember the rights of the dying; we would meet their needs naturally.”

This fact becomes even more significant when one considers the impact of moral distress on the caregivers, family members, and loved ones who care for individuals at the end of life. The possible reasons and—perhaps more important—the possible solutions to these factors will be discussed throughout this chapter, but important considerations at the forefront of the discussion are not only the impact of a so-called bad death on the dying person (which is certainly the main focus in improving end-of-life care) but also the emotional impact of being witness to, or even being involved in, what might be considered as a bad death and a poor quality of life during the last days or months of one’s life. Family members are known to experience
significant burdens when caring for their loved one, even if the person lives in a nursing home. Families’ needs must be considered as morally significant and part of the overall plan of care for the individual. In addition, researchers have found that owing to the relationship that develops between staff and residents, staff often refer to the residents in terms generally attributed to family members and are as protective and caring of their patients as if they were family.⁴

Andrew Jameton’s 1984 definition of moral distress focused on perceived institutional constraints, which he believed prevent individuals from taking what they believe is a morally correct action.⁵ As discussed previously, if these issues are left unaddressed, employees can begin to feel voiceless, powerless, and unable to provide the care that they believe their patients require. Ultimately, these feelings can culminate in moral distress.⁶ It is important to consider the fact that within the long-term care setting, owing to the extended time during which staff provide care to residents, intimate personal relationships develop between them.⁷ By the year 2020, it is estimated that 40% of deaths in the United States will have occurred in long-term care facilities.⁸ Despite these statistics, both long-term care communities and society at large remain largely inadequate in terms of facing the challenges that end-of-life decisions require of all those involved in this sacred event. Before a meaningful discussion can take place concerning the end-of-life experience within long-term care, it is helpful first to agree on what factors can positively affect quality of life for nursing home residents. One researcher with expertise in geriatrics correctly points out that until researchers, providers, residents, and society at large can achieve common understanding in terms of defining the quality of life within a nursing home and can establish standards that correctly define those factors that support quality of life, it may be unrealistic to expect providers to effect what she terms “a universal happy ending.”⁹
A thorough understanding of the complexities involved in providing care that continuously ensures the quality of life within a long-term care environment may demonstrate that interventions can be established that are appropriate for addressing this very intimate and spiritual time in the life of both residents and caregivers. The three main components treated in this thesis—the culture, leadership, and methods of communication used within an organization—will be reviewed in terms of improving the quality of both life and death for the patients, the caregivers, and families of nursing home residents. It will be demonstrated that only the joint efforts between an organization’s leadership and all who work and live there can establish and maintain an organizational culture that supports end-of-life practices and communicates those efforts by ensuring that a strong ethical climate is supported in all operational decisions. This knowledge will then serve as one of the most important components in reducing moral distress in long-term care. One final, important note regarding the following discussion into the impact of the end of life on incidents of moral distress is observations from Vogt on current discussions about end-of-life practices. Vogt notes a change in focus over recent years in writings on ethics at the end of life, observing that it has shifted away from the dying person to the response of family members, friends, and caregivers to the person who is dying. This awareness reminds us that efforts to improve the dying process through a coordinated approach from the culture, the leadership, and organizational communication are first and foremost aimed at improving the end-of-life experience for the patient. Incidents of moral distress will thereby be reduced as all involved with the patient will share in that more positive experience.
1. Defining Quality of Life in Long-Term Care

Citing an overly conservative approach to establishing parameters for defining the quality of care in nursing homes, Kane and her research team sought to change the long-standing paradigm of life in the nursing home by aiming first to establish the best possible quality of life consistent with the health and safety of the individual. In doing so, the research team was able first to establish tested quality-of-life indicators and then to seek to implement those findings against a backdrop of health and safety—but only after the quality of life indicators were established. The research team identified eleven components that may contribute to a positive or enhanced quality of life within the nursing home. It should be noted that although the survey team did not identify their research approach as the appreciative inquiry method (discussed in Chapter 5), they did stress the importance of “accentuating the positive” and not defining quality as merely the absence of negative outcomes. The eleven indicators identified are 1) sense of safety, security, and order, 2) physical comfort, 3) enjoyment, 4) meaningful activity, 5) relationships, 6) functional competence, 7) dignity, 8) privacy, 9) individuality, 10) autonomy/choice and 11) spiritual well-being.

If one compares these indicators with the descriptions provided by the Thomas, Jude, and others as outlined in Chapter 5, it becomes clear that the goal of providing a good end-of-life experience for the residents of nursing homes needs to begin with providing a good quality of life while they are in a position to benefit from and enjoy it. Particularly significant in terms of determining the factors that may positively contribute to the quality of life within the nursing home is Thomas’s identification of three plagues that define life in a long-term care setting: loneliness, helplessness, and boredom. Thomas believes that these account for the bulk of suffering among elders. Unfortunately, as previously mentioned, despite the personal
relationships that exist between the caregiver and the resident, over 90% of the nation’s nursing homes were found to have too few workers to take care of residents properly.\(^{16}\)

Additionally, the care provided within the nursing home has been described as detached, impersonal, hierarchical, and rule governed.\(^{17}\) Such depictions are inconsistent with the eleven indicators, as outlined above, that are thought to support quality of life within the nursing home. The issues mentioned here may ultimately lead to moral distress when they cannot be successfully addressed by the caregivers, whether licensed staff or administrative staff. If, on the other hand, conditions known to tend toward moral distress are addressed proactively, a better work environment will be created that includes continuity of care, interdisciplinary collaboration, and strong patient advocacy, thus serving to improve the quality of care.\(^{18}\) Most, if not all, of the eleven indicators of a good quality of nursing home life help to address the concerns expressed by Thomas and others who have identified the obstacles to quality of life within the long-term care environment. It is particularly informative to consider the eleven quality-of-life indicators in terms of how they might serve to improve not only the quality of life but also the end-of-life experience for the residents. Specifically, eight of the eleven components are equally important for addressing both quality of life and improved end-of-life experiences, as follows.

- Sense of safety, security and order—this sense is perhaps best seen as the minimum requirement for one’s life in a long-term-care setting. Ensuring the safety of all residents is one of the most important aspects in building trust between caregiver and resident, and in creating an environment where residents can feel secure in expanding their interactions rather than limiting them out of fear.
- Physical comfort—this aspect can encompass being free from physical pain and discomfort as much as possible in addition to being comfortable with the physical
environment of the long-term care community. Thus, the cleanliness of the community and personal spaces, along with good attention to the needs of residents in a timely, consistent manner, are important.

- **Relationships**—the importance of continuing to be encouraged to develop relationships within a long-term care community is essential for the ongoing emotional support needed for continued mental and physical development. Relationships with staff and other residents are encouraged as a means of establishing oneself as part of a community of caring individuals. These relationships not only enhance the quality of life for individuals during their healthier times but also can be called upon for support and encouragement when their health declines.

- **Dignity, privacy, individuality, and autonomy**—as four of the eight components, these represent respect for the individual and for the inherent desire to live in a manner consistent with past routines. In honoring individual dignity—including persons’ ability to make their own choices on issues regarding flexibility in dining, sleep, and wake times, and when or when not to participate in community events—the staff is acknowledging and respecting residents’ right to make their own choices and to maintain as much control over their daily lives as possible. These issues of control become even more important when choices are needed regarding treatment decisions at the end of life.

- **Spiritual well-being**—acknowledges the responsibility of the community itself for supporting the spiritual as well as physical needs of the residents. Whether this involves offering religious services that represent various faiths or a willingness to be open to spiritual and religious beliefs that may not be consistent with one’s own, spirituality is a supremely important aspect of a person’s life and death that should be honored and
respected. If each of these domains could be fully embraced within the community, not only would the end-of-life experience be supported in a more meaningful way but also the day-to-day life experiences of each resident could be enhanced through such caring and respect.

These quality-of-life indicators can be thought of in terms of what John Abbott Worthley so appropriately describes as the “Ethics of the Ordinary,” by which he is referring to the everyday challenges confronted by healthcare practitioners, which, he argues, are as important as the more macro bioethical issues resulting from our advanced technological age and the possibilities these advances have for prolonging life. As was discussed in detail in Chapter 3 of this thesis, Austin concurs with Worthley’s argument in asserting her belief that bioethics today deals too much with theoretical or high profile cases and is therefore too far removed from the everyday ethical issues facing practitioners. In relation to the quality-of-life indicators discussed above, others argue similarly that too much emphasis is being placed on theoretical ethical issues, whereas the more practical issues of needed supplies and addressing staff shortages are being left largely unaddressed. Daniel Callahan offers similar cautions relating to an overly aggressive reliance on technological interventions and offers his opinion that human relationships are often neglected or judged less important in favor of machines and lab results, replacing the needed conversations with the patient. One practical example of this phenomenon can be found in the debate over the appropriate use of artificial nutrition and hydration (ANH) and under what circumstances ANH may be seen as ethically sound. Though decisions about whether ANH is medically necessary must be made individually, the fear of some scholars is that by focusing on the single issue of ANH apart from a broader discussion about the more commonplace ethical issues that surround end-of-life care, stakeholders may delay important
discussions that could improve the quality of life for residents in favor of more ethically complex decisions, such as those concerning the use of ANH.\textsuperscript{24} Though none of these issues should be thought of as being more important than the next, it is likewise true that none should be considered less important. If everyday challenges could be successfully addressed prior to having to confront the complexities that surround the end of life, related decision making could be met with greater trust and ideally a better end-of-life experience for all involved. Additionally, in attempting to isolate the specific issues surrounding end-of-life experiences in the long-term care setting, the next section of this chapter will explore both the historical and cultural aspects of end-of-life decision making and the potential impact of these practices on the experience of moral distress by all those involved in the experience.

2. A Historical Perspective on End-of-life Care—Is There Such a Thing as a Good Death?

It is estimated that each year, 2.5 million people die in the United States, with most dying from progressive health conditions. Since the 1976 landmark case of Karen Ann Quinlan and the resulting changes both legally and culturally regarding a patient’s right of choice and the legal role of a surrogate decision maker, support has grown for establishing both legal and ethical rights to decisions regarding one’s own care in terms of who may be designated to make those decisions, should one become incapacitated.\textsuperscript{25} Whereas at one time in our history, one’s death was a very personal and often spiritual experience, more recent efforts to intervene in the dying process, however well intended by either prolonging the dying process or hastening it, might be seen as shifting the focus away from the individual and placing it in the hands of the medical personnel overseeing the care. It has been said that it is “hard to die in America.”\textsuperscript{26} It is interesting to consider that as far back as the 15\textsuperscript{th} century, death was thought to be a ritual
organized by the dying person him or herself: people believed that the individual understood the protocols and exerted a degree of control over the process. How ironic, then, to observe that while the attitudes and customs surrounding the end of life have changed markedly since the 15th century, including changing moral traditions and advances in medical science, we have entered the 21st century where we began centuries ago, with the desire—and perhaps now, the capability—actually to control the dying process. In considering the emotional burden that is placed on healthcare professionals and their duty to patients in terms of end-of-life care, it is helpful to consider the impact of the Hippocratic Oath on the practice of medicine.

It is generally accepted that the Hippocratic Oath was not written by Hippocrates but more likely reflects the thought of the Pythagoreans of the 4th century BC, and that by the end of the first century after Christ, the Hippocratic Oath had become a well-known and referenced document. Of particular significance when discussing the origins of the Hippocratic Oath is the fact that it helped to designate the practice of medicine as a moral enterprise. In positioning medicine thus, it bestows on the practice of medicine and its practitioners a standard and perhaps a set of expectations that may be beyond what men can achieve. If it creates unreasonable expectations, it may in fact be one of the factors that contribute to moral distress for the patient, the family, and the medical professionals who are unable to bring about a so-called good death. In a more positive sense, this adoration of physicians and their work as almost God-like establishes the practice of medicine as sacred in many traditions and highlights the importance that men have placed on the connection between medicine and religion. Religious traditions were very closely tied to the dying process in the period before the Middle Ages and remain so today. This connection between the practice of medicine and the religious beliefs of those near the end of life is further complicated by the lack of a common
understanding concerning what is meant by the sanctity of human life and how that understanding affects decision making at the end of life.

Equally challenging is the fact that today, even death itself requires a specific definition and criteria. The Uniform Determination of Death Act (UDDA) was adopted in 1980 by the National Conference of Commissioners on Uniform State Law in 1980; and though it is not a statute as such, a majority of states now use the UDDA language in their statutes. The original version of the UDDA defined death as follows: “An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards. These criteria were later expanded to specify that a determination of death could be made according to either circulatory and respiratory criteria or neurological criteria. This expanded definition had implications for decisions regarding the transplantation of human organs, as it opened the door for organ transplants from those individuals who, though technically dead, still had organs that could be potentially life-saving to someone in need of transplantation. With these varying definitions come differing notions of exactly how a good death might be defined by specific individuals, given their traditions, culture, and religious or spiritual beliefs. Consequently, care for the person at end of life becomes more complex, and opinions surrounding decisions made regarding the pronouncement of death can in themselves cause moral distress to those who may not be in agreement with the pronouncement of death.

In a 2004 study specifically designed to review the state of end-of-life care in U.S. nursing homes, nine factors were studied that were thought to contribute either to positive end-of-life care or to some degree of dissatisfaction with the care given. These measures were
determined by both qualitative and quantitative measures that included survey results, chart reviews, and analysis of secondary databases as well as interviews, focus groups, case studies, and observations. The nine categories are prognosis and prediction, pain, use of hospice services, hospitalization, advanced care planning, communication, family perceptions of end-of-life care, staff education, and miscellaneous. The significance of these findings for those in organizational leadership positions is the realization that these factors can, to a large extent, be controlled by the organization. Specifically, staff, residents, and family members can become more involved in the decision-making process through education in such areas as hospice education, advance care planning, and patient-centered care. These discussions could include family members with their loved ones and could be accomplished in such a way that residents themselves are as active in participation as their condition allows.

Proven methods of effective communication, such as those discussed in Chapter 5 that include appreciative inquiry and humble inquiry, could be employed to continue to solicit input from both residents and their families concerning what areas they are comfortable with and what areas might be improved upon that would enhance their individual experience at the community. Open communication regarding realistic goals for care can be developed and tailored to the individual needs of both the residents and the family members. If the care team, the residents, and the families collaborate, all who are involved can contribute to the care of the resident and take comfort in the fact that they have each done all that they could to make the end-of-life experience for that resident as meaningful as possible.

In an attempt to provide guidance to healthcare providers and to present benchmarks for providing a degree of context regarding end-of-life care, the Hastings Center has developed the following ethical guidelines that are believed to provide a roadmap to ensure quality care in end-
of-life practices. The ethics goals presented by Hastings are offered with the hope that they will serve as the cornerstone of care at the end of life:

- To relieve suffering
- To respect the experience of living and support the process of dying
- To promote well-being
- To respect persons
- To respect dignity
- To respect relationships
- To respect difference
- To promote equity
- To preserve professional ethical integrity
- To use organizational systems to support good care and ethical practice.

Dr. Ira Byock, a national spokesperson for hospice and palliative care, has come to believe that so-called “good deaths” are not random events or the luck of just a few; rather, they can be understood and fostered so that the goal of a good death can become a reality that all can share. Byock further seeks to differentiate the goal of dying well from what is commonly described as a good death. Though the distinction is subtle, it does help to connect the goals of end-of-life care with practices that can work to ensure that those goals are respected.

3. The Role of Culture in Determining the Quality of End-of-Life Care

The role of culture was reviewed in detail in Chapter 2 of this thesis. The discussion that follows addresses the role that the culture of the organization can play specifically as it relates to end-of-life care within the long-term care setting. Some of the major factors that contribute to
each institution’s culture are thought to include a facility’s size and financial base; its location and architecture; the backgrounds and health status of its patients; the privacy patterns and expectations of residents; the home’s recreational programs and community ties; and the goals, hierarchies, and support systems of its staff. Researchers studying the effects of the environment on end-of-life care have confirmed that an individual’s physical setting can have long-range effects on both the cognitive functioning and physical well-being of residents in nursing homes, including the impact of their desire to participate in social activities.

This fact becomes all the more important as residents and family members are confronted with the realities of end-of-life discussions and the need for privacy and comfortable surroundings as personal matters are attended to. Unfortunately, this is not always what is available to either the resident or the family members. The systems in place for providing end-of-life care have been found to be fragmented and unsustainable, owing largely to the cost and complexity of navigating a system that appears to be riddled with conflict and disagreement. Given the complexity surrounding end-of-life decisions and the propensity for conflict, an ethics of collaboration has been endorsed for addressing the ambiguity that can exist during this time, which may help to prevent issues of moral distress that can result if conflicts are left unattended. Medical conflicts surrounding the end of life serve to make that time even more difficult for surviving family members, a situation that calls for medical providers to become skilled at dispute resolution if they are to successfully address the moral issues that can become so much a part of the dying process. The goal in seeking collaboration in caring for a dying patient is to shift the focus, which has historically been on life-sustaining treatment, to providing comfort and relieving suffering for the patient when appropriate through palliative care. This shift in practice can be regarded as a recognition of the importance of allowing individuals to choose the
treatments they desire and to respect their freedom without imposing excessive burdens on them or their loved ones.\textsuperscript{42} Palliative care, like bioethics itself, seeks above all to respond to the human needs of the patient and his or her particular interests.\textsuperscript{43} In addition, when attempting to understand the moral issues surrounding end-of-life care in connection with attempts to reduce the incidents of moral distress, the use of palliative care helps to broaden existing healthcare discussions that focus on those needs of the patient that are thought to result from demographic changes, the increasing burden of chronic disease, and the desire to improve the overall quality of care being provided.\textsuperscript{44}

It is also interesting to note that research into the potential impediments to quality end-of-life care within the nursing-home setting include, among other institutional barriers, a lack of training in palliative care.\textsuperscript{45} While awareness of the lack of education surrounding palliative care is helpful in attempts to address this shortcoming, this fact also helps to highlight an area where immediate efforts could be made for staff and family education, which could have an immediate positive impact on the end-of-life experience for all involved.

An organization’s willingness to train the staff and its attention thereto can have a highly positive impact on the quality of care given. In building upon the discussions surrounding palliative care at the end of life, a well-trained staff will be attentive to both the physical and emotional signs of pain and will seek remedies to address both. Those who work with individuals in extreme pain have written that in their experience, pain and distress always have both a physical and emotional component, and oftentimes social and spiritual components as well. They suggest that it is a basic tenet of palliative care that the nature of pain is subjective and that the pain is not relieved until the patient says it is relieved.\textsuperscript{46} The culture that is established within the community regarding its desire to educate, support, and model practices
that support all aspects of pain management can serve to demonstrate not only to the staff but also to the patient and the family members that the community is committed to doing all that is within its power to provide the support so much needed during the end-of-life process.

Daniel Callahan has shed light on the difficulties and complexities of end-of-life decision making by asking what appears to be a very simple question: “What is the best balance between control and relinquishment?” Callahan argues that one of the reasons individuals have such difficulty when faced with end-of-life decisions is the fact that missing from our society is any type of shared language or common public view of death. Most cultures, Callahan believes, have had a characteristic view of death that usually includes common public rituals, customary practices, and patterns of acceptable methods for grieving the loss of a loved one. In the absence of such societal standards, individuals are left to seek their own answers to the larger meaning of both life and death, and what once brought comfort to those involved with the end of life seems to generate only more difficult questions, particularly in relation to what the best next steps might be in terms of treatment options and finding the right “balance” between control and “relinquishment.” Given the enormous responsibility placed on those who are personally confronting such decisions or are asked to share in that decision making with someone at the end of life, the need to feel empowered to take on that role in a competent, caring manner becomes critical for all involved.

B. Leadership Empowerment of Caregivers to Address Moral Distress

1. Family, Patients, and Staff—Views of the End of Life

Expanding on the discussion in Section A.2 above, the following section attempts to focus the narrative on the specific views of death and of what might constitute a good death from the perspective of the patient, the family, and the caregivers at the end of life. The different
priorities identified within the research help to explain why an exact definition of what could be called a good death remains highly subjective, based on the individual experiences of those assessing end-of-life care. There are, however, certain recurring concerns expressed by all three of these groups (families, patients, and staff), and it is those concerns that provide the greatest insight into what actions might be taken to improve the quality of the dying experience. In a research study that drew upon patients randomly selected from the National Veterans Affairs Patient Treatment File, family members of VA patients who had died six months to a year prior to the study, physicians, and professional caregivers were selected from membership lists of national professional associations, including the American College of Physicians, American Society of Internal Medicine, National Nurses Association, National Association of Social Workers, Association of Professional Chaplains, and the National Hospice Volunteers; five hundred surveys were sent out to each of the four groups being surveyed (patients, family members, physicians, and other caregivers).

Survey items were developed based on twelve previously conducted focus groups and in-depth interviews with patients, family members, physicians, and other care providers. Participants were asked to provide a definition of a good death and to rate the attributes of a good death on a five-point scale. Though the results from each of the four groups were evaluated separately, the findings that were consistent across all four groups are highlighted for purposes of the current discussion. Each of the four groups identified twenty-six items of mutual importance and concern, broken down into four general categories:

1) Personal care, including symptom relief associated with freedom from pain, freedom from anxiety, freedom from shortness of breath, being kept clean, and having physical touch;
2) Preparation for the end of life, including having financial affairs in order, feeling prepared to die, believing that one’s family is prepared for one’s death, and knowing what to expect about one’s physical condition;

3) Achieving a sense of completion about one’s life, such as saying good-bye to important people, remembering personal accomplishments, and resolving unfinished business;

4) Decisions about treatment preferences, including having treatment preferences in writing and naming someone to make decisions in the event that one cannot, being treated as a whole person, having a physician who knows one as a whole person, presence of close friends and having someone who will listen. Additional items linked to the relationship between healthcare professionals included trusting one’s physician, having a nurse with whom one feels comfortable, knowing that one’s physician is comfortable talking about death and dying and having a physician with whom one can discuss personal fears.51

These findings represent patients and family members within the Veterans Administration system and thus are not necessarily generalizable beyond that cohort. Nonetheless, the findings are consistent with other research seeking to quantify the attributes of a good death as well as to identify shortcomings leading to less than optimal end-of-life care. In a study designed to develop a conceptual model of quality end-of-life care—developed with input from dying patients, their family members, professional guidelines and experts in the field—participants shared their opinion that high quality end-of-life care results when the health care professionals are able to 1) ensure desired physical comfort and emotional support, 2) promote shared decision making, 3) treat the dying person with respect, 4) provide information and emotional support to family members, and 5) coordinate care across settings.52 A third example that supports the previous two research studies is the work of Sara Rosenthal and Maria Clay,
who sought to address the concerns of medical trainees who were experiencing moral distress when involved in end-of-life cases. According to Rosenthal and Clay, the medical students cited eight different areas that they believe were not addressed appropriately by either themselves or their mentors/instructors. These eight are 1) delayed end-of-life discussions, 2) delayed or poor decision making, 3) medically inaccessible or inappropriate care, 4) poor communication during notification of death as determined by neurologic criteria, 5) codes gone bad owing to incorrect code status or their misunderstanding of what a full code actually requires of them, 6) health disparity cases—where end stage diagnosis could be avoided with proper primary care access, 7) patients with psychiatric problems, and 8) grieving family members, oftentimes owing to the death of younger patients and grieving parents.53 The findings of these three studies are significant for the current thesis because they identify commonalities of practices that could, if addressed, improve end-of-life care and in so doing reduce incidents of moral distress for the caregivers, family, and (in some instances) the patients themselves. Ideally, as these issues are addressed, some of the variables known to contribute to incidents of moral distress from certain aspects—like unmet needs of the patient, inability to manage pain and symptoms, and/or simply not having the time to spend with a patient at the end of life owing to chronic staffing shortages—can also be addressed and may consequently reduce the associated issues of moral distress that could result if left unattended.

2. Stewardship, Servant Leadership, and the Sanctity of Human Life

One of the strongest examples of individual empowerment and the responsibility that each individual has towards others is found in the work of Albert Schweitzer, a philosopher, an ordained minister, and a physician. His leadership abilities came not from intentional acts of
desiring to lead but from the very human desire to develop a philosophy of life that could help to improve not only his own life but also the lives of everyone he touched.

Albert Schweitzer expanded on traditional religious definitions of the term sanctity of life in what he termed as “reverence for life,” which he defined as the will of each human being to behave responsively to all living beings.\(^{54}\) As with the role of the servant leader, Schweitzer stressed the responsibility that comes from the fact that in his view, all life is sacred; and he called upon every person to develop his or her own human potential, maintaining further that each person has an obligation to act in accordance with his highest ideals. For Schweitzer, as for Robert Greenleaf, a reverence for life is characterized by each person’s accepting the other and caring and responding to all living beings in recognizing their sacredness.\(^{55}\)

It is interesting to note that while Schweitzer advocated for individual responsibility and stressed the interconnectedness of all individuals, he did not fear advancements in medicine and was known to support them in his work as a physician. What Schweitzer feared in terms of medical advances was the potential lack of ethical and spiritual ideals to guide the development of science and technology, which he believed could prevent these technologies from being used for the highest interests of humanity.\(^{56}\) The beauty in the work of both Schweitzer and Greenleaf is the balance that they both present between the responsibility of the individual and the greater society or on a smaller scale—the balance of responsibility between the individual and the organization in terms of individual empowerment and organizational and/or societal empowerment. In relation to issues of moral distress, this individual empowerment can become reduced when employees do not feel empowered to act in accordance with their highest ideals. As discussed previously, moral distress is thought to occur when individuals are constrained or prevented from making what they
believe to be the right decision or performing the correct action owing to an impediment over which they believe they have no control.57

Marten Hailer and Dietrich Ritschil offer an interesting observation regarding human dignity in suggesting that the concept of human dignity is not inherent within the individual but must be cultivated or developed from interactions with society, from fellow human beings, and, in their opinion, from God.58 One can ask how a regard for human dignity can be cultivated within the healthcare professional/paraprofessional who will be interacting with a dying patient, often on a daily basis. One means is through ongoing ethics education specifically designed to address issues at the end of life. Such education empowers both the caregiver and the organization to continue to improve their offerings and provides an avenue for individual caregivers to improve their skills continually, both personally and professionally level. The following nine guidelines were developed by Hastings Center to reflect what they believe is a professional consensus concerning practices designed to promote sound outcomes in treatment decision-making and in end-of-life care.

Competency 1: To maintain current knowledge of practice recommendations and research findings on life-sustaining treatment and end-of-life interventions. This would be seen as a shared obligation between the organization and the individual practitioner and/or caregiver.

Competency 2: Learn how to integrate pain and symptom management into all treatment plans in all care settings for patients of all ages and into discharge plans.

Competency 3: Learn how to elicit patients’ treatment-related values and preferences, establish and document goals of care, and develop care plans that reflect these preferences.

Competency 4: Learn how to collaborate with patients and surrogates and work with loved ones during treatment discussions and decision-making.
**Competency 5:** Learn how to collaborate with other professionals during treatment discussions and decision-making, in the process of transfer, and in discharge planning.

**Competency 6:** Learn about the common causes of distress experienced by patients, surrogates, loved ones, professionals, and staff in end-of-life care settings, and how distress may affect treatment decision-making and the delivery of care.

**Competency 7:** Learn how disagreements arise in decision-making about life-sustaining treatment in care near the end of life and how to prevent and resolve conflicts with patients, among loved ones, and among professionals.

**Competency 8:** Learn how to recognize legal myths about decisions concerning life-sustaining treatment and end-of-life care and to take responsibility for correcting misinformation.

**Competency 9:** Develop personal capacity for ethical reflection and participate in opportunities to explore ethical concerns in decisions about life-sustaining treatment and care near the end of life.

Each of these competencies shares the common thread of placing the responsibility on healthcare professionals to educate themselves as a means of improving the lives of those they are caring for at the end of life. As healthcare professionals become more skilled and more aware of their unique responsibilities, their compassion and their understanding of the complexities of end-of-life care will be enhanced, and the benefit to both the dying patient and the caregiver will be appreciated by both parties.

3. **Compassion and Suffering at the End of Life—Implications for Caregivers**

It has been said that the relief of suffering is the fundamental goal of medicine. What is less clear, however, is how exactly to do so, given that not all suffering can be relieved despite the physician’s best efforts and high quality care.
Ruth Purtilo and Charles Dougherty write that from a medical perspective, compassion has two key components: “1) it is an ability and a willingness to enter into another’s situation deeply enough to gain knowledge of the person’s experience of suffering; and 2) it is a virtue that is characterized by the desire to alleviate the person’s suffering, or, if that is not possible, to be of support by living through it with them vicariously.” 62 This definition is important to the current discussion of moral distress in that it helps to highlight the enormous emotional impact on the caregiver to assist in providing compassion and care at the end of life by actually entering into that individual’s suffering or by living through the pain vicariously. Considering the statistics noted above—that by the year 2020, 40% of the deaths in the United States will take place in long-term care facilities, combined with the Epsteins’ work in 2007 on developing the crescendo effect model as discussed fully in Chapter 5—the need to provide support to the caregivers for these individuals at perhaps the most vulnerable time in their lives becomes a mandate to all those in leadership positions within organizations. They need to provide the appropriate training, leadership, and empowerment to allow those providing the care to stay emotionally strong, compassionate, and engaged. 63/64

The most significant premise of the crescendo effect, briefly, is that repeated incidents of moral distress over time can lead to a build-up of moral residue, which may result in a breaking point for the individual. Unfortunately for all concerned, this crescendo is sometimes expressed outwardly as a numbing of moral sensitivity on the part of the healthcare practitioner or a withdrawal from involvement in ethically challenging patient situations.65 If healthcare practitioners find it impossible to be fully engaged in the end-of-life experience of their patients, the compassion spoken of by Dougherty and Purtilo is not possible, and the likelihood that moral distress may result for the caregiver is increased. Henri Nouwen offers additional insights into
the emotional toll that compassion can have on individuals in his description of what is truly involved for people to express their compassion towards another. Nouwen believes that “no one can help anyone without entering with his whole person into the painful situation; without taking the risk of becoming hurt, wounded or even destroyed in the process.” Similarly, David Thomasma writes that as a virtue in medicine, compassion is “the capacity to feel, and suffer with, the sick person, to experience something of the predicament of illness, its fears, anxieties, temptations, its assault on the whole person, the loss of freedom and dignity, the utter vulnerability, and the alienation every illness produces or portends… compassion, therefore, entails not just feeling for others, but acting for others.” Finally, James Marcum speaks of his belief that the root of compassion “resides in our humanity, the awareness that misfortune may befall anyone at any time. For a physician or other health care provider, compassion is as necessary for clinical practice as medical competency.”

Generally it is considered normal for those at the end of life, their loved ones, and the health care professionals and paraprofessionals who have become close to them to experience strong and frequently changing emotions. While these fluctuations in emotions can be disconcerting to those who care about the patient, insight into the possible causes of these highs and lows can be very helpful in understanding and appropriately addressing them. One factor to consider is the role that existential suffering may play in these emotional fluctuations. Though there is no exact definition of the term existential suffering, the term is thought to describe suffering that is not relieved by the treatment of physiological systems or that occurs in the absence of such symptoms. For the individual facing end of life, possible sources of existential suffering might include such issues as facing their fear of death, fear of pain, profound loneliness, and a loss of meaning.
Eric Cassell has a unique view of suffering and what he believes is the role of the physician in helping to address such suffering for their patients. Cassell effectively seeks to address any concern on the part of the medical professional about becoming too involved or too attached to their patients for fear of the emotional cost to them as a result of the relationship. Cassell argues that the more physicians open themselves to their patients and the less concerned they are about preserving themselves from the emotional toll this relationship may take on them, the greater the reward for the physician and the less emotional stress they will experience.71 From the viewpoint of attempting to reduce incidents of moral distress as a result of the emotional toll that involvement with patients at the end of life can cause, Cassell’s experience and arguments in favor of the caregiver’s totally embracing the patient and developing a relationship rather than pulling away as a means of self-preservation is encouraging for both the patient and the caregiver.

The value of the relationship in terms of learning important information in order to treat the patient better cannot be overestimated. Cassell suggests that the information that is gained from this relationship is sometimes called the “law of soft facts.” A focus on hard facts only (such as lab results or life expectancy) can overshadow the information that can be gained from learning about the person, their values, and goals for care, and their fears may be overlooked. This information, argues Cassell, can be more important for addressing the suffering of the patient than other more conventional means.72 Each person suffers in a unique way and consequently dies in a manner that is specific to his or her personal journey.73 The more the caregivers and those close to the patient understand their concerns, the more they can address them and share in this last journey.
C. Methods of Effective Communication in Providing End-of-life Care While Addressing Concerns to Reduce Moral Distress

Information from the 2013 “Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life” lends support to the premise of this thesis. In this document, the authors acknowledge that working with individuals and their loved ones in determining end-of-life care requires strong communication and collaboration with the patient, the family, and others whom the patient wants to be involved in such discussions. The authors point out that successful collaborations are often enhanced by the availability of hospice services within the environment where the patient is currently receiving care, the resources available, the service amenities, the physical space, and—perhaps most relevant to the current thesis—a culture established within the community which supports strong end-of-life programs and services as well as the presence or absence of strong role models who can demonstrate good practice on a daily basis. This observation by the Hastings Center acknowledges the need to address end-of-life issues systemically and holistically by including not only the patient but also the family, those individuals invited by the patient to participate in discussions regarding their care, and the professionals and paraprofessionals entrusted with providing the appropriate care for their loved one.

1. Methods of Effective Communication at the End of Life: Verbal and Non-Verbal

One of the most significant aspects of communication at the end of life is the sensitivity required to communicate effectively with the dying person by non-verbal as well as verbal means. Though the need to determine what a dying person is attempting to communicate can place a burden on those attempting to understand and may in fact lead to misunderstandings, the need to be present and to participate fully through active
listening can more often provide reassurance and allow patients to feel they are being heard. A belief expressed by those in the medical profession regarding the special relationship that can exist between physicians and their patients relates to the healing function of language. Listening fully to the dying patient is regarded as important as talking. One method of communication proposed as a means of understanding non-verbal communications is termed symbolic communication. Symbolic communication is characterized by four key principles:

1) That communication is literal and symbolic and that all communication is expressed through multiple modalities. 2) The symbolic messages convey legitimate information in much the same way as information conveyed through normal language. 3) The symbolic messages may come from the unconscious and may express things that the individual is not consciously aware of or is not able to express verbally. 4) Symbolic messages may bypass conscious censorship and may operate independently from what one’s conscious mind may speak.

An appreciation of symbolic communication requires the listener to focus on multiple sources of data, including sights, sounds, feelings, and movement, and to be prepared to process the data in both a literal and symbolic framework. Although Marshak used the term symbolic communication in relation to interpersonal communication within a work environment, its applicability to the need to understand the non-verbal communications that may provide insights into end-of-life communications appears equally beneficial. It is important to note that interest in communication beyond the spoken word is not a new phenomenon. In 1967, Albert Mehrabian isolated three elements of communication thought to play a role in conveying feeling and attitudes to one another in face-to-face encounters: words, tone of voice, and non-verbal behavior, such as facial expressions and eye contact. Generally, the relative strength that people
assign to each of these three elements is 7% to words, 38% to tone of voice and 55% to non-verbal behaviors. Of particular significance to the current discussion is the fact that in situations where these three elements are not perceived as working in support of one another, non-verbal communication is thought to outweigh the importance placed on words by 100%.\textsuperscript{80} In situations where the dying patient may not be able to communicate in any way other than through non-verbal means, the importance placed on their ability to communicate in a manner other than verbally becomes all the more critical. The ability of the family, those close to the patient, and medical professionals to look for messages in these symbolic, non-verbal communications will improve the end-of-life experience for all involved and have the added benefit of helping to reduce the moral distress that may have resulted from unresolved issues that could not be effectively communicated. Effective communication skills form the foundation of being able to advocate both personally and professionally and permit one to honor one’s own values or moral code as well as the values and moral code of the organization.\textsuperscript{81}

2. Organizational Systems Supporting End-of-life Care

As discussed above, the role of the leader in establishing and modeling a culture that supports strong end-of-life practices should be evident throughout the organization in its policies and practices. By extension, the leader is then responsible to ensure that policies form the basis for integrating these practices throughout the organization or, in effect, to systematize them across all departments. The systems within an organization thought to have the most influence in supporting end-of-life care are the following: patient safety, information technology, health communication directed to patients and the public, and quality improvement.\textsuperscript{82} Though the systems that support patient safety are applicable to all levels of care, individuals at the end of life exhibit greater risks and possible harms in several specific areas. These include the possibility of
increased medication errors as medications change based on a progressive medical condition, nosocomial infections, the progressive impact of co-morbidities, errors associated with miscommunication among the caregivers (both professional and support staff), and the possibility of increased falls and respiratory infections. Information technology, when properly employed, can be used to provide updated information, which can be entered into the medical record at the bedside, in a timely manner to all departments who are working with the patient. This ability helps to ensure that accurate information is in the record at all times and that any changes in medications or treatments are noted at the time the order is changed. Health communication directed to patients and the public can serve to inform the public about the organization’s policies that are related to end-of-life care. The organization’s website can be used for this purpose in the form of a question-and-answer format with this information also being used to support decision making. Continuous quality improvement efforts relating to end-of-life processes are an essential component of ongoing efforts to improve end-of-life care. By systematically seeking input from patients, family members, and staff regarding how each view the way end-of-life care is being addressed throughout the organization, corrective measures can be taken to address any known shortfalls, and ideally issues that have the potential of eliciting moral distress will be greatly reduced.

A second important factor supporting a systems theory of organization is the relationship of the role of communication to systems theory. One of the main features of systems theory is that the organization is thought to be defined not by the characteristics of each individual component or department, but rather by how those components/departments are structured as well as the patterns of interaction and interdependence that exist among them. Because of this interrelationship, the system can be viewed as more than the sum of its parts and is defined as a
totality, often referred to as being defined holistically. As may be recalled from Chapter 5, when considering such interrelationships from a systems perspective, two methodologies have been offered to explain these connections; critical systems thinking (CST), also known as creative holism, and total systems intervention. When confronting areas of weakness or areas thought to need improvements, such as providing quality end-of-life care, calling on a systems approach—such as creative holism and/or critical systems thinking—allows the organization to seek corrective actions that address these interdependencies and in so doing, to address each subsystem of the organization as well. Communication has an important role in systems theory, wherein it is thought to be a “systems binder,” which is regarded as indispensable for the survival and growth of any organization.

A systems approach requires that the system be looked at and analyzed as a whole and forces the leader to acknowledge that if any one aspect of the system is changed in any way, the system itself has been changed and must be assessed to determine exactly what the impact of that change might be on all of the interrelated sub-systems. Though this is a fine point, the freedom of thought that the leader can bring to addressing issues from a systems perspective, serves to distinguish systems that are designed to serve perhaps one specific purpose from those that require the deliberate choices of human beings and must be evaluated to determine patterns and connections between seemingly isolated events.

3. Implementation of Positive Organizational Programs Designed to Reduce Moral Distress In End-Of-Life Care

Just as lessons can be learned from improving the quality of life in the nursing home, which can be shown also to improve end-of-life practices, programs designed to reduce moral distress across the organization can be shown to have particular benefits in also improving end-
of-life care. In their work with medical students in academic medical centers who were expressing concerns over their own experiences of moral distress when addressing end-of-life decision making with their patients, Rosenthal and Clay identified the following organizational programs believed to address/reduce their moral distress: Clinical Ethics Consultation Service, Preventative Ethics Rounding in Targeted Areas, Moral Distress Debriefings, Schwartz Center Rounds and Medical Education Initiatives.\textsuperscript{90} Significant to the current thesis is the fact that these organizational programs parallel those identified with interventions specifically targeted to address moral distress on a system-wide basis, which are discussed earlier in this thesis.

By way of providing the connection between measures taken to improve end-of-life care and to address and ideally prevent concerns for moral distress, the following organizational measures have been found to improve the outcomes for both measures:

Schwartz Center Rounds: developed by the Schwartz Center for Compassionate Care in Boston, MA, the rounds provide an opportunity for healthcare providers to meet at a regularly scheduled time to discuss the social and emotional issues they are experiencing in caring for their patients. The goal of the Schwartz Center is to promote compassionate care that allows patients and their caregivers to relate to one another in a manner that provides hope to the patient and support to the caregiver.\textsuperscript{91} The evidence that these rounds are embraced on a system-wide basis is found in the openness with which the administration accepts feedback on possible errors in judging in a specific course of treatment; empowerment of employees, which is evident in the open sharing of information, and the common goals that are achieved through open dialogue; and an ongoing belief that care can be improved and stress reduced if everyone is able to participate, offer their insights and concerns, and learn from both the positive and negative experiences of providing care.\textsuperscript{92}
A second example that supports Rosenthal and Clay’s observations is found in work first developed and implemented at Virginia Commonwealth University Hospital, which is called the Moral Distress Consult Service (MDCS). The MDCS functions in much the same way as the ethics consultation services but differs in that it focuses solely on issues that have resulted in morally distressed staff versus ethics consultation, which generally focuses on addressing ethical dilemmas resulting from clinical cases.  

A third system-wide approach that is designed to be proactive in identifying and preventing moral distress was developed by the American Association of Critical Care Nurses; it is called the 4 A’s (ask, affirm, assess and act). The 4 A’s places the initial responsibility on healthcare practitioners for determining whether or not a given set of circumstances may cause moral distress. The 4 A’s method generally highlights the importance of empowerment as a tool to address moral distress by leaving assessment of the degree of moral distress up to the judgment of the individual experiencing it. This approach places the responsibility of addressing that distress on individuals as well, requiring them to act to address it.  

Consistent with the approach of the 4 A’s is the research of Pijl-Zieber et al., specifically that related to proactive measures for nurses working in long-term care. Based on a review of the literature, Pijl-Zieber et al. have suggested that educating nursing students in recognizing ethical issues, which constitute a large part of providing care, should be addressed in the context of their nursing education and that the identification of moral distress be included in this awareness. With this education and individual empowerment, nurses will learn to develop individual coping strategies, along with a peer group support system similar to that referenced above at Virginia Commonwealth University, and will be empowered to work with the administration to develop policies on best practices, improve communication systems, and improve interdisciplinary collaboration. Each
of these strategies, whether taken alone or as part of an overall educational program focusing on efforts to reduce moral distress and improve care at the end of life will serve to increase awareness of the issues surrounding the complexity of end-of-life decision making and will provide the needed education and resources to the caregivers, who are critical to helping to achieve a quality end-of-life experience for all those involved: the patient, the family, the caregivers, and others who are close to the patient.

D. Conclusion

Considering the three main areas concentrated upon in this dissertation—culture, leadership, and communication—has clarified that the ethical issues thought to lead to moral distress cannot be separated from the organizational and social settings in which they arise. These ethical issues, such as those surrounding end-of-life care, should not be viewed as isolated failures of the systems in which they function but as failures of those systems to properly support these functions in an integrated holistic manner.\(^98\) It is useful here to recall the words of Elizabeth Kubler-Ross discussed earlier in the chapter: if we could “remember to treat the living well, we wouldn’t need to remember the rights of the dying; we would meet their needs naturally.”\(^99\)

The old and those who care for them can teach us about ourselves if we are willing to listen to them, to consider their questions, and—when necessary—to respect their silence. They show us that the purposes and passions that people live with, the service or the work they perform for others, and the memories they hold to as proof of having lived are among the ends of time that unite us all.\(^100\)

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27. Philippe Aries, Western Attitudes Towards Death from the Middle Ages to the Present (Baltimore: John Hopkins University Press, 1974), 11.
45 Haiden Huskamp, Christine Kaufmann, and David Stevenson, “The Intersection of Long-Term Care and End of Life Care,” Medical Care Research and Review 69 (2012): 37–38.
49 Karen Steinhauser, Nicholas Christakis, Elizabeth Clipp, Maya Nc Meilly, Lauren McIntyre, and James Tulsky, “Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers,” Journal of the American Medical Association 284, no. 19 (November 15, 2000): 2476.
50 Karen Steinhauser, Nicholas Christakis, Elizabeth Clipp, Maya Nc Meilly, Lauren McIntyre, and James Tulsky, “Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers,” Journal of the American Medical Association 284, no. 19 (November 15, 2000): 2476–2477.
51 Karen Steinhauser, Nicholas Christakis, Elizabeth Clipp, Maya Nc Meilly, Lauren McIntyre, and James Tulsky, “Factors Considered Important at the End of Life by Patients, Family, Physicians, and Other Care Providers,” Journal of the American Medical Association 284, no. 19 (November 15, 2000): 2476–2480.
52 Joan Teno, Brian Clarridge, Virginia Casey, Lisa Welch, Terrie Wette, Renee Shield, and Vincent Mor, “Family Perspectives on End-of-Life Care at the Last Place of Care,” Journal of the American Medical Association 291, no. 1 (January 7, 2004): 88–89.
Chapter 8: Conclusion

If there is one thought that could be said to express the premise of the previous seven chapters and to provide an ethical justification for the current thesis, it is Peter Senge’s description of the systems within organizations as being “bound by invisible fabrics of interrelated actions.” The invisible fabrics referred to in this thesis are the culture, the leadership, and the methods of communication used in the organization and their individual and collective impact on helping to reduce incidents of moral distress across the organization.

In demonstrating why a systems approach is the most comprehensive and most successful intervention for helping to reduce incidents of moral distress within long-term care, it is important to understand the evolution of perspectives on the causes of moral distress since Andrew Jameton first introduced the term “moral distress” in 1984. Because the experience of moral distress has historically been attributed to individual responses to certain stressors, initial research into the causes of and possible remedies for moral distress focused almost entirely on the individual. More recent research has expanded to include the interrelationship of individuals with their organizations, seeking interventions that include both individuals and their organizations.

The significance of this expanded view has been twofold. First, it has allowed a broadening of the research to include the long-term care environment as opposed to the historical view that focused primarily on the acute-care setting. Compared to acute care, the long-term care setting has provided a unique, somewhat more controlled environment in which to evaluate the effectiveness of a systems approach to addressing moral distress. This expanded view has provided a framework that balances the responsibility of the organization with the needs of the individuals in confronting and reducing incidents of moral distress. Second, this perspective of
divided responsibility between the individual and the organization has, in turn, made it possible to examine systems within an organization that might contribute to moral distress, as well as the possible changes to those systems that might be useful for addressing the distress.

Systems thinking challenges the healthcare team to seek to understand the connections that exist within an organization and to expand their knowledge as a result of these interconnections. Systems thinking allows one to see beyond what may initially appear to be isolated or independent incidents. These interconnections allow the leadership of the organization to understand events better and therefore be in a position to influence them. In applying a systems approach to moral distress within long-term care, three specific components of the organization were identified as playing a significant role in defining it, and it was demonstrated that when used effectively and purposefully, these components may help to reduce moral distress across an organization. Two systems methodologies were reviewed. The first was critical systems thinking (CST), also known as creative holism and total systems interventions. When confronting weaknesses or inefficiencies within the organization, creative holism seeks to study the whole organization rather than focusing on individual parts, and in so doing, seeks remedies for addressing interdependencies and takes corrective action at each level and within each subsystem of the organization. Creative holism and total systems intervention both provide a framework for addressing moral distress across an entire organization by recognizing the potential interconnections that can lead to distress and consequently providing system-wide interventions for reducing it. One of the most important arguments in the current thesis is that to address issues of moral distress effectively within a long-term care setting, the leader must seek to understand all of the factors that may influence moral distress both individually and organizationally. The current study has sought to highlight the three main
aspects of an organization—culture, leadership, and methods of communication—and their impact on experiences of moral distress, and the underlying premise of the thesis supports the theories above in seeking a holistic assessment of all factors that may influence such distress.

Though each of the three main aspects referred to above were found to play a key role in supporting policies and programs that could positively affect efforts to reduce moral distress across the organization, none was determined to be solely effective in the absence of the other two. Organizational culture has been defined as that which develops around a set of mutually agreed-upon standards and practices. Over time, these practices come to define the organization and exert a degree of control over those working in the organization in terms of acceptable and unacceptable behaviors. If one agrees with the premise that organizations do develop a culture that comes to define both the organization itself and the individuals who work there, it follows that the organization also shares responsibility with its workforce to operate in an ethical manner. It is this shared responsibility that helps to substantiate the premise of the current thesis, which seeks to demonstrate that both the causes of and reductions in the incidents of moral distress should be viewed as a shared responsibility between the individual and the organization, and that such incidents can be shaped by the established organizational culture.

In applying a systems approach to moral distress in long-term care, the role of the leader and of the leadership practices within the organization are recognized as a key component in establishing the desired culture in addition to establishing effective methods of communication within that culture. The leadership of the organization is critical to establishing a culture in which ongoing learning is supported and rewarded and wherein the leader accepts responsibility for modeling the behavior desired in the employees. Research indicates that only those organizations that learn how to identify employees who are both committed to the organization
and possess a strong desire for continuous learning will be truly successful in the future. The significance of the importance of the learning culture is perhaps best understood by the words used to describe it as “characterized by openness, freedom of expression, and a focused curiosity in which learning becomes practices as both a central value and a core competency.” These aspects of the culture and of the leadership that supports it are critical to the ability to develop an empowered workforce in which psychological safety will be insured. It is important to recognize that the culture of the organization comes not only to define its core values but also to influence and ultimately define the values of the individuals who work there; thus, organizational culture can be regarded as one of the three main aspects that can influence a reduction in the experience of moral distress within the organization.

Two important concepts have been reviewed here that relate to the importance of understanding why not all methods of communication are perceived in the same way by the individual receiving the information. These concepts are reflected in the work of Glaser and her research team about “reality gaps” and Senge’s work on “mental models.” In the case of reality gaps, Glaser stresses the impact of life experiences, culture, educational backgrounds, and family upbringing on our perceptions and, hence, on our defining our own reality. Mental models, according to Senge, are deeply ingrained assumptions about the world that influence how we interpret the world around us. These assumptions may be conscious or unconscious, but the impact on how we process information and how one responds are now readily accepted as playing a significant role in our communications with one another. The work with both reality gaps and mental models gives credence to the main difficulty that has made the study of moral distress so problematic over the years, which is how individuals can interpret the same information or the same practices from a totally different perspective, and how, as a result, the
experience of moral distress can be individualized unless confronted systemically and purposefully throughout the organization.

Finally, this thesis has explored the important role that an empowered workforce can have when working in conjunction with an organization whose mission, vision, and values are aligned with their culture, their leadership, and their methods of communication in positively affecting the issue of moral distress across the organization. Because moral distress is now known to be an experience of the individual versus an experience of the situation, methods of addressing the distress must be sufficiently broad to include interventions on several different levels, both for the individual and the institution. One of the most insightful descriptions of leadership requirements in today’s world has been provided by Stephen Covey, who suggests that leaders of today are moving away from attempting to lead from the outside to leading by inspiring others to look within themselves and to help to develop what is best within each individual.14

The final answer to how incidents of moral distress can best be addressed on a system-wide basis within long-term care may be the one Dr. Ira Byock provided when asked how to explain his belief that pain and other symptoms causing physical distress at the end of life can be alleviated, even when they are severe. He replied, “One patient, one person at a time.”15

Bibliography


Crouter, B. J. “The AMA Code of Medical Ethics’ Opinions Related to Moral Distress.” *AMA Journal of Ethics* 19, no. 6 (June 2017): 564–567.


Joinson, C. “Coping with Compassion Fatigue.” *Nursing* 22 (1992): 116, 118–9, 120.


Kennedy, Bernice Roberts. “Stress and Burnout of Nursing Staff Working with Geriatric Clients in Long-Term Care.” Journal of Nursing Scholarship 37, no. 4 (2005): 381–382.


Steinhauser, Karen, Nicholas Christakis, Elizabeth Clap, Maya McMeilly, Lauren McIntyre, and James Tomsky. “Factors Considered Important at the End of Life by Patients, family, Physicians, and Other Care Providers.” *Journal of the American Medical Association* 284, no. 19 (November 15, 2000): 2476–2482.


