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IssueBrief

December 2017

Cultivating moral resilience: Balancing heart and mind for a better practice and better you

Ethical practice calls case managers to act "with integrity and fidelity with clients and others."[1] That principle is a lodestar for case managers as they navigate rocky instances in which clients and their families disagree on the path forward, or when clients choose a path the case manager may not believe is in their best interest.

"Within each of us is a moral compass, based on our own values, that helps us to know the right thing to do in ethically challenging situations. It points relentlessly to our personal 'true north,'" says Vivian Campagna, MSN, RN-BC, CCM, the Commission for Case Manager Certification's chief industry relations officer. "Philosophically, we know there is more than one right way and one wrong way to approach a difficult decision. Clients and their family members bring their own values to the table, and we're obligated to go with their choices in health care."

But it's not reasonable to believe case managers can simply shrug off these challenges to personal moral integrity without consequence.

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[1] Principles, Code of Professional Conduct for Case Managers, revised January 2015. https://ccmcertification.org/sites/default/files/docs/2017/code_of_professional_conduct.pdf

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What causes moral distress?

The causes for moral distress can vary widely, because every client case is unique and we each bring our own beliefs and moral values to the experience. But Rushton believes many can be described within some common categories.

- Overly aggressive care, which can include following family wishes for life support when it's not in the client's best interest, or initiating life-saving actions that only prolong the inevitable;
- Treatment that's futile, or where likelihood of any benefit is extremely low;
- Poor or inadequate pain management;
- Ineffective communication, which can include poorly defined goals of treatment, disregard for the client's choices and preferences, concern when clients and their families haven't been completely informed about their treatment or status, lack of informed consent, or poor communication within the health care team;
- Lack of provider continuity and the accompanying differences in opinion and institution of treatments and plans;
- Differences in authority and intra professional conflict, including situations in which some clinicians don't believe others are competent to provide care;
- Lack of or inappropriate use of health care resources, which may occur when patients are uninsured or under-insured, and case managers must balance resource availability with client needs. "Many of us are probably struggling with this today, and it will only become more intensified as changes in health care financing and payment structures evolve," Rushton says.

Research shows nurses and other health care professionals do, indeed, feel the pull and strain of moral challenges in the body, mind and spirit.[2] And the result is moral suffering.

"Moral suffering is the anguish we experience in response to moral harms, wrongs or failures and unrelieved moral stress," says Cynda H. Rushton, PHD, RN, FAAN, professor of clinical ethics at Johns Hopkins Berman Institute of Bioethics and the School of Nursing.[3]

It's an umbrella term that can be triggered by a wide range of events, but moral suffering generally involves witnessing, participating in or directly advancing situations that produce negative moral outcomes.

"The bottom line is that moral suffering is tied to our sense of integrity," Rushton says.

Within moral suffering is found the concept of *moral distress.* Rushton says moral distress is best understood as pain or anguish affecting the mind, body or relationships in response to a situation in which the person is

- aware of a moral problem,
- acknowledges moral responsibility, and
- makes a moral judgment about the correct action.

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2 Epstein E, Hamric A. Moral Distress, Moral Residue, and the Crescendo Effect. *Journal of Clinical Ethics*. 2009; 20(4): 330-342.

3 Rushton C, in press.

"Yet, as a result of real or perceived constraint—either internal or external—we're not able to enact the desired action," she says. And again, personal integrity suffers. "The distress is in response to challenges, threats or violations of our integrity."

Case in point: Maria

To illustrate moral distress, Rushton offers the example of a 62-year-old patient, Maria, who was diagnosed with pancreatic cancer five months ago. Maria has experienced multiple complications and hospital stays. She is in pain. She is able to make her own decisions, and she communicates to her case manager that she wishes to seek palliative rather than curative care. But her husband of 30 years, who is also her health care agent, disagrees, and asks you to convince his wife to continue treatment. The conflict between Maria's desires and her husband's request is acute.

When a case manager is placed in a situation like this, it's typically a trigger for moral distress, Rushton says. In such cases, it's important to become aware of your own reaction. For example, some people react physically, with tightness in the chest, a churning stomach or shallow breathing—symptoms that overlap with our body's natural stress response.

"The body is an incredible reservoir of information. As clinicians, we are so focused on others that we often miss the cues in ourselves," Rushton says. In times of moral distress, it's important to be attuned to our body's response. "Those are very common sympathetic nervous system responses to situations that produce a sense of threat in one way or another, whether it's to our sense of what it means to be a good case manager or our sense of integrity as a person, or what we might be assuming the patient or family might be experiencing. Those responses are pieces of information that can help us to notice when something is occurring that needs our attention."

Emotional responses are also common, such as feelings of sadness, frustration, or even anger. Being empathetic is a critical part of our psyche—that ability to attune our feelings and thoughts to the experiences in others. But there's a balance between how much empathy we can and should take on ourselves, Rushton says. An accumulation of negative experiences and emotions can cause a case manager to experience empathetic overarousal, which in turn can derail our natural empathetic abilities. "That can create a kind of dysregulated state that undermines, in the end, our ability to be compassionate toward others' experiences," Rushton notes.

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In such cases, the response to a new situation may be to deny or turn off the emotion. "We kind of check out; we turn away; we abandon ourselves and what we know to be true to ourselves, and sometimes we abandon others, like the family," she says.

Another common response to difficult ethical situations is a desire to "fix" the conflict. "We try to take a cognitive approach," Rushton says. "We want to get more data, we want to try to ask more questions." While there's nothing wrong with soliciting more information, a cognitive response doesn't always resolve the essential moral conflict, either.

What's at stake for case managers

The effects of moral distress are realized in two ways: the initial distress that occurs in the moment, and the feeling that remains after the event is over, when the individual continues to struggle with awareness of the inability to act in alignment with personal moral judgement. This latter, lingering distress is called *moral residue.* Left unaddressed, moral residue can build up as new morally

distressing situations occur, leaving behind additional layers of suffering and anguish.[4]

Moral residue remains when case managers are faced with two competing moral demands. In Maria's case, the demands are whether to comply with her husband's request to try to "convince" her, or to honor the obligation to Maria's desires to discontinue curative care. "Moral residue often follows a time when health care professionals have to make a tough choice, prioritizing one set of values over another. And sometimes it's choosing what's the least worst outcome," Rushton says. "It's not like either choice is without consequences. And sometimes that can ignite shame, guilt, regret or remorse on our part."

Moral residue may also arise from situations when case managers "have seriously compromised or allowed ourselves to be compromised," she says. When situations don't lend themselves to clear and morally acceptable resolution for all stakeholders, moral residue often remains.

And moral residue can lend itself to burnout. "It's important to be attuned to what's happening within ourselves and to think about how we want to respond, rather than react, to these challenging situations," Rushton says.

What's at stake for others

Responses to moral distress can carry significant consequences for others as well. Anger or frustration can color the respect professionals have toward clients and their family members, which may manifest itself in how the team honors the client's health care choices.

Also at stake are issues of justice and fairness, especially when situations concern allocation of resources and access to care.

"The bottom line for everyone in these circumstances is how do we preserve integrity—for the patient, for their family, for the professionals involved and, in a broader sense, for the team and organization?" Rushton says. "There's a lot at stake."

CCMC's Code of Professional Conduct for Case Managers offers principles to guide the way. When the focus is on the public interest rather than the individual case manager's interests, and the call is to respect the rights and dignity of clients, it lends clarity to situations like Maria's. Although it's a challenge to "always" maintain objectivity in a case manager's relationship with clients, it is certainly a good aspiration, Rushton says. Other principles within the Code, such as acting with integrity and fidelity and maintaining competency to ensure clients receive the highest quality of service, also lend themselves to responding thoughtfully and with intention to challenging scenarios.

The Principles within the Code of Professional Conduct are intentionally high-level and broadly applicable, the Commission's Campagna says. "They're intended to guide case managers in our daily work, and to remind us of our commitment to our clients and the public interest—and to our own professional integrity," she says.

[4] Epstein, et al. Op. Cit.

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"Maya Angelou once said, 'you may not control all the events that happen to you, but you can decide not to be reduced by them,'" says Campagna. "As case managers, we're often confronted with the need to acknowledge that circumstances are difficult, and we need to take steps to take that breath, take that moment for ourselves, so we aren't overwhelmed or distracted from fulfilling our professional obligation to the client."

The response: Cultivating moral resilience

Rushton's research goes directly to the conscious effort required so case managers are not reduced by situations that cause moral distress. "The bottom line is that when we are out of integrity, we suffer in ways that affect our patients, our families and ourselves," she says. It's critical to develop constructive ways to navigate our response to these situations.

Rushton's research delves into the means by which individuals develop that response—what she terms *moral resilience,* or the capacity to sustain or restore integrity in response to moral adversity. Importantly, moral resilience is not complacency, or acquiescence to circumstances or to authorities outside ourselves. "It's not positive spin, or a stance of blaming the victim," she adds. Moral resilience requires a strong grounding in personal values and "a strong, courageous spine so we can respond to those challenges in a way that allows us to have integrity in the end."

The Code of Professional Conduct for Case Managers

Originally adopted in 1996, the Commission developed the Code of Professional Conduct for Case Managers to assure quality and protect the public interest. It includes broad principles—advisory in nature—and prescriptive rules and standards for professional conduct.

Those principles are:

PRINCIPLE 1
Board-Certified Case Managers (CCMs) will place the public interest above their own at all times.

PRINCIPLE 2
CCMs will respect the rights and inherent dignity of all of their clients.

PRINCIPLE 3
CCMs will always maintain objectivity in their relationships with clients.

PRINCIPLE 4
CCMs will act with integrity and fidelity with clients and others.

PRINCIPLE 5
CCMs will maintain their competency at a level that ensures their clients will receive the highest quality of service.

PRINCIPLE 6
CCMs will honor the integrity of the CCM designation and adhere to the requirements for its use.

PRINCIPLE 7
CCMs will obey all laws and regulations.

PRINCIPLE 8
CCMs will help maintain the integrity of the Code, by responding to requests for public comments.

Compliance with the rules and standards in the Code is an expectation for every board-certified case manager (CCM®). Accepted throughout the industry, the Code provides the framework for all case managers to follow. Case managers who carry the CCM credential commit to providing ethical advocacy for their clients, putting the client's safety, privacy and autonomy first.

Rushton has identified six themes that constitute the capacity for moral resilience. Developing our ability to exhibit the themes in our personal and professional lives equips case managers to effectively navigate encounters that can cause moral distress.

Personal integrity is understood best as a sense of wholeness, or harmony between our values and

what we think. There's also a sense of being undiminished in the midst of the situation around us. Personal integrity refers to honesty and sincerity—of living our values rather than just talking about them. It also refers to doing what is right when it's difficult, and sometimes acting on values when that action comes at a personal cost.

Relational integrity acknowledges the interpersonal nature of team-based care. "It's one thing to have our own personal values, but we also negotiate them and express them in relationship with others," Rushton says. "This implies a sense of moral solidarity and community values, and at the same time it distinguishes one's own values and views as perhaps separate from the people that we're serving."

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An important part of relational integrity is being flexible and willing to accept viewpoints that are not the same as our own. "That's sometimes tough to navigate," she says. It positions integrity as "whole oneness," the relationship between our individual selves and the way integrity—or the lack of integrity—becomes contagious within an organization.

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Buoyancy, or the ability to bounce back and withstand threats to integrity, is another moral resilience theme. Beyond the common understanding of buoyancy, though, is also the ability to move from feelings of distress to learning to grow through adversity. "It's this idea of not only bouncing back, but also what some would call *bouncing forward*," Rushton says. "It's being like bamboo—putting down strong roots so you're able to withstand the storms and come back to a place of stability and wholeness in the end."

Self-regulation and awareness support integrity and buoyancy. It may involve both biological and psychological mechanisms that are vital to responding and adapting to stress and adversity. Rushton recommends developing mindfulness skills to enhance self-regulation and awareness. "Mindfulness is paying attention to the present moment, without judgment and in service to self-understanding and wisdom," she says. "It's the sense of being able to focus our attention in a kind, non-judgmental way so we are able to bring our best to the situation."

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Mindfulness can be as simple as pausing to take three deep breaths and focusing on the present situation and its effects on our mind and body. "That alone can be very effective in helping the sympathetic nervous system to calm down and to get our parasympathetic system on line," Rushton says. She advises case managers to find ways to create pauses in the day, and to develop rituals that carve out space between what's being experienced and our response to it.

Rituals are commonplace activities that remind us to pause and be mindful. "Create a ritual for how you move from one place to the next, incorporating the things you do routinely and bring more

mindful awareness to them," Rushton says. "It's pausing to acknowledge how we're feeling, how we approach the world, and when we are off balance and just need to close the door for a while."

Moral efficacy, another moral resilience theme, is the ability to see ourselves as capable of exercising moral agency. "It's realizing that we have the knowledge, skills and confidence to address ethically challenging situations, and the capacity to be able to do what's necessary to embody our values." Rushton says moral efficacy involves a well-developed moral sensitivity to perceive root issues clearly, and to be able to discern the right path to take—and then to honor our values through principled actions.

Self-stewardship, the final theme, is committing to know ourselves and to responsibly, intentionally manage our scarce personal resources. It's also the ability to recognize personal limits. "Through self-stewardship, we choose actions that are wholesome and make us happy. It allows us to bring our best to our work every day," Rushton says.

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Wisdom seeks counsel

It's also important to recognize that, depending on the situation, case managers should tap into available resources to help resolve ethical issues. For example, in Maria's case, palliative care professionals may be able to bring new information to the case and offer valuable perspective. A member of the clergy could lend expertise as well.

Many patient care organizations have standing ethics committees, which are designed to help employees parse competing moral demands and work through challenges. They can also lend an outside point of view, or serve to level the playing field among clinicians who may be at odds about how to manage a client case. An ethics committee may provide support by simply naming the underlying issue that's the basis of moral residue.

"Sometimes people really struggle with 'I know I'm upset about this, but I don't really know why.' Ethics committees can help you explore the facts in the case, identify what's at stake, think about where boundaries are and help determine how one might move forward in a way that acknowledges all the perspectives at play," Rushton says.

And when a case manager feels pressure to abandon moral integrity from organizational demands to meet financial goals, it's critical to consider all that's at stake. While organizations have a responsibility to create an environment where ethical practices matter, individuals have a responsibility to put forth effort to change factors that lead to moral distress.

"I really think there's a force beyond all of us that's calling us to integrity, and all of us have to do what we can to harness the goodness in the world and to be beacons of light for others," Rushton says. "I invite case managers to be part of the change we want to see, and to see yourselves as capable of making change, even if it's only in ourselves. Because that has the potential to create a ripple that can produce really profound change." ■

About the Experts

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A founding member of the Berman Institute of Bioethics, Cynda Rushton co-chairs the Johns Hopkins Hospital's Ethics Committee and consultation service. Her research focuses on moral distress and suffering of clinicians, the development of moral resilience, palliative care, and designing a culture of ethical practice.

Rushton is currently designing, implementing, and evaluating the Mindful Ethical Practice and Resilience Academy to build moral resilience in novice nurses. Her forthcoming book, *Moral Resilience: An Antidote to Moral Suffering,* to be published by Oxford University Press, aims to transform current approaches for addressing moral suffering by focusing on innovative methods to cultivate moral resilience and designing a culture in health care that supports ethical practice.

She has served on the Institute of Medicine's Committee on increasing rates of organ donation and was a consultant to its When Children Die project. She was appointed the first chair of the Maryland State Council on Quality Care at the End-of-Life and is an American Academy of Nursing "Edge Runner." She is a Fellow of the American Academy of Nursing and a Hasting's Center Fellow.

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Vivian Campagna works with individuals and organizations to foster strategic partnerships and alliances and to provide insight and guidance related to industry trends and developments. She has been involved in case management for more than 20 years, working in both acute and non-acute care settings. She has published articles on case management topics, presented at professional conferences and taught continuing education courses. She was a founding member of the Long Island chapter of CMSA, and served on the board and the conference committee of the New York City chapter.

She was a member of the inaugural class of Certified Case Managers and worked with CCMC as a volunteer for more than a decade. As a former Commission Chair, she was instrumental in implementation of computer-based testing, as well as development of the online dashboard for continuing education and recertification. She has facilitated item writing workshops and has led numerous committees for CCMC, including the Ethics and Professional Practice Committee, overseeing revision of the Code of Professional Conduct.

Campagna earned a bachelor's degree and a master's degree in nursing. She is certified in case management by both the Commission for Case Manager Certification and the American Nurses Credentialing Corporation.

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