THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center
Making Cancer History®

Methods to Address Moral Distress Experienced by Stem Cell Transplantation Nurses and Build Resiliency

Joyce Neumann PhD, APRN, AOCN, BMTCN
Lourine Davis BSN, RN, OCN
Colleen Jernigan PhD, RN

Background

- **Strong relationship** between a patient with life threatening illness and health professionals (Kovács, Kovács, Hegedus, 2010).
- Demand for health professionals to be **competent** in both the **rendering of care,** the provision of **emotional comfort and moral obligation to advocacy for their well being.** These demands may lead physical and mental exhaustion, with negative work-related results (Demirci, Yildirim, Ozsaran, Uslu, Yalman, Aras, 2010).
- **Life and work events** may erode work engagement, professionalism and ultimately influence quality of care (Shanafelt, Boone, Tan, et al. 2014).

Moral Distress(1)

Painful feeling or state of psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it because of constraints: lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policies or legal consideration (Corley 1995, Erlen & Sereika, 1997; Livingston & Livingston, 1984; Sorlie et al. 2005; Epstein, 2014). First described by Jameson in 1984.

Moral distress (2)

- Exposure to patient suffering and deaths, despite improved outcomes and faced with challenges of recognizing the ethically appropriate action undertaking.
- Ethical issues may be present across the transplantation continuum
  - Who do we offer treatment to (do no harm)?
  - How do we prepare (veracity)?
  - What do we do when bad things happen (autonomy)?
  - Transitioning to end of life care (do no harm)?

Moral distress (3)

Unresolved ethical conflicts and moral distress lessen job satisfaction and cause burnout.

Varies among professional, may result in the following:

- Numbing of moral sensitivity and withdrawal from involvement in challenging patient situations;
- Conscientious objection by voicing opinions, refusing to care for a patient on artificial life-support when perceived as having no chance for meaningful recovery
- Demonstration of the effects of burnout and leave the job or even the profession;

Houston, Casanova, Leveille, et al., 2013; Allen, Judkins-Cohn, deVelasco, et al. 2013; Lazzarin, Biondi, Di Mauro, 2012.

Factors contributing to MD (4)

- Unrealistic expectations (patient/ family/provider) what we CAN do vs. what we SHOULD do.
- Not telling the patient/family likely outcome denying them opportunity to decide how they will spent the rest of their life, however long.
- Not having a voice to share observation and concern.
- Not understanding and accepting each others perspective

Impact on Healthcare Providers / Patients

- Need for HCT provider increase becoming more complex
- Projected shortage of health professionals will greatly impact capacity to meet the need for patients
- Needs assessments conducted identified challenges in recruitment/retention including:
  - **Burnout =** medical errors, loss of professionalism, reduced hours/turnover
  - **Moral distress =** ↓ moral sensitivity and withdrawal from ethically challenging situations; leaving the job/profession

Neumann, Burns, et al (2016). Hematopoietic Cell Transplantation Multidisciplinary Care Teams: National Survey of Transplant Provider Burnout, Moral Distress and Career Satisfaction. ASBMT Tandem meeting, Honolulu, February.
Corley MC. Nurse moral distress: a proposed theory and research agenda. Nurs. Ethics 2002;9(6):636-650. doi:10.1191/0969733002ne557oa.
Shanafelt, T., & Dyrbye, L. Oncologist burnout: causes, consequences, and responses. JCO. 2012;30,11: 1235–41. doi:10.1200/JCO.2011.39.7380

ARTICLE IN PRESS
Biol Blood Marrow Transplant ■■ (2017) ■■–■■

Biology of Blood and Marrow Transplantation

journal homepage: www.bbmt.org

Burnout, Moral Distress, Work–Life Balance, and Career Satisfaction among Hematopoietic Cell Transplantation Professionals

Joyce L. Neumann [1,*], Lih-Wen Mau [2], Sanya Virani [3], Ellen M. Denzen [2], Deborah A. Boyle [4], Nancy J. Boyle [5], Jane Dabney [6], Alexandra De KeselLofthus [2], Marion Kalbacker [7], Tippu Khan [8], Navneet S. Majhail [6], Elizabeth A. Murphy [2], Pamela Paplham [9], Leslie Parran [10], Miguel-Angel Perales [11], Todd H. Rockwood [3], Kim Schmit-Pokorny [12], Tait D. Shanafelt [13], Elaine Stenstrup [9], William A. Wood [14], Linda J. Burns [2]

[1] Stem Cell Transplantation and Cellular Therapy, The University of Texas MD Anderson Cancer Center, Houston, Texas
[2] National Marrow Donor Program/Be The Match, Minneapolis, Minnesota
[3] University of Minnesota School of Public Health, Minneapolis, Minnesota
[4] University of California Irvine Health/Chao Family Comprehensive Cancer Center, Orange, California
[5] Knight Cancer Institute, Center for Hematologic Malignancy, Oregon Health & Science University, Portland, Oregon
[6] Blood & Marrow Transplant Program, Cleveland Clinic, Cleveland, Ohio
[7] Pediatric BMT, Duke University Medical Center, Durham, North Carolina
[8] Department of Pharmacy, University of North Carolina Hospitals and Clinics, Chapel Hill, North Carolina
[9] Roswell Park Cancer Institute, Buffalo, New York
[10] University of Minnesota Medical Center, Fairview, Minnesota
[11] Department of Medicine, Adult Bone Marrow Transplant Service, Memorial Sloan Kettering Cancer Center and Department of Medicine, Weill Cornell Medical College, New York, New York
[12] Blood and Marrow Transplant Program, Nebraska Medicine, Omaha, Nebraska
[13] Division of Hematology, Mayo Clinic, Rochester, Minnesota
[14] Division of Hematology/Oncology, University of North Carolina–Chapel Hill, Chapel Hill, North Carolina

Article history:
Received 1 August 2017
Accepted 13 November 2017

Key Words:
Hematopoietic cell transplantation
Burnout
Moral distress
Work–life balance
Career satisfaction

ABSTRACT

A projected shortage of hematopoietic cell transplantation (HCT) health professionals was identified as a major issue during the National Marrow Donor Program/Be The Match System Capacity Initiative. Work-related distress and work–life balance were noted to be potential barriers to recruitment/retention. This study examined these barriers and their association with career satisfaction across HCT disciplines. A cross-sectional, 90-item, web-based survey was administered to advanced practice providers, nurses, physicians, pharmacists, and social workers in 2015. Participants were recruited from membership lists of 6 professional groups. Burnout (measured with the Maslach Burnout Inventory subscales of emotional exhaustion and depersonalization) and moral distress (measured by Moral Distress Scale–Revised) were examined to identify work-related distress. Additional questions addressed demographics, work–life balance, and career satisfaction. Of 5759 HCT providers who received an individualized invitation to participate, 914 (16%) responded; 627 additional participants responded to an open link survey. Significant differences in demographic and practice characteristics existed across disciplines ($P < .05$). The prevalence of burnout differed across disciplines ($P < .05$) with an overall prevalence of 40%. Over one-half of pharmacists had burnout, whereas social workers had the lowest prevalence at less than one-third. Moral distress scores ranged from 0 to 336 and varied by discipline ($P < .05$); pharmacists had the highest mean score (62.9 ± 34.8) and social workers the lowest (42.7 ± 24.4). In multivariate and univariate analyses, variables contributing to burnout varied by discipline; however, moral distress was a significant contributing factor for all providers. Those with burnout were more likely to report inadequate work–life balance and a low level of career satisfaction; however, overall there was a high level

Financial disclosure: See Acknowledgments on page 11.

* Correspondence and reprint requests: Joyce L. Neumann, PhD, APRN, AOCN, BMTCN, Stem Cell Transplantation and Cellular Therapy, The University of Texas MD Anderson Cancer Center, Houston, TX.
E-mail address: jneumann@mdanderson.org (J.L. Neumann).

Predictors of EE, DP and BURNOUT for Nursing Participants

All factors were statistical significant (P≤ 0.05) ↑indicates positive correlation, ↓indicates negative correlation

EE	
Work environment	Work setting: inpt ↓ Pt pop: both pedi/adult ↓ Program size: w > 150 allo ↑ Hrs work/wk: 51-60 ↑ Hours/week on research > 10 hrs: ↑ Hrs spend CE/certification > 10hrs.: ↓ No personal factors
DP	
Working environment Personal factor	Hrs/wk on research: > 10 ↑ Program size: w >150 auto HCT ↓ Program size: w >51 allo ↑; >150 ↑ Age: > age 40 years ↓ - progressively < as age increases/decade
Burnout – 38%	Multivariate logistic regression
Working environment Moral distress - 37% high 2nd highest mean score ; widest range of scores	Nights on call: 1-5 nights on call ↑ Work setting: inpt. ↓ HCT vol.: 51-150; >150 ↑ Hrs. work/wk: 51-60 hrs ↑ ↑ by 2% for every 1 point increase on MDS-R

Most frequently occurring MDS-R items by discipline

Questions from MDS-R – bolded items greater than75% respondents experienced situation (question number)	Responded frequently – very frequently %	Frequency – rank order				
		RN	MD/ DO	APP	Pharm	SW
Witness healthcare providers giving "false hope" to a patient or family (2)	85	3	3	4	4	2
Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient (3)	87	2	1	1	4	3
Initiate extensive life-saving actions when I think they only prolong death (4)	80	4	5	4	4	7
Carry out the physician's orders for what I consider to be unnecessary tests and treatments (6)	76	5		3	1	
Work with nurses or other healthcare providers who are not as competent as the patient care requires1 (17)	72	7	7	7	7	
Witness diminished patient care quality due to poor team communication (18)	88	1	2	2	2	1
Watch patient care suffer because of a lack of provider continuity (20)	80	6	4	6	3	4

Nursing Ethics at MDACC

Background:

Ethical dilemmas are inherent in oncology nursing practice due to the complexity of care, patient/family expectations, and the treatment direction provided by the healthcare team

Created standing Ethics PACT (September 2012) in Nursing Practice Congress

Plan:
- Survey
- Computer Based Training (CBT)
- Train the Trainer
- Implement Unit Based Nursing Ethics Rounds
- Re-survey

Survey

- Completed summer 2015
- 8.5% response rate (n=316)
- 75% of respondents aware of resources
- 68% able to identify and manage difficult ethical situations
- 40 commented feeling uncomfortable initiating ethics consult

Confident in ability to identify and discuss (32% responded no)

- Uncomfortable – MD pushing for chemo or refusing to talk end of life discussion
- Don’t feel equipped/training/inexperienced
- Don’t know who to call
- Conversation with medical team difficult, negative response from MD, retaliations (X3), MD ignore requests
- Don’t agree with MD decision to make the patient happy
- I don’t have all facts, on the fringe

Confident in ability to identify and discuss (32% responded no)

- Lack of support from management/clinic team
- Too much emotion involved
- Does not occur
- Swept aside by the providers/got shot down when brought up
- Hard to know right thing to do
- Cultural difference make it difficult

Reasons Identified For Discomfort With Ethics Consult (40 comments)

- Overstep boundaries, MD makes decision, policy here who calls consult
- Retribution, new fear of getting in trouble/losing job, may cause issues in my office
- Ethics committee not effective
- Not sure I know the whole story
- Don’t know how to call one, never had done one, not familiar with ethics consult

Ethical dilemma most frequently identified

Goals of care:

- aggressive treatment in elderly, futility, transfer to ICU

  end of life establish DNR, code status

  MD gives false reassurance more treatment available,

  patient may not want further trx/medical team (or family) wants to continue,

  idea is to give the patient treatment and get the patient out (unmet needs)

Need for better explanation of protocols, treating MD pushing research nurse to put on protocol, treating patients with a lot of co-morbid condition, what is best for research NOT what is best for patient

International patients

Conflict of interests

Next Steps

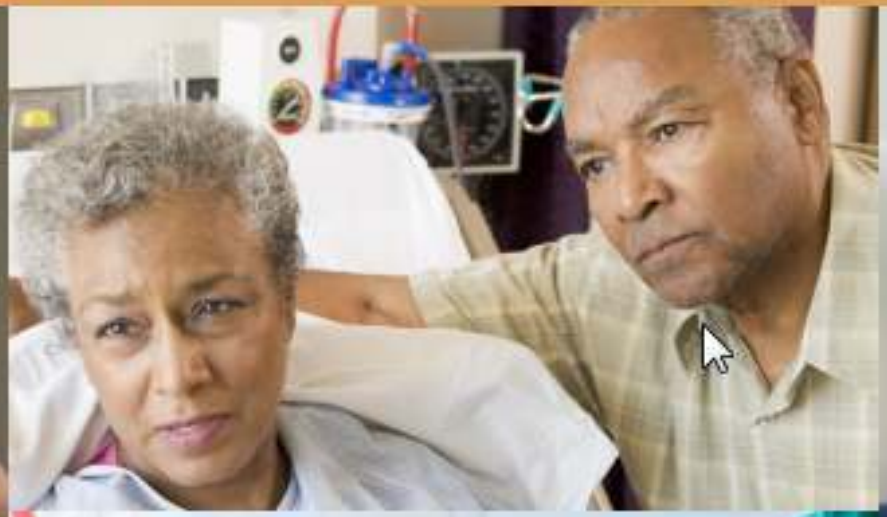
- Most nurses where aware of resources and felt comfortable using those resources, younger nurses used discussion with colleague
- Opportunities for increasing education and establishing forums for discussion
  - Computer based training (CBT) in education center now will be required post EPIC
  - Ethics rounds on other units: train the trainer X1, first unit to go live next month

  Resurvey in 2 year planned

Computer Based Training

- Mandatory content
- Interactive
- Released summer 2016
- 93% compliance (total 2700 RNs)
- Added to nursing orientation
- Promoted to other groups – APPs, Research Nurses

Ethical Principles
for Nursing practice

THE UNIVERSITY OF TEXAS
MD Anderson Cancer Center

Making Cancer History®

Nursing Professional Practice Model

Ethics is present in all aspects of our professional practice.

Place the magnifying glasses on the two hands that most represents ethics in professional practice.

PREV NEXT

Ethics of Nursing Practice

Ethical issues and dilemmas are inherent in care provided to patients and their families across the life span and especially at the end of life.

Professional codes and standards serve to assist in the resolution of ethical dilemmas.
Nurses, individually and collectively, are responsible to serve as advocates for the resolution of ethical issues.

Quarterly Nursing Ethics Rounds

- Multiple Train the Trainer sessions offered
- Monthly PACT meetings started 2016
- Tool kit distributed
- Collaborated with Nursing Education
  - Plan
  - Advertise
  - Offer CEU

Topics for Discussion

- Professional nursing code of ethics – Ethical terms and theories (ANA handout)
- Advanced Directives – patient's self-determination act (PSDA) – nursing role
- Shared decision making end of life
- Do not resuscitate orders (DNR)/Allow natural death (AND)
- Communication with patients/families – breaking bad news/communication sensitive information.
- Informed consent – patient autonomy, therapeutic misconception
- Moral distress / Resiliency
- Professional Caregiver Fatigue (also known as compassion fatigue)
- Withholding and withdrawal of life sustaining treatment
- Social media and ethical issues
- Use of palliative care – cultural perspective
- Care for high risk vulnerable people – children, prisoner, international patients.
- Balancing truth-telling (veracity) and preservation of hope

Goal

Provide nurses with a forum for discussion of difficult/challenging patient situations (23 practice areas – inpatient / outpatient; over 65 offerings)

Increase knowledge base/use of supportive institutional resources

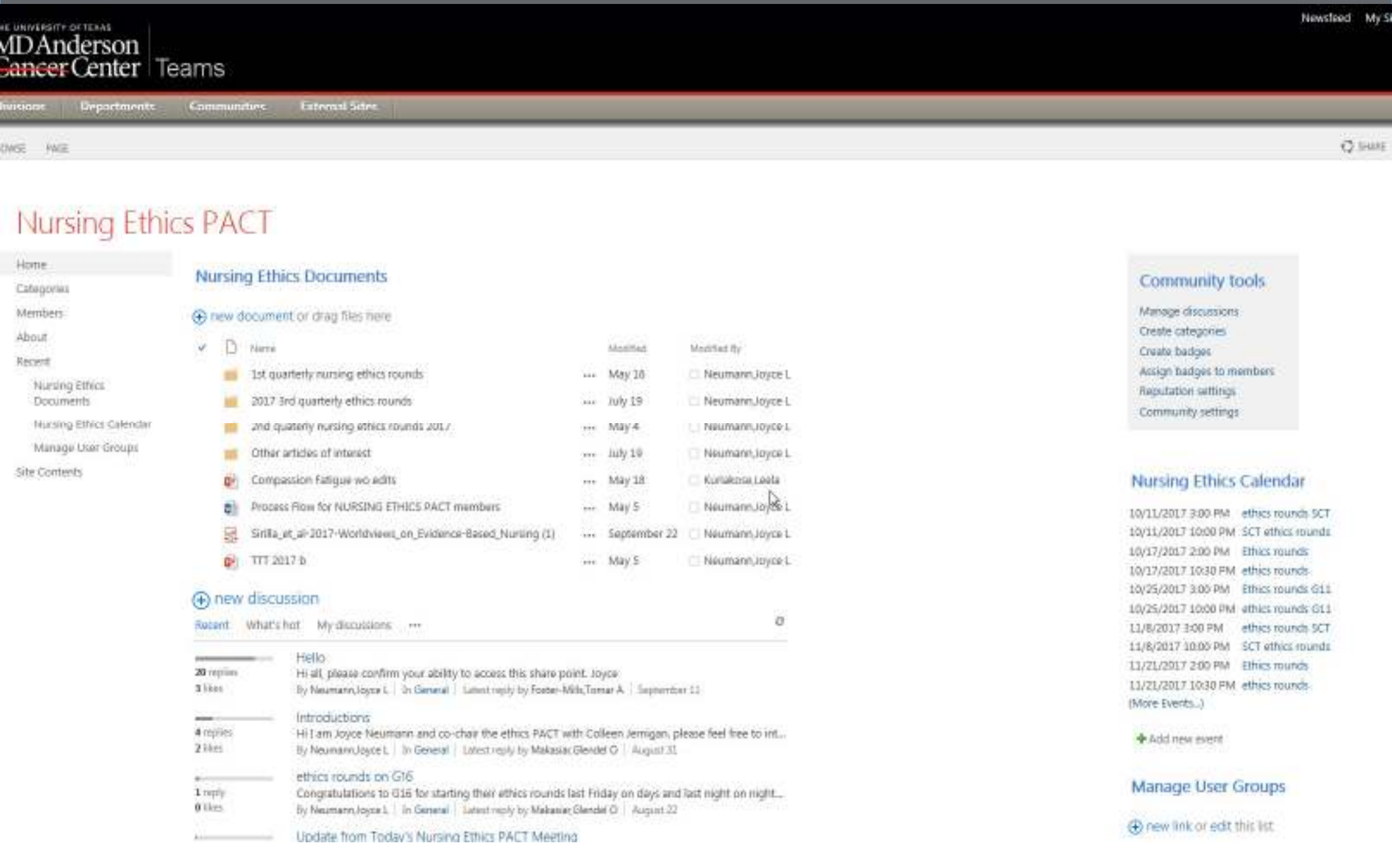
Enhance unit based skill regarding management of ethical dilemmas

Decrease compassion fatigue/moral distress

Advance professional nursing competency

NURSING ETHICS PACT SHAREPOINT WEBSITE

https://myteams.mdanderson.org/cop/nursingethicspact/SitePages/Community%20Home.aspx



By Cynda Hylton Rushton, PhD, RN, FAAN

Cultivating Moral Resilience

Shifting the narrative from powerlessness to possibility.

ABSTRACT: Decades of research have documented the frequency, sources, and consequences of moral distress. However, few studies have focused on interventions designed to diminish its negative effects. The cultivation of moral resilience—the ability to respond positively to the distress and adversity caused by an ethically complex situation—is proposed as a method to transform moral distress.
Keywords: moral distress, moral resilience, nursing

Moral distress occurs when "one recognizes one's moral responsibility in a situation; evaluates the various courses of action; and identifies, in accordance with one's beliefs, the morally correct decision—but is then prevented from following through."[1] Broadly understood, moral distress is a particular form of moral suffering that reflects the anguish experienced in response to moral harms, wrongs, or failures and is often accompanied by the feeling that one's integrity has been compromised.

The concept has been studied since 1984, when philosopher Andrew Jameton first proposed it to describe the distress nurses experience when institutional and systemic barriers prevent them from acting according to their own moral judgment.[2] In 2001 Corley and colleagues developed the Moral Distress Scale (MDS)—an instrument for measuring the degree of moral distress among nurses.[3] The tool has since been refined and revised, most notably in 2012 by Hamric and colleagues who reintroduced it as the MDS-R in order to measure moral distress in other health care workers (in addition to nurses) and in various settings.[3-5] The concept continues to be studied and refined,[6] and evidence of the prevalence of moral distress among nurses, physicians, pharmacists, and other health care workers is increasing.[7]

Sources of moral distress in nurses include internal factors such as real or perceived powerlessness[5]; external factors such as inadequate resources or staffing[8] and insufficient administrative or organizational support; and specific clinical contexts, such as end-of-life care,[8-10] critical care,[11] and neonatal or pediatric care.[10,12]

Despite the burgeoning interest in moral distress, controversies have persisted.[12-15] Because it has increasingly become an umbrella term used to describe a variety of moral stresses,[14,15] some believe the concept should be overhauled,[14,16] whereas others have sought to further refine its definition.[17,18] Still others have suggested new conceptualizations, involving a more nuanced understanding of clinicians as moral agents acting within complex organizational contexts.[6]

CONSEQUENCES OF UNRESOLVED MORAL DISTRESS

Moral distress has been associated with negative consequences such as emotional distress—often manifested as frustration and anger—and nurse attrition.[15] It has also been correlated with burnout and long-term consequences such as emotional exhaustion, depersonalization, feelings of disengagement, numbness, and diminished moral sensitivity.[9,19,20]

Negative effects aren't limited to clinicians; patient care is also affected. As specified in the 2015 update of the *Code of Ethics for Nurses with Interpretive Statements* from the American Nurses Association (ANA), nurses' primary obligation is to their patients, whom they must treat with "compassion and respect for [their] inherent dignity, worth, and unique attributes."[21] Unresolved moral distress can compromise nurses' ability to uphold these ethical standards if feelings of depletion or powerlessness diminish the physical and emotional energy they need to fully address patients' needs. The inability to care for patients with integrity raises the risk of burnout, which further affects the quality of patient care and the stability of the workforce; it can also lead to higher mortality rates.[22] In response to clinicians' increasing feelings of exhaustion, depletion, and frustration in the workplace, the Critical Care Societies Collaborative recently released a statement calling on professional and academic health care organizations to join together to stem the rising prevalence of burnout.[22]

Nursing Ethics Rounds

3rd Quarterly Nursing Ethics Rounds

August / September, 2017

Unit/Area Based

Article: Rushton, C.H.(2017) Cultivating Moral Resilience: Shifting the narrative from powerlessness to possibility. *AJN*, 117, 2, S11-S15.

Objectives for Discussion

1. Define moral resilience and factors which contribute to its occurrence.
2. Identify moral resilience as a method to cope with moral distress.
3. Identify strategies for incorporating moral resiliency into the practice of oncology nurses in different work settings.

At a Glance: Decades of research have documented the frequency, sources, and consequences of moral distress. However, few studies have focused on interventions designed to diminish its negative effects. The cultivation of moral resilience—the ability to respond positively to the distress and adversity caused by an ethically complex situation—is proposed as a method to transform moral distress.

Introduction

Moral distress definition: Moral distress occurs when "one recognizes one's moral responsibility in a situation; evaluates the various courses of action; and identifies, in accordance with one's beliefs, the morally correct decision—but is then prevented from following through." (Rushton C. Building moral resilience to neutralize moral distress. *Am Nurs Today* 2016;11(10).

Moral distress sources: "internal factors such as real or perceived powerlessness; external factors such as inadequate resources or staffing and insufficient administrative or organizational support; and specific clinical contexts, such as end-of-life care, critical care, and pediatric care"

Moral resilience: "person's capacity to sustain, restore, or *deepen* her or his "integrity in response to moral complexity, confusion, distress, or setbacks." (page S13).

Consequences of unresolved moral distress

Emotional distress – frustration, anger and leaving profession. Burnout with emotional exhaustion, depersonalization, feeling of disengagement, numbness, and dimished moral sensitivity.

Compromised patient safety - nurse feeling powerlessness to uphold the code of ethics for nursing practice. Unresolved moral distress can also lead to burnout which may affect quality of patient

Key Characteristics of Moral Resilience

- Cultivating mindfulness to support focus and clarity of mind
- Learning to self-regulate to disrupt negative patterns of thinking and behaving
- Developing self-awareness and insight
- Deepening moral sensitivity
- Wisely discerning ethical challenges and principled actions
- Nurturing the willingness to take courageous action
- Discovering meaning in the midst of adversity
- Preserving one's integrity, as well as the integrity of the team, and others.

Rushton CH. Moral resilience: a capacity for navigating moral distress in critical care. *AACN Adv Crit Care* 2016; 27(1):111-9. ,

Resiliency training

- **Personal resilience plans**
  - **External activities –** developing problem-solving skills or engaging in work, prayer, physical exercise, play or art
  - **Internal ways of thinking** that lessens impact of experiences – sense of hope – sense of meaning or purpose in life- sense of value of life even if lived strenuously in adverse circumstances. Coping, hoping, meaning

Rushton, Bacheller, Schroeder, & Donohue, 2015. Burnout and Resilience Among Practicing in High-Intensity Setting. American Journal of Critical Care.

Mindfulness Training

- **Strategies for renewal**
  - **Mindfulness practices – communication and self-awareness enhance spiritual well-being and improve attitude associated with patient-centered care**
  - **Meditation**

PROMISING PRACTICES

Promising Practices to Optimize Individual Moral Resilience and Organizational Responsibilities to Create a Culture of Ethical Practice

The American Nurses Association Center for Ethics and Human Rights convened a Professional Issues Panel with an Advisory Board to explore promising solutions to build individual and organizational capacities for addressing the detrimental impact of moral distress and other forms of moral suffering. 'Promising practices' does not imply endorsement, but rather acknowledges various current mediums of interventions that have not yet been studied or published in the literature. Individuals and organizations are encouraged to do their own evaluation to determine appropriateness.

Resource Toolkit

Media Type	Year	Title & Author(s)	Web Address	Description
Program Website	2012	University of Virginia School of Nursing Compassionate Care Initiative (CCI)	https://cci.nursing.virginia.edu	The purpose of the CCI is to cultivate a compassionate workforce through educational programs. The vision is to have safe and high-functioning health care environments with happy and healthy professionals caring for others with heart and humanity. The program bolsters resilience in the process of teaching compassion, including a public radio documentary called Resilient Nurses. University of Virginia. (2017). School of Nursing compassionate care initiative. Retrieved from www.cci.nursing.virginia.edu
Program	2016	Johns Hopkins University School of Nursing & Johns Hopkins Hospital Mindful Ethical Practice and Resilience Academy		This six-session program focuses on building moral resilience in nurses. The goals are to 1) apply mindful practices to ethical issues in clinical practice, 2) demonstrate ethical competence by applying tools and skills to ethical issues in clinical practice, and 3) cultivate resilience in response to ethical challenges and moral suffering including moral distress. Skills in mindfulness, moral discernment and analysis, self-regulation, communication, and principled action are fostered through experiential, didactic, and high-fidelity simulation methods.
Article	2014	Clinical Residency Program for Nurses (CERN)		The CERN was developed to strengthen moral agency and provide clinical ethics competence through didactic learning, simulation and role-play, and clinical mentorship over a nine month period. Robinson, E. M., Lee, S. M., Zollfrank, A., Jurchak, M., Frost, D., & Grace, P. (2014). Enhancing moral agency: clinical ethics residency for nurses. Hastings Center Report, 44(5), 12-20.
Program Website	2017	George Washington University School of Nursing Professional Well-Being Initiative	https://nursing.gwu.edu/wellness	This program of nine seminars is designed to develop knowledge and skills to help nursing students cope with stress and adversity in a healthy and proactive manner.
Program Website	2013	Lee Memorial Health Journey to Empowerment	http://www.nursinglibrary.org/vhl	Professional development seminar designed to focus on a health care provider's individual journey to empowerment, self-efficacy, emotional intelligence, spiritual intelligence, and moral courage. McNulty, D. M. (2015). Using the journey to empowerment professional development seminar to enhance nurses' sense of empowerment. Retrieved from http://www.nursinglibrary.org/vhl/bitstream/10755/602909/1/3 McNulty_D_p69934_1.pdf
Program	2014	Mercy Health Saint Mary's/Trinity Health Tea for the Spirit		With the support of our oncology social worker and chaplain, A safe environment established for nurses to process difficult and traumatic events through debriefing and verbalizing of feelings with others who understand the workplace environment. Tea for the Spirit is led by social work and chaplaincy as an open forum where use of reflection and self-care are discussed for maintenance of nurses' emotional health and resiliency. Nurse's report improved sleep ability, less fatigue, and greater capacity for compassion. Arnot, M. N. (1996). Healing teas: Boost your health. New York: Avery. American Association of Critical-Care Nurses (2004). The 4As to Rise Above Moral Distress Handbook. Retrieved http://www.aacn.org/ Nancy Jo Bush, D. A. (2012). Self-healing through reflection: A workbook for nurses. Pittsburg: Oncology Nursing Society.

Questions

Other interventions in HCT

- Proactively discuss issues before treatment begins, psychosocial as well as medical
- Appropriate co-morbidity evaluation before treatment and record baseline
- Pre-hab (enhanced recovery) program for vulnerable
- Multidisciplinary care conferences with specific care agreements as indicated
- Disseminate what we have learned
- Encourage administrative support for employees
- Develop interventions:
  - Schwartz Rounds
  - Multidisciplinary Rounds
  - Professional Networks
  - Need for personal time and relief from emotional exhaustion
- Consider interventions study

Methods to address HCT

- Team decision and promotion of transparency:
  - Provide opportunities for input from team members in a patient-review forum
  - Provide opportunity for team to witness discussions and consent sessions of patient/donor's preparation
- Presence of inpatient/outpatient team at care conference discussed risks
- Compliance 'trial' to determine improvement pre-SCT
- Donor evaluation by MD not caring for recipient to review risks/benefits