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CASE STUDIES

It Is Not Your Fault: Suggestions for Building Ethical Capacity in Individuals Through Structural Reform to Health Care Organisations

Comment on "Moral Distress in Uninsured Health Care" by Anita Nivens and Janet Buelow

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Moral distress is known to cause skilled nurses to exit the profession (Schluter et al. 2008), resulting in less-than-optimal patient outcomes (Aiken et al. 2002). For the case presented by Nivens and Buelow (2013), two broad responses are required. First, management should recognise this field of nursing may cause moral distress. This has implications both for nurse and patient safety. A timely and focussed review or implementation of structures to support staff to maintain moral momentum is required. Second, all nurses need to recognise that moral distress is an occupational hazard and accept support and training in managing the ethical implications of these very difficult cases.

We will now explore these recommendations in detail. Health care managers have a clear responsibility to keep their staff safe. This is both an ethical obligation and in some practice environments legally mandated.[1] While concern should be for staff members, the logic of staff safety as requisite for patient safety has been acknowledged (Sinnott and Shaban 2011). Much work has been done to improve staff safety in the physical sense. Yet safeguarding the moral health of nurses who are repeatedly exposed to traumatic and difficult cases, where their best response will be constrained by circumstances beyond their control, is only recently gaining recognition. This is despite a well-established literature on moral distress and the related concepts of compassion fatigue in nursing, stretching across several decades (Jameton 1977).

Recognition of the moral impact of particular forms of health care work leads to managerial responsibility for creating and sustaining ethical work environments that

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[1] For comprehensive legislative requirements in Australia see "Safe Work Australia" (www.safeworkaustralia.gov.au).

support the ethical safety of staff as well as their physical well-being. Structural elements can be introduced into the work environment that develop and sustain ethical resilience in staff members. These include promoting and scheduling regular case review for debriefing (van Soeren and Miles 2003), establishing peer supervision (Begat, Ellefsen, and Severinsson 2005), monitoring the case-mix for individual clinicians (Rice et al. 2008), and tracking and treating levels of moral distress and compassion fatigue amongst staff (Luquette 2005). Hiring a clinical ethicist to build ethical capacity within the organisation also has been recommended (Bell and Breslin 2008).

These managerial interventions are visible markers of support for clinicians to help navigate and manage the moral distress associated with many fields of nursing practice. More nuanced and complex is the work required by nurses to actually use the services provided; to overcome what has been identified in other domains of the staff safety literature as a "self-blame culture" amongst health workers (Sinnott and Shaban 2011). This type of behaviour occurs where clinicians "self-blame" based on the cultural perception of risk. That is, they know these situations are difficult, but they feel they should be able to cope. When they fail to do so, they attribute the fault to themselves. This requires, as Wakefield (2000) argues, a "relentless approach to self-care" to enable nurses to reconcile their limitations and obligations. Heroic measures are frequently demanded from all clinicians, including nurses, who willingly oblige by negotiating a plethora of emotional and physical barriers to provide excellent care. Ultimately, however, unless systematic structures are not only established but also accessed by nurses exposed to these morally challenging environments, the wellspring of compassion runs dry—causing poor outcomes for staff and ultimately patients.

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