Reducing Moral Distress in Case Managers

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ABSTRACT
Purpose: Moral distress can be caused by ethical conflicts that are common in acute care settings. Hospital case managers are unique caregivers in hospital environments. Case managers are advocates who coordinate organizational, clinical, and personal standards. Ethical conflicts embedded in performing delegated responsibilities are burdensome, therefore creating a risk for moral distress. Mindfulness education is suggested as a meaningful process to mitigate moral distress for frontline caregivers.
Primary Practice Setting: Moral distress describes organizational, clinical, and personal ethical conflicts and constraints a caregiver experiences in acute care settings.
Findings/Conclusions: Theories and tools addressing moral distress continue to evolve. Researchers are revising and creating new tools defining moral distress, but triggers and responses vary among ethically conflicted nurses. Causes of moral distress include burden and frequency of ethical conflict and constraints leading to depression, anger, and impaired perception of competency. Little attention has been given to hospital case management as a caregiving profession at risk. The ethical dilemmas research defines as "risks" for moral distress are prevalent in the ethical responsibilities delegated to case management.
Implications for Case Management Practice: The hospital case manager's responsibilities contain compelling and competing ethical priorities of patient advocate, organization representative, and competent professional. General suggestions to moderate moral distress have been inadequate in mitigating the problem, because they do not adequately offer the caregiver a way to identify and process moral distress. Causes and conditions describing moral distress due to ethical conflicts are similar to themes of suffering and awareness identified in mindfulness and other reflective exercises. A workshop series introducing reflective practices is an appropriate approach to reduce negative outcomes of moral distress in caregiver roles.

Key words: active imagination, case management, mindfulness, moral distress, moral residue, nursing education, nursing ethics

Hospital caregivers, including case managers, make decisions every day interconnecting organizational, clinical, and personal ethics. Organizational ethics determine "network providers" or benefit reimbursement on the basis of business contracts. Clinical ethics influence care decisions for comatose patients or terminal chemotherapy. Personal work ethics influence all interactions and responsibilities regardless how impossible or menial. For example, if a patient is diagnosed with dementia, new stroke, or terminal condition or is underinsured and financially vulnerable, then a professional caregiver is constrained as an advocate on appropriate placement. The caregiver is required to accurately assess resources while simultaneously meeting rigorous industry time lines for hospital length of stay. "Successful caregiving" is defined on the basis of selected ethical perspectives; conflicting priorities can be burdensome over time.

Ethically burdened caregivers are at risk of experiencing moral distress; accumulated experiences of this kind can disrupt care planning processes. The intensity of moral distress depends on personal values and life experiences. Examples include unexpected discharge roadblocks, conflicting goals between providers and family, and inadequate time because of administrative duties or sick calls. These types of ethical conflicts and constraints are ubiquitous for hospital caregivers, including case managers. Ultimately, moral distress generates adverse outcomes for patients who depend on professional advocacy,

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creates redundant administrative costs, delays treatment, and catalyzes self-destructive behaviors of the affected caregiver.

The three-fold purpose of this article was first to define themes of ethical conflicts that embed the cycle and syndromes of moral distress, second to suggest the case manager's vulnerability for moral distress despite inadequate research on this professional caregiver role, and third to suggest a program mitigating moral distress for the case manager and other caregivers at risk. The mindfulness program recommendation is predicated on the program's borrowed themes from Eastern (Buddhist) philosophy. In general terms, Eastern philosophy believes suffering can be reduced if humans learn to reflect on conditions leading to and identified with stress responses. The mindfulness training for Westerners has been shown effective in defusing symptoms similar to moral distress. A mindfulness program is based on reflection and mindful awareness and could reduce moral distress in caregivers. Mindfulness creates a structured intervention to reduce stress for individuals with Western lifestyle. The mindful person uses everyday ethical conflicts as opportunities to create life-changing self-awareness, compassion, and insight.

What Is Moral Distress?

Moral distress is created by "on the job" ethical conflicts. This term was created by ethicist Jameton (1984), describing a painful condition experienced by a professional caregiver who knows what is ethically appropriate but is unable to act upon it. Caregivers in high-risk environments experience moral distress when perceived ethical standards are breeched or unappreciated. Examples of conflicts are chemotherapy during terminal care, justified rehabilitation needs for underinsured patients, or mandated high-risk assessments using marginal documentation. Organizational ethics creates conflict by expecting the care environment to accommodate decreasing precertified inpatient days and shortened lengths of stay. Organizations expect caregivers to distribute limited resources in an environment of underfunded or high deductible insurance benefits. Organizational

caregivers are expected to accomplish technological advancements that range from data collecting computer programs to allocation of life-sustaining expensive machinery or medications regardless of the severely diminished quality of life. Clinical ethics create conflict around patient suffering. Perceived personal ethic violations exist because of inherently futile treatment decisions, unrealistic expectations, and redundant and incomplete communications among disparate education levels (Comrie, 2012; Edmonson, 2010; Edward & Hercellishyi, 2007; Ferrell, 2006; Houghtaling, 2012; Kopala & Burkhart, 2005; Lawrence, 2011; Maloney, 2012; Pauly, Voarcoe, Storch, & Newton, 2009; Pavish, Brown-Saltzman, Hersh, Shirk, & Nudleman, 2011; Pendry, 2007; Rice, Mohamed, Hamrick, Verheijde, & Pendergast, 2008; Shepard, 2010; Silen, Kjellstrom, Christensson, Sidenvall, & Svantesson, 2012; Ulrich, Hamric, & Grady, 2010; Vanlaere, Timmerman, Stevens, & Gastmans, 2012; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012; Wilkinson, 1987).

Moral distress erodes coping skills. When moral distress accumulates, the result can be instability in the health care environment. Research suggests that frontline caregivers in highly conflicted environments include intensive care unit, pediatrics, and oncology. Ethical conflicts that create negative reactions lead a caregiver to destructive coping patterns that, in turn, impact patient advocacy, organizational obligations, and job performance. Moral distress is ubiquitous in health care professions, including physicians and social workers (Gaudine, 2011; McGregor, 2011; Openshaw, 2011; Silen et al., 2012). Regardless of cause, specialty, or symptoms, the moral distress residue cycle needs to be identified to maintain a stable health care system.

What Causes Moral Distress?

Moral distress is a human response to conflict. The root causes are found in any human social structures containing ethical conflicts and constraints. Rittenmeyer and Huffman (2009) identified ethical conflicts in social structures causing caregiver vulnerability: human reactivity, institutional culpability, advocacy to alleviate patient pain and suffering, and an unequal power hierarchy. These specific causes for

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TABLE 1
Ethical Categories Confronting Case Management Professionals
Organizational. Appropriate constraints on pursuit of self-interest or profit of institution
Clinical. Interdisciplinary professional activity working for interests and welfare of patient and family
Personal. Standards of one's commitment and interpretation of immoral or moral acts

ethical conflicts in society apply to three major ethical categories for caregivers: organizational, clinical, and personal (see Table 1).

1. *Organizational ethics*: Human reactivity of a community devaluing caregiving expertise because of financial constraints. Organizational ethics concern institutional culpability for meeting contractual obligations and regulatory mandates. Institutional culpability in resource management is regulated by complex prior authorizations or underfunded coverage that can create slow decision-making in fast-paced settings.
2. *Clinical ethics*: Advocacy to alleviate patient pain and suffering becomes irrelevant in bureaucratic regulations. Clinical ethics are based on moral principles about indications (treatment available), patient preferences, quality of life, patient advocacy, and other contextual features (Jonsen, Siegler, & Winslade, 2006; Pergert, & Lutzen, 2012).
3. *Personal ethics*: Unequal power hierarchy of higher authority, diverting, underfunding, or denying funding for the "best" advocacy. Personal ethics also include values and self-worth. These types of social ethics create unique dilemmas based on human reactivity, unequal power hierarchy, advocacy (O'Donnell, 2003; Rittenmeyer & Huffman, 2009), and professional competency.

Professional caregivers must accommodate to these equally valid, but opposing, ethical views. Moral distress results when a caregiver's perceived responsibility is trumped by opposing ethical categories. For example, if organizational priorities prevail over patient advocacy or impair personal work ethics, then resentment, anger, and self-deprecating feelings can linger. If a care plan is imminently "futile" but encouraged by protocols or naive family, the professional caregiver values become marginalized or repressed. The unappreciated insidious impacts of accumulating ethical conflicts and constraints, the ignorance of using ineffective antidotes, or denying the problem altogether become the root cause for moral distress and residue in the caregiver.

SIGNS, SYMPTOMS, AND EXPERIENCES OF MORAL DISTRESS

The more immediate reported symptoms, responses, and consequences of moral distress are anger, anxiety, depression, disgust, guilt, sadness, and worry (Weigand and Funk, 2012). Adverse symptoms (anger, bullying, and powerlessness) and devastating residual conditions (ineffective patient advocacy, revenue loss, absenteeism, and resigning positions) suggest that unresolved moral distress affects patient care, hospital efficiency, and individual careers. Manifestations of unresolved moral distress include loss of confidence, self-blame, self-doubt, disappointment, or loss of self-worth. Psychological and physical responses included crying, losing appetite, unable to sleep well, nightmares, diarrhea, headaches, heart palpitations, and vomiting. Coping mechanisms reported are resistance to personal organ donation based on "wasted" allocation, withdrawal from others, isolation, and self-medication with alcohol. Long-term outcomes of moral residue are decreased patient interaction, decreased working hours, or leaving the position outright (Corley & Selig, 1992) for both new and long-term staff. Moral distress is present when a caregiver reports intensity of feeling burdened, frequency of conflicts, lack of autonomy over authority, and decreased advocacy.

Creating or finding research tools that define the experience of moral distress is challenging. Therefore, identifying consistent proximate causes is also challenging. Researchers claim that moral distress is present among individual caregivers within the same specialties or groups *but* each caregiver defines concepts of "principled thinking" differently (Corley, 2002). Controversy remains about the impact of demographics such as age, years of service, education, scope of practice, cultural and professional variables in relationship to moral stress (Corley, 2002; Corley, Elwick, Gorman, & Clor, 2001; Corley & Selig, 1992; Eizenberg, Desivilya, & Hirschfiled, 2009; Hamric, 2012; Pauly et al., 2009; Robichaux, 2012). In addition, measuring moral distress can be confused with symptoms of burnout; the latter being a collage of issues broader than the intense ethical conflicts causing moral distress (Wlosdarczyk, 2011).

Wocial and Weaver (2013) introduced a new tool called moral risk "thermometer scale" that identifies accumulated effects of moral distress and accommodates different ethical conflicts and scenarios having similar impact between nursing specialties. Epstein and Hamric's (2012) morale crescendo concept echoes the well-known Selye's *General Adaptation Syndrome*: the inevitable outcome of moral distress is eventual

exhaustion if adverse conditions do not change. A meta-analysis by Catherine McCarthy (2013), the editor of *Nursing Ethics,* articulates complex details and concepts. Although research to date has identified variables contributing to moral distress for bedside nurses in high-risk ethically challenging positions, how ethical conflicts for case managers might contribute to moral distress has not been studied.

Although *causes* and *symptoms* of moral distress vary among individuals, the *outcomes* of unresolved conflict appear consistently harmful if not addressed. If moral distress due to relentless ethical crisis becomes overwhelming and symptoms threaten one's reputation or effectiveness, then intervention, protection, and support by a mentor will prevent escalation of ethical crisis for the professional caregiver.

MORAL DISTRESS AND THE CASE MANAGER

The case for moral distress in case managers is compelling because this role includes daily exposure to cycles of ethical conflicts and constraints. Case management responsibilities across diverse employment environments include efficient management of complex caseloads, accommodating to shifting expectations of business organizations, and communicating with multilayered medical teams. Often, case managers assume significant accountability without commensurate authority. These relentless experiences combine to create an environment of conflict and constraint that are common risk factors for moral distress (see Figure 1). The case manager is expected to identify contributing ethical values, but often lacks commensurate authority because of unequal hierarchies common in health care environments. The case manager's clinical foundations learned as a bedside nurse are essential in advocating and coordinating care plans with a parliament of health care providers, appearing as the patient transitions through health care systems. The American Case Management Association (2013) states a case manager is expected to have the "expertise, knowledge, and professional experience to provide the right services to patients with serious or complex medical conditions, and/or catastrophic injuries and illnesses." The Case Management Society of America (2010) Standards of Practice defines that a case manager's intervention "fosters the careful shepherding of health care dollars while maintaining a primary and consistent focus on quality of care and client self-determination. (p. 4)" The National Association of Social Workers (2008) Code of Ethics aligns with a similar discipline to maintain a commitment to employer policies, to facilitate competent client advocacy, and to prevent exploitation of the underserved.

Expectations and responsibilities within a demanding work environment are the catalysts for ethical conflicts and constraints. A case manager is a patient advocate, a reimbursement/utilization specialist and, despite having advanced clinical expertise, spends significant time in redundant clerical duties. Although job descriptions can vary between institutions, the
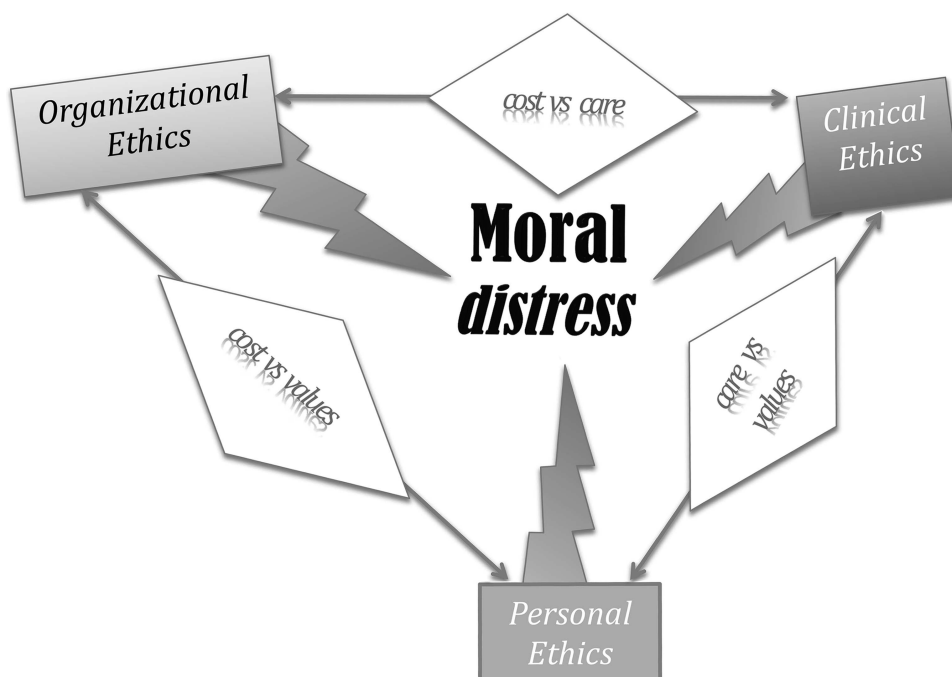

FIGURE 1
Risk factors for moral distress in case managers.

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hospital case manager performs episodic care (acute vs. chronic), always assesses and facilitates "high risk" complex patients (Laabs, 2011), and often has a case load of 20 to 25 patients a day, each of whom have unique concerns.

A case manager's advocacy role is to be correct and consistent in identifying obstacles to discharge, puzzling together discharge plans based on desires of patient clinical needs identified by medical teams, and understanding financial resources, and exhibiting time management skills to accommodate a full assignment. As an organizational representative, the case manager identifies or is delegated to fix problems at every turn. Roadblocks and dangling care plans are the norm. Expectations often conflict between different health care professionals (McLaughlin, Miller, & Wooten, 1999; Redman & Fry, 2000). A case manager workday contains frequent disagreements, misunderstandings, redundant conversations (text, phone, e-mails, and face to face) with different providers on different patients. A "successful" case manager is responsible to minimize delays, futile or failed plans and to communicate details sufficiently to satisfy patient, supervisor, treating physicians or other staff (nurse, physical therapist, and social worker). Common job duties include appealing denied coverage for current hospital care. Contentious topics include high copays, preauthorizations for physician-preferred versus insurance-covered medications or treatment, risk of readmission because of a transition plan of inadequately covered safety needs, and pressure to meet hospital metrics for length of stay. Camouflaged benefit limitations, outdated or changing patterns in regulations, cumbersome policies or procedures combined with caregiver demographics and coping skills contribute to a unique experience of ethical conflicts.

Professional competency is judged by peers and management. Maintaining a healthy self-esteem is not a professional competency metric but is expected by all customers despite pressure to comply with and reconcile conflicting interests that occur during care planning. Specifically, case manager's noncaregiving duties include the embattled inpatient verses observation levels of care affecting hospital reimbursement, reducing readmission rates, completing required regulatory processes. Patient satisfaction about discharge transitions organized by the case manager can be lost in competing administrative responsibilities. Although peers may perceive competency on the basis of outcomes in caregiving, management measures competency by metrics of network provider use, cost containment plans, and compliance regulations mandated by the health care system.

In summary, no performance metric reconciles the internal burden and conflict a case manager experiences in striving for the best patient outcome, accommodating to management expectations, and maintaining personal self-worth as a nurse. The case manager job contains conflicting ethical priorities and imposed constraints, creating a virtual petri dish for moral distress in the scope of case management duties.

WHAT CAUSES MORAL DISTRESS IN CASE MANAGERS?

Case managers share the same demographic variables as bedside nurses identified in research defining moral distress. Caregiver responsibilities described can easily create ethical conflict. When case manager's values are marginalized and authority is lacking, the decision-making perceived to be "inferior ethical prioritizing" puts case managers at risk for moral distress. Unavoidable frequent ethical conflicts are described within established ethical categories.

1. Organizational Ethics, Business Advocacy, and Case Manager

Business ethical dilemmas that can trigger moral distress for the case manager may come from business rules of health care, including length of stay, interprofessional conflicts, reimbursement, interagency conflict, privacy, confidentiality, and (increasing) compliance regulations (Banja, 1996; Craig, 2010; McGonigle, Mastruan, & Farcus, 2002). The case manager as an organizational representative facilitates financial consultations and insurance benefits (institutional reimbursement) when needed, documenting required clinical details for insurance companies, adhering to compliance regulations, and performing data entry for employer reports that evaluate length of stay, case mix, and cost containment initiatives.

The case manager role in organizational ethics creates conflicts of moral distress based often on financial constraints upstaging advocacy or personal ethics. Three examples of this are decreasing or increasing length of stay igniting interprofessional conflict, reimbursement and interagency conflict about appropriate affordable care plan, and, finally, payer or government compliance directives that lack depth of insight on the difficulty and time-consuming communications required by the case manager when dealing with challenging patients (cultural, psychiatric, and clinical) or adverse determinations or both. The case manager is aware of the harm–benefit ratio between alleviating suffering and vulnerabilities of patient/family relative to available resources approved by organizations paying the bill. Over time, this painful inequity accumulates internally and moral distress increases.

2. Clinical Ethics, Patient Advocacy, and Case Management

Meaney (2002) believes that the caregiver suffers moral distress when clinical ethics conflict with organizational ethics. Several examples are nurses risking clinical ethical conflicts leading to moral distress when providers withhold or withdraw treatment, administer life-sustaining futile support such as nutrition, or deliver inadequate pain management in the setting of terminal or vegetative patients. Clinical ethics are also jeopardized by incompatible patient/family dynamics and requests that are conflicting with standards of care or available payment options. The case manager experiences conflicts when complex risk assessment planning is discounted and contentious discussions or, worse, no discussions occur among the hierarchy of professionals acknowledging opposing ethical priorities. The case manager collaborates with many professionals to create a safe, timely, and cost-effective transition out of the hospital for each patient assigned. During every professional conversation, the case manager concurrently is expected to empathize with patients experiencing unexpected health events (accidents, cancer, stroke), organize resources to meet gaps in family resources, confirm or correct payment preauthorizations for high-cost or polypharmacy prescriptions, follow up on services promised by vendors, and, when necessary, advocate with community resources for unfunded medically necessary services. Case managers have inadequate time to educate and advocate. Therefore, case managers can easily experience diminishing satisfaction in accomplishing caregiving responsibilities and goals. In addition, the case manager may feel constrained to alter care plans perceived as inappropriate. Aggregated unresolved accumulating clinical conflicts contribute to moral distress.

3. Personal Ethics, Self-Esteem, and Case Managers

Conflicts that challenge personal ethics also lead to moral distress. Strong personal work ethics are essential for competent case manager performance. The causes of conflict that impact personal ethics include relentless expectations to coherently communicate complex issues repeatedly and to consider various levels of sophistication. Demeaning time-consuming duties include entering endless data into cumbersome "clickie" computer systems for other departments, insurance companies, and management to analyze performance of organizational metrics.

In the aggregate, case managers risk moral distress because of routinely and relentlessly facing external expectations that conflict with a caregiver's perceived failed professional mission. A case manager knowing the ethically best decisions may be too overwhelmed to act because of clinical, organizational, or personal roadblocks. Professional competency is judged by accurately assessing the clinical priorities of the patient and allocating resources between conflicting expectations of management, physician, patient, payer source, and regulatory agency mandates. Overexposure to ethical conflicts cause a creative professional care planner to become instead a messenger of underfunded benefit plans, regulation mandates, or under-resourced care providers. These experiences of ethical turmoil and futility appear parallel to the causes, symptoms, and experiences documented as moral distress in other caregiver roles.

SIGNS, SYMPTOMS, AND OUTCOMES OF MORAL DISTRESS IN CASE MANAGERS

Case managers, as frontline caregivers, are often unaware that everyday ethical conflicts create moral distress. The ubiquitous scope of "nursing" responsibilities and the commensurate lack of authority in decisions generate ethical conflict. Case manager's behavior signaling moral distress could include frequent rationalizations, cynicism, apathy, blaming, attitudes of powerlessness over conflicts and constraints dismissed as "part of the job," isolation, and low self-esteem. Internal demoralization is overshadowed by high volume of suffering patients in health crisis. Uncontrolled or misidentified ethical conflicts create unavoidable

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devaluation and inequities for case manager advocacy roles. The symptoms of moral distress can be perceived as professional weakness by the uninformed community. Supervisors under pressure to deflect or repress conflict may be quick to judge a person's professional competency. By disregarding the underlying constellation of burdens, conflicts, and constraints of staff, supervisors could unwittingly contribute to moral distress by misinterpreting moral distress symptoms exhibited by the case manager. Eventually, a case manager experiencing moral distress could be judged as incompetent, indifferent, stupid, or burned-out.

Moral distress may explain one reason competent case managers choose to leave frontline duties for predicable repetitive tasks requiring clinical knowledge. In recent years, the health care industry has created desk jobs exploiting accumulated clinical expertise and requiring minimal ethical decision-making. Nurses have reported drastic actions such as leaving a job in an attempt to alleviate pain or depleted self-esteem due to symptoms identified by researchers as moral distress. The motivation to leave based on unresolvable conflicts and constraints in unequal hierarchy can produce postemployment ambivalence or resentment because of a perceived failure as a clinically expert caregiver (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2004; Hamric, 2012).

Without competent ethical case managers working diligently to advocate for various participants during care planning, the Western health care systems would grind to a halt, patients' rights to self-determination would be nonexistent, and safe ethical transitions of care would lack compassionate choices. Case mangers' tasks that contain underlying ethical decision-making are full of conflicts and constraints. Therefore, these tasks are high-risk indicators for moral distress. Case managers deserve support in maintaining a sense of integrity in health care decisions.

MITIGATING MORAL DISTRESS

Professional descriptions of moral distress lack creative cost-effective interventions (Kopola, & Burkhart, 2005; Ethics Work Group AACCN, 2004; Canadian Nurses, 2003; LaSala, & Bjarnason, 2010;

McCarthy, & Deady, 2008; McCue, 2011; Zuzelo, 2007). Academic articles eloquently define theories and symptoms, yet give insufficient attention to individual frontline staff solutions or outcomes. Mary Corley and other academic researchers have established that moral distress triggers are unique to the individual (Beumer, 2008; Corley, Minick, Elswick, & Jacobs, 2005). Therefore, the assumption needs to be that the remedy is unique to an individual's complexities. The remainder of this article defines qualities for an effective employer-sponsored program that includes an intervention called mindfulness, why it works, and other recommendations for workshop content addressing moral distress.

Parameters for a program mitigating moral distress include cost-effectiveness, creative approaches to patient advocacy, and meaningful interventions for adult caregivers. Mindfulness training described below meets these parameters. Mindfulness programs created by Jon Kabot-Zinn (1990) are being introduced as interventions for complex human conditions and conflicts found in Western cultures (Cohen-Katz et al., 2004; Foureur, Besley, Burton, Yu, & Crisp, 2013; Kim et al., 2012; MacKenzie, Poulin, & Seidman-Carlson, 2006; Pipe, 2009; Shaver, Lavy, Saron, & Mikulincer, 2007). Original principles underpinning mindfulness training are underreported in research literature. Mindfulness training is a scaffolding of concepts derived from Buddhist systems of beliefs about experiences of suffering. Buddhism recognizes that suffering is not an isolated experience, has infinite causes, and takes many forms. Mindfulness instruction extracts pragmatic Buddhist insights defining suffering and removes religious references. The facilitator introducing mindfulness creates curiosity and insight about suffering by exploring and dissecting Western values and assumptions about happiness and expectations. Mindfulness training works because it requires little financial investment, generates motivation to learn by using cognitive insights, and promotes creative solutions immediately accessible to the caregiver (see Table 2).

The mindfulness training process is a blend of cognitive, experiential, and creative interventions. The facilitator applies cognitive processes reframing

TABLE 3
Take a Moment for Mindfulness…
To feel your lungs inhale and exhale, inhale and exhale. When you observe your breath, you are learning to focus in the present.
To listen to sounds surrounding you. What do these sounds represent to you personally? Do you value that association in a positive way or do you find your body tensing up.
To watch how many thoughts ripple in; let them fade away gently just for this minute. Letting go of thoughts allows another way to be aware.
Inhale and exhale again.

the causes and conditions of suffering and then presents opportunities for the participant to create sustaining antidotes. Specifically, mindfulness combines westernized "linear" logical thoughts about cause and outcomes with "nonlinear" reflective and creative skills such as meditation venues. Skills of emotional intelligence are developed by combining didactic "linear" information with experiential "nonlinear" contemplative and creative methodologies (Tsenten, 2013). The awareness and experience of interdependencies of mind, body, and relationships are liberating. *Mindfulness meditation* can be "viewed as a vehicle for a deconstructing process in terms of conventional reality" (Hirst, 2003, p. 362). For further explanations detailing the secular theories about stress (conflict) with various Buddhist theories and practice, see Hirst's article and others (Baer, 2009; Brown, 2004; DeGrace, 1975; Jagodzinski, 2002; Jinpa, 2010; Klatt, Steinberg, Marks, & Duchemin, 2012; Levin, 2008; Shaver et al., 2007; Travis, & Shear, 2010; Virtbauer, 2011; Vokey, 1999). When mindfulness and other creative personally meaningful methods are integrated into one's routine, moral distress triggers are identified and personally meaningful antidotes are effective (see Table 3).

TARGETED CATEGORIES FOR MINDFULNESS

Mindfulness training enhances interventions that alone have not eliminated moral distress. Current recommendations for short educational workshops lack depth and creativity. In contrast, mindfulness training does offer an effective, cognitive, and creative solution for at least three areas contributing to moral distress—organizational strategies, patient advocacy, and dynamic interventions—for individuals during day-to-day operations.

1. Organizational leaders dismiss the gravity of constant conflict by assigning human resources, employee assistance, or ethic committees as mediators, mentors, or facilitators to fix complex everyday conflicts. These well-intended delegated organizational agents lack effectiveness because the dynamics of constant moral distress requires timely access and status within the hierarchy of leadership.

Mindfulness training offered to hospital caregivers and management would reduce sources of conflicts. Hospital organizations have a mission to alleviate illness and suffering and to contain costs. Nurses as caregivers are relentlessly exposed to expectations about this mission. Compounding caregiving responsibilities are the antagonistic behaviors and self-promotion creating suffering and conflict for many staffing levels. Individuals applying mindfulness become more authentic, feel increased self-esteem, and are less likely to create or respond defensively to morally distressing triggers. Management competencies also need to measure leadership accountability in identifying moral distress vulnerabilities currently identified in research. At a minimum, management's mindful interactions would encourage authenticity and role modeling.

2. Frontline caregivers, including case managers, are not given sufficient and relevant information

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about ethical conflicts creating moral distress. Cognitive education about moral distress is limited to cursory descriptions, simple labels, simplistic recipes, or ways of aggressive posturing despite evidence that moral distress is specific to each individual. Workshop themes suggesting "resilience" or "conflict resolution" ignore the subtleness of accumulated moral distress and do not apply to every encounter triggered in moral conflict. Unfortunately, short workshops euphemistically labeled "dealing with difficult people" or "anger management" are structured around PowerPoint slides, sound bite conclusions, 1:1 role play, and clever mantras having limited influence on internal values and complicated uneven hierarchy. One research study found long-term staff in high-risk positions who express a "comfort" level in questionnaires about job stress may be unaware of stress related to moral distress conflicts due to disconnection. Manifestations of this are lack of assertiveness, depersonalizing others, and believing external factors prevail (Heard, 2010). For these reasons, advocating risky "moral courage" to confront ethical conflicts is unrealistic because the stakes are too high and threatening for patients, customer relations, and personal sacrifice.

Managers need to support provocative didactic education, identify vulnerable caregivers, and allow staff training sessions over time to explore interventions and receive mentoring. Insight brings knowledge and this knowledge creates behavior changes. Unique outcomes of this knowledge are based on the individual's ability to identify external moral conflicts and internal constraints (Callahan, 2004; Chalmers, 2009; Epstein & Delgado, 2010). Moral distress vulnerability is found in direct revelations about how it is caused and what negative impacts are created when ignored.

3. A person in conflict needs meaningful and effective interventions and mentoring. Short workshops are inadequate to address a complex and internalized response to conflict. Outside the workshop environment, confounding ethically conflicted conversations continue. In a naive environment, the frontline "mindful" caregiver deserves a committed accessible mentor as protection from perceived failure as an advocate, isolation, bullying peers, and distracted managers during early implementation of elements introduced in mindfulness training. Burston and Tuckett's (2013) literature review article categorized ethical conflicts as the individual's relation to self, others (community), and system. Successful individual interventions develop "conscious reflexivity" through relevant self-reflection, access to methods for personal growth during reactions during conflicts, and authentic coping skills. These goals are possible if remedial interventions are personally relevant to the caregiver, accessible during conflicts, and supported by the institution's culture.

Mindfulness and other contemplative interventions target individual revelations versus broad organizational top–down policies and procedures defining mission. The essential goals of mindfulness are to gain personal knowledge and awareness about choices. Ethical choices causing moral distress are complex and accumulate painful reactions and that manifest suffering in a variety of ways depending on the individual. Moral distress is a form of suffering, the causes and conditions for which mindfulness is an antidote.

INTERVENTIONS IN MINDFULNESS WORKSHOP

Workshops accomplish mindfulness expertise slowly. The antidote of mindfulness is best introduced through workshops over several weeks to establish daily meditation practice and apply mindfulness in various experiences. Participants are guided to be curious about suffering by investigating personal experiences. Mindful reflection brings new insight. Learning about mindfulness, the participant conjures antidotes on the basis of wisdom and kindness. The

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individual is motivated to see suffering as a multifocal and ubiquitous experience common for all sentient beings. Mindfulness and other meditation venues reduce impulsive reactions causing the pain. Mindfulness creates an understanding about the relationship between the origins of suffering based on choices we make and how antidotes such as meditation create new personally meaningful coping patterns. These workshops over time allow space for participants to explore in detail experiences and consequences of unavoidable suffering within "real life." Interventions are specifically designed reflective exercises using personal ethical challenges causing moral distress to reveal layers of bias or judgments, expectations, aversion, or indifference to particular outcomes. Afflictive emotions and thoughts become entangled when outcomes matter the most: life, death, pain, financial burdens, employment, and judgment by the "powerful." Repressed conflicts and responses to ethically ambivalent events are revealed through group discussion and personal reflection. Experiences of suffering become reasons to justify, rationalize, or "get through" confounding ethical conflicts rather than investigate the internal triggers causing suffering.

Through advancing weekly workshops and homework, the participant learns to observe *everything* about a situation triggering internal reactions: physical and emotional pain, pleasure, vindictiveness, anger, jealousy, rationalizations, and other emotionally charged experiences. These reactions, considered positive or negative coping mechanisms or reactions, are linked to behaviors established in research as moral distress: "afflictive emotions," repulsion, powerlessness, and devaluation. To redirect the energy behind these knee-jerk reactions, mindfulness and other contemplative activities cultivate intentional responses to the same conflicting scenario. Insight about suffering of conflicts brings awareness that thoughts and emotions and a person's perceived "truth" are interconnected with personal history, layered, dependent, and transitory.

A mindful person experiences less suffering by vetting differences between emotions, thoughts, and consequences of unresolved attachments. Mindfulness teaches how a healthy mind develops equanimity in general and makes specific choices developed from insight about the origins of suffering. Understanding the interdependence of thoughts, emotions, wisdom, and compassion can be a lifelong adventure.

WORKSHOP CONSIDERATIONS

Developing mindfulness in the hospital environments involves organizational commitment and application of adult learning theories by a competent mentor. Workshops on moral distress require an action plan commensurate to the organization's mission and adult learning interventions introduced by a committed educator tracking researchable outcomes (see Table 4).

1. Organizational commitment: Workshops supported by patient care services departments are recommended to sustain "mindful" approaches by members in the organization and to provide organizationally endorsed accessible interventions. Resistance to change is not uncommon and should be expected at some point, with participants in an extended program requiring homework (tapes) and engagement during day-to-day operations. Slowly, a more "mindful" community of role-modeling mentors develops. A successful mindfulness presence of staff during conflicts models authenticity and emotionally intelligent responses. Collaboration becomes "intentional" —not reactive—even if not always "perfect." Everyone benefits.

2. Adult learning theories: Mindfulness workshops accommodate to adult stages of development defined by Knowles' (1978) adult learning principles: when adults are self-motivated, use life experiences, and are given practical relevant information in a respectful manner they will learn. Ethical conflicts are investigated using lecture, and mind–body activities including mindfulness methods, journey meditations, and ceremony. Ethical conflicts creating moral distress are revealed by observing the quality and quantity of a participant's specific triggers. Mindfulness teaches the participant to be curious about triggers for moral distress. Yoga, journeying, and ceremony are dynamic tools for developing self-regulation. Yoga has become a main stream mind–body activity. Journeying or "active imagination" (Jung's term) is a form of visualization. Journeying engages the mind in active creativity as a vehicle for positive problem-solving (Harner, 1980; Ingerman, 1991). Jung (2009) used

TABLE 4
Suggested Topics for Workshop
Awareness and self-responsibility
Breathing, body movement to keep focused on present
Stress: reaction, response, resilience
Daily mindful engagement: thoughts, behaviors, eating
Additional experiences in active imagination and ceremony
Creating discipline of equanimity in everyday life

this approach as he created the Red Book and endorsed this process as a method to gain insight about personal conflicts (Hall, & Nordby, 1973). Personalized ceremonies decrease obstacles and increase access to emotional intelligence to mitigate effects of moral distress. Ceremony originated with indigenous cultures, our ancestors, as a method of reducing suffering and healing wounds of the psyche. Ceremony brings equilibrium in unique venues, using symbols and imagery. Ceremony is used every day in our society. Theoretically, these interventions reduce self-reported ethical decision burdens because "personal baggage" attached to the situation is reduced or unstuck.

3. Mentoring facilitator: The workshop facilitator must have intimate knowledge and commitment of the organizational culture, multifaceted frontline caregiver dilemmas, and of course, interventions selected for the workshop. Examples of interventions include, but are not limited to, journaling, yoga, and ceremony. These interventions have been anecdotally reported to enhance awareness about moment-by-moment reactions, self-regulation, creativity, and authenticity in individuals. Ultimately, relationships with others benefit. Specific interventions selected have been reported to increase equanimity and ability of preparing the mind to transfigure conflicting experiences. Interventions like these teach ways to untangle thoughts, emotions, expectations, and outcomes. The nonjudgmental facilitator knows how to identify the sources of ethical conflicts for the participants and can offer creative pathways to disempower negative outcomes of highly charged inevitable conflicts.

Measuring the significance of "active imagination" and ceremony is challenging. Paralleling the challenge of quantifying the moral distress experience with variable demographics is the fact that ceremonial details are not conducive to replicating results by using "cookie cutter" tools. More is needed to qualify reported experiences and impact of ceremony in healing trauma and conflict. On the basis of available narratives (Ingerman, 2007), creative interventions are appropriate in a workshop to mitigate causes and symptoms of ethical conflicts currently associated with moral distress. Research measurements for these interventions over time need to combine qualitative narratives and quantitative self-reporting of decreasing destructive behaviors and increasing constructive role-modeling after learning to identify moral distress triggers.

Specific (Mindfulness) interventions selected have been reported to increase equanimity and ability of preparing the mind to transfigure conflicting experiences. Interventions like these teach ways to untangle thoughts, emotions, expectations, and outcomes.

CONCLUSION

Ethical conflicts are expected consequences in daily routines for caregivers, including case managers. Hospital case managers' work environment contains an inconsistent, unequal power hierarchy among organization, patient, and caregivers. Conflicts and constraints within systems of unequal hierarchy result in devaluation of advocacy and contentious communications. Increasingly, protocols are required by nurses delegated to facilitate hospital reimbursement and meet compliance regulations. These combined interactions create a perceived lack of authority in the hierarchy and erode self-esteem as a caregiver. Definitions of ethical conflict theory are consistent. However, definitions of moral distress and how it is triggered vary by a caregiver's specialty, ethical priorities, and demographics. Researchers confirm that moral distress is a risk for staff whose job requires ethically conflicting decisions about patient care. Defining and mitigating moral distress is increasingly discussed in literature, so it appears current interventions are absent for some groups, or inadequate to address institutional needs. An example of this gap is the lack of research or commentary identifying hospital nurse case managers who, for reasons stated, are a high risk group for moral distress. Additional research and intervention is justified for this group and other caregivers.

Current theories explaining conditions and causes of suffering specifically labeled as moral distress correlate with Buddhist principles of suffering, ignorance, attachment, and aversion. However, current interventions to mitigate moral distress have not engaged effective Eastern antidotes for moral distress such as mindfulness, sensitivity, interconnectedness, creativity, and asana yoga. Also, personally meaningful ceremony can reconcile latent or traumatic life events (Ingerman & Wesselman, 2010) experienced during moral distress such as loss, powerlessness, and isolation.

Awareness, education, and a commitment to change individual destructive perceptions are essential. Personalized mindful actions will promote beneficial

healthy living skills and improve conflict resolution in work environments. The successful workshop introduces methods to better reflect on patterns of responses to ethically challenging conflicts. Meditation, active imagination, and yoga heighten awareness of internal triggers and generate antidotes during contentious decision-making events. Ceremony reconciles residual burdens about unresolved conflict. Moral distress will always be a risk of conflicting ethics involved in caregiver decisions. However, the negative impact of moral distress to hospital culture and the staff is vulnerable to intervention.

This workshop curriculum is not exotic or religious. Mindfulness and other meditation venues are becoming a more conventional structure for reducing the experience of suffering moment by moment. The content of this workshop will advance communication and reflection skills for the caregiver. Qualitative research is needed to study case managers' experiences of ambivalence due to ethical conflicts and symptoms of moral distress before and after practicing a personally meaningful combination of these techniques.

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