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Institutional Ethics

Moral Distress: A Framework for Offering Relief through Debrief

Shilpa Shashidhara and Shaylona Kirk

ABSTRACT

Moral distress, if left unaddressed, leads to a number of harmful emotions and behaviors that take a toll on the personal and professional well-being of healthcare workers. In this article, a clinical case is used to illustrate a moral distress debriefing framework that can be utilized by clinical ethicists and healthcare professionals with the appropriate skill set. The first part of the framework is preparatory; it includes guidance on how to identify the needs of healthcare providers, set goals for a debriefing session, gather relevant information, and plan the logistics of the meeting. The second part of the framework is implemental; it outlines an eight-step method to conduct the session from beginning to end. It describes how to constructively reflect on the experience, explore emotional responses, share coping strategies, and identify takeaways for future positive outcomes. This framework can be used to empower healthcare team members to deal with moral distress and be better equipped to handle challenging situations.

Shilpa Shashidhara, PhD, is a Bioethicist at the Sutter Health Program in Medicine and Human Values in San Francisco, California. *shashis@sutterhealth.org*

Shaylona Kirk, MD, MA, is a Bioethicist at the Sutter Health Program in Medicine and Human Values in San Francisco, California. *Shaylona.Kirk@gmail.com*

INTRODUCTION

Feelings of moral distress, a natural response to the violation of one's core values, are often triggered in healthcare settings when constraints prevent healthcare providers from fulfilling their perceived duty to patients.[1] If unaddressed, moral distress often leads to anxiety, anger, guilt, apathy, and other harmful emotions that take a toll on personal and professional well-being.[2] The occurrence of moral distress is highly predictable in cases that involve significant conflict between members of a healthcare team or between the healthcare team and a patient's family.[3] Moral distress has the potential to negatively impact job satisfaction, recruitment, and retention, all of which are linked to diminished quality of patient care.[4]

There are three fundamental principles to guide healthcare providers towards relief from moral distress. First, moral distress must be recognized and acknowledged, so individuals can understand where their painful feelings originate.[5] Second, there is evidence that moral distress can be mitigated in many instances when individuals are encouraged to openly discuss their experiences and feelings, during and after a difficult case.[6] And third, it has been shown that moral distress may be alleviated when ac-

tion is taken, whether the action is speaking up about an issue or taking steps to improve a situation or a longer standing problem.[7] Interdisciplinary debriefing sessions combine all of these elements to successfully manage and minimize the effects of moral distress for individuals and groups.[8]

DEBRIEFING SESSION: DEFINITION AND TRIGGERS

In a healthcare setting, a debriefing session is a meeting between two or more people with the purpose of discussing the thought processes, emotions, and actions involved in a specific patient care situation. Participating in a debriefing session at the end of a sad, disturbing, or heartbreaking case can be a pivotal opportunity to overcome moral distress.[9] Clinical ethicists who are asked to consult on cases are well positioned to recognize moral distress[10] and to conduct debriefing sessions when needed. Clinical ethics training and experience in interpersonal communication, conflict resolution, ethical assessment, and resource awareness allow consultants to successfully organize and conduct meetings that can help alleviate moral distress.[11] Likewise, other healthcare professionals with similar skill sets can learn to effectively conduct debriefing sessions.

Over the course of working with healthcare providers, patients, and families in seven hospitals within a large health system, we have come to appreciate the value of interdisciplinary debriefing sessions that provide an opportunity for staff members to speak up, be heard, and work through their feelings of moral distress in a safe, respectful environment. We have also found that debriefing sessions are an excellent forum to motivate professional growth and increase job satisfaction among participants as they share healthy coping strategies, constructively discuss problems and mistakes, and plan improvements for the future.

Debriefing sessions are not necessary for every case that involves moral distress. Sometimes feelings of moral distress may be sufficiently managed during a case, especially when an ethics consult has been requested early in the case. Simply calling for an ethics consult may immediately ease feelings of moral distress in team members. The very act of requesting a consult constitutes taking positive action, as opposed to remaining immobilized by concerns about a case. In addition, having a clinical ethicist on hand to monitor stress-provoking situations means that issues that pertain to moral distress are addressed early and their effects are minimized.[12]

Debriefing sessions are recommended when healthcare team members display and/or express substantial and lingering signs of moral distress.[13] This article presents a moral distress debriefing framework that can be used to organize and facilitate an effective debriefing session for healthcare providers. The framework consists of two parts: (1) preparing for the debriefing session and (2) conducting the debriefing session using an eight-step approach. We use a clinical case to illustrate how a trained facilitator can use the moral distress debriefing framework as a catalyst to offer relief.

THE CASE

Ms Lewis, an 80-year-old woman, underwent aortic valve replacement and three-vessel coronary artery bypass surgery. Her postoperative course was complicated by acute pancreatitis, renal failure that required continuous renal replacement therapy (CRRT), acute respiratory failure, atrial fibrillation, and damage to her liver. Maximum therapy was being provided to treat the patient's multiple medical issues when she developed encephalitis, an infection in her brain. Specialists from neurology and neurosurgery responded with additional treatments, but no surgical intervention was deemed appropriate. The patient's health continued to deteriorate, with neurological damage and the failure of multiple organs. The healthcare team recommended that Ms Lewis should be transitioned from life support to end-of-life comfort care.

Despite the involvement of multiple supportive services, the family persisted in requesting that all aggressive treatments be continued, including interventions that her physicians considered to be medically nonbeneficial, such as the insertion of breathing and feeding tubes. The entire medical team agreed that these types of treatments would only increase and prolong Ms Lewis's suffering.

The conflict between the medical team and Ms Lewis's family persisted for an extended period. Her healthcare providers became increasingly frustrated and upset because they felt powerless to care for their patient in what they believed to be the most medically and ethically

appropriate manner. The Ethics Service was consulted to help resolve the conflict with the family and to support the staff in dealing with the turmoil of negative emotions.

Although the case was ongoing, the clinical ethicist quickly recognized the need for an interdisciplinary debriefing session when the case ended. This recognition was based on her initial conversations with several members of the medical team, who showed signs of suffering from moral distress, and reinforced by her observations of the strained interactions between the team and the family.

MORAL DISTRESS DEBRIEFING FRAMEWORK

Preparing for an Interdisciplinary Debriefing Session

Ideally, preparation for a debriefing session should begin well before the end of a difficult case. The facilitator can make preparations while providing ongoing support for members of the healthcare team. Maintaining contact and developing a trust relationship during the preparation is essential for the success of the debriefing session. Key components of preparation include (1) identifying the needs of the healthcare providers, (2) setting goals for the meeting, (3) gathering accurate information, and (4) planning the logistical aspects of organizing an interdisciplinary gathering (see table 1).

Identify the Needs of Healthcare Providers

To identify the needs of healthcare providers, a facilitator should directly ask those involved in the case about their concerns regarding the case and then actively listen.

In the Lewis case, it was quickly established that some team members were harboring a great deal of guilt; they felt responsible for causing the patient pain even though they were following the family's treatment requests. Other team members felt very angry about being forced to perform procedures that they felt were cruel and unnecessary.

Set Goals for the Debriefing

During the preparation process, the goals for the debriefing session become apparent. In some instances a group may simply need to express their thoughts and feelings, but in other situations a group may wish to focus only on "fixing" or finding solutions to the problems encountered.

In Ms Lewis's case, it was clear that the team definitely needed a forum to vent, but they were also worried that they would face the same problems in the future and wished to discuss how they could better handle similar cases down the road. After Ms Lewis passed away, some members of the healthcare team had unanswered questions such as, "Why did the family do that?" and made statements such as, "That shouldn't have happened!" The intensity of these feelings motivated team members to attend the debriefing session and helped them to recognize it as an opportunity to reflect, understand, process, and develop a level of emotional resolution.

Gather Accurate Information

It is important for a facilitator to know the facts of the case before the debriefing session. To obtain clinical background information, the facilitator should thoroughly review the patient's chart. If gaps are found, it is essential that the facilitator take a closer look to obtain a true and complete picture.

While reading the social work notes for the Lewis case, the facilitator learned that some family members had been adamant about keeping Ms Lewis alive as long as possible in order to spend time with her. They felt terrible that they had neglected her over the past few years. As sometimes happens, it seemed as though their guilt had overwhelmed their ability to understand Ms Lewis's medical condition. This information was valuable during the debriefing session in helping the staff to better understand the family's behavior.

Plan Session Logistics

The design elements of a debriefing session, including the timing, setting, attendees invited, and other logistical considerations, will differ depending on the situation and available resources. There are times when it is helpful to debrief within the first 24 to 72 hours after a

TABLE 1. Prepare for an interdisciplinary debriefing session

1.	Identify the needs of the healthcare providers
2.	Set goals for the debriefing
3.	Gather accurate information
4.	Plan session logistics

case, especially when distress impacts the ability of the staff to function effectively in their jobs. The facilitator will need to survey potential participants and schedule a meeting at the most convenient time for the greatest number of people.

We generally recommend that debriefing sessions are 60 minutes long to provide enough time to accomplish the set goals. An hour is usually manageable for participants. When a session extends beyond an hour, the discussion tends to become less productive. The facilitator may wish to ask management to protect the time for the meeting, so that those involved can give their full attention to the meeting. The option of scheduling multiple debriefing sessions to increase opportunities for participation, particularly for night or weekend staff, may also be considered.

A comfortable, safe, conveniently located, private location should be chosen for the debrief session.[14] At a minimum, the goal should be to find an adequately sized room with a door that can be closed to protect confidentiality.

In most cases, a multidisciplinary debriefing session will be the most productive because the context of teamwork is so vitally important in healthcare settings. However, in some situations, providing a safe environment may mean that specific groups, such as nursing staff, debrief separately.

For the Lewis case, in addition to medical team members, the facilitator chose to invite a hospital administrator, who had not been involved in the case, to attend the session to assure participants that their concerns were being taken seriously by the organization.

The facilitator of a debriefing session should be knowledgeable about the case and experienced in how to manage an organized, focused, and respectful group discussion. A debriefing session is usually not a linear process, so the facilitator should be responsive and flexible to needs that arise during the session but maintain a focus on the goals for the session.[15] A clinical ethicist who has earned the trust of the team and who understands the facts of the case is an excellent choice to act as facilitator.

The ethicist who had been assigned to the Lewis case moved easily into the role of facilitator because she had gained the respect of the staff during previous interactions.

TABLE 2. Conduct the debriefing session

1.	Begin the session
2.	Set rules and expectations
3.	Summarize the case
4.	Reflect on the experience
5.	Explore emotions
6.	Share coping skills
7.	Identify take-aways
8.	Wrap up

Conducting a Formal Debriefing Session

We recommend utilizing a step-by-step approach to ensure that the formal debriefing session is organized, effective, and focused towards meeting the goals of the participants. This approach is adapted and built upon the work of critical incident stress debriefing (CISD) sessions that are offered as part of clinical simulation and learning,[16] bereavement debriefing sessions,[17] and reflective debriefs.[18] Our eight-step process includes (1) beginning the session, (2) setting rules and expectations, (3) summarizing the case, (4) reflecting on the experience, (5) exploring emotions, (6) sharing coping skills, (7) identifying take-aways, and finally, (8) wrapping up the debriefing session (see table 2).

We will continue to refer to the Lewis case to demonstrate how a debriefing session can be conducted by a facilitator who uses this approach.

Begin the Session

The session commences with the facilitator identifying herself and briefly explaining her role. Those in attendance will be asked to introduce themselves by sharing their names and roles in the case.

Following the introductions in the Lewis case, the facilitator acknowledged that the healthcare providers present had been through a difficult experience that had caused moral distress. The facilitator briefly defined moral distress and explained that the purpose of the debriefing was to allow those in attendance to safely express their feelings and discuss possible strategies to better address future cases with similar challenges.

Set Rules and Expectations

The facilitator reviews a few basic rules and sets expectations for the debriefing. The group

is informed that everyone who wishes to speak will be given the opportunity to do so in an orderly manner. The rules to be followed include showing respect for the views of others and maintaining confidentiality.

For the Lewis debriefing session, the facilitator explicitly emphasized that what was discussed in the debriefing session should not be discussed outside the session, unless it involved improvements in patient care or the enhancement of staff wellness. This rule allowed the healthcare providers to feel comfortable sharing their personal feelings and experiences.

If the rules are not obeyed during a session, the facilitator pauses the discussion, and, without placing blame or scolding, simply restates the rules and reiterates the goals of the meeting.

Summarize the Case

The facilitator briefly summarizes the case so that everyone has a clear and accurate understanding of the relevant facts.

Key points reviewed in the Lewis case included a description of the patient's medical condition, clinical data, the specialists consulted, the medical team's recommendations, and the family's requests to continue aggressive interventions that the team considered nonbeneficial. The facilitator then asked the group to contribute any additional details that should be considered. A nurse shared a discussion she had with the family about Ms Lewis's end-of-life wishes. A social worker reported that Ms Lewis's main caregiver, her daughter, felt an immense sense of guilt about her mother's deterioration under her watch. A physician had learned that the family's mistrust of doctors could have been caused by a previous hospitalization during which the family believed a serious mistake was made. Such details helped the staff to better understand why the family had demanded aggressive, medically inappropriate interventions and to gain a different perspective on the family's behavior.

Reflect on the Experience

The facilitator encourages reflection by asking nonjudgmental, open-ended questions, such as, "What was it like for you to care for the patient?" and "What was it like communicating with the family?" When several answers have been given, the facilitator reflects back the experiences and emotions expressed with short summaries.

For the Lewis case, the facilitator asked further questions to move the discussion to a consideration of the family's experience, such as, "What concerns were shared by the family? What do you think were some of the underlying emotions or driving factors for these concerns?" The facilitator continued to summarize the group's answers.

As the discussion continues, the facilitator shifts the focus to the healthcare providers as a team, asking, "How did the team work well in this complex case? What were some challenges? What should be done differently?" The facilitator reflects back on the statements made and summarizes the emotions expressed.

In the Lewis case, a nurse and a social worker, who both felt exasperated, made comments that the family had driven them crazy. The facilitator responded by saying, "It sounds like interactions with the family took a tremendous amount of time and energy."

At times a request for an opinion or advice may be directed to the facilitator.

In the Lewis debriefing a participant asked, "Couldn't we have just allowed one of the more reasonable family members to make decisions, instead of letting the family members who didn't seem to care about the patient's suffering be in charge?"

When the facilitator is asked for an opinion, she should elicit the group's voice and carefully monitor her own thoughts and emotions to ensure that any comments she makes are carefully worded to avoid misunderstandings or offense.

After the facilitator listened to the Lewis group's comments, she stated, "It is understandably difficult to deal with people who are making decisions with which we disagree. In most cases, when a family has chosen to make decisions together, we need to continue to work with the family as a whole to come to an agreement, even if that agreement means reaching a compromise." When statements were made by participants that obviously made others feel uncomfortable, such as, "The problem is that people are too soft on families like this," the facilitator took a moment to remind the group that differing views were acceptable and often helpful. She restated the rule about expressing and receiving all opinions in a respectful manner and moved the discussion along.

Frequent brief summaries provided by the facilitator help the conversation progress and

enhance understanding. These summaries, followed by directional questions, also help the facilitator manage time constraints and keep the discussion moving.

Explore Emotions

The facilitator transitions the discussion to an exploration of the team's deep and painful emotional and behavioral reactions to the debriefing. The goal in this step is to identify these feelings as symptoms of moral distress and to normalize them through shared experience.

The facilitator in the Lewis case elicited participation by using carefully chosen open-ended questions such as "How have you been feeling since taking care of Ms Lewis? What emotions have you been experiencing?" As comments were made, the facilitator summarized the emotions and behaviors described, such as "anger, fatigue, guilt, apathy, frustration, sadness, fear, addictive behaviors, powerlessness." Reluctant participants were more willing to share once they realized others were experiencing similar symptoms and feelings. Several of the participants in the debriefing commented that knowing others understood how they felt immediately made them feel lighter and more hopeful.

Share Coping Skills

At this point the facilitator encourages participants to share healthy coping strategies to alleviate the distress they are experiencing. These will flow naturally as group members turn their attention to supporting one another.

During the Lewis debriefing, participants described how they had coped during past difficult situations, including discussing their feelings with coworkers and friends and intentionally making time outside of work to do things that rejuvenated and calmed them.

The facilitator asks a few clarifying questions, summarizes the responses, and enthusiastically endorses and encourages the use of appropriate ideas shared. During this step, the facilitator listens carefully to assess individuals' needs and determine which staff members may need further support. She makes certain the group is aware of the institutional resources available to them, such as the Employee Assistance Programs and Spiritual Care Services.

Identify Take-Aways

This step emphasizes guiding participants towards identifying valuable take-aways from the case and using them to outline a plan of action to minimize incidents that trigger moral distress.

In the Lewis debriefing, the facilitator asked questions such as, "What did you learn from this distressing situation? What went well? What did not go well? What should we do differently if we have another patient like Ms Lewis?" During the Lewis debriefing, many participants surmised that the breakdown in communication between the healthcare team and the family might have been less acrimonious if the family's perspective had been better understood early in the case. That concession quickly led to practical ideas for future courses of action to mitigate similar conflicts. Together, the team decided that holding initial care conferences much closer to the time of admission and scheduling care conferences more frequently would make a positive difference. They also determined that future conferences should include all members of the medical team, especially neurology and neurosurgery.

Participants in the Lewis debriefing agreed that when faced with future difficult cases, it would be helpful to consult the Ethics Service earlier to assist the team in developing rapport with the patient's family or decision maker. In response to a question about the hospital's Nonbeneficial Treatment Policy, the facilitator explained the policy and its application to the Lewis case. Finally, a participant suggested that resources, such as Spiritual Care, could be utilized more regularly to provide ongoing support for people like Ms Lewis's daughter, as well as to offer comfort to healthcare providers in distress.

Wrap Up

Wrapping up the debriefing session takes only a few minutes. The facilitator briefly summarizes the action plan that has been suggested by the participants and wishes them success in incorporating their plan into future cases. The facilitator acknowledges and validates the healthcare team's struggles and hard work on behalf of their patient and expresses appreciation for their courage in sharing their feelings and supporting one another in the healing process. Finally, the facilitator reviews the resources available to participants who feel in need of further assistance and offers to hold group or individual follow-up debriefing sessions upon request. After the debriefing session, the facilita-

tor checks in with some of the participants to make sure that the meeting met the needs of the healthcare team.

CONCLUSION

Moral distress is highly prevalent among healthcare providers, and impacts their well-being, job satisfaction, and retention. It has also been shown to adversely affect the delivery of quality patient care.[19] The moral distress debriefing framework described in this article can help healthcare professionals manage the negative emotions that are engendered by challenging cases.

We developed the two-part framework presented in this article to be utilized by clinical ethicists and others as a tool to implement focused, productive debriefing sessions that can provide real relief from moral distress. The first part of the framework emphasizes preparation for a debriefing session by identifying needs, setting goals, gathering relevant information, and planning meeting logistics. The second part of the framework details an eight-step approach to conduct and facilitate a moral distress debriefing session from beginning to end.

The case of Ms Lewis illuminated how reflecting on the experience, exploring emotions, sharing coping skills, and creating an action plan for the future can move participants away from moral distress and towards individual and collective release from debilitating emotional turmoil. Healthcare providers with the appropriate skill set can facilitate positive change by utilizing the moral distress debriefing framework approach to offer healing to healers in distress.

BLINDING OF THE CASE

Details of this case were altered to protect the identity of the patient and the family.

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