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See table of contents

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Article abstract

Canadian healthcare systems are facing unprecedented challenges in recruiting and retaining workers. Literature on healthcare burnout and professional exit suggest multiple intersecting causes. Understaffing, residual trauma, compassion fatigue, demanding hours, rigid hierarchies, and moral distress, interlock and compound to create and sustain the current burnout crisis. In the face of this frightening reality, healthcare institutions and governments are investing billions in wellness programs, aimed at attracting new workers and incentivizing staff retention. Amid this rapidly evolving landscape, our workshop asked: Does clinical ethics have a role in addressing the ongoing burnout crisis? If, as the research suggests, moral distress and moral injury are key drivers of the burnout problem, should bioethics be part of the “wellness” solution?

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ACTES DE COLLOQUE / CONFERENCE PROCEEDINGS

Bioethics and Burnout: Unpacking the Relationship

CANADIAN BIOETHICS SOCIETY SOCIÉTÉ CANADIENNE DE BIOÉTHIQUE
In collaboration with / En collaboration avec

Carey DeMichelis[a], Randi Zlotnik Shaul[b,c], Roxanne Kirsch[b,c]

Résumé
Les systèmes de santé canadiens sont confrontés à des défis sans précédent en matière de recrutement et de fidélisation du personnel. La littérature sur l'épuisement professionnel dans le secteur de la santé et l'abandon professionnel suggère de multiples causes qui se recoupent. Le manque de personnel, les traumatismes résiduels, l'usure de la compassion, les horaires contraignants, les hiérarchies rigides et la détresse morale s'imbriquent et se combinent pour créer et entretenir la crise actuelle de l'épuisement professionnel. Face à cette réalité effrayante, les établissements de santé et les gouvernements investissent des milliards dans des programmes de bien-être visant à attirer de nouveaux travailleurs et à encourager la fidélisation du personnel. Dans ce contexte d'évolution rapide, notre atelier a posé la question suivante : L'éthique clinique a-t-elle un rôle à jouer dans la lutte contre l'épuisement professionnel? Si, comme le suggère la recherche, la détresse morale et le préjudice moral sont les principaux moteurs du problème de l'épuisement professionnel, la bioéthique devrait-elle faire partie de la solution de « bien-être »?

Mots-clés
bioéthique, épuisement professionnel, détresse morale, préjudice moral

Abstract
Canadian healthcare systems are facing unprecedented challenges in recruiting and retaining workers. Literature on healthcare burnout and professional exit suggest multiple intersecting causes. Understaffing, residual trauma, compassion fatigue, demanding hours, rigid hierarchies, and moral distress, interlock and compound to create and sustain the current burnout crisis. In the face of this frightening reality, healthcare institutions and governments are investing billions in wellness programs, aimed at attracting new workers and incentivizing staff retention. Amid this rapidly evolving landscape, our workshop asked: Does clinical ethics have a role in addressing the ongoing burnout crisis? If, as the research suggests, moral distress and moral injury are key drivers of the burnout problem, should bioethics be part of the "wellness" solution?

Keywords
bioethics, burnout, moral distress, moral injury

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INTRODUCTION

Canadian healthcare systems are facing unprecedented challenges in recruiting and retaining workers (1-5). Literature on healthcare burnout and professional exit suggest multiple intersecting causes. Understaffing, residual trauma, compassion fatigue, demanding hours, rigid hierarchies, and moral distress, interlock and compound to create and sustain the current burnout crisis (6-8). In the face of this frightening reality, healthcare institutions and governments are investing billions in wellness programs including resilience workshops, self-care offerings, and mindfulness programming, aimed at attracting new workers and incentivizing staff retention (9-10). Amid this rapidly evolving landscape, our workshop asked: Does clinical ethics have a role in addressing the ongoing burnout crisis? And if, as the research suggests, moral distress and moral injury are key drivers of the burnout problem (11-13), should bioethics be part of the "wellness" solution?

These questions were taken up in a 3.5-hour workshop, entitled "Bioethics and Burnout: Unpacking the Relationship", hosted by the Canadian Bioethics Society's Community Forum in May 2023. We, the authors of this summary, were the workshop facilitators. Participants identified as clinical ethicists, academic ethicists, leaners/students/fellows, healthcare providers, administrators, and organizational wellness specialists, representing healthcare institutions across Canada. Building on the analysis presented in our 2022 paper "Healthcare's search for 'wellness': how bioethics reduces burnout among health professionals" (9), workshop facilitators 1) reviewed the current state of burnout amongst healthcare providers in Canada, 2) described the spectrum of wellness strategies currently being marketed to healthcare institutions, 3) discussed the relationships between moral distress, moral injury, and burnout, and 4) brainstormed about the role of bioethics in supporting hospital wellness strategies or programs addressing burnout.

KEY INSIGHTS

Through a combination of full group discussion, break out groups, and chat-based activities, workshop participants contributed several new lines of analysis and inquiry that were under explored in our prior work. The first key insight was that a more expansive understanding of who experiences burnout is needed – one that moves beyond bedside providers to include hospital

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leadership, staff, and especially bioethicists themselves. The second novel contribution was a discussion of trauma informed ethics consultation and the need to acknowledge the risks inherent in our practice.

Locating Burnout

Much of the literature on healthcare burnout and professional exit focuses on doctors, nurses, and allied health professionals working at the bedside in patient care (14,15). ICU settings, with their high-stakes caseload, competitive workplace, and hero culture, are regularly understood as driving burnout statistics within healthcare institutions (16-17). Our workshop participants, however, argued that this relatively narrow conceptualization of burnout at the bedside may miss key vulnerability points within our institutions. In particular, they were concerned about burnout among hospital leadership. Participants raised concerns that burned out leadership may inadvertently deepen the problem, by attempting to implement problematic quick-fix wellness solutions, such as those described in our previous work (9).

A more expansive mapping of the burnout crisis must also account for burnout among bioethicists themselves. Workshop participants noted that clinical ethicists, like other providers, have weathered a firestorm of distressing experiences in recent years. Due to their unusual scope of practice, which cuts across hospital hierarchies, bioethicists were called to work on resource prioritization frameworks, family leave policies, and mandatory vaccination initiatives during the pandemic, while simultaneously remaining on call for bedside healthcare providers, patients, and families who were confronting alarming wait times, underfunded health systems, and increasing public hostility.

It is important to clarify, then, that when we suggest bioethics may be an important part of the “wellness” solution, we are not implying that skills in ethical analysis will make a provider immune to burnout. Indeed, many workshop participants, highly skilled in ethical analysis, attested to themselves having feelings of burnout and compassion/empathy fatigue. We regard these experiences as a natural human response to the day-in-day-out work of bearing witness to profound suffering and injustice (18).

Trauma Informed Care

The second key idea raised by workshop participants, but under explored in our previous work, is that bioethics debriefs themselves bear risk. Moral distress consultations are often suggested as the best clinical ethics “tool” for addressing burn out (9,11). In a moral distress consultation, the aim of the ethicist is to identify the institutional constraints that may cause a person to behave in a way they experience as unethical. Ideally, moral distress consultations also support the person experiencing distress by attempting to identify concrete actions they or others could take to shift structural conditions and mitigate these harms (19,20). Workshop participants who regularly conduct these debriefs expressed their belief that these conversations are valuable. But they also emphasized that these are high stakes conversations. Asking individuals and teams to exhume difficult and painful experiences, to name conflicting values, to reflect on injustice that is inherent and sometimes unchangeable in their workplaces, can itself be emotionally traumatic. This is particularly the case for people who closely identify with their vocation, as do many clinicians. In fact, several participants recommended that ethicists should conduct moral distress debriefs in collaboration with mental health professionals – e.g., psychiatrists, psychotherapists, or social workers trained in trauma informed care – who can help attend to the psychological dimensions of distress.

A move to trauma informed approaches to ethics consultation is supported by recent literature (21-24). Though much of this literature focuses on supporting patients and families in clinical ethics consultations, Lanphier and Anani (23) also extend their analysis to healthcare providers themselves, noting that caregivers often bear witness to traumatic events and carry significant levels of distress. Extending a trauma informed approach to moral distress consultations would work to promote the realization that trauma is pervasive among healthcare workers, and that moral distress interventions must be conducted in ways that resist re-traumatization. This is not to say that ethicists are ill equipped or should not be trusted to offer ethical analysis and intervention. But rather that moral distress debriefs entail unique emotional risks for participants and need to be handled with care, particularly in our current context of extreme healthcare provider over-work and vulnerability.

FURTHER INQUIRY AND NEXT STEPS

With these fresh insights in mind, we return to our guiding questions: What role should clinical ethics play in addressing the ongoing burnout crisis? And if moral distress and moral injury are drivers of the burnout problem, should bioethics be part of the “wellness” solution? Workshop participants endorsed the view that bioethicists have a role to play in addressing moral distress and moral injury, two key drivers of the burnout crisis. Notably, bioethicists can assist by:

1) Offering dedicated moral distress consultations to help providers identify and navigate values conflicts in real time.

2) Offering moral distress “pre-briefs” to help providers anticipate ethical challenges they may experience when they enter new practice environments.

3) Offering moral distress “de-briefs”, co-facilitated with mental health professionals as needed, to help providers unpack value conflicts and institutional constraints encountered in their work.

4) Promoting moral distress services to healthcare workers beyond the bedside, specifically targeting allied health professionals, staff, and hospital leadership.

5) Growing a professional community where bioethicists can identify and seek support for their own experiences of moral distress, burnout, and compassion / empathy fatigue.

6) Advising hospital leadership on the just implementation of "wellness" solutions;
    a. avoiding programming that constructs "burnout" as an individual deficit;
    b. promoting solutions that harness local knowledge for systems-level change.

Importantly, many working-group members emphasized that the interventions above fall well outside their current scope of practice, which focuses primarily on navigating ethical dilemmas related to a particular patient's care. We are not arguing that these "next steps" should be added to ethicists' already overflowing plate. If healthcare systems want ethicists to take on this important work, they need to invest adequate resources in their ethics services. For example, depending on the size of the health system/authority, one or several dedicated ethicists might be hired to develop, run, and promote moral distress interventions. Such a service would also need to support the time of mental health workers to co-facilitate complex debriefs in some cases. A forward-thinking institution might even consider hiring one or several empirical researchers to join this team, to measure and evaluate the effectiveness of these interventions for reducing moral distress and burnout over time, as well as to carefully map the unique burnout landscape of the institution.

In sum, the opportunity to work through these questions with colleagues meaningfully deepened our understanding of the relationship between bioethics and burnout. An expanded view of where burnout may be located, along with a more critically reflexive look at the risks entailed in our own practice has yielded a more nuanced position on the role that bioethics may play in responding to the burnout crisis. We believe that targeted ethics interventions can effectively reduce the depleting sequela of moral distress, one of the structural root causes of the burnout crisis. We also believe that bioethicists are uniquely trained to carry out these interventions, and that ethics services must be properly resourced to do this work.

Inspired in part by the workshop, and the valuable national forum of the Canadian Bioethics Society, some workshop participants from Ontario, British Columbia, Nova Scotia and Alberta have begun collaborating on the development of a common best practice approach. The aim is to develop a common approach to moral distress interventions, which can be studied and evaluated across multiple settings. The organizers of this workshop are looking forward to reconnecting with participants at the joint Canadian Bioethics Society – International Conference on Clinical Ethics Consultation conference in Montreal, in May 2024 to continue the national conversation on the relationship between moral distress and burnout.

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