HOW HEALTHCARE SOCIAL WORKERS CREATE MEANING FROM THEIR EXPERIENCES WITH MORAL DISTRESS

By

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MAJOR PAPER SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

In the School of Social Work and Human Services

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UNIVERSITY OF THE FRASER VALLEY

Spring 2015

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Date Approved: March 10th, 2016
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Abstract

Social workers employed in healthcare are often present for clients during times of heightened stress and emotion. They are called upon to diffuse tensions that frequently exist between competing interests that involve clients, colleagues, external resources, and agency interests. Moral distress arises when value conflicts exist, and create implications to the social worker or client. In pursuit of core values that honor social justice, social workers in healthcare are often caught within conflicts as they pursue advocacy for marginalized clients. Using an ethics of care perspective within a feminist framework, this study uses a cross-sectional exploratory design to examine the ways in which social workers in healthcare make meaning from their experiences with moral distress. Eight social workers employed with the Fraser Health Authority were interviewed and offered their experiences with moral distress within a healthcare setting. They revealed their perspectives on the origins and outcomes of their moral distress, means of resolve and the transformations that have occurred. Implications for practice and possibilities for future research are discussed.
Acknowledgement

My deepest thanks to the social workers who participated in this project and shared their time, experiences and insights. Each of you is a credit to this profession and without your participation, this research would not have been possible. I want to acknowledge the faculty at the University of the Fraser Valley who reminded me of my purpose as a practitioner and guided me in this journey.

In particular, my thanks to Dr. Leah Douglas who cultivated a learning environment that was challenging and enriching. Your accessibility, your ability to recognize my study interests and simplify the research process is a testament to your skills as an instructor.
Dedication

The ability for people to endure exceptional adversity is what inspires my journey for continued learning and social work practice. During my career, I have come to recognize that within the course of an average day, many of my fellow social workers experience adversity in the form of moral distress. This research has enriched my regard for these dedicated professionals.

I want to acknowledge my parents, who nurtured the confidence I needed to pursue higher education. To my husband Norm, who offered unwavering support, encouragement, and laughter when needed. To my children, Kayla, Daniel and Denise, who center me, and remind me of what is important in my life...I thank you.
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Introduction

Little is known about the subject of moral distress as it applies to social workers in healthcare, and even less is understood about the approaches used to heal or make meaning from these experiences. Social workers in healthcare are engaged with clients during periods of heightened stress and emotion. Moral distress can manifest when practitioners are obligated to perform work duties that are in conflict with personal values based on external factors including policy expectations, organizational pressures, and client expectations. In their role as advocates, social workers frequently interface with opposing opinions and are called to diffuse the tensions that exist, at times, at a compromise to their own values. It is expected that practitioners will experience value conflicts during the course of their careers. “Through research and anecdotal reports, moral distress is a reality of clinical practice” (Rushton, Kaszniak, & Halifax, 2013, p. 1074).

Moral distress was originally defined approximately thirty years ago by nursing ethicist, Andrew Jameton (1984) who described it as a state of conflict between knowing the right thing to do but being restrained by organizational structures (p.6). Moral distress has been researched from a narrow lens, primarily with studies aimed at nursing. Thus, it has a limited application to social work because of the variance in core competencies, job requirements and political perspectives. There is a need to examine moral distress within the local landscape in order to account for unique features that may arise within the regional political climate.

The presence of moral distress can influence a professional’s sense of well-being and job performance. Research has shown moral distress can have short and long term consequences and create implications on the delivery of patient care, retention and job satisfaction (Pauly, Varcoe, & Storch, 2012, p.1). Complex care situations within a stressful work environment are shown to
contribute to moral distress among healthcare professionals, and the current political climate requires that healthcare social workers respond to increasingly complex situations with fewer resources. At times, it may seem the worker is focused more on the agency objectives versus the client who is in receipt of care. Social workers follow a professional code of ethics, which may conflict with opposing forces when a lack of understanding about ethical frameworks exists. Compassion for others contributed to my fit with the social work profession but overriding this was my instinct for fairness and justice. At times, it is challenging to work in a way that honours both values.

There is value in learning more about moral distress in order to mitigate consequences that may extend to the practitioner, organization and recipients of care. The burden of care is linked with moral distress. “All too often, providers feel completely responsible for whether a client succeeds or fails, lives or dies, and they can become emotionally overwhelmed by this heavy burden” (Teixeira, Ribeiro, Fonseca, Cervalho, 2014, p. 98). Compromising care to clients, avoidance of certain situations, anxiety and depression, and withdrawal from practice are unfortunate outcomes of moral distress and may lead to employee turnover and burnout. It is important to learn more about the strategies employed for resolving value conflict and whether positive outcomes can formulate from experiences with moral distress. If managed effectively with individual and organizational structures, moral distress “can be an opportunity for transformation and growth” (Hanna, 2004; as cited in Pauly et al., 2012, p. 4). My interest in the topic of moral distress has evolved from my experiences as a social worker in healthcare over fifteen years. Circumstances abound that involved conflict between professional values and job expectations and I was curious about the immediate and cumulative effect of these experiences for social workers in healthcare. I have witnessed the erosion of caring responses among
colleagues and their clients and this led me to research the possibilities to interrupt the frequency and intensity of moral distress. The intent of this study is that it may inform opportunities for support and education for healthcare social workers, leading to professional growth and retention. These outcomes may then improve the delivery of care within healthcare and the experiences for social workers and consumers.

**Literature Review**

**What is the Issue?**

Moral distress was originally defined in the 1980s with significant information about the outcomes and contributing factors becoming more available during the past five to ten years. This allows for reflection of current social and political influences. Performing mainstream social work within the current conservative climate was a theme that did arise in the research. Social workers often tend to task-oriented work and avoid an advocacy role. Social workers frequently resist taking a stand against the social injustices that present for clients (Musil, Kubalí’kova, Hubí’kova’, and Neasova’, 2004, Papadaki & Papadaki, 2008; Stanford, 2010; as cited in Fine & Teram, 2013). Clarity surrounding the rationale behind these practices may offer relevant insight regarding the prevalence of moral distress for healthcare social workers.

Within the published literature, there is limited material on the subject of moral distress within a healthcare setting. To date, what is available is primarily tailored to nursing practice but there has been evolving recognition towards the impact moral distress will have for a broader base of healthcare providers. “Through research and anecdotal reports, moral distress is a reality of clinical practice” (Rushton, Kaszniak, & Halifax, 2013, p. 1074). Complex care situations
within a stressful work environment are shown to contribute to moral distress among healthcare professionals. Research has shown moral distress can have short and long term consequences and create implications on the delivery of patient care, retention and job satisfaction (Pauly, Varcoe, & Storch, 2012, p.1). The presence of moral distress can influence a professional’s sense of well-being and job performance. Patient care may also be affected in situations where the social worker cannot do what they believe to be right due to lack of confidence, level of training or limited resources (Grady, Danis, Soeken, O’Donnell, Taylor, Farrar, & Ulrich; 2008, p. 7). Neo-liberalism is instrumental in the distribution of resources in society and has influenced a decline in social welfare programs (Raphael, 2011, p. 354). The current political climate requires healthcare social workers respond to increasingly complex situations with fewer resources. Social workers follow a professional code of ethics, which may come into conflict with organizational constraints (BC College of Social Workers, 2009). As a result of these factors, ethical dilemmas may occur. The lack of understanding about ethical dilemmas within multidisciplinary teams frequently places social work at the center of controversy. Ethics are frequently discussed in relation to moral distress, though information related to the interactions between ethics education, ethical practice and moral distress for healthcare social workers is inconsistent and sparse.

Research on moral distress has been primarily tailored towards nursing, however, there is growing interest on the topic as it relates to healthcare social workers. A healthy working environment is suggested for fostering safe, competent, and ethical care (Pauly et al., 2012, p. 7). It is important to learn more about the strategies employed for resolving moral conflict and whether positive outcomes can formulate from experiences with moral distress. If managed
effectively with individual and organizational structures, moral distress “can be an opportunity for transformation and growth” (Hanna, 2004; as cited in Pauly et al., 2012, p. 4).

Features of Moral Distress

Moral distress can manifest when practitioners are obligated to perform work duties that are in conflict with personal values based on external factors, including policy expectations or organizational pressures. “Moral distress is often described as psychological disequilibrium associated with knowing the morally right course of action to take in a situation but failing to follow through with that action because of institutional constraints” (Bell & Breslin, 2008, p. 94). “The feeling of discomfort arising from the conflict between professional values and job tasks is referred to as professional dissonance” (Taylor, 2005, p. 89). Kalvemark, Hoglund, Hannsson, Westerholm, and Arnetz (2004) define moral distress as a symptom of stress, which arises when “the health providers feel she/he is not able to preserve all the interests and values at stake” (p.1082).

Values that define what is important to an individual are frequently discussed in research and act as a contributing force to sources of conflict. A value is held dearly and is informed by environmental factors that can affect one’s attitudes, behaviours and task performance (Horne, 2014, p. 52). It is critical to be self-aware of values in order to know your fit with a job, a client group, and agency because positive alignment of personal and organizational values can foster job satisfaction.
Outcomes of Moral Distress

All professionals working in healthcare can experience moral distress (Bell & Breslin, 2008, p. 95). Among social workers, moral distress has been correlated with a sense of powerlessness and feeling undermined by others (Openshaw, 2011, p. 4). Moral distress may manifest into “feelings of anger, frustration, guilt, depression, nightmares, anxiety, helplessness, powerlessness, compromised integrity, dread and anguish” (Bell & Breslin, 2008, p. 95). Moral distress can also weaken the social worker’s ability to offer empathy and compassion to the client. The burden of care is linked with moral distress. “All too often, providers feel completely responsible for whether a client succeeds or fails, lives or dies, and they can become emotionally overwhelmed by this heavy burden” (Teixeira, Ribeiro, Fonesca, Cervalho, 2014, p. 98). Compromising care to clients, avoidance of certain situations, anxiety and depression, and withdrawal from practice are unfortunate outcomes of moral distress and may lead to employee turnover and burnout. Symptoms of burnout include depersonalization, emotional exhaustion and overall dissatisfaction with work and with one’s personal life. According to a literature review completed by Epp (2011), there is no standard definition of burnout, however, common features include emotional exhaustion or detachment, or lack of job satisfaction (p. 25). Feeling ineffective and lacking a sense of accomplishment is linked to burnout and can be compounded when there is a lack of support from supervisors (Epp, 2011, p. 28).

Research indicates that a high percentage of nurses leave the profession due to moral distress (Bell & Breslin, 2008). Shared features in burnout and moral distress include the presence of ethical dilemmas, feelings of powerlessness, power imbalances within the work environment, workload issues, perception of inadequate care and communication styles (Dalmolin, Lunardi, Lunardi, Barlem, & de Silverman, 2014, p. 36). Results from the study by
Dalmolin et al. (2014), revealed a low level correlation in the association of moral distress and burnout between most groupings explored. However, there was a relation between the two where futile medical interventions were the focus. While there were intersecting features between burnout and moral distress, there was limited evidence to support a strong correlation outside of issues involving lifesaving treatment.

**Contributing Factors**

There is an increased risk of burnout among healthcare workers if they perceive incongruence between agency policy, professional values and ethical standards. “When a situation arises that contains moral reasons both for and against a certain action, and that challenges one’s ethical beliefs, the result is an ethical dilemma” (Davis, Schrader, & Belcher, 2012, p. 738). “Moral distress is specifically associated with ethical dimensions of practice and concerns related to difficulties navigating practice while upholding professional values, responsibilities and duties” (Epstein & Hamric, 2009; Hardingham, 2004; Kalvemark, Höglund, Hansson, Westerholm, & Arnetz, 2004; Kalvemark Sporrong, Hoglund, Hansson, & Arnetz, 2006; as cited in Pauly et al., 2012, p. 2). Ethicist, Jameton, distinguishes ethical dilemmas and moral distress by suggesting that the ethical dilemma is identified but not yet resolved whereas moral distress arises when the worker defies the right course of action as a result of institutional restraints (Jameton, 1984; as cited in Pauly et al., 2012, p. 3). “Staff burnout and emotional exhaustion are a common response to ethical problems in providing patient care services” (Bell & Breslin, 2008, p. 95).

Professional ethical standards influence the response to a situation. The Social Work Code of Ethics suggests that practitioners promote fairness and the equitable distribution of resources and act in a way to reduce barriers and expand choices for all persons (Canadian
Association of Social Workers, 2005, p. 5; as cited in Fine & Teram, 2013, p. 1313). Where ethical differences exist, it is important to engage in conflict resolution to reduce the perceived value incongruence and prevent burnout that may be fostered through competing values (Gabel, 2011, p. 424). It is illogical to suggest social workers stand up to every injustice that may be produced out of policy, but a better framework for ethical practice may be valuable to reducing the incidence of moral distress (Fine & Teram, 2013). Facilitating, maintaining and promoting ethical practice require agency commitment. “A 2007 study that included nurses and social workers, found that half of 1215 respondents felt frustration and fatigue when they could not resolve ethical questions” (Bell & Breslin, 2008, p. 95). Recognizing an ethical conflict but feeling unqualified to respond or taking no action increases the susceptibility to moral distress (Grady, Danis, Soeken, O'Donnell, Taylor, Farrar, & Ulrich, 2008, p. 6). There is a lack of consensus about the content and delivery of ethics training for health providers but in one study by Grady et al. (2008), it was identified that social workers have more education overall, more ethics training and use ethics resources more often than their nursing colleagues (p. 7).

Moral distress is influenced by the political climate and allocation of resources. The current social-political climate does not favor social work clients and has created a growing emphasis on the marketplace and personal autonomy, thus reducing its responsibility for establishing and maintaining equity for those who need it most. Neo-liberal ideals emphasis on self-sufficiency combined with a residual government state has resulted in shifts to resource allocation (Raphael, 2011). The distribution of resources influences a social worker’s ability to link clients to supports that could improve quality of life. Healthcare social workers often work with marginalized population groups who do not have reasonable access to resources. Research participants have identified feelings of helplessness and powerlessness when interfaced with the
political climate (Pauly et al., 2012, p. 7) while workload constraints interfere with the resolution of moral distress.

Social work is involved at the micro and macro levels of practice. Social workers may operate in direct practice assisting individuals in need of immediate service while social reform and social justice are addressed at a macro level (Bransford, 2011, p. 933). Ferguson and Layette suggest there has been a shift within social work that favors the needs of the marketplace above the needs of the public (2006). Critical consciousness encourages social work to link private troubles and public issues, but agency priorities often conflict with this practice. Social work in healthcare has taken an increasing responsibility towards managing resources and mitigating risks to clients, leading to an increase on administrative tasks and less time for client-centered engagement and building rapport (Oliver, 2013, p. 211). The limited research available related to moral distress and social workers suggests workers “choose not to address injustices in their places of work” (Musil, Kubálková, Hubíková, and Neasová, 2004, Papadaki & Papadaki, 2008; as cited in Fine & Teram, 2013, p. 1314) and because of a neo-liberal ideology, many social workers have “adopted a more defensive and morally timid position in response to the pervasive and insidious political and moral conservatism of neo-liberal risk society” (Stanford, 2010, p. 1067).

Life and death decisions are frequently related to ethical dilemmas and contribute to moral distress amongst healthcare workers. Research has found that intensive care nurses are vulnerable to moral distress because they are often powerless to make decisions, and instead are required to execute physician orders (Epp, 2012, p. 26). Moral distress is frequently present in situations where families want to continue life-sustaining treatments deemed futile. Information is lacking in reference to how moral distress translates to other professions outside of nursing
Research that utilized the participation of nurses, social workers, respiratory therapists and doctors revealed that the triggers to moral distress varied between disciplines. In one study that reviewed the causes of moral distress among physicians and nurses, a high incidence of moral distress associated with life-saving treatments was present, specifically in situations related to prolonging life and subjecting patients to invasive treatment that were deemed inappropriate (Allen, Judkins-Cohn, deValasco, Forgers, Lee, Clark, & Procunier, 2013, p. 116). This same study by Allen et al. (2013), suggests that providing less than optimum care was the primary trigger of moral distress for social workers while patient suffering due to poor continuity of care ranked second and life-saving treatment issues was the third leading source of moral distress (p. 116). Research is available which uncovers other contributing factors to moral distress among multidisciplinary teams, including workload and time pressures that interfere with patient care, changes in the health system including advanced policy and legal parameters, and issues related to treatment decisions. Those organizational values and constraints that may be contrary to professional values in healthcare include discharging patients too soon, lack of information sharing between healthcare providers and clients, insufficient time allowances for patients, and disregard or avoidance of less desirable patients (Gabel, 2011, p. 422).

Moral distress then, can be conceptualized as a by-product of the interaction between internal and external forces (Pauly et al., 2009; Varcoe, Pauly, Webster, & Storch, 2012; Webster & Baylis, 2000; as cited in Oliver, 2013, p. 206). An approach to practice is influenced by the social worker’s individual values and its interface with client values as well as agency goals. The combination does not always align and a person’s beliefs about right and wrong may at times come into conflict with organizational expectations and philosophies. Some of those internal constraints which have been correlated to moral distress include a fear of speaking up, being
perceived as imperfect, fear of conflict, socialization towards compliance, lack of courage, fear of job loss and self-doubt (Oliver, 2013, p. 206).

A commitment to social work ethics may also contribute to moral distress. The social work code of ethics endorses a set of values to guide practice but does not offer support to practitioners when their values are in conflict with agency policy (Openshaw, 2011, p. 5). Over the past ten years, there has been increasing attention to ethics and encouraging moral sensitivity as part of student education (Oliver, 2013, p. 205). Education systems are promoting the concept of moral sensitivity leading to heightened awareness of incongruent moral frameworks within agency settings and feeling “unsupported in their moral burden” (Oliver, 2013, p. 211). From this perspective, there is suggestion that moral sensitivity correlates with moral distress (Austin, Rankel, Kagan, Bergum, & Lemermeyer, 2005; Lutzen, Blom, Ewalts-Kuist & Winch, 2010; Lutzen, Dahlquist, Eriksson & Norberg, 2006; as cited in Oliver, 2013, p. 205).

**Suggestions to Reduce Moral Distress**

Management participation on the frontline and increased attunement on moral distress is suggested (Epp, 2011, p. 29). The combined approach of frontline social workers and their supervisors may influence the frequency and intensity of moral distress. When social workers feel supported by their employer, there is less moral distress (Corley, Minick, Elswick, & Jacobs, 2005; Pauly et al., 2009; as cited in Oliver, 2013, p. 210). Supervision over the span of a career is suggested as a potential strategy to prevent professional dissonance. Supervisors may stimulate dissonant discussion by exploring anxieties and illuminating sources of the inner and outer conflict (Taylor, 2007, p. 97). Encouraging practitioners to identify and process moral issues may decrease the prevalence of employee turnover and promote collective solutions (Schluter, Winch, Holzhauser, & Henderson, 2008).
There has been increasing attention towards problem solving through ethical dilemmas to prevent distress. Research suggests that leaders have a responsibility for promoting ethical climates, but available information does not convey the leadership role in addressing staff moral distress (Bell & Breslin, 2008, p. 96). Many agencies do not promote a climate towards ethical decision-making and little is known about the outcomes within those agencies that do. Advocating for one’s values and beliefs and encouraging change within one’s agency are suggested in literature. Noteworthy is that standing up against a system may come with a cost and seem ineffective to enact change, and an agency’s climate can influence the courage it takes to address policy. People may act based on the climate and the perceptions of others around them (Openshaw, 2011, p. 8). “Acting with moral courage involves bringing the internal or external constraints that are prohibiting appropriate action into the light so they can be recognized and then dealt with appropriately” (Openshaw, 2011, p. 10). Promoting an ethical climate does not necessarily address the presence of moral distress amongst care providers. The ethical climate should be expanded to include “strategies to recognize and name the experience of moral distress, critical stress, debriefings, ethic committees, grief counseling, and protocols for end of life care” (Bell & Breslin, 2008, p. 96). Ethics education specifically designed to address moral distress may be useful to reducing its prevalence particularly if provided within a climate that promotes discussion about ethical dilemmas. Moral distress could arise throughout the span of one’s career and therefore, information related to the ingredients surrounding the dilemma and improving self-awareness is imperative to mitigating the risk. Through a process of education, experience and reflexivity, social workers are able to formulate their “ethical selves” (Oliver, 2013, p. 213). One study found participants felt more confident to address ethical dilemmas after receiving weekly sessions with supervisors who had ethics training (Bell & Breslin, 2008, p. 96).
Gaps in Research

Moral distress illuminates the complexities within social work practice and the conflicts that exist, but further knowledge is required. Moral distress has been researched from a narrow lens, primarily within the nursing profession. This restricted view is often directed towards life-saving treatments within the intensive care units. In September, 2011, a search for the term, moral distress, within academic databases for nursing produced approximately 550 hits while two main social work databases, social work abstracts, and social service abstracts produced a collective seven articles using the same term (Oliver, 2013, p. 204). Research has highlighted negative outcomes of moral distress for nurses (Bell & Breslin, 2008; Dalmolin et al., 2014; Epp, 2011; Oliver, 2013; Texeira et al., 2014). Nurses provide physical care to their patients and develop bonds that stem from intimate and frequent contact. The study that Epp (2011) completed was done with nurses in Alberta, and was very focused on the stressors within nursing practice including high acuity of patients, job responsibilities, advances in technology and caring for families. With its application towards nursing, it is understood that moral distress is often related to carrying out physician orders that involve invasive tests or treatments deemed to be unethical. The hierarchy of nurses within the healthcare system may also have an influence on their experiences with moral distress and may not be transferrable to other disciplines. Quantitative studies have been used to measure moral distress using a moral distress scale, primarily with nurses (Oliver, 2013 & Pauly et al., 2012). Qualitative studies directed at social workers in health could offer distinctions in the experiences between them and their nursing counterparts. A multidisciplinary approach was considered in a small amount of studies and revealed shared psychological experiences of moral distress amongst professions. Grady et al. (2008), considered a multidisciplinary approach in their research while Pauly et al. (2012)
focused on nursing, but acknowledged that other professions would also be impacted by moral distress. Findings that are focused on nursing have a limited application to social work because of the variance in core competencies, job requirements and political perspectives.

Moral distress and its consequences are well defined in literature but its application to healthcare social workers is lacking. The concept of moral distress is extending beyond the nursing profession to include other health providers including psychologists, pharmacists, and doctors and its relevance to social work has only just begun (Weinberg, 2009; as cited in Oliver, 2013, p. 204). “There is a need to expand research on moral distress in disciplines other than nursing and/or approach research on moral distress from an interdisciplinary perspective” (Pauly et al., 2012, p. 6). Social workers are often the only member of an interdisciplinary team who can speak to the social determinants of health but research has not identified the potential linkage between this area of knowledge and the incidence of moral distress.

Most information on the subject of moral distress is from North America and the United States of America in particular. International studies were available but avoided due to potential disparities in concepts and structural influences. Information from Pauly et al., (2012) was gathered from a forum presented in British Columbia, which considered information from an international lens, but again, with a focus towards nursing. There is a need for more local information in order to examine unique features of moral distress that may arise within the regional political climate.

Most articles lacked information regarding gender and age. Participants from research by Grady et al. (2008) were over 80% female and primarily Caucasian. Studies conducted by Fine & Teram (2013) sampled fifty-one women and twenty men and 15% of participants identified
themselves as minorities. This would account for the higher representation of females working in the social work profession. Differences in the experiences of moral distress between men and women and race are not addressed.

Moral distress seems to be “understood differently in different studies” (Pauly et al., 2012, p. 2). At times, the concept of moral distress and burnout were interchangeably used in the literature. The interactions of ethics and moral distress were reported differently. Some information presents ethical dilemmas and moral distress with similar definitions while other information was distinctly different. Also, the importance for cultivating ethical climates is clearly outlined but its effectiveness to reduce moral distress is again divided. Bell & Breslin (2008) suggest a positive ethical climate does not address moral distress (p. 96) whereas Grady et al. (2008) suggest ethics education is correlated with moral distress. “Not feeling qualified or responding to an ethical conflict by feeling concerned but taking no further action makes one susceptible to moral distress – distress resulting from a discrepancy between what one thinks ought to be done and what is actually done” (Grady et al., 2008, p. 7). The existence of moral distress among healthcare social workers has been established but the outcomes of effective strategies to reduce the prevalence are needed. Attention toward positive outcomes forming from moral distress and how this may influence job satisfaction and retention could be valuable. It could be useful to explore whether the frequency or intensity of moral distress is influenced by specific social work traits, practice situations or job experiences. Actual outcomes surrounding the impact of supervisory support to reduce moral distress has been suggested but the outcomes are unclear. A review of the supervisor’s role to reduce moral distress was divided and not specific to social workers in healthcare. Bell & Breslin (2008) were not able to correlate leadership’s role to reduce moral distress, however other studies could articulate some benefit
Peer supervision may also alleviate moral distress. The importance of peers for resolving moral distress is noted in the studies (McAuliffe & Sudbery, 2005; Pauly et al., 2012). However, limitations exist in the analyses by McAuliffe & Sudbery (2005), which was completed in Australia within social services agencies using a small number of participants.

**Theoretical Framework**

Social work practice is guided by theory and principles, unique to each clinician. For the purpose of this research, moral distress among healthcare social workers will be discussed from an ethics of care perspective. Ethics of care prescribes an emphasis on relationships and highlights the need for care that every individual requires at various points within their life (Held, 2006, p. 10). The ethics of care is rooted in feminist theory and provides a framework for understanding that the basis of moral action is caring relations. The need for care is intrinsic. Moral tendencies do not arise from a sense of duty but rather from a natural tendency for reciprocal relationships. Feminist theory suggests ethical behavior stems from a sense of compassion rather than obligation and stresses the importance of interactions and meanings within relationships (Gray, 2010, p. 1804). Ethics of care is interested in the issues that manifest from ability, class, gender and race (Meagher, 2004, p. 22). Social workers consistently advocate for patients and families and frequently interface with opposing opinions, which can occur interchangeably between clients and medical providers and/or between patients and their families. It is the social workers role to identify and diffuse the tensions that may exist within these systems, regardless of internal beliefs. Their interest in the person within the environment offers a broad perspective of the individual’s psychosocial situation and the interplay with
presenting medical issues. The relationship between the client and therapist forms the foundation for uncovering needs.

Social work aligns with feminist theories through their mutual interest in justice, compassion, empowerment and emancipation of patriarchal oppressions. Feminist theories consider oppressions that are perpetuated by patriarchal systems (Machold, Pervaiz, & Farquahar, 2008, p. 670). Acts of caring within formal or informal systems is largely unrecognized in society because women often perform in the capacity of care. An ethics of care perspective describes social work as a caring occupation, devalued within patriarchal societies (Payne, 2005, p. 255). Its reference as a soft profession with an emphasis on caring is even more disregarded when positioned next to other healthcare professionals that demonstrate measurable outcomes. In a quest for justice, social work is often perceived as the profession that creates barriers against desired outcomes. Virginia Held is a contributor to ethics of care theory and stresses her thoughts that justice should be secondary to care in the formation of a moral framework (2006, p. 71-2). Justice and care should be considered together in order to foster a fair and just society. “Justice says everyone is entitled to the same treatment but an ethics of care may lead to differential treatment as it may dictate that some people are needier of care than others based on situational and subjective judgments” (Gray, 2006, p. 1806). Healthcare is a rationed service, which creates barriers to service access especially among vulnerable individuals. Social workers are required to advocate and seek justice for marginalized individuals with complex care needs within a system that does not necessarily endorse the cause.

The medical system can be daunting to consumers. The jargon, chaos, frequent breakdowns in communication, and emotion can create significant distress for patients and their families. Healthcare consumers are often vulnerable and may not be equipped to stand against
systemic barriers and unfair practice. Furthermore, the medical model frequently ignores the specialized needs of marginalized individuals. “The political approach to the ethics of care explores how the ethics of care can illuminate problems of power and difference in existing social arrangements (including arrangements for the giving and receiving of care) and can help overcome some of the characteristic problems and dilemmas of care that unequal power engenders” (Meagher, 2004, p. 17). An ethic of care is interested in empowerment within a framework of caring and recognition of unequal relationships (Machold et al., 2008, p. 673). The theory considers the power that is manifested through social norms, laws and values. Important in its application to moral distress, ethics of care acknowledges, “every aspect of practice takes on a moral dimension as the ethical self negotiates with the wider environment” (Hugman, 2003, as cited in Oliver, 2013, p. 209). Utilizing a concerned, fair-minded approach, social workers are in a position to assist people to navigate the complex systems. However, moral distress can arise when “health providers feel she/he is not able to preserve all the interests and values at stake” (Kalvemark, Hannson, Westerhold, & Arnetz, 2004; p.1082). Moral distress is an outcome of “competing values within power dynamics” (Varcoe, Pauly, Webster, & Storch, 2012, p. 51).

The political arena influences the interactions between client and agency. There are macro-level influences in the formation of moral distress, which include economic factors and resource allocation. Within a capitalist marketplace, there is value toward economic savings, and workdays are often defined by rules versus client needs. The political climate has left social work with less time for client-centered engagement in order to concentrate on gate-keeping resources, managing client behaviours and mitigating risks (Oliver, 2013, p. 210). Neo-liberal Canadian policies typically inform strategies that will reduce risks of ethical dilemmas and engage in top-down decision-making (Oliver, 2013, p. 205). Those social workers that are able to follow
procedure and detach from moral sensitivity are less susceptible to moral distress but may compromise authentic, caring relationships with clients (Oliver, 2013, p. 208). Social service work has a tendency to “undermine moral concepts, because of their contradictory nature: their stated goal is to help clients, yet their actual operation serves the interest of preserving the bureaucracy. When this conflict is not recognized, workers often function as if the bureaucratic decisions do not have moral dimensions” (Rhodes, 1986, p. 134). Social work is sensitive to the barriers that agency priorities create for clients. Neo-liberalism fosters oppression by enforcing autonomy and individualism and disallowing structures to support people who are frail, sick, and in greater need of care. “Unless society places value on caring for others, we will not care whether their rights are respected or not, especially in the case of people who are too weak to make serious trouble for us, as the history of domination, exploitation, and indifference makes evident (Held, 2006, p. 89). Varcoe et al. suggest that the current socio-political climate, which blames the individual for the health and social issues, also blames the health provider for their own distress (2012, p. 51). Moral distress has become an increasing reality of the profession’s discourse. The emotional issue has been defined as “the state experienced when moral choices are thwarted by constraints” (Austin, Bergum, & Goldberg, 2003; as cited in Oliver, 2013, p. 204). Resource shortages can interfere with an ability to provide adequate care to patients, and health providers are frequently asked to follow standardized formulas to address identified issues. A focus on managerialism decreases the caring relationship (Meagher, 2004). Professional codes of conduct may assist social workers to navigate the external conflicts that may exist but this may not address internal value conflicts. The shortcomings of systematic reasoning have led to increased interest in relational ethics approaches to address one’s sense of
moral responsibility (Oliver, 2013, p. 205). Ethics of care draws attention to the internal conflict that can occur within conflicted or value-laden situations (Oliver, 2013, p. 204).

I am drawn to the ethics of care and its emphasis on caring relations and social justice. These concepts align with social work values and also aide in the explanation of moral distress. Moral distress would not exist in absence of caring practitioners who are invested in the professional relationship and interested in preserving social justice. Individuals depend on social workers to advocate for services on their behalf, to act as a liaison with medical providers and to ensure their dignity and rights are preserved. However, the care and justice that is provided by social workers in health continues to be devalued, especially for those people who are seen as a burden to the system. The current socio-political system placed high regard on individualism and autonomy and blames the victim for their circumstances. “If through the process of caring systems, structures and institutions that oppress men and women are maintained and perpetuated, it easily deteriorates into an ethics of suffering within is antithetical to feminist ethics” (Machold et al., 2008, p. 671).

Design and Methodology

Research Design

The research question: How healthcare social workers create meaning from their experiences with moral distress.

Type of Research Design

This was an exploratory study using qualitative methods, intended to offer a rich understanding of the topic pertaining to healthcare social work. Qualitative research can promote an understanding about the incidents of moral distress within a “larger social context” (Dudley, 2011, p. 26). Utilizing a design that was flexible was important for data collection in order to
explore meaning, context and provide opportunity for participants to expand on open-ended interview questions. This was a cross-sectional study, collecting data at one point in time (Dudley, 2011, p. 126). A level of measurement was used to capture data such as education level and years of experience as a social worker. Moral distress was considered using a feminist lens. According to Dudley (2011), feminist research typically wants to create benefits for participants (p. 31). The intention from this research is to inform education and practice within the Fraser Health Authority. The Fraser Health Authority is one of six health authorities in British Columbia (BC) dependent on the Ministry of Health for funding and is registered as a charity organization that represents health regions in BC, spanning from Burnaby to Hope.

**Recruitment**

Approval to conduct research was received from the Ethics Board at the University of the Fraser Valley on March 11, 2015 (Appendix A) and from Fraser Health Authority on April 10, 2015 (Appendix B). As part of the ethics application, Fraser Health also required confirmation of experience and qualifications to carry out this research. This was obtained from the principal investigator’s manager, Jan Olsen. For the purpose of the study, a convenience sample was obtained through invitation to social workers currently employed with the Fraser Health Authority on a full time, part time or casual basis. The sample was solicited through email request by the Regional Social Work Practice Leader, Terry Brock, on April 13, 2015. An invitation explaining the research study, its purpose and criteria for participation was included within the email (Appendix C). Fraser Health social workers, who self-identified as having experienced moral distress, were invited to participate in the study. Interested participants were asked to contact the principal investigator, ask questions and arrange for an interview at a time and place that was convenient, outside of work hours. Thirteen social workers responded to the
invitation and received a consent form to review (Appendix D). Of those thirteen people who expressed interest, one person cancelled prior to the interview, two were excluded because they did not fit the employment and/or qualification criteria, and two others did not follow through to schedule interviews. Eight social workers met the criteria and participated in the study. Pseudonyms were assigned alphabetically in the order that contact was made with participants.

Sample

In-person interviews took place with eight healthcare social workers between April 25 and May 29, 2015. Semi-structured interviews offered the benefit to clarify questions and introduce prompts for further exploration as new information arose. These interviews lasted between forty-two to ninety-seven minutes, with an average of seventy-six minutes. Three interviews took place on Fraser Health property, three were completed in public areas, and two were conducted in someone’s home. All interviews were audio recorded and then later transcribed by the principal investigator. Some notes were written to highlight salient points. Demographic information was obtained at the beginning of the interview and participants were invited to share information about their social location at their own discretion. Three people did not disclose features of their social location. Among the other participants, one person identified as South Asian, three identified as Caucasian, two people identified as heterosexual and one person identified as middle class. One person stated having no fixed religion. Four participants had a Bachelors degree in Social Work and four had a Masters Degree in Social Work. One person was working in a casual position at the time of the interview, three were part time and four were full time employees. Five participants worked in an outpatient services while three worked in acute care. It should be noted that participants drew upon their experiences as healthcare social workers within acute, chronic care and outpatient services and did not
necessarily refer to experiences within their current job positions. Seven participants were female and one person was male. Their age range was as follows: two people were in the 51-60 year age range; four people fit within the 41-50 year age range; two people in the 31-40 year age category. Participants’ experience working as healthcare social workers ranged from 2.5 years to over 20 years. Five people had nine to twelve years of experience as healthcare social workers.

**Data Collection**

To ensure clarity of terms, moral distress was explained to participants in the consent form and at the beginning of interviews. A series of open-ended questions were used as a guide to collect data (Appendix E). Participants were invited to share their experiences with moral distress at work. Moral distress was described as a conflict that arises when the worker’s values and perceived obligations diverge with the work environment (Epstein & Delgado, 2010, p. 1). The value conflicts may exist between worker and client or agency. Causation of distress was explored including value conflicts involving client, policy and agency expectations. Organizational influences that involved operational restraints, case complexities, and task centered work that is prioritized above counseling and advocacy services were discussed. Implications on job satisfaction and retention were addressed as well as motivating factors that support or hinder the social worker’s ability to preserve his or her values. The participants were asked about ethics training and their practice in seeking consultation when faced with moral dilemmas. Important to the study was the participant’s perception of positive outcomes secondary to their moral distress. How the social worker has created meaning and healed from moral distress was a principal component to the study.
Ethical Considerations

Approval to conduct research was obtained from the ethics boards at Fraser Health Authority and the University of the Fraser Valley. Participants were advised of my qualifications and relationship with Fraser Health. A consent form explaining the nature and purpose of the study was given to participants to sign. Each participant received a copy of the consent. The study explored interactions with the organizations, and findings of the research will be made available to Fraser Health. These results could foster negative perceptions on the profession. Some participants expressed concern about sharing information about their experiences with moral distress. Because findings will be shared with members of the organization, it was imperative to reinforce the parameters of confidentiality with participants. Furthermore, the option to withdraw from the study at any time was discussed prior to every interview and participants were advised they could decline to answer any questions during the interview process. Confidentiality was discussed within the recruitment letter and consent form. Some participants expressed relief to hear that their own identity and the identity of the client groups they referred to within their narrative would be protected.

The potential for a psychological impact was reviewed within the consent. It was important to monitor the “effects of participation and extend support to participants when needed” (Dudley, 2011, p. 42). Dialogue related to experiences of moral distress did prompt an emotional response for some participants and interviews were paused when this occurred. Participants were then reminded of the option to discontinue the interview or withdraw from the study, but each interview continued. Counselling support through Fraser Health’s employee assistance program and extended health services were discussed.
Findings

During this study, interviews revealed two major sources of moral distress that result from issues of fairness and justice and preserving client autonomy. Throughout the interview process, participants talked about strategies used to relieve distress as well as the factors that hinder resolve. Outcomes of their moral distress were also reviewed. Central to the research findings were the circumstances in which participants make meaning from their experience. Research focused on what moral distress signifies to the participant’s practice; how did participants process their experiences and move forward. There was interest afforded to the purpose that participants could identify with these dilemmas, and whether these incidents strengthened or changed the social worker’s approach to value conflicts.

Value Conflicts That Create Moral Distress

Obligations to perform work functions that directly conflict with personal and professional values contribute to moral distress. These value conflicts often stem from external issues that rest outside of the social worker’s control and may involve systemic influences.

Fairness and justice. As demonstrated in research and practice, social workers are involved with marginalized people and act as advocates for individuals who are unable to navigate complex health systems. As advocates for clients who are misunderstood or mistreated, social workers often experience moral distress. Interviewees revealed that the injustices that triggered distress was often linked to the availability and response of resources and services, stigma, systemic issues, internal conflicts, role ambiguity and communication issues.
\textit{Resources and services.} The challenge to link clients to resources was an identified source of moral distress for all research participants. According to one participant, “it was the lack of resources and not feeling like you can be helpful. And that’s why I went into this field, to be helpful, not to be useless” (Participant A). Within health settings, social workers facilitate transitions for clients, but the lack of appropriate resources poses barriers and creates moral distress. “Home health could be more flexible….people who really need it (home health services) but they don’t fit the criteria or the resource doesn’t exist or the resource is inflexible, then that creates distress” (Participant F). According to participants, many gaps exist which interfere with access to services including age restrictions or residential location. Services may not adequately support the individual and there could be expectations that informal supports fill the gaps that exist. A lack of resources and inequitable distribution of services impacts the client’s quality of life. “I’m not able to provide all the resources I would like to my clients in order for them to have the best quality of life that they need” (Participant C). Some respondents thought services were lacking for those individuals who are less valued in society, such as the aged and disabled.

“I’m not convinced that we’re using our resources in the best possible way. I think there is room to open more continuing care beds and room to increase mental health support in the community. And if that’s not happening, then should the patient be caught in the middle? Its not their fault” (Participant H).

Discharges are a priority in acute care but limited community resources is a persistent source of distress for social workers. “Where the moral distress comes in for me is where I’m being asked to discharge someone and I don’t think its safe and there isn’t adequate resources to
support the person” (Participant H). Research respondents emphasized sentiments of respect and understanding towards the constraints and mandates that other systems must follow. However, moral distress may still be aroused if there is uncertainty about another agency’s commitment to assume responsibility for the safety and care for a vulnerable individual “It’s a lack of faith in the resources that are there” (Participant A).

Some patients or clients have strong advocates who can navigate the healthcare system and are willing to engage in formal complaints. Research participants spoke of distress that erupts when care is afforded to clients not provided to other equally deserving clients. Some social worker participants have been inclined to withhold or buffer information about the distribution of resources in order to protect the client. It is understood clients may not utilize resources appropriately but the consequence if a social work intervenes by altering or discontinuing services may cause clients to decompensate. Clients may develop an inability to maintain their previous level of function, which could result in a hospital admission. Agency expectations and policies can create significant consequences to clients who may be banned from services due to minor infractions and was a noted source of distress for participants.

**Stigma.** Clients who have been stigmatized based on socioeconomic positioning or specific afflictions were a noted source of distress for social work participants. Marginalized individuals are frequently treated unfairly but may be unaware of their rights or may be without the support to navigate complex systems. Interviews revealed that those individuals perceived as making bad choices are inadvertently blamed for their situation and further marginalized by a system that rations services. Examples that were identified in the study included people struggling with obesity, mental health or addictions. Service availability for these groups is often
meager and difficult to access. One participant referred to the distress experienced when residential addiction programs do not permit clients to receive prescribed medications. An individual’s social location may also affect team perceptions. During interviews, participants suggested that patients with similar medical issues would be treated differently based on stigmatized issues. One participant referred to a situation where the patient struggled with drug addiction. “If you remove the stigma of the lifestyle and gave the medical issues to another patient, then I don’t think they (the healthcare team) would have looked at her the same way” (Participant H).

**Systemic issues.** The health system must impose its mandate regarding the delivery of services onto its clients and staff. Interviews revealed that philosophies can differ between various levels management and the frontline worker. Workload impacted by bed utilization, large caseloads, lack of resources, case complexities and task-oriented work are examples of external conflicts that five of the social workers identified with. Due to persistent patient turnover, compassionate care may be overshadowed by task-centered duties. “I’m being pulled away from doing the things I need to do because I’m too busy doing the things I’m told to do” (Participant D). One participant felt that workload demands led to rushed interventions with clients. Another social worker felt enmeshed with agency priorities at a sacrifice to other important tasks. “It’s a brainwash, its oppression and I have it” (Participant G). Distress can arise when workers are required to interpret policies that will impose stress to clients. “You just want to quit, you want to say forget it, you can’t work like this, with people that think like this” (Participant A). System flow is a reality in healthcare. Facilitating transitions perceived to be unhelpful to clients or when there is potential for harm can foster a sense of helplessness for workers. “Its an us/Them
mentality. So you won’t have success there” (Participant B). Patient risk and suffering were significant triggers of moral distress identified by some participants in this study.

**Internal conflicts.** Three participants acknowledged a lack of confidence and skills as an influence on the experiences of moral distress. An internal conflict may surface when clients experience a poor outcome and lead the worker to question their ability to have done more to improve the situation. One participant spoke of a sense of responsibility towards good or bad discharges (Participant F). Improving skills through education opportunities is at times hindered by workload and financial matters and was a noted concern for two participants. Social workers may not be allotted time off if coverage is not available and costs can be at the expense of the individual.

**Role ambiguity.** Five participants identified role ambiguity as a source of moral distress. The role of social work is often misunderstood and devalued by team members and leadership. This compels staff to impose their own perceptions and expectations of the role onto the social worker. “…you’re always being pulled in different directions and you have to prioritize the organization’s values versus yours and sometimes that manager’s calling the shots and you might bend to what they want” (Participant D). An advocacy role is often required to mediate patient needs and organizational priorities, placing social work at the center of controversy. One participant referred to “bullying tactics” that were frequently used to influence the social work intervention (Participant C). A lack of appreciation or understanding of the role was an identified barrier for clients to access social work services. Referrals may be missed if other team members do not recognize or appreciate the social worker’s role. Furthermore, interviewees identified
value conflicts that arise when other team members disregard or oversimplify resolutions to the social worker’s identified concerns.

**Communication issues.** Their expertise with communication creates a natural fit for social workers to diffuse the tensions and conflicts that arise for clients. Communicating agency policy, especially in relation to discharge planning can place social work in a position that compromises rapport with clients and was a notable issue among five participants. “You’re made to be the bad guy” (Participant F). Social workers become the perceived gatekeepers of resources and often deliver difficult news to clients. Educating clients about services and resources can be a positive interaction, but workers can become disillusioned if client expectations are unmet. Participants reflected on examples when clients were misled about services and resources they thought would be available after transitioning into a new area of care. The social worker is the person who responds to misunderstandings and is asked to diffuse the conflict “I’m the deliverer of bad news” (Participant D). Social work is based on caring relations and not until there is a foundation of rapport and trust can social workers uncover client needs. Relying on social work to convey difficult news directly impacts the professional relationship central to social work practice. “So it stops us from being able to do the rest of our work” (Participant A). Respecting the client’s rights to information and clearly articulating messages is highly valued for social work but the lack of transparency about treatment plans and goals of care has encouraged distress for some participants. Unwarranted stress for the client may arise “….we need to be transparent with these families. I think it (information) is vague and I think it’s intentional in the means that if they are vague, then they don’t have to be held accountable” (Participant G).
**Autonomy.** Preserving client autonomy was the second major theme identified as a source of moral distress. Supporting client self-determination, avoiding dependency and mitigating risks were notable sub-themes among respondents. Study participants reflected on experiences when they were called upon to preserve individual interests while interfaced with the broader system.

**Self-determination.** Social workers are frequently in the position where they are diffusing tensions between family members and members of a care team, who may allow their own values to infringe on the client’s right to make decisions or live at risk. Advance care planning and the rights of family members to override a client’s previously held wishes for treatment can also create conflict if family do not agree with the medical providers’ recommendations surrounding goals of care. Family members who make decisions to consent to futile or invasive treatments were a noted source of unease for a couple participants. In reference to an end of life situation, one participant noted, “It was torture. Why would we do that to this poor woman” (Participant D).

The system’s need to prioritize bed utilization may also influence the client experience. Two participants reflected on concern when clients are placed in a care facility before their baseline is established, leading to greater chance of unnecessary moves and disruption to the client. Social workers may experience distress when alternate care programs must be considered that could disrupt the client’s routine and stability. Moral distress can result when agency caregivers do not endorse a philosophy and invest the time to preserve client autonomy. One participant spoke of the propensity for residential care facilities to erode independence and self-determination through the use of scheduled services. Dependency can arise when caregivers
disregard program mandates and consistently do for the client rather than encourage independence. Supporting clients often requires an active response but caregivers may be doing “the bare minimum with clients” (Participant J).

**Mitigating risks.** For five participants, moral distress manifested from feeling powerless to alleviate potential harm. Client safety is paramount to healthcare workers, but there are times when all elements of risk cannot be mitigated for various reasons. Some interviews revealed that a lack of support services create risks while organizational priorities seem to overshadow risks. Clients who are assumed capable have the right to live at risk, but a distinction between tolerable and intolerable risk can be difficult to conclude. Preserving independence is a deeply held value for social work and moral distress can erupt when practitioners are required to make decisions regarding client capability. It is a weighted burden. “I take power out of people’s lives and I experience moral distress when I need to do that” (Participant C). Clients may have impairments that impose upon their judgment but still be deemed capable to make decisions for themselves. Two participants reflected on the careful consideration required surrounding the level of intervention to impose on clients who are participating in behavior that may provoke risk to themselves or others.

**Outcomes of Moral Distress**

Respondents identified an interplay between moral distress and physical and psychological symptoms. Anger and frustration in response to unresolved moral distress were noted during five interviews. The manifestation of these feelings differed among participants. In response to value conflicts, one participant reported feeling “indignant, very indignant” (Participant B). Another person acknowledged that anger has prompted candid discussions with
clients about feelings they have associated with systemic conflicts, but question the utility of the information provided (Participant A). Issues of moral distress resonate beyond hours of work and have interfered with personal time for some participants. Episodic and chronic depression, anxiety and fatigue were issues for five participants that were associated with moral distress and low job satisfaction. One participant commented: “I feel sad, really sad sometimes” (Participant A). Three participants acknowledge a timid response to conflicts, or doubt in their ability to stand against injustices, which led to heightened stress. For five of the participants, a lack of confidence and knowledge of systems was an identified factor in the source of moral distress at the beginning of their careers but then eased over time.

Five of the participants linked sleep issues or insomnia with moral distress. Feeling conflicted about case decisions or ruminating about client outcomes has triggered symptoms and interfered with job productivity. Some participants also mentioned headaches, fatigue and sick time when struggling with moral distress. Feeling depleted can inhibit the energy that is required to resolve issues that erupt from distress. Poor job satisfaction secondary to large caseloads, stress, and exhaustion were notable issues for four participants. As the literature suggests, questioning your suitability for a job can also arise from value conflicts. Three participants attribute moral distress as a factor in their decision to leave their jobs. Feeling helpless to enact positive change, and feeling devalued within their role were aspects in these decisions. One participant had loved her job but left due to persistent value conflicts.

The outcomes of moral distress can extend beyond the social worker and implicate interactions with clients. During four interviews, it was noted that avoiding clients or specific elements of a client situation were tactics used to evade moral distress. One participant spoke of
detaching emotionally from clients. Workers have also avoided specific people within the organization in order to prevent potential value conflicts. A sense of hopelessness and frustration may deter investment in a situation and disengagement may be used when the worker is aware the client will not qualify for services. “It feels like you’re flogging a dead horse. You can’t do anything about it. So you just don’t bother” (Participant D). A reduced commitment to resolve situations may enhance feelings of distress and helplessness to enact positive change. One participant noted they had become complacent to task oriented work and felt remorse at the lack of meaningful contact with clients (Participant D). Three people acknowledged a timid response to value conflicts due to fear of retribution or fear of speaking up to leadership. Participants spoke of the need to consider the benefits of an advocacy role in response to value conflicts on their teams.

Support with the moral burden

According to participants, an important component for reducing moral distress involved the support of others who could validate their concerns and who understood the social work role and core competencies. Supervisors, peers, and ethics services were among those sources of assistance noted by some as being useful to conceptualize problems, provide guidance, and offer new perspectives relevant to the dilemma.

Clinical practice leaders. The Fraser Health Authority employs clinical practice leaders to provide leadership and clinical support to social workers. Engagement with clinical practice leaders was a common strategy employed for reducing moral distress among participants. It was important that supervisors were authentic, approachable and understood the issues surrounding moral distress. Practice leaders were identified as a source of support, especially when the value
conflict exists between social work values and organizational priorities. Participants may refer to practice leaders to streamline identified concerns and ease the pressure on the situation, or encourage the social worker to take further action to address the source of conflict. “What I typically do is I go to the clinical practice leader and if I get the support of the practice leader, then I will have more courage to advocate” (Participant H). However, the infrastructure does not always allow for the availability of practice leaders and this was noted as a source of heightened distress for one participant.

**Peers.** Drawing upon social work peers for suggestions, support and guidance was another common theme. Shared experiences with peers can offer validation and opportunities to draw from others’ skills, experience and expertise. “Hearing from others who understand what I’m feeling really lowers my distress” (Participant B).

I also have social work friends that I can talk to who get it, and understand the depth of the struggle or the weight of it for me. I second-guess myself so having someone help me brainstorm, who understands the system and reminds me what my role is and understands the complexity of the system helps. (Participant J).

A sense of camaraderie can evolve from shared experiences with moral distress. “It’s like sharing battle scars” (Participant A). It was noted that not all participants have been able to garner support from peers. Rapid turnover and separation from a team of social workers or peers can hinder support. One participant noted that while peer consultation is valuable, moral distress could actually increase if the support person did not share similar values. Useful for some was the support from partners and friends willing to offer different perspectives but who are not caught up in the emotion that can arise when navigating systemic challenges.
**Ethics services.** Social workers are often at the center of controversy when ethical dilemmas arise and can contribute to moral distress. Among the research participants, all but one participant had received ethics training during their healthcare employment. The amount of training ranged from half a day, up to an eight-module training series. All participants were aware of Fraser Health ethics services to resolve dilemmas, but there was a range of positions regarding the interest towards ethics consultations. The two participants who participated in the extensive training did not express shared positions related to the value of introducing ethics services. Three participants spoke of resistance received when introducing an ethics consult to their teams while one person noted that the team neither encouraged nor discouraged consultation and thereby questioned its utility. Two participants noted they embrace ethical discussions that involve wading through the different elements of the dilemma. There was credit granted for the support ethic services can offer healthcare teams to identify salient points to a situation and there was also recognition that the involvement of ethics services will not necessarily change outcomes for the client or healthcare team. One participant reflected upon an ethics consultation for end of life issues and concluded, “nothing came of it so what’s the point” (Participant D). Consistent with the published material, there were no conclusive findings that arose from this study relative to the interplay between moral distress, ethical dilemmas, ethics training and ethics consultations.

**Creating Meaning from Moral Distress**

During interviews, research participants were not directly asked how they create meaning from moral distress, but there was exploration surrounding outcomes, benefits and implications to their practice. Interviewees revealed resistance to factors that created distress and indicators of
resilience that has formed in their practice. In response to experiences related to value conflicts and leadership, one participant noted, “I went along with it but it didn’t feel very good. Over time I just stopped” (Participant C). While some participants were able to link experiences of moral distress with professional growth, others did not recognize their strength to overcome the conflicts they endured. One person seemed uncomfortable to admit they left two jobs as a result of moral distress. I saw this as a potential testament of commitment to the profession and awareness that those jobs were not a good fit with their values. As the literature suggests, finding the right fit for a job can decrease value conflicts and improve job satisfaction. Another participant noted that a lack of fear was the incentive to maintain integrity and resist moral distress. This person contends they would leave a job if there were a lack of freedom to act ethically. A sense of autonomy without any fear of retribution or job loss allows this person to stand up against injustices and perform ethically. “I anticipate moral distress would elevate if ever I believed I couldn’t influence the situation” (Participant B). Not experiencing a fear of job loss enhanced the courage to respond to injustices for two participants.

During interviews, participants revealed the need to experience moral distress in order to recognize its influence on practice “You need experiential examples before you get it” (Participant G). A trend erupted among seven participants who recognized an increased commitment to resolve value conflicts following previous experiences with moral distress. “I’ve learned how to deal with it more. I have my little anger attack and then I get on with it” (Participant A). Previous occurrences can offer resolution strategies, knowledge of system navigation and increased confidence. Decisions imposed by the agency, which created significant consequences for clients inspired commitment to resolve future conflicts for some participants.
There are some things I won’t compromise even if I’m disciplined and I have been disciplined. I think once I’m able to take action, one way or another, then I’m usually able to get resolve, or I get to a place where I’m so burnt out that I retreat and take care of myself (Participant C).

Previous experiences can inspire the social worker to discern professional and personal boundaries and reduce the propensity for distress. Choosing not to become enmeshed in situations can reduce the prevalence of moral distress without compromising the relationship with clients. One participant noted the importance of asserting boundaries and deciding not to convey difficult information to clients on behalf of the organization. Acting against moral distress by resisting some of the expected task oriented work can be liberating and help define values and priorities. “It’s the outcome for the client, not how I get there. And that helps quite a bit in dispelling the moral distress” (Participant C). Good communication skills are vital for social work and three people noted that their experiences with moral distress led to increased courage and skills to address value conflicts within their teams.

Previous situations can highlight the importance of the advocacy role and the need to persevere. Anger can motivate social justice initiatives. “It’s my privilege to work with people to preserve their self determination” (Participant G). “I think those cases with moral distress has helped me to advocate effectively for a patient and that gives me job satisfaction, even if the team is annoyed with me” (Participant H). The presence of moral distress may be useful. “It indicates I care, that I’m invested and it predisposes me to take action on behalf of someone, for something, which are all good things, although they are not always fun at the time” (Participant
C). “I’m more mobilized when people have no ability to fight back. There are things that are unjust and I’m not prepared to walk away from those kinds of situations” (Participant B).

Seeking solutions and validation from other social workers and colleagues can offer valuable information. “I don’t ever stop seeking solutions. I’m hopeful” (Participant A). Social workers may create alliances with others in the quest for resolution. “It feels manipulative sometimes because you’re taking these back routes trying to meander around the case and trying to plant information to enough people that maybe the ideas will shift” (Participant H). Professional guidelines strengthen practice and may also be used as a tool for reference in educating team members about the social work perspective and reduce incidence of conflict. Three people noted that their professional code of ethics and professional practice standards offered validation and prompted their commitment to preserve client rights. “…The code of ethics provides a great deal of comfort to fall back on when something falls out of my experience” (Participant C).

An intersect between low confidence and moral distress inspired four respondents to seek education. Two participants had actively sought education specific to moral distress, compassion fatigue and burnout. Counselling services were an identified source of support for some social workers struggling to resolve moral distress. Some participants had relied on union representatives for support with conflicts within the organization and two participants actively sought work within the union as a means of enacting change within the larger system. One person noted that work with the union led to a sense of productivity as an agent of change. One person felt that union work can “…mobilize other people to advocate for change” (Participant F).
One person identified a positive change in interactions with leadership after committing to their union role.

According to five participants, an awareness of limitations to the social work role is important for setting boundaries and reducing moral distress. Experiential knowledge can encourage flexibility within practice and promote insight relevant to the constraints of the role. “I have to preserve myself and that benefits my health and my family and clients” (Participant H). The ability to discriminate on the costs and benefits towards taking action against a conflict is an important strategy some participants have adopted. Decreasing expectations of external agencies can also decrease the propensity for moral distress. Two people acknowledged that external agencies and other disciplines are also coping with significant caseloads and doing their best within a chaotic system. That awareness is useful to reduce ruminating thoughts and distress. One person noted that after years of practice, “…I calm down faster” (Participant A). Understanding organizational pressures and the interface with bed utilization is an important objective. When there is a breakdown in the system, such as a failed discharge, some respondents consider their contributions to strengthen plans for clients, offsetting distress that might otherwise appear without an investment of time. “There have been cases where I have had problems where I’ve struggled with someone else’s work or a policy, but I did solid work, I maintained integrity and authenticity, and I provided the resources” (Participant G). For one participant, she and her team were making a concerted effort to concentrate on the positive exchanges with clients. According to participants, moral distress can be interrupted by acknowledging the responsibility clients have towards outcomes and reminding yourself that you have done all you can towards resolving a situation.
Limitations of the study

The small sample size was a limit to the study. With only eight participants from Fraser Health, the results cannot be generalized to the organization’s social work department or profession overall. Exploratory research is intended to gather new details about a subject and while the findings have offered interesting insight, using a small sample group and qualitative design does not offer conclusive findings. Individual participants were assured that their area of work would not be identified within the analysis, but regardless, participants may have been reluctant to fully engage in the discussion about moral distress at work. Because the principal researcher and participants all work for Fraser Health, there is a likelihood of future encounters and this may have limited a participant’s comfort with full disclosure during interviews. This may also have deterred some people from responding to the invitation to participate. Also, there is potential that as a social worker in health, I may have over-identified with some aspects of information while overlooking other areas.

Noteworthy was that six participants had more than nine years of experience and only one person had less than five years of experience. None of the participants were under thirty-one, while six were over forty-one. Those new to the profession may not recognize the features of moral distress or may have felt apprehensive to identify with their experiences and these factors may have influenced participation in the study. This research does not uncover potential linkages or associations between age, experience, and moral distress.

The topic of moral distress is often confused with burnout, compassion fatigue and ethical dilemmas. Although interview questions were designed to reflect the established definitions and constructs relating to moral distress in the literature, it is possible that participants could not always distinguish these variances in response to every question.
were framed with intent to explore the distress that arises when there is a conflict or compromise with the social worker’s own values and beliefs and while professional values may be an extension of one’s personal belief system, exploration of the distinct influence personal beliefs may have had with moral distress was not identified.

**Discussion and Implications for Practice**

Although research participants may not deliberately consider the strategies and strengths they use to make meaning from moral distress, they were able to draw upon experiences that motivate or inhibit actions for resolve. Several participants have strengthened their strategies to cope with dilemmas or become selective with the conflicts they shoulder, and some have made job changes that better fit with their own values. Research participants reflected on past and present experiences of moral distress and generally felt more adept to address value conflicts compared to earlier years in their careers. Previous experiences had become useful to define the course of action during future encounters with moral distress. Symptoms of moral distress are uncomfortable in nature but may also create the impetus for change and resolve. While some of the participants may have previously adhered to agency objectives, the subsequent moral residue that arose from inaction influenced future actions. As noted in the findings, one participant reflected on changes to professional practice as a result of past experiences with moral distress. “I went along with it but it didn’t feel very good. Over time I just stopped” (Participant C). “Not feeling qualified or responding to an ethical conflict by feeling concerned but taking no further action makes one susceptible to moral distress – distress resulting from a discrepancy between what one thinks ought to be done and what is actually done” (Grady et al., 2008, p. 7).
Social workers and the ethics of care theory have a mutual interest in justice, compassion, empowerment and the emancipation of power. Understandably that within the current healthcare climate, controversy can appear between the social worker’s goals and that of the organization. Value conflicts that develop while preserving client rights to fairness and justice were obvious in this study. Moral distress often surfaces from unfair treatments bestowed upon clients who are stigmatized or devalued within the healthcare system. “Justice says everyone is entitled to the same treatment but an ethics of care may lead to differential treatment as it may dictate that some people are needier of care than others based on situational and subjective judgments” (Gray, 2006, p. 1806). Efforts for justice and care can be thwarted by organizational priorities and some participants noted that at times, they felt their role was questioned, devalued and ignored. Power imbalances are frequently present within hierarchal systems and may inhibit or inspire the worker’s ability to enact change but dedication towards fairness and justice can motivate action, especially when advocating for vulnerable populations. A willingness to stand up against injustices benefits the client and thus reduces the risk of moral residue and burnout. However, social workers do not always feel empowered to stand against injustices. Research related to moral distress and social workers suggests staff “choose not to address injustices in their places of work” (Musil, Kubalíková, Hubíková, and Neasova’, 2004, Papadaki & Papadaki, 2008; as cited in Fine & Teram, 2013, p. 1314). Interviews revealed fear and intimidation are factors sometimes inhibiting work with clients and creating stress for the employee. Fear of speaking up, fear of conflict, socialization of compliance, lack of courage, fear of job loss and self-doubt are correlated with moral distress (Oliver, 2013, p. 206). It is illogical to suggest social workers stand up to every injustice that may be produced out of policy and process, but a solid framework for the resolve of moral distress may offer greater job satisfaction and less job turnover.
Additionally, enhanced awareness and support could alleviate the propensity for agency staff to misinterpret or condemn the social work role.

Within this study, little attention was afforded issues related to end of life, advanced care planning or sudden death. Value conflicts that surface in these situations between the healthcare team and clients have been a source of moral distress during my years in practice. However, during this study, participants primarily reflected on value conflicts that emerged between themselves and the agency. This does not negate the incidence of moral distress that does occur during work with patients and families; however, this could suggest that the overriding factor in moral distress currently, stems from the challenge to navigate the organizational system. Future research could be concentrated on experiences that arise from value conflicts between worker and client during end of life situations.

Economic factors and resource allocation frequently undermine the social worker’s ability to perform their role as change agents. Social work has become less about client-centered engagement and is more closely aligned with gate-keeping resources, managing behaviour and mitigating risk (Oliver, 2013, p. 210). Connecting clients with services intended to improve quality of life and mitigate risk is a common practice, but frequently interrupted by various factors. During this study, the struggles associated with resource linkages were significant triggers to moral distress. The current social-political climate does not favor social work clients and has created a growing emphasis on the marketplace and personal autonomy, thus reducing its responsibility for establishing and maintaining equity for those who need it most. Neo-liberal ideals’ emphasis on self-sufficiency combined with a residual government state has resulted in shifts to resource allocation (Raphael, 2011). The social worker’s sense of fairness and justice
can be motivating but a sense of hopelessness to enact change could perpetuate moral distress and impact client care.

Moral distress is a reality of practice and all study participants had benefitted from support from peers and practice leaders to clarify roles, offer validation, alternative perspectives, and direction. Benefits from these supports are consistent within the literature. Creating structures that prioritize and promote support specific to moral distress could be beneficial to social workers, especially early on in their healthcare career. Focusing attention on the features, consequences and coping strategies associated with distress could foster better outcomes for worker and client. Encouraging practitioners to identify and process moral issues may decrease the prevalence of employee turnover and promote collective solutions (Schluter, Winch, Holzhauser, & Henderson, 2008). At times, low confidence contributed to the formation of moral distress suggesting educational opportunities to increase skills could decrease the prevalence of incidents.

I was intrigued that no social workers with less than two years experience chose to participate in this study and only one person had worked as a social worker in health for less than six years. This may suggest there is a lack of awareness related to the features of moral distress or discomfort to acknowledge one’s struggle with these experiences. Future research could be focused on the new social worker’s knowledge and response surrounding the features and outcomes of moral distress and moral sensitivity. We may also consider the possibility that some social workers are able to follow structure and procedure and detach from issues of moral sensitivity. This tendency, however, may come at a cost to authentic, caring relationships with clients (Oliver, 2013, p. 208). Published research frequently suggests social workers in health
will experience moral distress during the course of their careers, however, studies remain sparse. A comparison study with social workers that do not identify with moral distress at work could offer valuable insight relevant to the dilemma.

As the published literature suggests, there is potential to accept a neo-liberal ideology and abandon social justice initiatives whereby many social workers have “adopted a more defensive and morally timid position in response to the pervasive and insidious political and moral conservatism of neo-liberal risk sociality” (Stanford, 2010, p. 1067). Those who contributed to this study presented with a strong commitment to care and social justice and acknowledge that recognition and management of moral distress has developed over time. This suggests the resolve of moral distress requires experience and contemplation of an individual’s threshold of tolerance. Furthermore, this study reinforces social work’s commitment to justice and care, which may be challenged or hindered by resource shortages, value discrepancies and agency priorities.

**Conclusion**

Social work in healthcare has become increasingly challenging due to constraints on the system and therefore it is possible that without an ability to enact change, moral distress, moral residue and burnout could increase. It is not known how many people left the profession as a result of unresolved moral distress, but the literature suggests that the dilemma is inevitable in practice and thus, stands to reason that social workers should be encouraged to critically reflect on their values, beliefs, and practice within the organization. Moral distress would not exist in absence of professionals who are invested in their clients and hence, it would seem valuable for organizations to preserve their commitment. Findings from this study could inform educational
opportunities for social workers and the organization at large. This study focused on the ability for social workers to create meaning from moral distress. Participants revealed that education, validation and support, experience, and authentic interest in the client experience supported a commitment to social justice, care and professional integrity.
References


# Appendix A

## University of the Fraser Valley Ethics Approval

### Certificate of Human Research Ethics Board Approval

<table>
<thead>
<tr>
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<th>Department</th>
<th>Protocol #</th>
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<tr>
<td>Hall Miller</td>
<td>Social Work</td>
<td>7435-15</td>
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<th>Co-investigator(s)</th>
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<tr>
<td>Leah Douglas; Margaret Coombes</td>
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<td>How Do Healthcare Social Workers Who Have Experienced Moral Distress Make Meaning From Their Experiences?</td>
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<th>Approval Date:</th>
<th>Approval Term:</th>
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**Certification:**

*The protocol describing the above-named project has been reviewed by the UBV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.*

Andrea Hughes, Chair, Human Research Ethics Board

*NOTE: This Certificate of Approval is valid for the above noted term provided there is no change in the procedures or criteria given.*

*If the project will go beyond the approval term noted above, an extension of approval must be requested.*
Appendix B

Fraser Health Ethics Approval

## CERTIFICATE OF FHREB APPROVALS

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<th>Official Notification - FHREB Number</th>
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<td>Principal Investigator:</td>
<td>MILLER, Hall</td>
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<tr>
<td>Hospital/Facility &amp; Department:</td>
<td>ARHCC/Renal Services</td>
</tr>
<tr>
<td>Institution(s) or Geographical Areas where research will be carried out:</td>
<td>ARHCC, BH, CGH, DH, ERH, LMH, PAH, RCH, RMH, SMH, JPOCSS</td>
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<tr>
<td>Co-Investigator(s):</td>
<td>Leah Douglas, Margaret Coombes</td>
</tr>
<tr>
<td>Funding Agencies and/or Corporate Sponsor:</td>
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### Title: How Do Healthcare Social Workers Who Have Experienced Moral Distress Create Meaning From Their Experiences?

### Documents Included in this Approval

- Application for Initial Ethical Review
- Researcher Response Form, dated 2015 April 01
- Protocol Version 2, 2015 March 21
  (*The FHREB has determined that the collection of the data elements as described in the protocol/data collection form are justified and required in order to conduct the research*)
- Consent Form Version 2, 2015 March 22
- Invitation to Participate, 2015 February 18
- Interview Questions

### Date of Approval | Date of Expiry | Type of Approval | Approval of the FHREB
|-------------------|---------------|-----------------|-----------------|
| 2015 April 08     | 2016 April 08 | Initial Approval; Delegated Review | Digitally signed by Sara D’Elia, Chair of the Fraser Health Research Ethics Board (FHREB)
|                   |               | Digital ID: 36395A3BB719193C5C5F584C7FB000163D713D16  |

### CERTIFICATION:

**With respect to clinical trials:**
1. The membership of the Fraser Health Research Ethics Board complies with the membership requirements for research ethics boards as defined in Part C Division 5 of the Food and Drug Regulations and the Tri-Council Policy Statement.
2. The Fraser Health Research Ethics Board carries out its functions in a manner consistent with Good Clinical Practices.
3. The Fraser Health Research Ethics Board has reviewed and approved the clinical trial protocol and the informed consent form for the trial which is to be conducted by a qualified investigator named at the specified clinical trial site. This approval of the documentation listed above and the views of the Fraser Health Research Ethics Board have been documented in writing.

**With respect to delegated review:**

A co-chair or delegated member of the FHREB has reviewed and approved the documentation listed above for the forenamed research study in accordance with the FHREB Policy on “Ethical Conduct of Research and Other Studies Involving Human Subjects”, the Tri-council Policy Statement: Ethical Conduct for Research Involving Humans”, and the “International Conference on Harmonisation Guidance E6: Good Clinical Practice E6: Consolidated Guidelines”.

**With respect to full board review:**

Full FHREB review and approval of the documentation listed above was completed for non-expedited review in accordance with the FHREB Policy on “Ethical Conduct of Research and Other Studies Involving Human Subjects”, the Tri-council Policy Statement: Ethical Conduct for Research Involving Humans” and the “International Conference on Harmonisation Guidance E6: Good Clinical Practice E6: Consolidated Guidelines”.

The FHREB approval for this study expires ONE year from the approval date of this certificate. Researchers must submit a Request for Annual Renewal for ongoing research studies prior to the expiry date in order to receive annual re-approval.

Appendix C
INVITATION TO PARTICIPATE IN A RESEARCH INTERVIEW

How Healthcare Social Workers Who Have Experienced Moral Distress Create Meaning from their Experiences

Dear Potential Participant;

I am conducting a research study exploring the experiences of moral distress among social workers in health. The purpose of the study is to uncover the ways in which social workers are able to make meaning and heal from their experiences with moral distress. The study is intended to identify contributing factors of moral distress and the means of coping with the internal and external conflicts that participants identify with.

The research is being conducted as part of the Master of Social Work program at the University of the Fraser Valley. The hope is that information from the study can be used for the purpose of social work education and professional development and ultimately to improve job satisfaction and the effectiveness of care to patients, residents and families.

If you choose to join the study, you will be asked to engage in one individual interview, which is expected to last up to one hour. A series of open-ended questions will be asked related to your experiences with moral distress. With your consent, the interview will be audio recorded. The interview will be arranged at a time and place that is convenient for you outside of your working hours.

The criteria for participation in the study are as follows:

1. You work as a social worker in Fraser Health
2. You self-identify as having experienced moral distress in your work with clients
   - Moral distress can be described as a state of conflict that may arise when moral choices are hindered by opposing constraints
3. You are receptive to discussing your experiences with moral distress

Your participation in the study will remain confidential and will not be shared with anyone within Fraser Health. Data that is collected in the study will not reveal any identifying information.
information about subjects involved. Prior to participating in the study, you will be provided with a consent form outlining the study. You are encouraged to ask questions before consenting to participate. If you choose to participate, you will have the option to withdraw at any time without giving a reason.

The research study, including its purpose and methodology is approved by the Research Ethics Boards at the University of the Fraser Valley and the Fraser Health Authority. If you have any concerns about this research, you can contact Dr. Leah Douglas at the University of the Fraser Valley at 604-504-7441, local 4292. If you have any ethical concerns about this research study, please contact Adrienne Chan, UFV Associate Vice President of Research, Engagement, and Graduate Studies, at 604-557-4074 or Adrienne.chan@ufv.ca. You may also contact the co-chairs with the Fraser Health Research Ethics Board at 604-587-4681.

I invite you to contact me if you would like to learn more about this study:

Hali Miller, BSW, RSW
Renal Social Worker
Abbotsford Regional Hospital
604-851-4700 local 646202
hali.miller@fraserhealth.ca
CONSENT FORM

My name is Hali Miller and I am a student at the University of the Fraser Valley in the Master of Social Work program. This study is intended to fulfill the requirements for the Master of Social Work program at the University of the Fraser Valley. As part of my educational requirements, I am conducting exploratory research to study the experiences of moral distress among healthcare social workers. Upon completion, the study will be published through the university library and presented to faculty and fellow students. The findings may be submitted for publication in academic journals.

As a social worker employed with Fraser Health, and who has self-identified as having experienced moral distress, you are invited to participate in this study. For the purpose of the study, moral distress is associated with a state of conflict that arises when moral choices are hindered by opposing constraints.

Background

Social workers in health are engaged with clients during periods of heightened stress and emotion. In their role as advocates, social workers frequently interface with opposing opinions and are called to diffuse the tensions that exist, at times, at a compromise to their own values and beliefs. It is expected that practitioners will experience value conflicts during the course of their careers. Moral distress can have implications on the delivery of care to clients as well as job satisfaction. There is limited research available related to moral distress for healthcare social workers. Insight that could be gathered about the features, outcomes and resolve of the social worker’s experiences could be meaningful to education and professional practice.
Purpose/Objectives of the Study
The purpose of the study is to uncover the ways in which social workers are able to make meaning and heal from their experiences with moral distress. The study is intended to identify contributing factors of moral distress and the means of coping with the internal and external conflicts. Moral distress has been linked to job dissatisfaction, employee turnover, burnout and absenteeism. Information from the study can be used by the organization to inform education and support services. Ultimately, we hope that findings may lead to improved job satisfaction and the delivery of care for patients and residents.

Procedures involved in the Research
The study will involve one individual interview with each participant. It is anticipated that there will be 6-8 participants and the interview is expected to last for one hour. The interview will be scheduled at a time and place that is convenient for you and will not take place during your work hours. You will be asked a series of open-ended questions exploring your experiences with moral distress and whether you were able to identify any resolve. With your consent, the interview will be audio recorded and notes will be taken. If you do not want the interview recorded, then only notes will be taken. The purpose of the recording and notes is so that I, the principal investigator, have the opportunity to review the information and look for themes between your responses and those of other participants.

Potential Harms, Risks or Discomforts to Participants
It is not anticipated that there will be significant harm or discomfort associated with this study however, potential risks and the means of mitigating these risks are included below. The interview will involve dialogue about your experiences with moral distress. It is possible that this could elicit an unexpected emotional response from thinking and talking about these experiences. The principal investigator is a social worker and is available to discuss any emotional discomforts resulting from this experience. You are also advised of the option to access counselling services through the Employee Assistance Program (at no cost). You may request an appointment at: www.efap.ca. You may also access counselling services through your Extended Health Services. You may experience some concern or discomfort talking about your experiences. You may feel regret surrounding your disclosures. Your confidentiality will be respected and there will be no identifying information linking you to this study. You may experience boredom or physical discomfort during the interview process. You will be encouraged to request a break during the interview process and will be encouraged to position or reposition yourself in a way that is comfortable for you during the interview.

Potential Benefits
You may benefit from the opportunity to reflect upon your experiences with moral distress. The hope is that the information could be used to identify contributing factors of moral distress, which could then be used to strengthen professional practice. Information from
the study could be used by the organization to inform education opportunities or gaps in support services available to social workers.
There may be no direct benefits to you from your participation in this study.
There will be no compensation for your participation in this study.

**Participation**

Participation in the study is voluntary. You may withdraw your participation at any time and will not be asked to provide a reason. You may contact the principal investigator by phone or email if you choose to withdraw. If you withdraw, your data will be destroyed, unless you indicate otherwise. You can decline to answer questions during the interview but still remain in the study. You may stop the interview at any time.

**Will My Taking Part in this Study be Kept Confidential?**

Your confidentiality will be respected. The Co-Investigators, Dr. Leah Douglas and Dr. Margaret Coombes will supervise the study. No information or records that disclose your identity will be published without your consent, nor will any information or records that disclose your identity be removed or released without your consent unless required by law.

You will be assigned a unique study number as a participant in this study. Only this number will be used on any research-related information collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a participant in this study will be kept confidential. Information that contains your identity will remain only with the Principal Investigator. The list that matches your name to the unique study number that is used on your research-related information will not be removed or released without your consent unless required by law.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to assure that your privacy is respected and also give you the right of access to the information about you that has been collected and, if need be, an opportunity to correct any errors in this information. Further details about these laws are available on request.

**Study Results**

You will be offered the option of receiving a copy of the final report. This will be sent via email.

Information from this study will be kept for 5 years.

**Questions**

If you have questions or would like further information about this study, you can contact the principal investigator at 604-897-3762. If you have questions or concerns that you would like addressed by the University’s co-investigators, please contact Dr. Leah Douglas at 604-504-7441 local 4292 or Dr. Margaret Coombes at 604-504-7441, local 4440.

The ethics of this project have been reviewed and approved by the University of the Fraser Valley Human Research Ethics Board. If you have any ethical concerns about this research
study, please contact Adrienne Chan, UFV Associate Vice President of Research, Engagement, and Graduate Studies, at 604-557-4074 or Adrienne.chan@ufv.ca

If you have any concerns of complaints about your rights as a research participant and/or your experiences while participating in this study, you may contact the co-chairs at the Fraser Health Research Ethics Board at 604-587-4681.

Consent Form

Principal Investigator: Hali Miller, BSW, RSW
(604) 897-3762
hali.miller@student.ufv.ca

Co-Investigators: Dr. Leah Douglas
(604) 504-7441 Local 4292
leah.douglas@ufv.ca

Dr. Margaret Coombes
(604) 504-7441 Local 4440
margaret.coombes@ufv.ca

I have read and understood the subject information and by signing below I freely consent to participate in the study titled:

“How do healthcare social workers who have experienced moral distress create meaning from their experiences?”

- I have had sufficient time to consider the information, ask questions and receive additional details and feel satisfied to consent to participate.

- I understand that my participation in this study is voluntary and I am completely free to withdraw from this study at any time.

- I understand there is no guarantee that this study will produce any benefits to me.

- I understand that I have the right to withdraw from the study at any time and that confidentiality and/or anonymity of all results will be preserved.

- I agree to the use of audio recording to be used during the interview ( ) Please indicate with a checkmark.

If I have any questions about the study, I should contact the principal investigator. Alternatively, I may contact the Co-Investigators, listed above. If I have any ethical concerns about this research study, I should contact Dr. Adrienne Chan, UFV Associate Vice President of Research, Engagement, and Graduate Studies, at 604-557-4074 or Adrienne.chan@ufv.ca.

If I have any concerns of complaints about my rights as a research participant and/or my experiences while participating in this study, I may contact the co-chairs at the Fraser Health Research Ethics Board at 604-587-4681. By signing this form, I do not give up any of my legal rights

Name (please print) ____________________________________________

Signature ____________________________________________________

Date _________________________________________________________
Principal Investigator Signature __________________________________________________________

Date _____________________________________________________________________________________

Once signed, you will receive a copy of this consent form.
Appendix E
Interview Questions

Research Question:

*How healthcare social workers who have experienced moral distress, create meaning from their experiences?*

Research Objectives:

The purpose of the study is to uncover the ways in which social workers are able to make meaning and heal from their experiences with moral distress. The study is intended to identify contributing factors of moral distress and the means of coping with the internal and external conflicts that may arise when working with clients. Information from the study may be used by the organization to inform education and support services. Ultimately, the hope is that findings may lead to improved job satisfaction and improved delivery of care for patients and residents.

Background Questions:

1. Level of education – BSW/MSW/PhD
2. Employment status – part time/full time/casual
3. Gender
4. Age (range 20-30, 31-40, 41-50, 51-60, 60+)
5. Other self identified features referring to social location (race, language, ability)
6. Years working as a healthcare social worker

Interview Questions:

1. What has been your experience with moral distress at work?
   – Prompt: reference to continuity of care, end of life decisions (prolonging futile life support, patient suffering), risks to patients
   
   a) Has your moral distress been the result of external conflicts?
      - Prompt: lack of time/workload restraints, case complexity, task oriented work that is prioritized over counseling/advocacy services

   b) or internal conflicts
      - Prompt: do you resist taking a stand against perceived injustices that your client presents with, lack confidence or courage to address the situation, lack of training, feel a sense of helplessness to change the situation
3. How do you identify with your experience with moral distress?
   -Prompt: do you experience specific feelings such as anger, frustration, powerlessness, guilt, exhaustion, anger, depression, anxiety, nightmares, feeling undermined, avoidance, detachment from the client/job

4. From your perspective, has agency policy or professional practice guidelines contributed to your experiences with moral distress?

5. Reflecting on your experiences, how do you think your work with clients has been impacted by moral distress?
   -Prompt: avoidance to situations, choose not to stand up to injustices, greater commitment to stand up against injustices, sought education; do you cushion or buffer the consequences for clients – eg: tell them they’re better off at home (opposed to being in hospital) because of all the disease

6. Did you take action to allow you to preserve your values? If yes, what allowed you to do this within yourself or within the agency?
   -Prompt -How do you respond to these situations that create moral distress?

7. Reflecting on your experiences with moral distress, can you identify with value conflicts between yourself and the agency priorities? What are the value conflicts for you? Eg: fairness and justice; safety issues; autonomy & self determination…. If so, how do you respond?
   - Prompt: fear of speaking up, fear of looking imperfect/unqualified, fear of conflict, fear of being perceived as non compliant, fear of job loss, self doubt

8. Do you feel responsible for client/patient outcomes?

9. Have you participated in ethics training?
   -do you use Fraser Health’s ethics services when you are experiencing an ethical dilemma and to resolve moral distress?

10. Can you identify any positive outcomes from your experience with moral distress? What are they?

11. Do you feel supported in your moral burden – in other words, do you talk to others about your experiences with moral distress? Who?
    – do you speak with peers? Supervisors? Why or why not?