Podcast Transcript

Moral Distress: How, Can, & Should We Respond to It

Episode 1 – Understanding Moral Distress

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Guest

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- She currently directs the RN to BS completion program at the school, along with an NP practice in pediatric sleep medicine.
- She has a Master's in Business Administration along with Master's in Jurisprudence in Health Law Studies
- Her nursing background is pediatric critical care and with post master's certificates as a Pediatric Primary Care Nurse Practitioner and Pediatric Acute Care Nurse Practitioner.
- She has also taught graduate ethics and public policy and undergraduate ethics.

Host

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- Over 30 years' experience in healthcare
- Teaching experience in leadership development and executive coaching
- Background in content development, visual performance, speaking and podcast hosting

Transcript

(Sound bite of Music)

LEANA McGUIRE, HOST: Hello, and welcome to a very informative podcast with Dr. Margaret Carno. Dr. Margaret Carno is Professor of Clinical Nursing and Pediatrics at the University of Rochester School of Nursing in Rochester, New York. Welcome.

MARGARET CARNO, GUEST: Thank you so much, Leana.

McGUIRE: We're so pleased to have you here today. This looks like a really interesting topic and one that I think a lot of us need to learn more about, including myself. So, I'm very intrigued. Today we're talking about moral distress. What is moral distress?

CARNO: Moral distress has actually been defined a number of different ways when you look in the literature, but really what it comes down to is, there is a situation where a healthcare provider, we normally think of it as nursing or medicine. However, social work pharmacists, even our veterinarian colleagues suffer from moral distress. And what it is, is that internal feeling of wanting to do something that you feel is correct. Or the more the ethical thing to do, and for some reason you are unable to do that. And so that's basically there's like 10 different definitions. That's basically the summary of, and the kernel in each definition.

McGUIRE: Okay. That's, that's interesting. I think a lot of us in nursing have had situations with this one, at varying degrees. Right. I'm assuming that there are a variety of different concepts related to this.

CARNO: Yes. So, there is, the concepts of distress itself. Is it physical distress? Is it psychological distress? There are concepts related to moral agency, like do you feel the moral or ethical dilemma itself? That is really important. There needs to be a reason why the provider or healthcare personnel cannot act in the way they want to. And there's a number of reasons for that. It can be internal; it could be external. and when I talk about external, I mean it could be institution wide systems. That are preventing the person, from acting in a way they feel is ethical. It could be family related. So, they feel that the classic example, in critical care is the family that wants to do everything. And the healthcare providers and the bedside nurse feel that this is futile.

McGUIRE: Right.

CARNO: And so those are some of the different concepts that surround moral distress. And we need to remember that not every ethical situation brings moral distress. Even if the person cannot act in the way they think it is ethical, there really needs to be kind of a threshold within the person.

McGUIRE: Oh, okay. An individual to each person, I would assume.

CARNO: Yes. And how individuals react is intrinsic to what they hold within themselves as the moral distress. For example, you might see a situation in critical care and be very upset about it. Family wants everything done. You're really upset. I might take care of the patient and say, “Yes. This is wrong”. However, by doing these little things, the family themselves are getting comfort. So, it's how we look at the situations that makes it important too.

McGUIRE: That's a great example. That's a really good example. From your perspective, can moral distress develop over time? If you're for example, if you're exposed to that scenario a number of times, eventually it becomes one that you're less comfortable with. Does that sound reasonable?

CARNO: That is correct. You know, the first time it's you know, you might be able to say, Yep, this is fine. But then the second time you're like, well, why aren't the healthcare providers really explaining this more to the family and then that keeps, can keep building and it doesn't have to be the same scenario. It can be different scenarios within the practice of the nurse that increases the moral distress, that physiologic and psychological feelings that they are experiencing. For example, you could go in one day and you're providing care that you think is futile. The next day you could go in and the family is asking you a ton of questions about their loved one who's had a transplant that they didn't understand.

A solid organ transplant really is one chronic illness for another chronic illness. You could go in the third day and be short-staffed and running around and then get distressed that you cannot provide the care that you feel you needs to be. You do just the basics. So, you get the meds done, you get the suctioning done, you get the dressing changes done, but you don't do those little things. So, that moral distress can build over time. And as you see, there's different situations. But at the end of the day, that nurse might be experiencing, accumulation of these small little levels of moral distress into a bigger level.

McGUIRE: Interesting. I would think that religion, religious practices, or beliefs of either the patient or the caregiver could get in the way of this too, maybe, or help to create this at times.

CARNO: Sometimes, and sometimes actually faith can help the nurse decrease the moral distress. They can rely on their faith to help them release whatever moral distress they're feeling. Other times in other situations it may, and then as nurses, we have the obligation to care for all of our patients, but if it's really that distressful, we should go to our leaders and ask to be reassigned. If they feel that, non-heart beating, organ donation, for example, some religious faiths, some people might feel that that is wrong. Then you go to your nurse manager, your nurse leader, and ask for a change in assignment. So, it can cut multiple ways. It's not always a cause of distress. In some ways, it can be actually a comfort and help decrease the stress.

McGUIRE: Oh, that's, that's good to know. Yeah. And I love what you're saying about asking for someone. To take on the care of that patient. Certainly, you know, we've all seen circumstances or been in them when it's been really difficult to look after someone or have someone, one of our coworkers have trouble looking after someone.

I remember in particular, just briefly one where we had a criminal who was in, and he had committed a really horrible crime against his family, and there were several people. That did not want to look after him. and it was a really tough situation for everyone. but it was, you know, you have to look back on that pledge, right on what we, what we agreed to do when we, when we started the profession. But, you know, for some, it's just, I hear you, you know, you need to find someone that's willing to.

CARNO: And the other thing too is we can use our peers and our colleagues to help us decrease our moral distress or help us reframe it in a way that may help us. I don't want to say diminish but help us to understand the situation. And sometimes just talking to a peer can really help someone see a different light.

And so in some places where there have been an issue or concern that's been very distressing for the unit, they'll actually bring somebody in. Whether it's from their ethics team, a counselor, an experienced nurse, a psychiatric nurse practitioner to really help the unit talk about what's going on and help them process it, that is one way that they can help with moral distress.

McGUIRE: Very good. I'm just curious, before we dig in a little bit further on this, how did your work start on this topic?

CARNO: My background is in pediatric critical care, and I've always loved the ethical portion of it, and how sometimes regulations and ethics conflict a little bit at times.

McGUIRE: Yes, it's really true.

CARNO: And so, and that's how I've really got into this, area. I think in pediatrics, I don't want to diminish to all my adult colleagues, but I think sometimes in pediatrics we get into some dilemmas that you don't necessarily see in the adult world.

McGUIRE: Sure. Can you give us an example?

CARNO: Sure. The classic example is certain religions do not approve of blood products.

McGUIRE: Okay.

CARNO: The administration of blood products. And if you have a child, let's say a four- or five-year-old who has a disease process where they need to receive blood products. The classic one is leukemia treatment or some sort of oncological treatment. What do you do ethically? How do you honor the parent's wishes, but uphold the standard of care for the patient,

McGUIRE: Right. Yeah, that's a big one.

CARNO: and how do you get to do that? Or the flip side of it? I had a patient once who was 15 and she had gone through multiple rounds of chemo, and she was ready to stop. She was just ready. She knew what it meant to stop, and her parents weren't there yet,

McGUIRE: Mm. Wow.

CARNO: And how to help the parents get there because she's a minor.

McGUIRE: Right, right.

CARNO: you know, she's at that age where she can say, you know, I don't want this, but the parents are still driving the healthcare decisions.

McGUIRE: Wow. Yeah. That's tough.

CARNO: That's just another example.

McGUIRE: Wow. Great examples. Thank you for that. I appreciate it. Now, how does reliance play into moral distress?

CARNO: Reliance and resilience really help the nurse handle their moral distress and I think that's one thing that we are seeing more and more is nurses with more resilience are really able to handle what is going on, whether it's short staffing, not enough personal protective devices, the whole thing, but if they are resilient and how they look at their lives and they look at it as, you know what?

We will get through this. We just need to figure it out. We will get through this; we've gotten through this before. We can get through this again. And they feel that internal power almost, that they can handle this. Those are the nurses that are going to be able to handle their moral distress and come out of the situation not psychologically harmed

McGUIRE: Got it.

CARNO: Or they know how to get support that they need.

McGUIRE: Tapping into those resources.

CARNO: Yes, whether it's personal within them, as we talked about earlier, faith traditions or just, meditation, self-care, you know, just taking time for themselves. Maybe even just a hobby where they can go home, they can rest after a long shift.

They might have the next day off and they can take a small portion of that day and help themselves recoup and recover.

McGUIRE: Excellent. Do you feel that this, resiliency is an innate quality, or do you think people can actually develop that over time with the right exposure to someone like that, for example.

CARNO: I think that they can develop it and the literature really supports that nurses can develop it. We're not taught how to develop it. That is one thing that I know schools of nursing are now starting to look at, is how to teach, how to be resilient, how to make sure you are taking care of yourself. Yes, self-care is this big buzzword, but really how to make sure you as an individual are getting your needs met and that you're meeting the needs of your patients. And I think that is really important.

McGUIRE: Yes. I'm really happy to hear that they're thinking about, putting that in curriculum because it's such an important piece. Wow. That's, that's great news. How do you see moral distress manifesting? Like, what's the effect that it has on the caregiver?

CARNO: It can have a wide variety of effects. You can have headaches, you can have stomach aches, just not feeling well. But I think the signs and symptoms that are prevalent that we don't see is how someone cares for the patient. They may, you know, do the, I'm going to put it in quotes, “task”, so the meds get done on time.

The suctioning, the turning, the, dressing changes. However, those little things or the interaction with the family is not as deep or as rich as that nurse had done in the past. So, they're competent in their job, but it's almost like they have developed a wall and have become very task oriented as opposed to holistically oriented.

McGUIRE: Yeah, I can see that.

CARNO: And I think that's what we're seeing a lot now in nursing for a wide variety of reasons. You know, let's just, let me just get through the day. Let me just get through the task. Let me just not make a mistake, let you know, I just have to keep going for another four hours, let's say, and then I get to go.

McGUIRE: Right. This had to have been exacerbated for a lot of people during covid.

CARNO: Yes, it was. And it was actually interesting. There's some literature that points out that it wasn't just the people that were caring for patients. There were a lot of nurses who were not working because they worked in an ambulatory clinic and those clinics were closed down

McGUIRE: Right.

CARNO: and they were not brought into the hospital.

So, they felt moral distress because they felt guilty that they are watching their peers work these horrendous shifts, some of their peers actually dying. Or getting long covid and they had the pleasure, luxury, or however you want to word it, of staying home because that is where their position was.

McGUIRE: Right, right.

CARNO: And this is across healthcare.

So, there's literature that demonstrates social workers, occupational therapists, physical therapists, music therapy there are a whole lot of people that were home or furloughed and that they could not help out because they didn't have maybe the skills or maybe it was not the opportunity.

McGUIRE: Right. Wow. That's a completely different angle I hadn't thought about, but you're absolutely right. Very interesting. What are some ways to combat moral distress. I know you talked about speaking with friends or colleagues, but what are some other ways

CARNO: Making sure you take care of yourself. So getting enough sleep, you know, the basics. Good old Maslow, you know, getting enough sleep, eating properly, decreasing the caffeine and the sugar. Trying to limit the alcohol, and also recognizing that your practice may have changed. You might not be as caring, or you're just a little more stressed and finding different outlets or even therapy. And it might not be a full, you know, long, long therapy, but it just might be a couple of sessions. Every employer I know has some sort of employee health where there is emotional health involved. You know, reaching out to that, experiencing gratitude.

McGUIRE: Oh, I love that.

CARNO: Keeping a gratitude journal. and just being grateful for what you have and also grateful for what you bring to the bedside. You might not change; you might not be able to change the outcome.

You might not be able to every, you know, like at the beginning of Covid, not everybody had appropriate PPE, but there are those little things that you can bring. To the family, to the patient, even if it's just holding the hand or just, you know, a pat on the shoulder. Just those little things to maintain that human connection.

McGUIRE: Beautiful.

CARNO: I think those are some ways. And just one other thing would be is see Wherever your healthcare agency is see if they can have somebody, especially if it's been a very stressful time in the unit, as I talked about before, seeing if the hospital can bring in somebody to talk to the group.

McGUIRE: Right. Oh yeah. Excellent. I love that. So, this can, I'm assuming you correct me if I'm wrong, I'm thinking this can really contribute to burnout.

CARNO: Yes. Yes, there is literature that demonstrates the higher the moral distress and how long it lasts, contributes to burnout. And some nurses leave the profession. Some nurses stay because they can't leave. But as I said, they put up that wall. And it's not that they're not caring, I don't want to imply that, but they're able to make sure that the care is adequate. But those small little things may be missing.

McGUIRE: Sure. Right. Demographics. I'm just curious. I'm, again, I'm making assumptions and I love that you're here to straighten me out because, when it comes to demographics, my assumption is that it's people who've been in the profession for a while and have had repeated exposure to scenarios like this. But can this be something that happens for a new grad, for example?

CARNO: It could depending upon where the new grad's working and people have the assumption also that we see moral distress really just in the ED or the ICU and in urban areas. That's not true. Actually, there was one study I read where the nurses that had the highest level of moral distress worked in telemetry.

McGUIRE: Really?

CARNO: Because they didn't have all the resources and weren't part of the team, like the ICU or the ED nurses were.

(Soundbite of Music)

McGUIRE: Wow.

CARNO: You know when you're working in the ED or you're working in the ICU, you're usually part of a team and you know what's going on. Where if sometimes when you work telemetry people just round and you don't know what's going on. The other thing is that it can happen in rural areas

McGUIRE: Huh?

CARNO: And it can happen in primary care. You know, moral distress, burnout, all these really related concepts happen across the nursing profession, no matter how long they've been a nurse, and no matter where they work.

McGUIRE: We hope you've enjoyed part one of our podcast on moral distress. In part two, Dr. Carno will delve further into this interesting topic. By exploring more real-world scenarios. We thank you so much for listening. This is Leanna McGuire for Elite Learning by Calibri Healthcare.

Episode 2 – Responding to Moral Distress

(SOUNDBITE OF MUSIC)

McGUIRE: Welcome back to part two of our Moral Distress Podcast, featuring Dr. Margaret Carno. Again, Dr. Carno is Professor of Clinical Nursing and Pediatrics at the University of Rochester School of Nursing in Rochester, New York. Welcome to the follow up on our previous discussion. What would be an example of moral distress in a rural area?

CARNO: In a rural area, it could be that it's hard to get access to more advanced care.

McGUIRE: Sure.

CARNO: You know this person really needs to get to the ICU. They've waited too long to come into the ED, or transportation is limited, or it could even be that there is only one ambulance in some rural areas, and you need to send three patients. And how do you pick which patient gets sent?

McGUIRE: Wow. Yeah. Oh, those are great examples. Yeah, that's a I actually had a telehealth experience at one point. I did telehealth and I had a couple call in and he was having severe chest pain and they were, they lived on a small island and the only access was a boat and it was nighttime and there was no light on the boat, and she was there alone with him.

It was, I'm glad you brought that up because, you know, that really makes sense. I've forgotten about that scenario until you brought that up. So, that's a really good point. Here's maybe not a tough question, but a question from a different angle. If someone's having, if a nurse is having a really, or any practitioner, in interdisciplinary, is having a moral distress with this scenario?

I know you talked about the blood transfusion example. Is it ever, I think I know the answer to this, but is it ever appropriate to try and convince the parents or the family or the patient to do something that is against their own beliefs because they're not consistent with your own? Or do you know where I'm going with this?

CARNO: Yeah, I do know where you're going with this. I think the key is open communication with the...

McGUIRE: Okay.

CARNO: and to provide the most accurate information you have.

McGUIRE: Okay.

CARNO: Because even amongst nurses, you could have two nurses that think one situation's fine, and another nurse thinks that that same situation is wrong.

McGUIRE: True. That's a good point. Yeah.

CARNO: Open. Being open and honest with the family. Not saying that I wouldn't do this because families ask, you know. What would you do if this was your mom?

McGUIRE: Right.

CARNO: And trying to go back and say, what were your mom's wishes? Had you talked to them about your mom's wishes? What else have you as a family talked about?

Is there somebody else I could bring in to talk about them? There are cases where we thought the patient was sedated enough. And nurses have commented, and other healthcare providers have commented that, you know, maybe not right to the family, but if this was my loved one, I wouldn't put them through that. And then the patient wakes up and knows that people said that can be quite difficult to face their patient.

McGUIRE: Sure. I think the other difficult thing is for family members, in particular, if they have a loved one who the staff feel that. So, the family wants to keep the patient alive, and the staff feel that, you know, it's against all odds that they're going to pull through. They can always find a story right, of someone who did. But I love that you talk about just giving them all the facts and presenting it.

CARNO: Yeah.

McGUIRE: Presenting it for what it is. Yeah.

CARNO: Yeah. I mean, cause that's all we really can do. We can't force patients or families to do what we want them to do. That's not our role. Our role is to support them, and I think that's what makes it. Hard and what really what brings the moral distress out. Because it's like, we wouldn't do this in this situation and now we're part of a situation that we don't necessarily believe in.

McGUIRE: Certainly. Certainly, I think anyone that's listening to this now has been exposed to some form of moral or ethical situation. but do you feel like there's varying degrees that is it always because, is it always a distress, do you think? Or is there a certain point where that. Oh, right.

McGUIRE: You spoke about crossing that line.

CARNO: Yeah. And that line is individual for everyone.

McGUIRE: right.

CARNO: And I think that's what makes it hard to discuss moral distress. What makes it hard to do research on moral distress because there really are so many components to the actual definition that we're not sure. While the instruments have all been tested and felt reliable, are they really measuring what we want them to measure?

McGUIRE: That's a good question. Given that, where did you start with your research? Like where do you start? Your journey is interesting to me.

CARNO: It's just been slowly reading articles. Being exposed. You know, one thing about being an educator, I also practice as a nurse practitioner, is that I have a little more time, unfortunately, to think about stuff like

McGUIRE: Right.

CARNO: You know, and students come back to me and go how would you handle this, you know, that are practicing nurses. So that's how I really started to read the literature, see what's out there, talk to people that are bigger experts than I'll ever be in the situation about the topic.

McGUIRE: Sure.

CARNO: But it's just that self-learning.

McGUIRE: Yeah. And obviously, you've been exposed to it throughout your career.

CARNO: Mm-hmm.

McGUIRE: Do you have any other examples that you can share with us of moral distress from, from your pediatric experience?

CARNO: Another big one in pediatrics is when you have child abuse and you don't know who the abuser is, and you have to let everybody in.

McGUIRE: Yeah. Wow.

CARNO: Because you don't know. You have suspicion of who it is, but you don't know exactly who it is. So that's one example. And another example in adults, and you brought it up a little bit is with prisoners or people that may have committed an illegal crime and the police are trying to figure out if they have or not.

McGUIRE: Right.

CARNO: You're trying to protect the patient's information, the patient's rights, and you have police talking, you know, trying to get the information from you.

McGUIRE: Right.

CARNO: That can be distressful also.

McGUIRE: Yeah, it's very interesting. Of course. we talked just a little bit before, before we were recording that, uh, you know, my experience has been in adult critical care. And again, hats off to our peds nurses because, as I mentioned, we're usually one or the other. And I always admired pediatric nurses for what you do. But yeah, I mean, certainly been exposed to situations like that and I think it's important as, as practitioners, as professionals, that we be able to talk our colleagues off the ledge as a, you know, a.

CARNO: Yes.

McGUIRE: As the saying goes, because I've had a couple of experiences that criminal in particular. He had, you know, his daughter was actually in a bed in the same ICU, and she had been a victim of his rampage. So, we, and she was really critical. So, it was challenging. But I've had at least three situations where I've had nurses say, I don't even want to give them pain medication, right? Because they're so angry. But I think it's crucial that we all step up in that situation and support each other and remind each other of what our role is because that can't happen, you know?

CARNO: No. Our role is to take care of the patient in front of us who we've been assigned to.

McGUIRE: Yes. And of each other, I think we forget that piece sometimes, right? Because it's the patient and then it's the family. but it's important that we look after each other. Especially when we get newer nurses who have those first experiences and come to us for advice, you know, to be kind and grace give, you know, give grace in those situations.

CARNO: And be kind to each other no matter how long it's been that they've been a nurse.

McGUIRE: Yes.

CARNO: Because the other thing too is, if Covid has taught us anything, and I hate bringing up Covid,

McGUIRE: I know.

CARNO: But we don't know what's also going on in people's lives.

McGUIRE: That’s it. Yeah.

CARNO: So, as you said, we just need to be kind to each other. Will that eliminate moral distress in everybody? No. I mean, as long as there has been some sort of healthcare, there's been, you know, moral distress.

McGUIRE: Sure

CARNO: You can read examples from what I happen to teach, a course. It's the history of cancer. And you look back at some of those early treatments.

McGUIRE: Uhhuh.

CARNO: and there were people that were like, no, you're going to kill the patient. And then there was others saying, well, this is all we've got. So, let's try it.

McGUIRE: Wow. That's, I love that you're bringing these up because every time you say them, I think, “oh yeah”. You know, we've been exposed to ones just like that. But that's, yeah. There's so many, And I think obviously, as you said, it's not just nursing. I know we're focused on nurses for this podcast, but physicians as well. I mean, they have a lot of issues with that as well.

CARNO: Yeah. our physician, even our pharmacy colleagues, depending upon where they work, and It could be a perfect storm. If the healthcare provider, let's say the physician or the nurse practitioner is really stressed about the situation and the nurses are really stressed and let's say OT or PT is really stressed. You have, everybody starts feeding off of each other and somebody needs to recognize that and say, hey, let's just take a moment to breathe. We might not be able to fix the situation, but at least we can recognize it.

McGUIRE: Yes. It's interesting from an interdisciplinary perspective, I remember a scenario in particular. In ICU where the patient was really ill and the family was, was waffling. They were at that stage where should we or shouldn't we? and, they requested that their pastor come in and the pastor was the one that convinced them to keep going when it really clinically was not the right choice, and the outcome was what we suspected that it would be. He was the one that, you know, flipped the switch in the direction of keeping the patient alive. As practitioners, we were really frustrated by that. As you can imagine. It was just a; it was a really sad situation. And, so to your point, it can come from any angle, from anyone that's involved. I'm remembering all these situations now. There have been a lot.

CARNO: Suppressed.

McGUIRE: Yeah, it's challenging, you know. I remember one colleague in particular at one point saying to me, I feel like I'm a professional flogger. And that's when I said, “Okay, we need, you know, we need to talk about this”. And I think that's the important piece that you've really brought to the table here, and I appreciate it. Is that if you start to feel that way, that's the time to start to tap resources and look for help.

CARNO: Yeah. Because there might not be anything that we can do. We have to remember also too, that healthcare or medicine, or nursing, however you want to say, it, is an imperfect science. There's still a lot we don't know. There's a lot of things that we learn, trial and error, and we're only human. And we need to remember that.

McGUIRE: Yeah. Yeah. And nothing's black and white.

CARNO: No, it's all shades of gray.

McGUIRE: It's every shade of gray. Isn't that the truth? This is really an interesting topic that I'm really loving. Do you have any information on cultures or different cultural perspectives other than the US? If not, that's fine.

CARNO: Um, a lot of this has been done. I have read in other healthcare. Like, there's been a lot done in the UK about it. I have not read anything where culture plays into it. I think that is a huge area of research that we really need to look at

McGUIRE: Yes. Yeah.

CARNO: Because that is so important when you work in an environment with so many different cultures.

McGUIRE: Yeah, that's a good point. That would be challenging because we all have different beliefs and that obviously affects those. Right?

CARNO: Yes. And how we approach things. And who is the decision maker and how do we respect the family and patients' culture?

McGUIRE: Right.

CARNO: and what they believe in and what they find healing from.

McGUIRE: Yes, exactly. Because certainly in critical situations, the family becomes a priority if the outcome isn't looking, I mean, Not the, we don't, we always look after the patient first, but their needs at some point have to step in. Any that you, any personal experiences with this that you would like to share with us or your most difficult?

CARNO: No, not the most difficult. But I can remember, we've had a First Nation ceremony when I was working, in another city. But in the same geographical area that I'm in now. It brought the family peace. I think a hard one was when the community's paying for the healthcare and then, they say no to something that's very expensive. So, you are trying to optimize medically what you can do,

McGUIRE: Wow.

CARNO: But the family is grateful that you're not punishing them because they're not doing X, Y, and Z. That you're trying to help to get their loved one out of the hospital and have the best life possible with what the community can afford. I think those are some examples.

McGUIRE: Yeah, it's interesting. Again, these varying scenarios keep coming back to me and I think it's probably helpful to speak about some of them. When you talked about culture, this is an interesting example in that, you

might be surprised by my reaction to this; but we had a patient who had a below the knee amputation and the family requested to have the limb. Now that was a cultural belief that if you buried it under a tree or with a tree, that it would give back to the earth. And, you know, it was a valid reason in my opinion.

CARNO: Oh yeah.

McGUIRE: But the healthcare system or the hospital, there was just no way that they were going to give that up to them. And that bothered me, in a way that I, I know people are probably thinking, why would you think that? But for, I felt that they, it was right. it was perfectly fine for them to have that, for the reasons that they were stating.

CARNO: Oh yeah.

McGUIRE: So that

CARNO: they want, oh, I didn't mean to interrupt.

McGUIRE: Please go ahead.

CARNO: Or if they wanted to cremate that, if the person wanted to cremate it.

McGUIRE: Yes. Yeah.

CARNO: Because you can cremate a just a limb.

McGUIRE: Yeah, exactly. So that was an interesting situation. And many do that with placenta right after birth are a lot of cultures that want to bury the placenta. And yeah, obviously they're not the majority, but there are still cultures that will do that or families with that belief. And. you know, I, my ethical dilemma, moral dilemma was more with the hospital at the time than it was with that request, which, you know, some people listening may feel completely differently, and I think that illustrates the point that we all come from a different place on this stuff.

CARNO: Oh Yes. Another example, that has been a hot topic, has been non heart beating donors.

McGUIRE: Interesting.

CARNO: So, not everybody you know in the healthcare profession believes in them. That idea that, you know. Usually what happens is you go to the OR. You let the family say goodbye, you extubate. You wait for so long until the heart stops, then you go back in. Sometimes you don't have to restart the heart, but other times you do, depending upon the organs you want, or the organs that I should say are being donated. So, there are a lot of different situations I think that you and I have brought up where there could be some significant moral distress over

McGUIRE: No, I can definitely see it. And again, some vary, the degree would depend on the situation of the individual. You know, I'm absolutely fascinated by this topic. I am so pleased that you have offered this up to us to do this podcast with us. Again, it's something that we all come across, but, as soon as I saw the topic, I went, oh, this is going to be good. It's and it has, it's really good information. Will your research continue on this topic?

CARNO: I will keep exploring. I don't know if I'll keep doing research, but I will keep exploring and learning. And I consider that research also. I think we put in nursing that research is, you know, where we're actually doing the experiment or the design or whatever. But really research can be looked at as just opening up your own knowledge.

McGUIRE: Right,

CARNO: about the topic and looking for what is new, what has changed, you know, have we looked at the culture issues? So, I think that will continue. I know that will continue.

McGUIRE: Excellent. I love that you said open our knowledge. because I think this is a really key point when it comes to moral, ethical issues for those who are listening is we may not agree with someone else's choice. But I think learning more about people's beliefs and their, you know, religious or otherwise, and getting ourselves to a place where we can be more accepting of people who have views or requests that are unlike our own, only helps us to grow as individuals and to become more effective in our practice.

CARNO: Or just looking at what tools are out there to help you as an individual to support yourself, to build your resiliency as we had talked about.

McGUIRE: Yeah. Your self-care point was not missed. Let's bring that up again just briefly, but self-care. People say, oh, you know, self-care, whatever. Self-care is crucial in this profession, especially when it comes to moral distress. In my opinion. In hindsight, in my own career, those were the things that stayed with me the longest after my shift, let's just say, you know, there's a lot of things that we see, but…

CARNO: and how we do it. You know, um, it's not just getting a manicure or a pedicure. But it's what we do every day to support ourselves. So, whether it's journaling. Whether it's just doodling. Whether it's singing nonsense into, you know, a speaker and just getting it all out, that is all self-care and that's all self-care. everybody can afford. Not everybody can or has the time or can afford the great, you know, hour and a half long massage. Or they might not even like it, but everybody can doodle,

McGUIRE: Yes.

CARNO: You know, so everybody can journal even if they just write words down.

McGUIRE: Yeah. Yeah. Journaling's huge. Yeah. That really helps just to get things out and there's some objectivity at some point that will seep in during that process. So, that's fantastic advice. I'm always happy when someone reiterates the importance of us doing a due profession cause it's not an easy one. It's very rewarding. No question. But it's not an easy one. All right. any final thoughts you'd like to share?

(Soundbite of Music)

CARNO: No, I think we've covered them all.

McGUIRE: Yeah, it's a great topic. I'm really glad that you're sharing your expertise with us today. It's an important topic. I've learned even more. I just, I've really thoroughly enjoyed it. And we hope you've also enjoyed this podcast on Moral Distress featuring Dr. Margaret Carno. Elite learning.com has a variety of great courses to help you throughout your profession. So, we always encourage you to take a look and see what else, what other courses or podcasts you'd be interested in participating in. We thank you so much for listening. This is Leanna McGuire for Elite Learning by Colibri Healthcare.

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