Moral Distress: Coping with Ethical Challenges In OT Practice

Introduction

Ethics in healthcare is a fundamental topic for providers to be educated on. While many aspects of ethics – both in rehabilitation, healthcare as a whole, and in a general sense – do not change, ethics tends to be a nuanced topic. This is partially because ethical scenarios do not always have an obvious solution. At times, providers may even find that many possible courses of action are associated with their unique drawbacks. For this reason, ethics and moral distress are closely related. Both moral distress and ethics are influenced by organizations, payors, societal trends, and more. However, some practitioners may not be aware of the difference between these concepts and how they apply (independently and jointly) to the field of occupational therapy. Yet, therapists should know the distinction between ethics and moral distress since they both influence clinical decision-making on all levels.

Section 1: Defining and Understanding Moral Distress

References: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11

To understand what moral distress is, therapists must know what falls under the heading of ethics. Ethics refers to a set of moral principles that impact someone's behaviors and the activities they engage in. Moral distress, on the other hand, is an emotional response that a person has when they are placed in a difficult situation or faced with unethical behavior in their environment. While moral distress is primarily focused on the emotional response such dilemmas evoke, some organizations also include other stress responses (such as those that are spiritual, social, physical, and psychological in nature) in its definition. However, the widely accepted definition is that moral distress is an emotional response to ethical quandaries. Most evidence classifies the other stress responses as secondary or indirect effects of moral distress or, in some cases, long-term effects of someone experiencing moral distress.

Someone's sense of right and wrong can cause them to undergo moral distress if there are discrepancies between their code of ethics and the morals of individuals around them. Moral distress stems from a person's inability to act in a morally correct manner when faced with difficult situations. This may occur due to a variety of external and internal factors, which we will discuss later.

There are various stances on moral distress. One researcher suggests moral distress in healthcare providers is an especially nuanced concept that should be weighed in terms of fittingness and fairness. Providers may take instances of moral distress in their workplace harder due to perceived wrongdoing to their patients while lay persons may view clinicians' roles as difficult and react in a more understanding manner. Since many instances of moral distress are unavoidable, this researcher notes that judging the provider for their reaction in a professional situation is simply unfair. While this is a blanket statement and - ultimately - one person's opinion, it offers providers some food for thought as they further explore this topic.

Moral Distress Theory

Since moral distress has been a growing problem in certain industries, nursing researchers (chiefly Andrew Jameton) have worked to name concerns related to moral distress as moral distress theory, or the conceptualization of moral distress. After years of research on the topic, publications have identified two main theoretical models of moral distress. The first is a collection of moral residues, which stems from the accumulated effect of various negative scenarios over time. Moral residue is what someone brings with them moving forward after not resolving their moral distress. This may be any negative trace, including a sense of failure, internalized feelings of humiliation, and the remnants of incorrect procedures in the workplace. This collection of moral residues is most likely to develop when someone does not take care to internally remedy the moral distress they are experiencing. With each instance of moral distress, the residues increase

and eventually influence a provider's psyche. Each moral distress will leave someone with a different-sized residue, and these residues do not always stack in a linear fashion. Some researchers have suggested terming this 'the crescendo effect' since the moral residues not only grow in size, but also in effect and intensity.

The second theoretical model of moral distress is considered the model of progress and potential consequences of moral distress. This model describes someone who repeatedly experiences moral distress and continually deals with the consequences of this distress. The progress and potential consequences of moral distress are dependent on two main factors: internal determinants and external determinants. Internal determinants are factors specific to the person, and have both sociological and psychological components. Sociological determinants include dissatisfaction with one's job because, while the job itself is external to the person, the dissatisfaction someone feels stems from within. Psychological determinants moreso pertain to someone's personality and individual responses to moral distress. This includes someone's values, skills, knowledge, moral integrity, the level of experience they have with any given situation, and similar factors. There are four major external determinants: specific decision-making situations, colleagues, the healthcare facility involved and how it's being managed, and the socio-political and cultural specifics of the country. There are many components within both internal and external determinants, and they will be elaborated upon later when we discuss the causes of moral distress.

Moral Distress in Your Practice

One of the best ways to understand moral distress is to relate it to your own practice. In order to start the discovery process, think of a situation in your professional life that caused you to feel significantly uneasy and anxious. Since we are discussing moral distress, remember these emotions must stem from a major conflict between your values and your actions. This occurs due to a misalignment

in your values and the values of those around you (either an entire organization or individuals). Moral distress is not an emotional response to the actions of others, rather it is conflicting because the discomfort comes from your own actions. To select a scenario to learn from, start by asking yourself some of the following questions:

- Is there a time when you were asked to do something in a work environment that you felt was wrong?
- Have you ever been asked to avoid doing something you knew was right?
- When thinking of situations that meet the above criteria, did you feel professionally and personally accountable for a patient's welfare as a result of your actions?
- Has there been an instance where you were emotionally distressed by the choices you were making in your work setting?
    - Providers experiencing moral distress may initially grapple with emotions such as hopelessness, isolation, frustration, anger, and possibly even suicidality. Therapists' self-esteem, job satisfaction, level of empowerment, and productivity may also suffer due to emotions like feeling unimportant, belittled, or unintelligent.
- Have you considered leaving your place of work as a result of the aforementioned scenarios?
- Have situations like this or similar cases made you contemplate leaving the field of occupational therapy?

As we progress through this course, keep in mind the scenario that you have identified as being morally distressing. Also take some time to recollect how you responded to that situation, and other similar situations, in the past. Use the course content to help you work through the problem and reflect on ways to improve your mindset, actions, and more.

Types of Moral Distress

The American Medical Association (AMA) and the Cleveland Clinic have proposed outlining multiple types of moral distress in an effort to better understand the concept. In order to emphasize each type of moral distress, let's use an example to illustrate the meaning of each. Women's rights, specifically women's reproductive rights, are being talked about more and more. This topic is the center of many political and ethical debates and, as such, serves as a great stepping stone to learn more about moral distress. Let's say a pelvic floor therapist is instructed by their supervisor to counsel a patient on abortion, including the procedure (or medication) itself, side effects, and long-term impact. If the therapist in this situation is staunchly pro-life, various outcomes of the situation can lead to moral distress.

One of the first types of moral distress is **moral-constraint distress**, which is considered the narrow definition of moral distress and the more widely accepted definition. Moral constraints are viewed as such because they limit a provider's moral distress to one major challenge or barrier that prevents them from acting in the way they wish to. When thinking of the scenario posed earlier, an example of moral-constraint distress involves the therapist's supervisor telling them not to express their beliefs on abortion - either to the supervisor or the patient - when providing the education as instructed.

The broader version of moral distress is referred to as **moral-uncertainty distress**. Moral uncertainty distress arises less from actions and more from difficulty with internally processing a certain situation. Moral uncertainty stems from a provider attempting to develop a plan for a certain patient or scenario, but having difficulty finding a clear and/or proper solution for it. Individuals with moral uncertainty will eventually make their mind up about a situation, but they often struggle to believe their choice is the right one throughout the decision-making process. Moral-uncertainty distress may enter the picture in the aforementioned example if the patient confides to the therapist why she is considering an abortion. If the

patient's reasoning makes the therapist reconsider or feel unsure about her current belief (that abortion is morally wrong), this is an example of moral-uncertainty distress because the therapist would be uncomfortable with the unease that results from this change.

Another type of ethical quandary is **moral-conflict distress.** Individuals with moral-conflict distress will openly engage in a dialogue with others (often disagreeing with the other person's stance) in an attempt to express what they believe is right. If the therapist experienced moral-conflict distress, they would express to their supervisor that they believe abortion is morally wrong and they choose not to have any part in the process - even if it means educating someone about it and not taking part in the procedure. If the therapist's supervisor is pro-choice and disagrees with the beliefs the therapist is expressing, they might engage in conflict over the situation. This may not be the most professional outcome, but it is a possible next step if the therapist is experiencing other types of moral distress (such as moral uncertainty or moral constraint).

Unlike moral conflict, **moral-dilemma distress** is another type of moral distress that is reflected in a person's internal emotions. Individuals experiencing distress from a moral dilemma often feel remorse and guilt. Remorse is present because the person fears they may have done something that hurt another person, emotionally or otherwise. Regret does not play much of a part here, since that involves someone wishing they did not receive punishment for their actions. An important aspect of moral-dilemma distress is that these emotions arise after someone makes a decision, because the distress comes from not knowing if they did the right thing. If the therapist in our example situation eventually moves forward with the process and decides to educate the patient on abortion, they may experience moral-dilemma distress in the form of guilt. The guilt may partly be due to acting in a way that did not align with their beliefs, and the guilt may also be attributed to not knowing whether they acted in the best interest of the patient or not.

The last form of moral distress is **moral-tension distress**, which occurs when someone feels uneasy about a morally-charged situation, but they cannot share their beliefs with others. Moral-tension distress is an internalized type of moral distress that occurs before someone is expected to act on a situation. When thinking of the situation posed at the start of this section, moral-tension distress may result if the therapist feels they cannot express their beliefs to their supervisor when asked to educate the patient on abortion. This tension can develop when someone feels unrest about something that does not align with their values, but they do not feel able to express their feelings to those around them. This lack of articulating how one feels may come about due to feeling nervous, having a fear of being insubordinate, or lacking communication skills.

Now that you are familiar with the types of moral distress, think back to the personal example that you pinpointed at the beginning of the course. Ask yourself the following questions:

- Can I identify the way I was feeling and acting in my personal example as characteristic of a certain type of moral distress?
- Did I experience more than one type of moral distress related to the same situation?
- Now that I know more about moral distress, can I think of a time when I have experienced other types of moral distress? This may be a different time altogether.

In summary, the various types of moral distress can be thought of as a continuum. While not everyone will experience each type of moral distress in every difficult situation, they will present in a certain order if they do arise. If someone is presented with a difficult situation, they often first experience moral-uncertainty distress, which can cause them to question how they feel based on their personal beliefs. While someone is weighing their beliefs about a situation, certain individuals in their environment may prompt moral-conflict distress where they

openly disagree with someone else's views. Some difficult situations do not come to that, so this type depends on the person's surroundings and relationships. At this stage in the continuum, individuals may experience moral-tension distress in place of moral-conflict distress. This occurs if someone feels like they need to keep their beliefs in rather than being prompted to confront someone about them. When it comes time to respond to the difficult situation, someone may then experience moral-constraint distress if they are held back from acting in the way they wish. If someone does not encounter any barriers that prevent them from engaging in the response they want, they will make the choice they think is right at the time. However, they still may experience moral-dilemma distress if they are later remorseful about the choice they made. It's important to remember that, while many therapists experience types of moral distress in this order, each situation and each person is different.

Concerns with Similar Presentations

Moral distress may look similar to other stress responses, including compassion fatigue, burnout, and even posttraumatic stress disorder (PTSD). However, there are important differences between each of these responses. Compassion fatigue is defined as a decrease in empathy (also known as empathy erosion) that results from being in a demanding caregiver role. Compassion fatigue also pertains to a waning of emotions such as hope and – understandably – compassion. This stress response results in trauma stemming from continually witnessing pain, suffering, or tragedy. Compassion fatigue can pertain to individuals in formal caregiving roles such as geriatric nurses, therapists, and other care workers, but also extends to include informal caregivers such as family members. Individuals with compassion fatigue may be less sensitive to the experiences of others due to a greater focus on one's own thoughts and feelings about the work they do. While individuals with compassion fatigue and moral distress may have similar presentations, emotions associated with compassion fatigue do not stem from a moral dilemma while those associated with moral distress do.

Burnout is another similar concern that may appear to be like moral distress. Burnout is a stress response that is caused by chronic workplace stress. The causes of burnout are multifactorial and are often attributed to a combination of sources, including organizational demands (such as unrealistic productivity standards and workloads or not receiving enough appreciation for one's work), role-specific demands (such as having a lack of control over one's work or not meaningfully connecting with the type of work one is doing), and personality traits (having perfectionist tendencies or possessing rigid thinking). Individuals with burnout experience an array of physical, psychological, and cognitive symptoms based on the burnout stage they are in. In some cases, more severe burnout results if individuals have experienced prolonged stress, but this is not always the case. Burnout symptoms can be classified in three main categories: emotional exhaustion, depersonalization, and a reduced sense of accomplishment. Burnout and moral distress are closely related, since individuals who experience moral distress for extended periods of time may suffer from burnout. However, individuals undergoing moral distress typically experience strong emotions related to the misalignment between their work role and their values, while those with burnout often feel emotionally disconnected from their work due to chronic stress.

PTSD is different from the others in that it's a mental health condition that results from traumatic events. Still, some individuals may confuse severe symptoms of anxiety along with feelings of persistent guilt and fear with the symptoms of this condition. PTSD is characterized by four main symptoms: intrusive thoughts, avoidance of anything that reminds someone of the trauma they experienced, negative emotions related to the trauma and one's self-view, and hypervigilance and other signs of increased arousal. As you can see, this condition is quite significant and can have a major impact on someone's function. While moral distress can lead someone to exhibit many negative emotions and possibly even intrusive thoughts as a result of their actions, moral distress does not typically cause heightened arousal or avoidance, which is what sets it apart from PTSD.

Moral anxiety is perhaps one of the most closely related concepts that may be mistaken for moral distress. Most forms of moral distress stem from the actions someone has already committed or the actions they are expected to perform related to an existing situation. Moral anxiety, on the other hand, involves worry, concern, and possibly even fear of making a decision in a difficult situation that has not happened yet. Since it is in the future, in some cases, moral anxiety may develop about a situation that does not ever happen. For example, someone may have moral anxiety over the possibility that their supervisor will ask them to complete fraudulent documentation and double the amount of sessions they performed on a certain workday. This anxiety may have developed due to hearing stories from other therapists in the department. However, if the supervisor gets caught, willingly or unwillingly leaves their job, or the therapist leaves their job, this moral anxiety will not have the chance to turn into moral distress.

Examples of Moral Distress in Therapy

In the case of healthcare, moral distress primarily focuses on the emotional response to acting in a way that goes against one's professional values, but it can also include engaging in behavior that goes against a provider's values. Therapists, healthcare providers, and other professionals who cannot act as they wish to in the face of moral dilemmas often feel inauthentic and that their integrity has been undermined. Some sources have even referred to moral distress as a 'psychological imbalance' stemming from multiple negative emotions, and it is widely considered to jeopardize a person's core values. While there are a wide range of situations that may cause a practitioner to experience moral distress, here are some examples:

- Providers grappling with their employer's unrealistic expectations to stay up-to-date on rapidly changing protocols

    - This was the case for many healthcare workers during COVID-19 and also is the norm in some workplaces that have frequent changes in administration or other concerns regarding organizational structure

- Creating or reconciling organizational policies that restrict or prevent patients from accessing care
- Preventing families from comforting dying patients due to stringent hospital protocols
- Taking a major risk in regard to one's personal health by treating patients without having the appropriate personal protective gear (PPE)
- Being unable to follow other hospital protocols due to staffing concerns and high patient census
- Failing to exercise care related to the confidentiality of patient medical records or any other documentation that has sensitive patient information
- Using a certain modality on a patient while knowing: (1) it will not be as effective as another modality would, (2) it has the potential to cause an increase in the patient's symptoms, or (3) you are not properly qualified or trained in the use of that modality
- Treating a patient under unethical circumstances:
    - Treating a patient purely to fulfill productivity standards from one's employer
    - Treating a patient due to pressure from one's supervisor
    - Continuing to treat a patient that has met their goals and is no longer in need of a reassessment or therapy of any kind
    - Treating a patient despite lacking experience in their diagnosis, symptoms, or presentation (e.g. continuing to provide individual

services even though the patient proves to benefit from a different medium such as group sessions)

    - Discovering a patient doesn't demonstrate a need for skilled therapy, but treating them anyway
    - Failing to discharge a patient who has met their goals and can no longer benefit from the type of treatment you are providing
    - Providing and billing for unskilled treatment

- Discharging a patient from therapy while still knowing they have deficits that make them a safety concern, a hazard to themselves and/or others, or unable to function in another setting with less assistance
- Treating patients but not providing the best possible care due to a lack of facility resources, including low staff, limited funding, severe time constraints, unrealistic productivity standards, lack of proper treatment space, etc.
    - This may happen in any practice area, such as hospitals, skilled nursing facilities, and even in school-based settings where districts are refusing or unable to enforce a student's IEP and offer the services they are legally entitled to
- Completing billing and/or documentation for patients that you have not even met or for patients who you are familiar with but have not treated at the time you documented for
- Failing to complete documentation in a timely manner, which leads to inaccuracies (intentional or not)
- Performing group therapy with a cohort of patients that are too dissimilar, have differing goals and needs, or with a group that is simply too large

- Not fulfilling the necessary requirements for OT/OTA supervision, either by rushing through required meetings or skipping them altogether
- Blurring the lines between personal and professional boundaries by getting too close with a patient
- Being restricted (by supervisors or the facility as a whole) from completing evaluations and screens to connect patients with services they need
- Having to discharge patients before their time because the decisions was made without occupational therapy input or guidance
- Working at a facility where unlicensed individuals are making occupational therapy-related decisions or completing occupational therapy documentation
    - This most often occurs when facilities have providers with other licenses (such as physical therapy, speech-language pathology, or registered nursing) do documentation that should be completed by an occupational therapist
- Acting inappropriately or disrespectfully toward vulnerable patients who may not be able to advocate for themselves or know the difference
- Working in a facility where staff are engaging in any kind of unethical behavior and practices
- Feeling unable and unwilling to voice your professional opinion due to fear of being deemed insubordinate by supervisors
- Improperly approaching the decision-making process with cognitively-impaired patients
    - Telling patients the truth about certain aspects of their care or coordination is one option that increases their distress and

symptoms, but goes against non-maleficence in making the patients' condition temporarily worse

- Lying to patients about aspects of their care or coordination protects their health status and peace-of-mind, in a way, but goes against veracity since they have a right to be aware of what is happening and involved to the best of their ability

These are some of the most common unethical or morally ambiguous situations occupational therapists experience in the field. However, there are many more instances, some of which are specific to certain practice areas and have distinct or unique causes.

Section 1 Personal Reflection

How often would you say moral distress presents itself in your current work role?

Section 1 Key Words

Ethics - A set of moral principles that impact someone's behaviors and the activities they engage in

Moral anxiety - Worry or fear about ethically difficult decisions one might need to make in the future

Moral-conflict distress - A type of moral distress where an individual speaks with others about what they believe is right or wrong in an attempt to work through their ethical problem

Moral-constraint distress - The most widely known definition of moral distress, which results when someone's ability to act in a difficult situation is limited by one major barrier or challenge that goes against their personal beliefs

Moral-dilemma distress - A more internalized type of moral distress that results when someone feels remorse and guilt about how they acted in a particular situation; remorse stems from not wanting to do another person harm and guilt often develops due to feeling that they acted wrongly; while this type of distress is internal, it comes after someone makes a decision and not before, which is what sets it apart from moral-uncertainty distress

Moral-tension distress - Another internalized type of moral distress where someone feels uneasy about a morally-charged situation, but they cannot share their beliefs with others (for whatever reason)

Moral-uncertainty distress - This is considered the broader definition of moral distress because it does not involve a person's actions, rather it pertains to their internal processing of a morally-charged situation; moral-uncertainty distress can develop when someone attempts to plan their actions in response to a problem but cannot find the best solution

Moral distress - Various uncomfortable emotions that a person experiences when they are placed in a difficult situation; there are several types of moral distress that each differ slightly based on a person's individual response and/or emotions

Personal Protective Equipment (PPE) - Any equipment used to minimize the impact of biological or chemical hazards on a person who is occupationally exposed to them

Psyche - A psychological term that encompasses the conscious and unconscious aspects of the human mind

Section 2: Sources of Moral Distress in Healthcare & Occupational Therapy

References: 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36

There is a growing body of research regarding moral distress, both in the healthcare field as a whole and among certain professionals, including but not limited to therapists. Many studies discuss the causes of moral distress, but others also cover how often it is occurring and the effects it has on patient care as well as provider job satisfaction. In addition, some research takes a look at what type of clinicians may be more likely to experience moral distress as compared to their peers.

Moral Distress in Nursing

Research shows many healthcare professionals experience moral distress in the work they do. Several studies, including Giannetta et al. (2021), Maunder et al. (2023), and others note that nursing professionals in particular experience some of the highest levels of moral distress out of the entire healthcare field. In fact, many experts find the severity and frequency of moral distress in registered nurses to be high and a large risk to their performance and job satisfaction. Different research by Fumis et al. (2017) found that providers who worked in the intensive care unit (ICU) were at a much higher risk of experiencing moral distress. The results of that study showed that ICU clinicians who reported higher levels of moral distress were far more likely to experience burnout.

Moral Distress in Rehabilitation Therapists

Additional research has explored the occurrence of moral distress in rehabilitation therapists. A small study by Howard et al. (2023) showed that the most common problems occupational therapists experienced that led to moral distress involved productivity and clinical decision-making. The same study also found that moral distress was more common in settings that treated adults and geriatrics than it was in other settings. In addition, results showed that both OTs and OTAs experienced moral distress in the field more regularly after the first 5 years of practicing. Another larger study by Bennett et al. (2019) supported these findings,

and found that the healthcare industry's growing emphasis on provider productivity standards is creating more unprofessional practices that are inevitably leading to greater moral distress. Durocher et al. (2021) suggests that moral distress in occupational therapists often highlights how often there are competing allegiances between a provider's values and the values of their clients, colleagues, employers, payors, and regulatory agencies.

Research by Cantu (2019) found that physical therapists in skilled nursing facilities reported experiencing the most moral distress and the lowest perception of the ethical state of their workplace. Cantu posits that these outcomes are similarly common in other therapists (OTs and SLPs) who work in the same setting. PTs in this study cited overutilization of services, stringent productivity standards, and billing or coding issues as the most difficult concerns. Cantu et al. (2021) also published a study on burnout, intent-to-leave, and moral distress in physical therapists across practice settings. Results showed that burnout in PTs was strongly correlated with provider views of their organization's ethics, while a provider's intent-to-leave was moderately correlated with the ethical environment at their workplace. Furthermore, burnout and intent-to-leave were linked to unethical billing and coding policies, productivity standards, and an organization not providing pro bono services.

Protective or Contributing Factors to Moral Distress

A study by Penny et al. (2019) found that additional factors – namely the age of the practitioner, number of years in the profession, and number of years in their current role – played a role in how much moral distress occupational therapists experienced. Therapists who were older and had less experience (both overall and at their present roles) were more likely to report moral distress than their counterparts.

Rivard et al. (2019) conducted a study that found nearly 50% of OTs have considered leaving their positions because of moral distress. This research also

explored the most common causes contributing to this feeling, including not having enough time to properly fulfill one's job roles, having unrealistic expectations placed on them, a lack of quality care in their workplace, and working with insensitive colleagues who do not value work in the same way they do.

Other research by Maffoni et al. (2020) found that support from administration and management as well as having an ethical vision of the work one does (e.g. patient care) was negatively correlated with emotional exhaustion related to moral distress. Additional protective factors for moral distress included resilience and positive affectivity, which is defined as distinct and stable positive emotional experiences. This study discovered that resilience and positive affectivity were most beneficial in lowering emotional exhaustion when they were supplemented with managerial support.

Moral Distress OTs Experience in Specific Practice Settings

Some research looks at the incidence of moral distress in therapists treating certain populations. A study by Tinkham et al. (2021) explored the occurrence of moral distress in occupational therapists who treat patients with traumatic brain injury (TBI). Research showed that OTs who work with this diagnosis do experience moral distress, but that the frequency did not differ across various practice settings. This suggests that therapists who work with TBI patients and other vulnerable groups likely experience this distress as a result of the work they do and not where they provide care.

Research by Prentice et al. (2018) looked at the incidence of moral distress in nurses and therapists working in the NICU. Results showed that moral-constraint distress was the most common type (93%) of moral distress the providers experienced. An overwhelming number of providers (72%) reported experiencing moral distress in any form at least once per month. NICU providers were interested in interventions that minimized the negative effects of moral distress.

However, less than 21% of providers feel that moral distress should be eliminated from this practice setting. Interestingly enough, NICU clinicians feel moral distress is an important component in their profession due to its ability to encourage reflection and prompt higher-level decision-making.

Maffoni et al. (2019) surveyed therapists and other providers working in adult palliative care to determine how often moral distress presents itself. Providers in this setting reported that some of the main sources of their moral distress were working with high acuity patients, lacking communication from other members of their team, managing their own emotions as well as the emotions of others, and constantly having to witness human suffering and debilitating illness. Palliative care clinicians also agreed with other standard causes of moral distress, including organizational constraints and a difficult relationship between providers and administration.

Goddard et al. (2021) found the highest ranking cause of moral distress among PTs and OTs in skilled nursing facilities was the inability to provide optimal services based on insurance limitations. In addition, more than half of therapists surveyed considered leaving their roles or actually left their roles as a result of the moral distress they experienced there.

Vahidi et al. (2021) assessed the incidence of moral distress in therapists who work with adults in physical rehabilitation programs. Results showed that OTs specifically have various ethical problems related to their patients' rights and their clinical practice. Participants also stated a lack of awareness about professional ethics in the field of OT and a lack of comprehensive monitoring rules are the main sources of moral distress and unethical practices.

Webber et al. (2022) looked at moral distress in home health providers and found that common causes included staffing shortages, reluctant patients, being unable to offer the frequency or quality of care that their patients and unpaid caregivers deserve, and systemic challenges. OTs and other providers shared feelings such as grief, anger, guilt, and frustration.

Gwernan-Jones et al. (2020) discovered therapists treating patients who have dementia felt they were unable to provide person-centered care due to a workplace culture focused on tasks, routines, and each patients' physical (but not behavioral) health. Participants also reported that the job satisfaction and emotional well-being of therapists significantly increased when providers were able to offer person-centered care. This was a systematic review, which took a comprehensive look at therapists across many regions. As a result, it's not a surprise that person-centered care was discussed so centrally since this concept is a hallmark of occupational therapy.

Moral Distress Resulting From Crises Such as COVID-19

Various societal events have even played a part in how often providers are experiencing moral distress, and this will likely continue to be the case. For example, COVID-19 exacerbated existing weaknesses of the healthcare system and created many difficult situations for clinicians. A study by Oorsouw et al. (2022) showed that hospital-based rehabilitation providers experienced moral distress in the realm of personal health and safety, dealing with a disease that is having a profound impact on patients, rapidly shifting roles, and staying grounded during this ever-changing time. Some providers found increased freedom during this time as a direct result of a greater connection with one's colleagues and the ability to show their motives are genuine. Researchers found that some of the best ways to manage COVID-related moral distress were increased empathy from employers and administration focused on creating a more ethical workplace. This study also emphasized the importance of autonomy in the face of moral distress, which can reduce moral constraint and possibly even other types of distress.

Wilson et al. (2021) studied the mental health differences between providers who treated patients during COVID-19 and providers who did not treat patients during COVID-19. This research assessed this relationship between these factors over the span of 7 months, and found that moral distress was a strong predictor of a

provider's burnout and mental health strain. The study also discovered that moral distress was not a consistent predictor of maladaptive coping. This suggests that both groups experienced a similar amount of moral distress despite the differing causes of each. Results also showed that the moral distress of providers who were treating patients at the height of COVID-19 was more strongly linked to their long-term mental health strain and burnout than it was in the other group.

Spilg et al. (2022) analyzed moral distress in healthcare workers who treated patients with COVID-19. These providers exhibited more grave moral distress, a higher amount of anxiety and depression symptoms, and a higher incidence of mental disorders when screened than healthcare providers who did not treat patients with COVID-19. The providers who displayed the lowest levels of moral resilience had a steeper decline due to moral distress along with poorer outcomes. Spilg et al. found some predictors of moral resilience included the absence of mental health conditions, higher than average sleep each night, being male, being middle-aged, and receiving a high level of support from colleagues and administrators.

Norman et al. (2021) conducted research that showed moral distress in therapists during COVID-19 was strongly linked to fear of infecting others, the disease having a negative impact on one's family, and work-specific concerns (namely competency in a more chaotic time). Each of these factors was also connected with a higher risk of PTSD symptoms and burnout along with interpersonal difficulties, especially at work. This research lends further support to the relationship between PTSD, burnout, and moral distress, which we've mentioned have similar presentations and may exacerbate one another.

Moral Distress in Healthcare Students

The research is not just limited to healthcare providers. A study conducted by Howard et al. (2020) looked at moral distress and moral reasoning among occupational therapy and physical therapy students. The study found that

students more often experienced the transitional phase of moral dilemmas while practitioners in these same fields more frequently entered the consolidated phase of moral dilemmas. The transitional phase is considered a beginner phase since it involves using various reasoning patterns in the same stage or across all stages of a moral dilemma. The consolidated phase, on the other hand, is characterized by consistent reasoning in response to a morally difficult situation. Researchers found that one of the best ways to prepare students for handling moral dilemmas is to blend clinical experiences into classroom coursework whenever possible. This technique can help introduce moral reasoning pattern development that eventually carries over into the students' practice.

Bring it Back to Your Practice

Let's return to the moral distress-related scenario that you identified earlier in the course. Hopefully this situation was far enough in the past that you may be able to take a scoping look at the big picture and the factors at play. To help dig into this instance of moral distress, start by asking yourself - "What am I (or what was I) experiencing?"

While this may seem vague and generally unhelpful, this general question is intended to be the most difficult of them all because it helps build the foundation for which someone will take action. This question helps identify what the problem is and also prompts you to compare your current situation to others you've experienced in the field. Try to break down this situation into smaller parts. By looking at the pieces of a situation rather than the issue as a whole, you may see some similarities. Your past experiences can inform your present actions, so remember you are not dealing with something entirely unfamiliar. For example, think back to the first patient you ever treated as an occupational therapist. Did you feel fully confident that you knew what to do first and would be able to provide what they needed? Many therapists doubt their training at this point in their career and get overwhelmed at the prospect of patient care. However, it's

best to take a look at the evaluation, decide on a couple of the most important goals for the patient's well-being, and go from there. A similar rationale applies to moral distress: looking for a few of the main areas to focus on can provide clarity for your plan of action. By taking these steps, you can remove some fear of the unknown, sidestep 'all or nothing' thinking, and encourage a greater sense of control. In the end, this makes the concern at hand become more manageable.

Many of the moral distress causes identified by the research can be classified largely as systemic issues. There are ways therapists can attempt to address these issues, some of which include advocating to the organization's administration for changes to be made and getting involved in the creation of healthcare policy to make large-scale changes. However, it is important to address the other component of moral distress, and that is uncomfortable or harmful emotions. It is equally important to get to the root of those emotions. Ask yourself additional questions to help reflect upon the cause. Is your frustration coming from wanting to operate in a higher role to have more control over the situation or from not being able to give patients the care they deserve? Depending on your answer, you may feel the best option is working your way up the ladder to a more behind-the-scenes role that allows you to make positive changes on a larger scale. On the other hand, frustration over not offering the care you want could mean that you wish to remain in patient care but want to do it on your own terms. This may mean working at an organization that allows you to offer this care, starting your own practice, or finding other ways to provide meaningful care within the confines of your organization.

As you can see, identifying the source(s) of your moral distress is really at the foundation of finding its solution. The following sections will offer a more detailed guide to ethical decision-making and developing moral resilience to assist in navigating moral distress.

Section 2 Personal Reflection

How do the causes of moral distress differ from the causes of burnout, PTSD, and compassion fatigue?

Section 2 Key Words

Positive affectivity - Distinct and stable positive emotional experiences

Section 3: Impact of Moral Distress on Occupational Therapy Practice

References: 37, 38

In order to understand the impact of moral distress on occupational therapy, you must be familiar with ways to measure moral distress according to the literature. The primary moral distress instrument – the Moral Distress Scale (MDS) – is based on Jameton's moral distress theory. Other foundational frameworks used to create this measure include House and Rizzo's role conflict theory and Rokeach's value theory. The MDS is composed of 32 items each rated on a 7-point Likert scale. Those who receive a higher score on the MDS exhibit higher levels of moral distress. There are also a few moral distress grading tools that are not based on Jameton's theory. These include the Moral Distress Risk Scale, the Moral Distress Thermometer (MDT), the Ethical Stress Scale, and Moral Distress in Dementia Care Survey. The MDT uses a thermometer as a visual to guide therapists in raking their moral distress somewhere between 1 (non-existent) and 10 (the worst possible emotional discomfort). The Moral Distress Risk Scale is similar to the MDS, but serves more as a preventive measure and the Moral Distress in Dementia Care Survey has several demographic-specific questions that set it apart from the others. If left unaddressed, moral distress has the potential to turn into occupational burnout. Both of these concerns can lead someone to experience a

host of emotional, physical, and cognitive symptoms. For this reason, it's crucial to both measure and understand the impact of moral distress, so it can be reasonably addressed.

Bring it Back to Your Practice

In order to effectively gauge the impact of moral distress in your example scenario, start by asking yourself a few more questions. The next question is - "What do I want to do [with what I'm experiencing]?" This is a bit more nuanced because each person may have a slightly different answer. The key here is not to focus on what *should* be done about the situation since this is precisely what causes moral distress. Rather, it's best to focus on what you want to do. Moral distress stems from the choices a person does or does not make, so regaining and keeping control over one's ability to choose should be the next step. If you still need help, try reframing the moral question based on personal and professional values rather than personal and professional obligations. This allows us to keep the power over our actions rather than having certain duties imposed upon us by supervisors, society, and other sources external to us. In addition, this question makes the answers and solutions to our moral dilemma more personalized. After all, how each person responds to any situation is shaped by their strengths, opportunities, resources, knowledge, and any other challenges that may present themselves.

Because each person and the situations they are exposed to are unique, the questions posed in this process are not an answer to situations causing moral distress. Rather, they help someone develop a personalized framework according to their lives. This framework is intended to help them work through situations as they arise in a more fluid manner. Along the way, such questions also help someone build resiliency and improve their ability to make decisions. For this reason, the exploratory process is better suited for frontline workers and others who are directly involved in the distress. If organizations and higher-level leaders

try to use this framework, they may come across additional barriers since the structure is meant for real challenges that those in patient care face.

Section 3 Personal Reflection

Moral distress is not a health condition, rather an occupational phenomenon. However, it sometimes requires a fair deal of insight and reflection in order to determine its cause. In addition to assessments such as the Moral Distress Scale, what other tools can be used to identify and explore moral distress in your work?

Section 4: Models for Ethical Decision-Making

References: 39, 40, 41, 42

In order to continue discerning moral distress in your work, let's go back to the scenario we identified at the beginning of the course. We've already identified the problem, its causes, and what you would like to do about it, so the logical next question is to ask yourself - "How do I approach it?" While this may seem like a complex question, it really starts with assessing the environment along with what tools you need to bring your choice to fruition. You should also take into consideration the type of decision you settled on. For example, if your plan of action involves making multiple decisions over a period of time - which is often the case for long-term solutions - this may cause you more intense and more frequent distress. If the choice you made entails making a single big move that resolves the situation, the distress will ideally subside after that occasion. Each of these considerations will come into play when planning your approach. For this reason, it's not only helpful but exercising sound judgment to recall past instances where you responded to situations of moral distress.

Therapists are also advised to think of how they wish to act during future scenarios, similar or otherwise. It's not always necessary to use realistic situations

as a barometer, since your judgment will likely be similar across each instance. Exercises such as this one will assist you in managing expectations and beginning to develop various approaches that can help you. By having this information in the back of your mind, you are already more prepared for the situation at hand and can prevent remorse about carrying out various alternatives. One of the last reasons for this step is so you can assess all the options, both good and bad. Taking such a comprehensive look at the scenario prevents you from getting stuck in earlier stages of moral distress such as determining what the dilemma is and what your two choices are. This is an action-focused approach that allows you to move forward by minimizing the distress or eliminating it altogether.

There are several models for all healthcare professionals to use when guiding their decision-making. While some of these have been developed by certain disciplines such as nurses and psychologists, they offer sound advice to anyone working in healthcare. Some of the following models are similar to the steps we've led you through above, while others have additional steps and other variations:

- American Association of Critical Care Nurses (AACN) Model to Rise Above Moral Distress
    - Ask
    - Affirm
    - Assess
    - Act
    - "How important is it that you try to change the situation?"
    - "How important would it be to your colleagues to have the situation changed?"
    - "How important would a change be to the patients you treat?"
    - "How strongly do you feel about trying to change the situation?"

    - “How confident are you in your ability to make changes occur?”
    - “How determined are you to work toward the change?”
- Steps in Ethical Decision Making for Canadian Psychologists
    - State the question or dilemma clearly
    - Anticipate who will be affected by the decision
    - Assess your level of competence and where you lack knowledge for this situation
    - Review ethical standards in your respective field, if needed
    - Review legal standards, if needed
    - Consider whether or not you have personal feelings or biases that may impact your judgment
    - Consider if there are religious, social, or cultural factors affecting the situation
    - Develop alternative courses of action
    - Think through each of these options
    - Adopt the perspective of each person who would possibly be impacted
    - Decide what to do
    - Take action
    - Document the process and track the results
    - Assume personal responsibility for the consequences
    - Consider implications for future prevention and planning

- Elaine Congress ETHIC Model of Decision Making
    - Evaluate your values
    - Think of ethical standards
    - Hypothesize consequences of decision options
    - Identify who benefits and may be harmed
    - Consult with colleagues and supervisor
- ACA Ethical Decision Making Model
    - Identify the problem
    - Apply your field's code of ethics
    - Determine the nature of the dilemma
    - Generate courses of action
    - Consider possible consequences
    - Choose a course of action then evaluate it and implement it
- Pearce & Littlejohn's Transcendent Discourse
    - Uncover basic assumptions
    - Compare differences
    - Explore rather than convince
    - Assess strengths and weaknesses of each possible decision
    - Reframe conflict in a more productive way
- Brown's Diversity Ethics Process Model
    - Make a proposal (Ask what should be done?)

    - Identify your observation (Why should I do it?)
    - State your values (Why is this the right thing to do?)
    - Align all values
    - Explore possible options
    - Uncover assumptions behind all values
    - Find the best option
    - Analyze the consequences afterwards
- Doug Wallace and Jon Pekel's Checklist for Resolving Ethical Dilemmas
    - Identify the key facts
    - Identify and analyze the major stakeholders
    - Identify underlying driving forces
    - Identify and prioritize operating values
    - Determine and evaluate all viable options
    - Test the preferred option with a worst-case scenario
    - Add a preventive component
    - Decide and build a short- and long-term action plan
    - Use a decision-making checklist

Wallace and Pekel's checklist also comes with a series of short questions to further clarify a decision in relation to moral distress:

- Relevant Information Test
    - Have I gathered the information I need to make an informed decision and take action in this situation?

- Consequential Test
    - Have I anticipated the potential consequences and attempted to make accommodations for them?
- Enduring Values Test
    - Does this decision and carrying it out uphold my values as they pertain to this situation?
- Light-of-Day Test
    - How would I feel if this decision and the resolution as a whole were disclosed for all to know?

In addition, therapists can use organizational tools that help alleviate moral distress. Ness et al. (2021) stated that shared governance, disaster management training modules, and enhanced communication can help leadership build their own models that prevent moral distress and encourage ethical decision-making.

Being able to reflect on the decision you made is one of the last key steps to address when thinking of your moral dilemma. No matter what decision you landed on, it's important for a therapist to take stock of what happened - from start to finish. This allows a therapist to pinpoint what they could have done differently, either to alleviate more stress or produce a more ideal outcome. Now we will move on to the next section, which will detail other ways therapists can ease stress and build resilience in the face of moral distress.

Section 4 Personal Reflection

What aspects are shared across many of the ethical decision-making models above?

Section 5: Practitioner Resilience, Coping, and Self-Care Amid Moral Distress

References: 43, 44, 45, 46, 47, 48

Occupational therapists are well aware of the ways high stress levels can impact someone in the short-term and long-term. For this reason, practitioner resilience amid moral distress cannot be overlooked. Research shows that bolstered resilience through building social support, improving problem solving, and increasing communication skills are some of the most effective strategies. Morley et al. (2021) cites various education interventions as being a strong predictor for resilience. These interventions can include facilitated discussions up to an hour in length, specialist consultation services, and even intervention bundles with more than one strategy. Multidisciplinary rounds are another way for therapists to grow their insight and ability to collaborate, which can help with decision making. Morley lastly notes self-reflection and narrative writing as more solitary activities to manage moral distress. Each of these methods has been found to significantly reduce discomfort from moral distress.

Helmers et al. (2020) emphasizes the importance of perspective-building exercises for individuals experiencing moral distress. These exercises should include structured, active, and reflective supports for optimal effect. In practicing these exercises, therapists should aim for outcomes such as being able to articulate formal support systems that are both accessible and appropriate. Davis et al. (2020) notes some personal resilience strategies that can help therapists build moral resilience for themselves and the sake of their work. Some of these strategies include spending more time with friends and doing social activities, debriefing regularly with peers, getting enough exercise, taking time to see one's family, practicing prayers and other faith-related activities, journaling, making meditation a habit, reading, attending counseling sessions, and utilizing PTO time by spending more time at home or taking vacations away from one's regular environments.

In the vein of jointly supportive and preventive strategies for moral distress and moral resilience building, several researchers mention self-empowerment, communication improvement, managing emotions, and engaging in specific educational programs - either through one's work or found via other means. Amos et al. (2022) also offers support for education-based resilience programs and interventions, which suggests these are some of the most effective mediums. These same studies also mention that holistic models of moral distress should be used to effectively gauge and integrate the cognitive, emotional, behavioral, and organizational factors of the concept. If individuals experiencing moral distress do not take a holistic, comprehensive approach to their emotional responses and the situation at hand, none of the aforementioned strategies for building resilience and managing one's emotions will make a difference for them.

The AACN, the organization that created the 4 As model for ethical decision making, states there are six standards therapists need for a healthy work environment that builds moral resilience. These standards include meaningful recognition, true collaboration, appropriate staffing, the ability to ethically make decisions, skilled communication, and authentic leadership. While therapists don't always have control over these factors in their workplace, they can seek employment at an organization that prioritizes these standards. The AACN cites many of the same moral resilience strategies mentioned above in addition to shifting one's perspective in order to find meaning in the present adversity. Therapists are also advised to nurture their willingness to take action so they are more comfortable with being assertive both now and in the future. Self-regulation strategies are also helpful, as practices such as meditation, mindfulness-based stress reduction (MBSR), and movement-based activities like tai chi and yoga can help emotional well-being. Self-awareness is also key for moral resilience, so therapists should better examine negative and positive assumptions about their own behaviors. The AACN also puts forth the 4 Rs to assist with managing moral distress:

- Recognize

    - Just as with identifying the cause of moral distress, the first step to managing the distress is recognizing the complexities of the problem.

- Release
    - Therapists should regularly keep in mind what is within their control and what is out of their control (what they can change and what they cannot change). This will help with moving forward and letting go of the barriers that may be in the way.

- Reconsider
    - Try reframing the issue in a different way. We mentioned before that perspective is key, so ensure you are consistently open to new approaches. This will help everyone remain on the same page while the problem is being solved.

- Restart
    - Don't be afraid to ask new questions or bring up new ideas about how to move forward in a positive way.

As you can see, there are a range of strategies therapists can use to learn about their moral distress and its causes. First, therapists should classify their moral distress as moral-uncertainty distress, moral-dilemma distress, moral-conflict distress, moral-constraint distress, or moral-tension distress. This will also help therapists identify the cause of moral distress, which is understandably an important step in managing this emotional discomfort. Once you know its cause, you can address it to the best of your ability. Regardless of what course of action they choose, it's common for therapists to continue experiencing feelings of guilt, frustration, remorse, and anxiety. However, there are a range of evidence-based strategies that can assist therapists moving forward. Strategies may focus on building personal resilience through methods such as journaling, mental health counseling, physical activity, and time with loved ones. Therapists can also utilize

perspective building and education interventions such as facilitated discussions, multidisciplinary rounds, and problem-based learning opportunities. With a combination of approaches, therapists can effectively identify moral distress in the workplace, address its causes, and engage in management strategies to strengthen their own emotional responses.

Section 5 Personal Reflection

How might an occupational therapist go about advocating for moral resilience building activities in their workplace? What strategies could they use to initiate a discussion or write a proposal justifying the need for such activities?

Section 6: Case Study #1

An occupational therapist and private practice owner offers community mental health treatment to individuals of all ages. While some of this therapist's patients also have co-occurring substance use disorders, many are seeking individual or group mental health treatment focused on skill building, emotion regulation, and productive leisure.

A 41-year-old male presents to the therapist as a new patient who is also self-paying. He was recently diagnosed with major depressive disorder and would like assistance learning what this condition means along with how to better manage the highs and lows that depression causes. This patient is also an intravenous drug user, but is not looking for that to be the focal point of his OT services. He does not willingly consent to a medical detox program at the local hospital.

This patient does not need vocational assistance, as he has a steady, white-collar job that he reportedly performs well at. He also notes little to no concerns with household and financial management, with the exception of when he is experiencing a depressive episode. He has a disabled 4-year-old child who he

cares for within the home along with the child's mother, who does not use drugs. The patient reports that his drug use is sporadic and takes place less than once per month. He states that it occurs most often when his child tantrums and cannot be soothed. He uses the drugs in their shared home in the bathroom, most often while he is watching the child before her mother gets home. The patient states this habit has been going on for the past 6 months and began shortly after his child's car accident that left her wheelchair-bound and severely cognitively impaired.

During their first session, the patient is requesting one-time assistance from the OT to learn how to inject heroin more safely and prevent injury. The OT is unsure how to proceed with this patient's request, as she has been trained to treat all illegal drug use from a rehabilitative lens.

1. What type of moral distress is this OT experiencing, if any?
2. What barriers are preventing the OT from operating in the way she wants?
3. Based on any identified barriers, what is the best way for the therapist to proceed?

Section 7: Case Study #1 Review

This section will review the case studies that were previously presented in each section. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What type of moral distress is this OT experiencing, if any?

   She is drawn to help a patient in need, since that is her calling and the purpose of her work. However, the therapist personally and professionally emphasizes a drug-free lifestyle. As a result, this OT is experiencing moral-uncertainty distress since she is undergoing the internal process to decide what action she will take.

2. What barriers are preventing the OT from operating in the way she wants?

   Since the patient is paying out of pocket for services, there are no insurer guidelines to structure their sessions. For this reason, the OT can tailor treatment to look exactly how the patient (and the therapist) wants. With the OT being the owner, she also does not have a supervisor to dictate what she does or does not cover during sessions. Due to the community-based setting where this patient is being seen, treating him will not take away resources from another patient in need because he also presents with concerns that are able to be treated without any moral distress (depression).

   If the therapist decides to provide this education, given that the drug of choice is illegal, there is the possibility that the patient will implicate the therapist if he is arrested for possession of an illegal substance. The patient may possibly tell law enforcement that his therapist condoned the behavior. If the police discover that the therapist knew about the patient using drugs while his child is in the home, they can also cite the therapist for neglecting to file a report with Child Protective Services (CPS). Therapists are mandated reporters, so this would be a breach of her professional code of ethics.

3. Based on any identified barriers, what is the best way for the therapist to proceed?

   The OT does not condone this behavior according to her personal values. In addition, she does not have the knowledge to educate the patient on this matter in good faith. As a result, the therapist should decline to provide harm reduction for this patient, but may begin helping him manage the new depression diagnosis. If the patient chooses not to work with the therapist at all after she declines to provide harm reduction, she can make a referral

for an agency that may better be able to assist him. The therapist should also file a report with CPS due to knowing about drug use with a child in the home.

Section 8: Case Study #2

An occupational therapist recently began working at an inpatient rehabilitation facility (IRF) that has many high acuity patients. The greater majority of the patients on this unit are being treated for recent traumatic brain injuries, strokes, and spinal cord injuries so they require a significant amount of hands-on care and close supervision during sessions. While the OT has 8 years of experience in acute care and considers herself to be skilled in the treatment of patients with these diagnoses, she is put off by her supervisor's instructions to complete point-of-service documentation for all patients. She feels it's not possible to do this while offering the high level of care these patients require. However, she is told by her supervisor and colleagues that this is the only way to maintain the high productivity standards (>95%) required by the department. The therapist had difficulty finding a job locally and is reluctant to leave her new position, but she also feels uncomfortable doing point-of-service documentation with this type of client population.

Throughout her first week of work, the therapist chooses to complete her daily notes in the evening after her visits have concluded for the day. She feels confident that she did not compromise her values, but she is aware that she will eventually be reprimanded. The next week, she is given a verbal warning about her productivity. Her supervisor states they will not fire her because she is the only OT and the patients cannot afford to go without services, but that she needs to raise her productivity for the sake of the department's outcomes. The therapist articulates her feelings about the unrealistic expectations of the role, the unethical position these expectations place her in, and the disservice that is being done to the patients amid all of this. The therapist ends the conversation by

stating she is leaving the role effective immediately. She goes home and feels overall assured with the decision she made since she did not have to compromise her values. But, soon after, the therapist begins experiencing some guilt and remorse after thinking of what will happen to her patients.

1. What type of moral distress is the therapist experiencing (if any) while speaking with her supervisor?
2. What type of moral distress is the therapist experiencing (if any) during the week where she was not completing point-of-service documentation?
3. Since she is no longer in the role, what options does this therapist have for managing the distress she feels?

Section 9: Case Study #2 Review

This section will review the case studies that were previously presented in each section. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What type of moral distress is the therapist experiencing (if any) while speaking with her supervisor?

   This therapist is experiencing moral-conflict distress because she expressed her feelings to her supervisor when she was again asked to compromise her values. She openly engaged in a dialogue with her supervisor in order to verbalize what she believes is right.

2. What type of moral distress is the therapist experiencing (if any) during the week where she was not completing point-of-service documentation?

The therapist was not experiencing any moral distress during this time, since she overall felt good that she didn't need to act in a way that went against her values.

3. Since she is no longer in the role, what options does this therapist have for managing the distress she feels?

   After leaving the role, the therapist begins experiencing moral-dilemma distress. She is no longer able to change her actions or their consequences since she does not work at the organization, but she can work on reflecting and building resilience to manage her own emotions about the situation. She should firstly engage in self-care by journaling about the issue, spending some time with friends and family, exercising, and taking time to be in nature. If these initial strategies are not effective, the therapist should consider speaking with a mental health counselor. This can help the therapist get a different perspective on the situation, collaborate to further build resilience, and take steps to avoid this emotional response in the future.

Section 10: Case Study #3

A 23-year-old newly graduated occupational therapist gets a position in a skilled nursing facility. As outlined in the job description, the therapist's caseload mostly consists of short-term rehabilitation patients with an occasional evaluation or treatment in the long-term care (LTC) wing. After working at this position for about a month, there has been a drastic change in staffing at the facility. Several therapists and nurses have left for maternity leave and a few moved on to other positions that offered higher pay. This has left both the short-term and long-term wings severely understaffed. The therapist is noticing that the LTC unit is especially seeing the brunt of this. Each time the therapist walks past the nurse's station in that unit, he hears several call bells ringing, patients yelling out for help, and

notices there is no one at the front desk. This is beginning to be a trend since it's happened on several occasions in just the past week. The therapist feels guilty for not assisting these residents, but he is similarly burdened by a very high caseload and does not currently have the ability to stop and check on patients who are not assigned to him. The director of rehabilitation has made many mentions that therapists should do "whatever they need to" in order to get through these staffing shortages. The therapist has a generally uneasy feeling, but isn't sure if it's justified.

1. What type of moral distress is this therapist experiencing, if any?
2. Has this patient committed an ethical misstep in the workplace?
3. What steps can this therapist take to manage how he is feeling?

Section 11: Case Study #3 Review

This section will review the case studies that were previously presented in each section. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What type of moral distress is this therapist experiencing, if any?

   The therapist does not feel good about what is happening on the LTC unit. Yet, he feels unable to say anything because of the advice from his supervisor. This is considered moral-tension distress. His supervisor's advice (in addition to some fear of being reprimanded due to being a new graduate) also prevents him from making any kind of report about the issue. This is moral-conflict distress because the therapist cannot act in a way that aligns with his personal values at work

2. Has this patient committed an ethical misstep in the workplace?

No, the patient has not technically committed an ethical misstep in the workplace. While he may not feel able to make the decision he wants to, he has not neglected his own patients nor is he ignoring a patient that is visibly in need of medical attention. This does walk a fine line between patient neglect on the behalf of the facility, who should have someone available to attend to all patients, but this is not the therapist's responsibility.

3. What steps can this therapist take to manage how he is feeling?

   The therapist can bring up the issue during staff meetings. While not outright mentioning the issue in LTC, he can start by advocating for time management, therapist rounds, and other strategies to better serve all patients in the facility. The therapist can also volunteer to assist with recruiting and hiring new therapists to manage the staffing shortages, which are the main source of the concern. Depending on how this is received, the therapist can engage actively in these methods to improve attentiveness to all patients. Regardless of the outcome, the therapist should also enhance his ability to identify moral dilemmas and manage his reaction to them. The advocacy efforts should be supplemented by resilience building strategies to broaden his experience in this area.

Section 12: Case Study #4

An occupational therapist employed in a Veterans Administration (VA) hospital walks into the rehabilitation department one morning to begin work. She notices another therapist using her phone to take pictures of electronic medical record (EMR) content on the screen of her work computer. The OT is surprised by this action, but quickly forgets about it once her work day starts. During her lunch break the next day, the OT goes on social media to check her feed and notices a post from the other therapist with the exact screenshots she took the previous day. However, once the OT refreshes the page, the post is no longer there. She

assumes they were likely posted in error and then deleted. The OT has an uneasy feeling about this since she knows this is a huge confidentiality violation.

1. What type of moral distress is the therapist experiencing, if any?
2. What actions can this therapist possibly take about the confidentiality violation?
3. What is the most appropriate option for this therapist to take?
4. Can the therapist take any steps to prevent feeling uneasy in such situations? If so, what steps would help her?

Section 13: Case Study #4 Review

This section will review the case studies that were previously presented in each section. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What type of moral distress is the therapist experiencing, if any?

   This therapist is likely experiencing moral-uncertainty distress, which stems from not knowing what to do in this situation.

2. What actions can this therapist possibly take about the confidentiality violation?

   As the therapist begins to think about the moral dilemma, its details, and how to move forward, she may begin to feel moral-constraint distress due to not knowing how to proceed. The therapist can choose to report this violation to her supervisor. However, the therapist should be aware there is a chance the other therapist will find out, there is also a chance nothing will happen due to a lack of proof, and there is a chance the supervisor will choose not to investigate the violation further. Another option is that the therapist anonymously reports this violation to the Department of Health

and Human Services. However, there is still a chance that a supervisor or other colleague at the VA Hospital could find out who submitted the report and retaliate. The therapist could also choose to do nothing about the violation.

3. What is the most appropriate option for this therapist to take?

   It's up to the therapist's values. According to her feeling uneasy, one can assume that this violation (not only taking a picture of confidential information, but posting it online) goes against her personal and professional values. As a result, the most appropriate action would be to report the violation to either her supervisor or the HHS. Neither one of those options is more appropriate than the other since that is also based on whether the therapist has more fear of retaliation or someone ignoring the report altogether.

4. Can the therapist take any steps to prevent feeling uneasy in such situations? If so, what steps would help her?

   It's perfectly understandable that the therapist feels uneasy about this situation. Feelings of unease and discomfort in a situation like this show that the therapist places patient safety first. However, moral distress can be uncomfortable and can take a toll on the provider. In order to ease some of these feelings, the therapist should report the violation to someone else. In addition, the therapist can try journaling about the situation. If the therapist chooses to report the violation to the HHS, they can try discussing the situation with them a bit more to learn about the process and what will happen after a report is filed.

Section 14: Case Study #5

An occupational therapist working in an outpatient clinic evaluates a 39-year-old patient who presents to therapy with a new onset of tendonitis in the shoulder.

The referring doctor writes an order for an occupational therapy evaluation and treatment with iontophoresis. The doctor's rationale is that the patient received it before when she had tendonitis in the knee and would like to try it again since it was quite effective for her. After completing the evaluation, the therapist uses her existing knowledge to determine that iontophoresis is likely ideal for this patient. This therapist is not trained in the implementation of iontophoresis. She is eager to prove herself at this new clinic since she hasn't fit in with the other therapists yet. For this reason, she also doesn't feel comfortable asking others how to administer iontophoresis. The therapist is embarrassed to tell the front office that she can't treat this patient and feels that will impact her standing in the clinic. The therapist is displaying a lot of moral-tension distress since she feels unable to verbalize how she is feeling to anyone.

1. What is the most appropriate action for this therapist to take?
2. How can the therapist manage the moral distress she feels about this situation?

Section 15: Case Study #5 Review

This section will review the case studies that were previously presented in each section. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What is the most appropriate action for this therapist to take?

   Since this instance of moral distress directly involves a patient, the therapist should firstly think of that patient's well-being. If the therapist proceeds with treating the patient using iontophoresis despite not knowing enough about the modality, the patient could be seriously harmed. If the patient is not injured as a result of that action, the best case scenario is that the patient will receive no benefit from the modality. If the therapist informs the front office that they can't provide the requested (and most beneficial

modality) and that the patient should be assigned to another therapist, the patient will not be at risk of injury and will have access to the care they deserve. Therefore, the last option is the best for this patient and the therapist.

2. How can the therapist manage the moral distress she feels about this situation?

   It's true that the therapist may feel embarrassed about passing a case back to the office and feel left out from the rest of the therapists. However, the discomfort from these sources is minimal compared to how the therapist would feel if she injured the patient by implementing a modality she didn't know enough about. The therapist can remind herself that the patient should come first in this scenario and she did the right thing according to that rule. Residual discomfort may be eased by venting to friends and family about the situation (being sure to leave out any identifying information when doing so), journaling about it, and engaging in self-care practices such as relaxation techniques, exercise, and enjoying hobbies. These practices can help the therapist manage remaining discomfort and reassure herself that she exercised good judgment.

Section 16: Case Study #6

An occupational therapist working at a hospital is approached by her supervisor one day. Her supervisor wants to discuss the progress that one of her patients is making. The supervisor addresses the patient by name and asks if the therapist feels she is ready for discharge. The therapist has been working with this patient for 5 days so far. The elderly patient is fully ambulatory without an assistive device, is entirely independent in ADLs, and demonstrates no cognitive or safety impairments. The patient's discharge plan will be to her own home where she will receive intermittent assistance from family for IADLs. The patient is also medically

stable as of today. During rounds tomorrow morning, the therapist planned to recommend the patient for discharge and assist with planning. The supervisor told the therapist she should recommend that the patient be discharged to an assisted living facility. He mentioned the patient will “only need more help in the coming years” and will likely “end up in assisted living anyway.” The therapist openly expressed this decision is not fitting for the patient, but the supervisor noted their caseload is low and the hospital will lose money if she’s discharged this quickly. The therapist again pushed back by openly stating that this is unethical. The supervisor replied by saying the therapist will be written up if she does not comply.

1. What type of moral distress is this therapist experiencing, if any?
2. What is the best move for this therapist to make?

Section 17: Case Study #6 Review

This section will review the case studies that were previously presented in each section. Responses will guide the clinician through a discussion of potential answers as well as encourage reflection.

1. What type of moral distress is this therapist experiencing, if any?

   This therapist is experiencing moral-conflict distress because she expressed her opinion to her supervisor as soon as the moral dilemma was made clear.

2. What is the best move for this therapist to make?

   The therapist already expressed not being comfortable with the supervisor’s request due to it being unethical. It’s clear the request goes against the therapist’s personal and professional values. In addition, the supervisor’s request is considered to be insurance fraud and can even prevent other patients from getting the services they need (someone taking

up a hospital bed who doesn't need one). Since this is both illegal and can harm other patients, the therapist should decline the request and make the recommendation she feels is fitting. It's also in the therapist's best interest to attempt to seek employment elsewhere, since this unethical practice may continue occurring in the future, especially if no one speaks up.

References

(1) Kherbache, A., Mertens, E., & Denier, Y. (2022). Moral distress in medicine: An ethical analysis. *Journal of Health Psychology*, *27*(8), 1971–1990. https://doi.org/10.1177/13591053211014586

(2) Salari, N., Shohaimi, S., Khaledi-Paveh, B., Kazeminia, M., Bazrafshan, M. R., & Mohammadi, M. (2022). The severity of moral distress in nurses: a systematic review and meta-analysis. *Philosophy, Ethics, and Humanities in Medicine : PEHM*, *17*(1), 13. https://doi.org/10.1186/s13010-022-00126-0

(3) Maunder, R.G., Heeney, N.D., Greenberg, R.A. et al. (2023). The relationship between moral distress, burnout, and considering leaving a hospital job during the COVID-19 pandemic: a longitudinal survey. *BMC Nurs* 22, 243. https://doi.org/10.1186/s12912-023-01407-5

(4) Fourie, C. (2017). Who is experiencing what kind of moral distress? Distinctions for moving from a narrow to a broad definition of moral distress. *AMA J Ethics*. 19(6), 578-584. doi: 10.1001/journalofethics.2017.19.6.nlit1-1706

(5) De Hert, S. (2020). Burnout in healthcare workers: Prevalence, impact and preventative strategies. *Local and Regional Anesthesia*, *13*, 171–183. https://doi.org/10.2147/LRA.S240564

(6) Cavanagh, N., Cockett, G., Heinrich, C., et al. (2020). Compassion fatigue in healthcare providers: A systematic review and meta-analysis. *Nursing Ethics*, *27*(3), 639-665. doi:10.1177/0969733019889400

(7) University of Rochester Medical Center Behavioral Health Partners. (2021). Moral distress: The struggle to uphold ethics in healthcare. Retrieved from https://www.urmc.rochester.edu/behavioral-health-partners/bhp-blog/january-2021/moral-distress-the-struggle-to-uphold-ethics-in-he.aspx

(8) Morley, G., Ives, J., Bradbury-Jones, C., & Irvine, F. (2019). What is 'moral distress'? A narrative synthesis of the literature. *Nursing Ethics*, *26*(3), 646–662. https://doi.org/10.1177/0969733017724354

(9) Cleveland Clinic. (2022). Addressing moral distress: A guide for leaders. Retrieved from https://clevelandclinicwellness.com/wellness/CST/MoralDistressLeaders.pdf

(10) Tessman, L. (2020). Moral distress in health care: when is it fitting? *Med Health Care and Philos*, 23, 165–177. https://doi.org/10.1007/s11019-020-09942-7

(11) Armin, J.S. (2019). Administrative (in)Visibility of patient structural vulnerability and the hierarchy of moral distress among health care staff. *Medical Anthropology Quarterly, 33*, 191-206. https://doi.org/10.1111/maq.12500

(12) Howard, B. S., Govern, M., Gambrel, A. M., Haney, M., Ottinger, H., Rippe, T. W., & Earls, A. (2023). Encounters with ethical problems during the first 5 years of practice in occupational therapy: A survey. *The Open Journal of Occupational Therapy, 11*(3), 1-14. https://doi.org/10.15453/2168-6408.2078

(13) Vahidi, H., & Shafaroodi, N. (2021). An investigation into ethical issues in occupational therapists in adult with physical disabilities: Using the qualitative approach. *Clinical Ethics*, *16*(3), 205-212. doi:10.1177/1477750920971799

(14) Howard, B. S., Kern, C., Milliner, O., Newhart, L., & Burke, S. K. (2020). Comparing moral reasoning across graduate occupational and physical therapy students and practitioners. *Journal of Occupational Therapy Education*, *4*(3). https://doi.org/10.26681/jote.2020.040305

(15)Cantu, R. (2019). Physical therapists' ethical dilemmas in treatment, coding, and billing for rehabilitation services in skilled nursing facilities: A mixed-method pilot study. *Journal of the American Medical Directors Association*, *20*(11), 1458-1461. https://doi.org/10.1016/j.jamda.2019.06.013.

(16)Tinkham, L., Guyton, K.B., Eddy, E.Z., & Erler, K.S. (2021). Moral distress among occupational therapy practitioners caring for clients with traumatic brain injury. *Annals of International Occupational Therapy*, *4*(4), e184-e190. doi:10.3928/24761222-20210601-01

(17)van Oorsouw, R., Oerlemans, A., Klooster, E., van den Berg, M., Kalf, J., Vermeulen, H., Graff, M., van den Wees, P., & Koenders, N. (2022). A sense of being needed: A phenomenological analysis of hospital-based rehabilitation professionals' experiences during the COVID-19 pandemic. *Physical Therapy*, *102*(6), pzac052. https://doi.org/10.1093/ptj/pzac052

(18)Penny, N.H., Benjamin, T.M., Gonsalves, C.R., Gordon, A.L., Kinsley, E.N., & Markel, S.R. (2019). An investigation of the moral distress experienced by occupational therapy practitioners. *Annals of International Occupational Therapy*, *2*(4), 161-170. doi: 10.3928/24761222-20190625-02

(19)Bennett, L. E., Jewell, V. D., Scheirton, L., McCarthy, M., & Muir, B. C. (2019). Productivity standards and the impact on quality of care: A national survey of inpatient rehabilitation professionals. *The Open Journal of Occupational Therapy*, *7*(4), 1-11. https://doi.org/10.15453/2168-6408.1598

(20)Cantu, R., Carter, L., & Elkins, J. (2022). Burnout and intent-to-leave in physical therapists: A preliminary analysis of factors under organizational control, *Physiotherapy Theory and Practice*, *38*:13, 2988-2997. DOI: 10.1080/09593985.2021.1967540

(21)Giannetta, N., Sergi, R., Villa, G., Pennestrì, F., Sala, R., Mordacci, R., & Manara, D. F. (2021). Levels of moral distress among health care professionals working in hospital and community settings: A cross sectional study. *Healthcare (Basel, Switzerland)*, *9*(12), 1673. https://doi.org/10.3390/healthcare9121673

(22)Durocher, E., & Kinsella, E.A. (2021). Ethical tensions in occupational therapy practice: Conflicts and competing allegiances. *Canadian Journal of Occupational Therapy. Revue Canadienne D'ergotherapie*, *88*(3), 244–253. https://doi.org/10.1177/00084174211021707

(23)Fumis, R.R.L., Junqueira Amarante, G.A., de Fátima Nascimento, A., & Vieira Junior, J.M. (2017). Moral distress and its contribution to the development of burnout syndrome among critical care providers. *Ann. Intensive Care*, 7, 71. https://doi.org/10.1186/s13613-017-0293-2

(24)Howard, B. S., Beckmann, B., Flynn, D., Haller, J., Pohl, M., Smith, K., & Webb, S. (2023). Moral distress in the time of COVID-19: Occupational therapists' perspectives. *Occupational Therapy in Health Care*, 1–17. https://doi.org/10.1080/07380577.2023.2181625

(25)Wilson, C.A., Metwally, H., Heavner, S., Kennedy, A.B., & Britt, T.W. (2022). Chronicling moral distress among healthcare providers during the COVID-19 pandemic: A longitudinal analysis of mental health strain, burnout, and maladaptive coping behaviours. *Int J Mental Health Nurs*, *31*, 111-127. https://doi.org/10.1111/inm.12942

(26)Prentice, T.M., Gillam, L., Davis, P.G., & Janvier, A. (2018). Always a burden? Healthcare providers' perspectives on moral distress. *Archives of Disease in Childhood - Fetal and Neonatal Edition*, *103*, F441-F445.

(27)Maffoni, M., Argentero, P., Giorgi, I., Hynes, J., & Giardini, A. (2019). Healthcare professionals' moral distress in adult palliative care: A systematic review. *BMJ Supportive & Palliative Care*, *9*, 245-254.

(28)Spilg, E.G., Rushton, C.H., Phillips, J.L., Kendzerska, T., Saad, M., Gifford, W., Gautam, M., Bhatla, R., Edwards, J.D., Quilty, L., Leveille, C., & Robillard, R. (2022). The new frontline: exploring the links between moral distress, moral resilience and mental health in healthcare workers during the COVID-19 pandemic. *BMC Psychiatry, 22*, 19. https://doi.org/10.1186/s12888-021-03637-w

(29)Norman, S.B., Feingold, J.H., Kaye-Kauderer, H., Kaplan, C.A., Hurtado, A., Kachadourian, L., Feder, A., Murrough, J.W., Charney, D., Southwick, S.M., Ripp, J., Peccoralo, L., & Pietrzak, R.H. (2021). Moral distress in frontline healthcare workers in the initial epicenter of the COVID-19 pandemic in the United States: Relationship to PTSD symptoms, burnout, and psychosocial functioning. *Depression Anxiety*, 38, 1007–1017. https://doi.org/10.1002/da.23205

(30)Howard, B.S., Beckmann, B., Flynn, D., Haller, J., Pohl, M.A., Smith, K., & Webb, S.W. (2023). Moral distress in the time of COVID-19: OT practitioners' experiences. *Am J Occup Ther*, 77(Supplement_2), 7711510236p1. https://doi.org/10.5014/ajot.2023.77S2-PO236

(31)Goddard, D. (2021) Moral distress among physical and occupational therapists: A case study. *Physical & Occupational Therapy In Geriatrics*, *39*(3), 316-324. DOI: 10.1080/02703181.2021.1887431

(32)Vahidi, H., & Shafaroodi, N. (2021). An investigation into ethical issues in occupational therapists in adult with physical disabilities: Using the qualitative approach. *Clinical Ethics*, *16*(3), 205-212. doi:10.1177/1477750920971799

(33)Rivard, A., & Brown, C. A. (2019). Moral distress and resilience in the occupational therapy workplace. *Safety*, *5*(1), 10. MDPI AG. http://dx.doi.org/10.3390/safety5010010

(34)Webber, J., Trothen, T. J., Finlayson, M., & Norman, K. E. (2022). Moral distress experienced by community service providers of home health and social care in Ontario, Canada. *Health & Social Care in the Community*, 30, e1662–e1670. https://doi.org/10.1111/hsc.13592

(35)Maffoni, M., Sommovigo, V., Giardini, A., Paolucci, S., & Setti, I. (2020). Dealing with ethical issues in rehabilitation medicine: The relationship between managerial support and emotional exhaustion is mediated by moral distress and enhanced by positive affectivity and resilience. *J Nurs Manag*, *28*, 1114–1125. https://doi.org/10.1111/jonm.13059

(36)Gwernan-Jones, R., Abbott, R., Lourida, I., Rogers, M., Green, C., Ball, S., Hemsley, A., Cheeseman, D., Clare, L., Moore, D.A., Hussey, C., Coxon, G., Llewellyn, D.J., Naldrett, T., & Thompson Coon, J. (2020). The experiences of hospital staff who provide care for people living with dementia: A systematic review and synthesis of qualitative studies. *Int J Older People Nurs*, 15, e12325. https://doi.org/10.1111/opn.12325

(37)Giannetta, N., Villa, G., Pennestrì, F., Sala, R., Mordacci, R., & Fiorenzo Manara, D. (2020). Instruments to assess moral distress among healthcare workers: A systematic review of measurement properties. *International Journal of Nursing Studies*, *111*, 103767. https://doi.org/10.1016/j.ijnurstu.2020.103767

(38)Epstein, E.G., Whitehead, P.B., Prompahakul, C., Thacker, L.R., & Hamric, A.B. (2019). Enhancing understanding of moral distress: The measure of moral distress for health care professionals. *AJOB Empirical Bioethics*, *10*(2), 113-124. doi: 10.1080/23294515.2019.1586008

(39)Heyman, J.C., & Congress, E. (2018). Health and social work: Practice, policy, and research. Springer Publishing Company.

(40)Semler, L.R. (2023). Moral distress to moral success: Strategies to decrease moral distress. *Nursing Ethics*, *30*(1), 58-70. doi:10.1177/09697330221114328

(41)Jacob, C.J., Thomas, A.M., & Wildermuth, D.L. (2020). A practical ethics worktext for professional counselors: Applying decision-making models to case examples. Springer Publishing Company.

(42)Ness, M.M., Saylor, J., DiFusco, L.A., & Evans, K. (2021). Leadership, professional quality of life and moral distress during COVID-19: A mixed-methods approach. *J Nurs Manag*, *29*, 2412-2422. https://doi.org/10.1111/jonm.13421

(43)Morley, G., Field, R., Cole Horsburgh, C., & Burchill, C. (2021). Interventions to mitigate moral distress: A systematic review of the literature. *International Journal of Nursing Studies*, *121*, 103984. https://doi.org/10.1016/j.ijnurstu.2021.103984

(44)Helmers, A., Palmer, K.D., & Greenberg, R.A. (2020). Moral distress: Developing strategies from experience. *Nursing Ethics*, *27*(4), 1147-1156. doi:10.1177/0969733020906593

(45)Davis, M., & Batcheller, J. (2020). Managing moral distress in the workplace: Creating a resiliency bundle. *Nurse Leader*, *18*(6), 604-608. https://doi.org/10.1016/j.mnl.2020.06.007.

(46)Amos, V.K., & Epstein, E. (2022). Moral distress interventions: An integrative literature review. *Nursing Ethics*, *29*(3), 582-607. doi:10.1177/09697330211035489

(47)Rivard, A., & Brown, C. A. (2019). Moral distress and resilience in the occupational therapy workplace. *Safety*, *5*(1), 10. http://dx.doi.org/10.3390/safety5010010

(48)Nishikawara, R., & Maynes, T. (2023). Moving from moral distress to moral resilience using acceptance and commitment therapy. *Canadian Journal of Career Development*, *22*(1), 30–40. https://doi.org/10.53379/cjcd.2023.350