What We Know About Moral Distress

2

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2.1 Moral Distress: Evolution of the Concept

When theory and practice in healthcare ethics started to evolve in the late 1970s, there emerged a growing consensus about how ethical principles ought to guide healthcare delivery [1, 2], yet the well-being of healthcare providers received relatively little attention. This lack of attention started to change with American philosopher Andrew Jameton's groundbreaking writing about moral distress in his book on nursing ethics [3]. Jameton's book, his subsequent publications, and the early related research work by nurse scholars such as Fry, Harvey [4], Hamric [5], and Wilkinson [6] initiated an important conceptual and practical shift. This shift has helped all of us involved in healthcare to recognize that the moral experiences of healthcare providers affect the quality of healthcare delivery and also the well-being of the providers themselves [7–9].

In this chapter, we offer a further contribution to growing contemporary commentaries on how the concept of moral distress has evolved and how it has been applied, including its pitfalls and promises. Our intent is to continue to support what we see as a lively and promising dialogue about moral distress in nursing, other healthcare provider groups, and healthcare ethics in general. On the basis of our experiences in practice and research, it is our conviction that continuing to wrestle with the clarity of the concept, its application, and the implications for *practice* (including leadership) in healthcare remains important. We believe that supporting nurses and all other healthcare providers as moral agents operating in complex

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organizational structures is prerequisite to offering effective and ethical healthcare and fostering a sustainable healthcare workforce.

We will therefore provide an overview of the evolution of the definition of moral distress, outline some of the critiques of the concept that have shaped our exploration, and point to areas for further research and development. We close our chapter with conceptual and practical recommendations for nursing, other healthcare provider groups, and for the structure and delivery of healthcare. It is important to note that while the study of moral distress was initiated in the United States, it is now also increasingly being addressed by colleagues from diverse parts of the globe—including, for instance, Australia [10, 11], Brazil [12], Canada [13], Ireland [14], and Iran [15]. While we will not be undertaking a full international analysis of the concept of moral distress, we will point to some of the implications of the expanding global interest in the concept toward the end of this chapter.

2.2 Conceptual Origin and Evolution of the Definition

Healthcare ethics evolved in response to the significant values-based challenges that healthcare providers faced in trying to provide competent, effective, and equitable care in the face of decisions regarding the effective deployment of healthcare technology and equitable access to healthcare resources[1] [2, 18]. As we have noted in our introduction to this chapter, attention to the well-being of healthcare providers started to emerge more directly when Andrew Jameton, a philosopher, was working with nurses and observed that "moral and ethical problems in the hospital could be sorted into three different types," moral uncertainty, moral dilemmas, and moral distress [3]. Jameton's original definition of moral distress stated that the experience arose "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" [3]. In identifying moral distress, Jameton put into words a collective experience that occurred when nurses confronted situations that created a conflict in their professional values—a conflict that often ultimately left the nurse with the sense that they had failed to live up to their moral obligations to the patient.

Although identification of the concept captured the attention of nursing scholars, when nurse researchers and researchers in other disciplines began to operationalize the definition, it soon became clear that there were gaps. As research on moral distress progressed, scholars articulated some of those gaps, including potential

[1] It is worth noting that early healthcare ethics work was largely silent on access to resources for *health*, such as ethnicity, education, and income. Although equitable access to resources for health is receiving more attention in contemporary healthcare ethics work (e.g., [16]), much more work is needed. Indeed, Varcoe et al. [17] argue that "…the same socio-political values that tend to individualize and blame people for poor health without regard for social conditions in which health inequities proliferate, hold responsible, individualize and even blame healthcare providers for the problem of moral distress" (p. 52).

conflation of moral distress and psychological or emotional distress, leading to a call for researchers to focus on the *ethical* component of moral distress [14, 19]; the view of moral distress as a *linear* process [20, 21]; the need for a richer understanding of moral distress as a process that unfolds over time [21, 22]; the actual location of *constraints* on moral action, for example, locating *constraints* to action internal to the nurse or externally within the institution [6, 23, 24]; the need to uncouple constraint as a necessary cause of distress and include related experiences such as *conflict* [25]; lack of clarity around what constitutes the right course of action and the role of action in general [21, 24, 26]; as well as a *lack of clarity overall* about the concepts that underpin moral distress [14, 17, 27].

As a result of working with an evolving definition, researchers continue to seek to refine the definition, and our full understanding of the concept remains "under construction" (see, e.g., Fourie [25]). One of the consequences is a growing list of definitions that seek to incorporate our developing understanding of moral distress (see Table 2.1). The table in this chapter is not intended to be exhaustive; rather, the intention is to provide examples that illustrate the evolution of the concept as scholars and researchers incorporate new insights into the definition of moral distress in

Table 2.1 Evolving definitions of moral distress

Authors	Definition
Jameton [3]	Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action
Wilkinson [6]	Psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision
Jameton [26]	*Initial moral distress* involves the feelings of frustration, anger and anxiety people experience when faced with institutional obstacles and conflict with others about values
	Reactive moral distress is the distress people feel when they do not act upon their initial distress
Hanna [28]	Moral distress occurs in the context of situations that have moral implications embedded within them, where the moral end, an inherent rightness or goodness, is understood to exist and understood to be or have been threatened, harmed or violated.
Austin et al. [29]	The state experienced when moral choices and actions are thwarted by constraints
Kälvemark et al. [30]	Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the healthcare provider feels she/he is not able to preserve all interests and values at stake
Nathanial [31]	Moral distress is pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, yet, as a result of real or perceived constraints, participates, *either by act or omission*, in a manner he or she perceives to be morally wrong

(continued)

Table 2.1 (continued)

Authors	Definition
Mitton et al. [32]	Moral distress is the suffering experienced as a result of situations in which individuals feel morally responsible and have determined the ethically right action to take, yet due to constraints (real or perceived) cannot carry out this action, thus committing a moral offence
Varcoe et al. [17]	The experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards
Rodney et al. [33]	What nurses (or any moral agents) experience when they are constrained from moving from moral choice to moral action—an experience associated with feelings of anger, frustration, guilt, and powerlessness
Crane et al. [11]	The experience of psychological distress that results from engaging in, or failing to prevent, decisions or behaviors that transgress, or come to transgress, personally held moral or ethical beliefs
Barlem and Ramos [34]	The feeling of powerlessness experienced during power games in the micro-spaces of action, which lead the subject to a chain of events that impels him or her to accept imposed individualities, have his or her resistances reduced and few possibilities of moral action; this obstructs the process of moral deliberation, compromises advocacy and moral sensitivity, which results in ethical, political and advocational inexpressivity and a series of physical, psychical, and behavioral manifestations
Campbell et al. [21]	One or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable

an effort to bring further clarity and move the concept forward. Despite this growing list of definitions and the scholarly analyses that have generated them, much of the current research on moral distress continues to be based on the foundation created by the earliest definitions of moral distress offered by Jameton [3] or Wilkinson [6]. Research studies over the years have indicated that causes of moral distress in nursing are "varied, and include conflict with other clinicians, an excessive workload, and challenges with end-of-life decision making" [7].

Tracking the Evolution in Our Understanding of Moral Distress It is important to note that the concept originated from within the discipline of nursing, and as such, the definition and early exploration of the concept have been influenced by the disciplinary culture of nursing. An example of the disciplinary influence on the definition is seen in the discovery that one of the contributing elements to the experience of moral distress in nursing is a lack of decision-making authority in relation to resource allocation or clinical care [10]. Although nurses do, for the most part, have less authority to make decisions in healthcare organizations, physicians also experience moral distress *because* they are responsible for the decisions they make [21,

35–37]. These disparate findings suggest that interpreting research findings through a solitary disciplinary lens may unintentionally limit our interpretations. The predominance of a focus on moral distress in *nursing* is, to a significant extent, "ethnocentric" and does not serve our colleagues in other healthcare provider groups well [7, 9]. It is clear that experiencing moral constraints and/or moral conflicts (however we define them) transcends professional disciplinary boundaries[2] [7, 9]. Research on moral distress as a transdisciplinary experience has added depth and breadth to our understanding of the concept. As indicated above, much of the multidisciplinary work continues to use early definitions of moral distress that are imbued with the nursing perspective on the experience. The significance of understanding that moral distress crosses disciplinary boundaries points to the necessity of moving the definition itself beyond the discipline of nursing to a level that can account for the range of the experiences of moral distress in healthcare.

2.3 Challenges and Critiques of the Definition

As we understand the original definition of moral distress, it was predicated on three main assumptions: (a) that nurses make moral judgments, (b) that they do not act on those moral judgments; and (c) that their inaction is related to institutional constraints [35]. In naming moral distress, Jameton made a distinction between personal and professional values [3]. Hanna [19] provides a critique of this "artificial" separation stating that the consequence would be that "personal values and beliefs that translate into private thoughts and deeds meant that any person's efforts would have no bearing on the social fabric of the community. Yet communities are comprised of the thoughts, words, and deeds of many people" (p. 75). The connection we want to highlight is that the moral obligations of a profession are established in and through community (society) and as such are based on societal values, which are both personal and professional. We will come back to this point when we discuss reciprocity between structures and agents laying the ground for recommendations aimed at developing a greater understanding of, and developing interventions for, moral distress.

Each of the assumptions listed above presents a unique set of challenges that we will summarize. Hanna [19], one of the first nurse scholars to offer a thorough critique of the definition, pointed to the assumption that the nurse had knowledge, and certainty, about what was the right course of action in a given situation.[3] Johnstone and Hutchinson [40] pick up on this critique and push it further by distinguishing between making an ordinary moral judgment based on personal opinion and a moral judgment based on "sound critical reflection and wise reasoning" (p. 4). Johnstone and Hutchinson [40] also draw on findings from the literature in

[2] For example, in a piece in *Narrative Inquiry in Bioethics*, a healthcare provider, Cheryl Mack, explores her response to the moral uncertainty she experienced in a complex organ donation situation [38].

[3] For further information on this critique, we refer the readers to McCarthy and Gastmans [39], Johnstone and Hutchinson [40], Hanna [19] and Repenshek [41].

neuroscience and moral psychology that suggest moral judgments are based in intuition and that people use post hoc justification to support their moral judgments. Further, the authors assert that nurses' judgments are grounded in personal, rather than professional, values [40]. From our perspective, these critiques are examples of how development of the concept has been influenced by an ethnocentric perspective based in nursing. By this, we mean that similar critiques could be leveled at all disciplines, not just nurses. However, as a number of scholars have noted [14, 40, 42], because moral distress came out of the nursing discipline, there may be a historical conflation of the concept with disciplinary narratives, such as moral suffering and powerlessness. We therefore believe that in order to develop conceptual clarity on the assumptions that underpin the definition, it is imperative to move the concept beyond one single discipline. Further, scholars from outside of nursing, such as philosophy and medicine, have begun to question the role of moral *uncertainty* in the experience of moral distress [21, 38], thereby extending our understanding of moral distress beyond an assumption of moral certainty to a place of engaging with moral ambiguity. It is also not clear that one can easily distinguish personal from professional values in making moral judgments [19] without greater comprehension of how moral judgments are actually made. Overall, these critiques highlight the need to draw from insights across academic disciplines—for example, philosophy, bioethics, and moral psychology[4]—in order to continue work to develop a comprehensive understanding of moral distress for nurses as well as other healthcare providers.

The role of *action*, or the enactment of moral agency, has been gaining attention in the literature on moral distress as researchers have been encouraged to seek conceptual clarity. In several of the definitions listed in Table 2.1, the language used to describe moral action sets up a binary; individuals either take action or they do not take action. Jameton's original definition suggested a linear conception of moral distress with action as the fulcrum.[5] The assumption was that if the nurse, or other healthcare provider, took action, they would not experience moral distress [27]. Applying a more nuanced lens to action revealed that nurses, and other healthcare providers, frequently do take action; however, their actions are often not recognized [24, 43]. Other research suggests that taking action not only does not alleviate the experience, it may also *contribute* to moral distress [43–46]. In a study that examined nurses' responses to morally distressing situations, Varcoe and Pauly [43] identified both the extensive actions taken and the ways in which these actions were dismissed within the healthcare system. These authors highlight the questionability of having the phrase "unable to act" as one of the assumptions that unpins the definition of moral distress and instead encourage examination of continuous actions that may fail to resolve the distressing situation. This perspective of action has

[4] For example, social psychologist Bandura's writing about *moral disengagement* can help us to understand how healthcare providers may respond to moral distress [33].

[5] We believe that Jameton's understanding of action was more nuanced than his definition suggests and refer readers to his 1993 article *Dilemmas of moral distress: Moral responsibility and moral practice* for a more in-depth view of his perspective on action.

contributed to a view of moral distress as a relational experience where moral agency cannot be separated from the context in which actions occur. The concept of *relational agency* inextricably links moral action to the last assumption in Jameton's definition, constraints to action.

Critiques about the role of constraints arose early in the history of the concept. The first research on the experience of moral distress for nurses and the impact on patient care was conducted by Wilkinson [6]. Her research identified a gap in understanding about the location of constraints. Originally Jameton [3] identified constraints as institutional and external to the nurse. Wilkinson's model of moral distress acknowledged that contextual constraints might be real or *perceived*. Recognizing that constraints to action are sometimes perceived suggests that institutional constraints on action don't actually exist or that nurses who fail to take action are lacking in moral competency or knowledge, are powerless to take action, or may choose not to take action based on moral aptitude or character [40]. Our response to this critique is to point to the importance of nursing's, and other healthcare provider groups', increasing awareness that the experience of moral distress may occur as a process that evolves over time for many people [21, 22]. The consequence is that awareness of constraints and our ability to articulate what contributes to the experience occurs through reflection on professional values and obligations and therefore may evolve over time [21, 37].

Recently, nurse scholars have examined moral distress in novel ways in order to bring more theoretical depth to the concept. For example, Peter and Liaschenko [47] draw on feminist moral theory to provide an explanation of what might be happening in the experience of moral distress, and Lützén and Ewalds-Kvist [48] draw on Victor Frankl's work on meaning in an effort to bring theoretical depth to their own work on moral distress. In applying different philosophical lenses to the experience of moral distress, these authors are able to examine the assumptions present in Jameton's definition and move beyond a linear concept of moral distress to explore the complexity of enacting moral agency. For example, Peter and Liaschenko [47] suggest that moral agency is a socially connected phenomenon that encompasses identity, relationships, and responsibility, thereby surfacing aspects of constraints to moral agency that may be present, yet ambiguous and difficult to articulate.

As well, researchers acknowledge that constraints could be internal or external to the individual healthcare provider [49]. Newer definitions offered by researchers either do not explicitly identify the location of the constraints on action (e.g., see [17, 30, 32]) or are beginning to point to constraints as being located at the complex relational interplay between structures and agents [12, 17, 24]. Many of us studying moral distress have discussed moral agency and constraints as if they are separate ideas underpinned by different assumptions. While this is partially true, in this chapter we want to move forward by acknowledging that these two components of the definition (agency and constraints) are, in reality, inseparable. As such, it is imperative to understand the relationship between enacting moral agency and the elements that constrain moral agency

2.4 Appreciating the Reciprocity of Structure and Agency

Scholars and researchers in moral distress are increasingly calling for a *relational* approach to exploration of the concept of moral agency in order to better understand the complex relationships that exist between organizational structures and healthcare providers as moral agents. The assumptions we have pointed to above reflect implicit understandings about the *agency* of healthcare providers, as well as the *structures* they operate in and attempt to influence. In a traditional philosophical view of moral agency, we see " …a person who is capable of deliberate action and/or who is in the process of deliberate action" [50, 51]. Further, "traditional perspectives on moral agency reflect a notion of individuals engaging in self-determining or self-expressive choice" [52] (see also [51]). Yet "moral agents in healthcare (patients, families, and professionals/providers) are not as 'equal' and autonomous as the traditional perspectives might assume" [51] (see also [43, 53]). This traditional view of moral agency has shifted over the past two decades as scholars have critiqued this view of agency as failing to acknowledge that agency is "enacted through *relationship* in particular *contexts*" [51]. In the context of healthcare, moral agency incorporates knowledge of such things as policies, protocols, unit and organizational culture and values, and interpersonal, human and material resources. Additionally, broad societal elements such as social, political, cultural, and economic values directly shape and influence both the healthcare environment and individual healthcare providers. Recognizing agency as relational moves decision-making about what actions are available to practitioners from the realm of the individual into the context in which the individual is operating and exposes the complexity that actually exists when someone chooses to act as a moral agent.

In moving decisions about moral agency from an individualistic perspective into a relational perspective, we want to move past the view of constraints resting either within the individual or with the organization. Rather, we believe moral agency and constraints reside at the *intersection* of structure and agent. We believe that structures, for example, sociopolitical and economic policies, influence decision-making at the micro, macro, and meso levels of healthcare delivery. The reverse is also true; individuals have the ability to influence sociopolitical and economic policies at these same levels. We are pointing to the idea of reciprocity between structure and agency, whereby individuals and organizations are in constant relationship with each other and therefore have the capacity to influence and be influenced by each other [19, 24, 54]. Sewell [55], a sociologist, describes the relationship between structure and agency as:

> Structures…are constituted by mutually sustaining cultural schemas and sets of resources that empower and constrain social action and tend to be reproduced by that action." Agents are empowered by structures, both by the knowledge of cultural schemas that enable them to mobilize resources and by the access to resources that enables them to enact schemas [55]

In using the word "empowered" to describe agents, Sewell's description of the relationship between structures and agents appears to overlook the fact that structures also have the capacity to disempower agents by constraining agency through

restricting access to resources. Examples of restricting access to resources are evident in healthcare, such as when healthcare providers are excluded for discussions on resource allocation. However, there is also an assumption that all agents have some, albeit perhaps limited, access to resources and therefore have some capacity for agency.

Sewell's [55] understanding of the reciprocity that occurs at the intersection of structures and agents emphasizes the dynamic and evolving nature of structures, meaning that even small actions of moral agency have the potential to create change in the healthcare system. For example, nurses can work through their professional associations to advocate for more equitable allocation of healthcare resources. In initially naming and later refining the definition of moral distress, Jameton held moral agency as central to ameliorating or mitigating the experience [3, 26, 56]. Having said this, Jameton and others [54] recognize that action in the healthcare system is "essentially collaborative and collective" [26] requiring HCPs at all levels of the healthcare system to take action when they are confronted by ethical challenges that contribute to moral distress. Building from Jameton, we propose that moral distress be defined in relation to influences beyond those that would be considered institutional to broader sociopolitical contexts and not depend on the level of impossibility of action. By this, we mean that the definition of moral distress must be moved beyond the level of the individual. Toward this end, we point to the strength of the definition proposed by Varcoe and Pauly [17]:

> the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment. (p. 59)

Conclusion

The work inspired by American philosopher Andrew Jameton's groundbreaking book on nursing ethics [3] continues to evolve. While more conceptual work is needed [7, 24], we certainly know enough to continue to improve the practice environments for nurses and other healthcare providers.

As we claimed earlier in this chapter, supporting healthcare providers as moral agents operating in complex organizational structures is prerequisite to offering effective and ethical healthcare and fostering a sustainable healthcare workforce. Our explorations in this paper have affirmed that the prevalence of moral distress is of significant concern. The expanding global interest in the topic means that we can continue moving the concept forward in order to help us have a more nuanced understanding of moral distress. A more nuanced understanding is foundational to supporting the well-being of healthcare providers so that they are in a position to more effectively deliver clinically and ethically sound healthcare.

This requires that we take action throughout our healthcare system, using a relational ethical perspective that attends to power dynamics across all levels [33], and the reciprocity that exists between structures and agents. At the

individual level, healthcare providers ought to learn about how to deal with moral distress and how to develop moral resilience [57] early in their professional educational programs.[6] Further, healthcare providers would benefit from having supportive practice mentors assigned to encourage them as they initiate their practice. At the organizational level, leaders for healthcare practice ought to provide guidance that is visionary, innovative, and inspiring [58, 59]. Such guidance can encourage a values-based orientation to organizing practice environments so that the resources required to deliver clinically and morally sound care are more readily available.

For this values-based orientation to flourish, leaders and policy makers at larger systems levels should be inspired by a commitment to values rather than just the "bottom line" [33]. Indeed, it is our conviction that healthcare agencies, healthcare funders, and healthcare professional groups should operate according to a principle of "justice as shared responsibility" [60], where all those involved in healthcare delivery see improved healthcare, as well as reduced healthcare providers' moral distress as their shared moral goals. The widespread enactment of justice as shared responsibility would mean that resources were in place to promote the well-being of all involved in healthcare delivery—whether they are patients, families, communities, or healthcare providers.

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[6] For an itemization of theoretically grounded and practical suggestions to develop moral resiliency in healthcare providers, we refer readers to the recent Rushton et al. [57] article, *A collaborative state of the science initiative: Transforming moral distress into moral resiliency in nursing.*

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