A Broader Understanding of Moral Distress

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Moral distress has become a well-established issue of concern in the nursing literature and is increasingly getting attention in other domains of healthcare.[1] According to Andrew Jameton, who first introduced the topic in the 1980s, "*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" [1, p. 6]. Since the time of this initial characterization, the phenomenon of moral distress has been discussed, defined, and researched by several authors. While there are subtle variations in how different authors have understood it, the following are widely held to be defining elements of moral distress[2]:

1. It arises when one believes one knows the morally right thing to do (or avoid doing), but one's ability to do this is constrained by internal and/or external factors.

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[2] For some representative characterizations of moral distress that include one or more of these features, see Jameton [1], Wilkinson [2], Jameton [3], Webster and Baylis [4, p. 218], Corley [5], Hanna [6], Rushton [7], American Association of Critical-Care Nurses [8], Canadian Nurses Association [9], McCarthy and Deady [10], Epstein and Hamric [11], Austin et al. [12], Chen [13], Ulrich et al. [14], Epstein and Delgado [15], and Hamric [16].

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2. It comes in two phases. There is "initial distress" at the time of potential action (or inaction); later, there is "reactive distress" or "moral residue" that occurs in response to the initial episode of moral distress.
3. It involves the compromising of one's moral integrity or the violation of one's core values.

This is the prevailing understanding of what moral distress is.

Our purpose in this essay is to motivate a broader understanding of moral distress. There is a wider range of cases that can sensibly be framed as moral distress, and it is important to recognize them as such. Embracing a broader conception of moral distress does not in any way undermine the relevance or importance of the groundbreaking work that has been done on this topic over the past several years. It simply implies that this previous work has focused on one type of moral distress. In the first section, we present six cases that fall outside bounds of the traditional characterization of moral distress. We argue that it is desirable for a definition of moral distress to encompass them. In the second section, we propose a new definition that accommodates all six cases, as well as the cases accommodated by the traditional definition of moral distress. In the third section, we respond to worries that this new definition is overly broad. In the fourth section, we take some first steps toward the development of a taxonomy of moral distress.

4.1 The Case for Broadening Our Understanding of Moral Distress

The purpose of this section is to motivate the need to broaden the traditional characterization of moral distress. Our strategy is to present six cases of distress and explain why they should be understood to be forms of moral distress. It should first be clarified that the inclusion of our six cases cannot be motivated by an appeal to the meaning of "moral distress." Although the words "moral" and "distress" are pieces of natural language, the phrase "moral distress" is a term of art. It was first coined in 1984 for the purpose of naming a phenomenon that was observed in nursing practice, and the phrase has had life almost exclusively within the medical and bioethics literature. For this reason, we are happy to grant that "moral distress" means whatever the scholars writing about it have taken it to mean. Since the prevailing understanding of moral distress in the relevant literature excludes the six cases, a brute appeal to meaning does nothing to motivate their inclusion.

What can serve to motivate the inclusion of the six cases is reflection on the features of moral distress that help to explain why health care professionals and bioethicists have had a sustained interest in this topic. The phenomenon of moral distress is, first and foremost, a practical problem. In the nursing profession, its problematic nature largely consists in its adverse effects on the well-being of nurses, the quality of patient care, and nurse retention [5, 17–21]. Of course, it is likely that any type of on-the-job distress or frustration can contribute to such problems—including, for instance, distress that stems from having an overbearing co-worker or being continually exposed to the suffering and death of patients. But there is

something especially problematic and worrisome about distress that arises when individuals feel morally compromised or tainted in some way. As we see it, this is what distinguishes moral distress from other kinds of distress. This may explain why the topic of moral distress, as opposed to mere distress, has received so much attention. Arguably, bioethicists, policymakers, and health care administrators have special reason to try to eliminate, or at least mitigate, this kind of distress in health care contexts. Admittedly, this talk of being "morally compromised" or "morally tainted" is rather vague. Even so, these expressions are useful starting points for thinking about what moral distress is and why it is often important to address it.

Although none of our six cases involves moral distress as traditionally conceived, each involves an individual in a health care context experiencing distress because he or she feels morally compromised in some way. Each of the cases describes a type of experience that certainly could, and probably often does, contribute to a loss of well-being, a diminishment of job satisfaction, poorer job performance, and burnout. As we hope to show, there appears to be no principled reason why a definition of moral distress should exclude these cases.

4.1.1 Moral Uncertainty

> A newly appointed general surgeon who has just finished his residency training is assigned to a disproportionate share of the Medicaid and uninsured cases. These patients are complicated, and many of them suffer with multiple comorbidities due to limited access to primary care and treatment. In fact, several of his patients have already experienced postoperative complications following gastrointestinal surgery, including abdominal sepsis and evisceration. He feels that assigning a new surgeon to these patients is unfair to them since he has less experience than other surgeons. He worries that he might be harming them. He is distressed about this but does not know the best way to respond. One option is to simply continue doing the surgeries to the best of his ability. Alternatively, he could complain to his superiors, though he is worried that he might be labeled as a troublemaker and that some of the surgeries might get delayed. He also considers seeking the advice of a more senior surgeon, but he suspects that he would be told that this is the way the system works and it is good training. He is not sure what the morally best course of action is.

Moral distress is commonly thought to arise only in cases where a person thinks she knows the morally right course of action. No doubt, there are times when we find ourselves in situations in which we think we know exactly what morality demands of us. Still, as illustrated in the case just described, it is all too common that we fall short of having such knowledge. Life as a moral agent is complex, and it is often difficult or impossible to know what the morally right course of action is. One reason for this is that it is no easy matter saying which moral theory or moral principles are correct. Even moral philosophers, whose careers revolve around thinking about ethics, are continually developing, revising, and fine-tuning their own views about morality. Another reason has to do with uncertainty or indeterminacy concerning the professional duties or proper role of different health care professionals and workers. A final reason for moral uncertainty is that we often lack pertinent empirical information about our situation. To appreciate this point, imagine a situation in which a patient is about to consent to a procedure without having

adequate information. Jameton [3] gives the following (nonexhaustive) list of ways in which a nurse might immediately react to this potentially distressing situation:

- Just relate the information to the patient.
- Ask the physician leading questions to elicit the information.
- Step aside with the physician and suggest that he or she reconsider the procedure, or suggest that the physician or nurse give the patient more information.
- Call in the head nurse.
- Resign on the spot.
- Scream.
- Undermine the process.
- Say a prayer.
- Do nothing.

Jameton goes on to list a host of other possible actions the nurse might take soon after the event or that he or she might take if this sort of situation arises regularly (pp. 544–45). Given the vast array of possible actions open to us at any given moment, it is no wonder that we often fall short of knowing what the morally right action would be. We often will not know all of the possible actions that are available to us, much less what consequences they would all have—and, as a result, will not know what the right thing to do is. Yet, even in the absence of such knowledge, it is possible for one to experience negative attitudes like guilt or unease. One might have a firm conviction that one did the *wrong* thing without having the faintest clue what the right action would have been. Or one might simply *suspect* that one failed to do the morally right thing, even if one is not at all sure. Distress in the form of guilt or self-criticism can arise under such circumstances.

4.1.2 Mild Distress

> An operating-room scrub nurse is frequently assigned to work with a pediatric cardiac surgeon who has a reputation for explosive outbursts in the operating room (OR). The surgeon has screamed profanities at the heart-bypass perfusion team, anesthesiologists, residents, and nurses, and has even been known to throw instruments across the room. The scrub nurse happens to be in the surgeon's good graces and is one of the few people immune to her outbursts. Even so, he finds it troubling to see his colleagues berated and thinks he should intervene in some way. Yet, when these outbursts happen, he feels constrained from saying anything to the surgeon for fear of falling out of favor with her and possibly making the situation worse, which might undermine the cooperation and teamwork needed to save the health or life of the child on the operating-room table. Taken in isolation, each episode is only mildly upsetting to the scrub nurse. Indeed, the first time he experienced the surgeon's behavior, he just rolled his eyes and continued to focus on his work. But these instances of distress have a negative cumulative effect over time.

Discussions of moral distress often give the impression that every episode of moral distress is a dramatic, life-altering affair. The common practice of associating moral distress with the compromise of one's moral integrity, the violation of one's

core values, or even the threatening of one's very identity suggests serious moral compromise. And the word "distress" could easily be taken to denote a very strong emotional reaction.

We grant that the most disturbing and significant instances of moral distress will be those that create intense feelings of distress and shake people to their "moral core" by violating their core values or compromising their moral integrity. However, individuals can be morally compromised in less momentous ways that are still damaging and worth addressing (cf. [5], p. 637). It can be distressing to be prevented from doing what you think is the morally right thing to do even when the action in question has nothing to do with your core values. People who are morally corrupt can have rare moments of moral conscientiousness and can experience distress if they are kept from acting rightly—even if they do not really have any moral integrity to compromise. Finally, as exemplified in the case just described, there are occasions on which a person finds it only mildly distressing that she is constrained from doing what she thinks is morally best. Episodes of mild distress, when they occur on a regular basis, can have an adverse cumulative effect on those who experience them. The difference between strong and mild distress is a difference only in degree, not in kind. Rather than denying the existence of mild moral distress, we should simply recognize that isolated instances of mild moral distress have lower moral priority than stronger forms.

4.1.3 Delayed Distress

> An experienced emergency physician is on duty when a 55-year-old female patient arrives at the emergency department via ambulance after being ejected from the vehicle during a roll over motor vehicle collision. She sustained multiple fractures, severe facial injuries, and a significant closed head injury. The patient was intubated on scene by the paramedics, and cardiopulmonary resuscitation (CPR) is in progress after a traumatic cardiac arrest. Upon arrival, she has no pupillary response and she remains in full cardiac arrest. The emergency physician, nurses, and trauma team immediately continue resuscitation, placing multiple lines, giving meds and blood products in accordance with Advanced Trauma Life Support protocols. Multiple units of blood, IV fluids, and medications are administered in an attempt to get return of spontaneous circulation and manage the patient's injury. After 30 minutes of aggressive resuscitation, the patient has return of spontaneous circulation and is transferred to the OR for a craniotomy to relieve intracranial pressure, which helps stabilize her condition although she is still in critical condition and the team questions the likelihood of a meaningful recovery. On his drive home, the physician begins to reflect on the attempts to resuscitate the woman and is troubled that they were so aggressive for so long. His knowledge and experience told him the chances of a meaningful recovery from her devastating injuries were very low. He wonders about the woman's quality of life and whether aggressive resuscitation was the best option.

On the traditional picture of moral distress, it comes in two stages. First, there is *initial distress*, which is felt at the very time at which one's action is constrained by internal or external factors. This is followed by *reactive distress*, or what some have called "moral residue." It appears to be widely assumed that both initial distress and reactive distress are essential elements of moral distress. Indeed, Jameton, one of

the first to explicitly draw the initial/reactive distress distinction, defines reactive distress in terms of initial distress: "Reactive distress is the distress that people feel when they do not act upon their initial distress" [3, p. 544]. This characterization of reactive distress presupposes the existence of initial distress.[3]

As our case of delayed distress illustrates, it is perfectly possible for a person to fail to have distress at the time of being morally comprised. In emergency situations, the urgent need for action can prevent a person from fully processing the nature of the situation and her actions and, as a result, from feeling the appropriate emotions. Yet, if later reflection leads a person to recognize that she had been constrained from acting in the morally best way and if she feels distress as a result of this, there is no reason why we should not treat this as a case of moral distress. Such a person might be in a mental state nearly identical to that of a morally distressed person who did have initial distress.

We can also imagine scenarios in which one experiences initial distress without reactive distress. After the period of initial distress, any number of events might prevent an individual from experiencing reactive distress. One might forget about the distressing episode (particularly in cases of mild distress), repress the memory of it, formulate a post hoc rationalization of one's behavior, or become occupied with more pressing concerns (such as the death of a loved one). An individual might not have reactive distress because she comes to see her initial distress as inappropriate—perhaps because she gains more information that leads her to revise her moral assessment of the situation. There are also cases where the experience of reactive distress is precluded by a medical condition or death.

In light of these considerations, it is a mistake to insist that initial distress and moral residue are necessary features of moral distress. Cases in which only one or the other occurs still deserve to be treated as cases of moral distress.

4.1.4 Moral Dilemma

A bioethics consultant is called by the pediatric oncology team to get advice about a 13-year-old patient with cancer whose clinical situation is precarious. The team members want to know what they should tell the patient about his diagnosis and prognosis. When the patient was diagnosed over a year ago, his parents were worried that knowledge of his condition would be overwhelming and cause him unnecessary distress. They asked the team not to give him details about his disease. Despite many months of aggressive treatment, his cancer is progressing and he is experiencing some debilitating complications from the treatment. The parents are still adamant that he should not be given details about his condition, and the team does not know how to respond. After meeting with the patient and his parents, the bioethics consultant feels torn between respecting the wishes of the parents who know their son and have his best interests at heart, and showing respect for the patient and his welfare by advising the team to disclose what they know about his situation that might help him make informed decisions. Each option seems morally regrettable: Either they deceive this patient about his condition, or they violate the parents' wishes and give the patient information that is likely to cause him distress. The bioethics consultant thinks there are

[3] See also [4, p. 218].

equally good arguments to be made against each of these choices. He ultimately recommends disclosing information to the patient, but he feels some guilt about making this recommendation.

When Jameton first introduced the phenomenon of moral distress, he contrasted it with two other kinds of cases: cases of moral uncertainty, and moral dilemmas. We have already challenged the idea that moral distress and moral uncertainty are mutually exclusive phenomena. We now wish to suggest that there is also some overlap between moral dilemmas and moral distress. Moral dilemmas "arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action" [1, p. 6]. Thus, if moral distress (as traditionally conceived) arises in cases where morality pulls a person in one direction but constraints pull her in another, moral dilemmas are cases in which morality itself pulls a person in competing directions. As a result, dilemmas are cases in which one cannot avoid doing something morally regrettable.

It seems a mistake to define moral distress in such a way that it cannot be experienced in moral dilemmas. Moral dilemmas are classic cases in which people do, and arguably should, feel morally compromised. Distress is a natural response to a situation in which you are "damned if you do, damned if you don't."[4] To make space for the possibility of moral distress in response to a moral dilemma, we should simply reject the idea that moral distress only results when one is constrained from doing the morally right thing. Moral dilemmas are situations in which there is no (purely) morally right thing to do. Being thrust into a moral dilemma can lead to feelings of distress and moral compromise, loss of well-being, and so on, just as naturally as being faced with a morally right option that one is kept from taking.

4.1.5 Bad Moral Luck

A psychiatrist pushes hard to get his patient to take a medication that he believes will help to address her intractable depression. The patient is initially reluctant, but he eventually persuades her. Two weeks later, she takes an intentional overdose of the medication, which results in her death. The psychiatrist feels terrible about his role in the patient's suicide and wonders whether he did the right thing. However, after reviewing the case, he continues to think that he did exactly what someone in his position should have done, given the evidence available to him at the time. Even so, he feels great distress about the consequences of his action.

One of the most firmly established beliefs about moral distress is that it is always the result of an individual failing to do the morally right thing where this failing is the result of internal and external constraints. However, it is possible for one to feel morally compromised or tainted even in cases where one is not constrained and one successfully performs what one judges to be the morally best action. One type of

[4] For an influential discussion of moral dilemmas and the appropriateness of one species of distress ("agent-regret"), see Williams [22].

case that fits this description involves a certain species of "moral luck."[5] As illustrated in the case just described, sometimes individuals perform what they deem to be the morally best action based on the best information and evidence available to them at the time, without any internal or external constraints. Yet their actions, in conjunction with factors beyond their control, turn out to have morally undesirable consequences (such as the suffering or death of another sentient being or the violation of someone's autonomy or rights). This can lead to feelings of distress. One need not think she should have acted differently. The person may firmly believe that it would have been wrong of her to do otherwise, given what she knew at the time. Still, she may feel terrible that she played a role in bringing about a morally regrettable outcome. This is an instance of distress rooted in the sense that one has been morally compromised, despite the fact that one is not guilty of acting in a wrong or blameworthy manner.

4.1.6 Distress by Association

> A nurse at the bedside is responsible for providing clinical care to her patient, who is also a participant in a research study. Based on conversations with the patient, she feels that the patient does not really understand the purpose of the research study and is desperately hoping for any benefit to extend his life. The patient tells her that he did not read the consent form carefully. As the study progresses, the patient's clinical status begins to deteriorate, yet he wants to continue on the study because he thinks it will benefit him. The nurse believes that the patient's continued participation in this research study is morally wrong. She encourages him to meet with the research team to discuss his clinical situation and the purpose and progress of the research, but he is uninterested in doing that. When she mentions her concerns to the research team, they respond that he understands the study well enough and that she should stop worrying. The nurse becomes increasingly troubled by her interactions with this patient. Although she is not part of the research team, she has responsibilities for caring for him and monitoring his clinical status at the bedside where research procedures occur. She feels guilty and distressed about her involvement despite the fact that she has tried very hard to remedy the situation.

This is a second type of case in which one is not subjected to internal or external constraints and one does not fail to do the morally right thing. Distress by association is not grounded in one's own action or omission but in one's association with another party—which might be one or more individuals, or a collective entity.[6] As we are understanding it, distress by association is not essentially a matter of emotional contagion, where distress in one person is triggered by exposure to another's distress. Nor is it a matter of empathetically experiencing the distress that someone else is, or should be, experiencing. Instead, distress by association springs from the sense of being morally compromised due to one's connection with some other party. Perhaps this other party acted immorally with malicious intentions, or acted

[5] The *locus classicus* for this topic is Williams and Nagel [23]. Our present focus is on what is often called "resultant luck," or luck in how things turn out.

[6] This idea is sometimes explored in discussions of "moral taint." See, for instance, Oshana [24].

negligently, or acted morally but with morally disastrous results. Or perhaps this other party has morally condemnable beliefs, attitudes, or motives, without being guilty of *acting* in morally questionable ways. In some cases, distress by association concerns one's membership in a group or organization that has caused a morally undesirable state of affairs, though the responsibility for this does not fall on the distressed individual—or, perhaps, on any particular individual. A doctor might experience distress by association because she works in a health care facility that does not provide adequate care or quality of life for its patients. Here, as in all of the previous cases, it makes good sense to recognize this phenomenon as a species of moral distress. It is distress that arises from a sense of being morally compromised, and it contributes to the sorts of practical problems traditionally associated with moral distress.

4.2 A New Definition of Moral Distress

We have argued that our understanding of moral distress should make space for the six types of cases we have discussed. But how should we revise our understanding of moral distress to encompass these cases? What definition of moral distress should we accept? There are countless possibilities, but we offer the following as a promising candidate:

> *Moral distress* $=_{df}$ 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.

This definition of moral distress has some elements that require clarification. First, it implies that moral distress is a matter of having negative emotions or attitudes that are *self-directed*. These might include self-criticism, guilt, shame, embarrassment, lowered self-esteem, or anger toward oneself or about one's behavior.[7] The restriction to self-directed attitudes is meant to rule out cases in which a person has only other-regarding negative emotions in response to being involved in a morally undesirable situation. Suppose, for instance, that a nurse feels resentment and anger toward a doctor for involving him in the morally questionable treatment of someone who is not his patient. He might feel angry about being involved with this case without feeling that *he* is morally compromised by the involvement. If moral compromise is at the heart of moral distress, it seems essential that there are self-directed negative emotions.

Our definition concerns one's perceived *involvement*. This is intentionally vague, allowing for a wide range of ways in which individuals might be related to a morally

[7] These attitudes should spring from a certain appreciation of moral values and not a purely instrumental concern. An egoist or a psychopath might strive to avoid acting immorally solely because it can bring about unwelcome legal and social consequences. If he slips up and does something wrong, he might chastise himself for his stupidity and carelessness. This would not be moral distress.

problematic situation. The involvement might be a matter of having acted or failed to act in certain ways, or having felt or failed to feel certain things. It might be that one has oversight over, and responsibility for, a situation even if one is in no position to intervene. Or it might be that one is simply connected, professionally or personally, to others who are more centrally involved in a morally undesirable situation. Since moral distress is grounded in individuals' perceptions of their involvement, and since individuals will vary quite a bit in the levels and types of involvement that lead them to feel morally compromised, it is ideal for a definition of moral distress to leave space for this variation.

The proposed definition of moral distress refers to situations perceived to be *morally undesirable*. It is notoriously difficult to define "moral." For our purposes, we understand morality to be concerned with the concern and respect that is owed to others. What types of being count as morally relevant "others" (or, we might say, beings with moral status) is a matter of dispute. Variation in people's views about the moral status of a given type of subject—for example, fetuses, animals, brain-dead patients—can help to explain variation in their experience of moral distress. Situations are morally desirable to the extent that due concern and respect to others are shown, and morally undesirable to the extent that they are not. The notion of a morally undesirable situation is meant to be somewhat open-ended. It might include situations that are morally optimal but still morally bad (e.g., where one chooses the lesser of two evils), as well as situations that are morally good but morally nonoptimal (e.g., where one chooses the lesser of two moral goods).

There are some notable contrasts between our proposed definition and the traditional understanding of moral distress. On the traditional view, moral distress is restricted to situations in which, due to constraints, one fails to do what one takes to be the morally right thing. However, cases of moral uncertainty reveal that the restriction to knowledge is too strong. Cases of bad moral luck suggest that moral distress can result from doing what was, in light of the information available at the time, the morally right thing. Cases of moral dilemma show that there need not be a "morally right thing to do." Cases of distress by association show that an individual's own action or omission need not be the source of distress—and, in turn, that the presence of internal or external constraints on action is not essential to moral distress. On our broader definition, moral distress can arise in situations where a person perceives herself to be involved in a morally undesirable situation. This allows for the possibility that an individual does not know what the morally right thing to do is (moral uncertainty), that the individual did the morally best thing though things turned out badly (bad moral luck), that there may not be a morally right thing to do (moral dilemma), or that one's own action is not the issue (distress by association).

Our definition does not place limitations on whether distress occurs at the very moment of one's involvement in a morally undesirable situation, afterward, or both. Unlike the traditional understanding of moral distress, which sees both initial distress and reactive distress as essential elements, our definition allows for the possibility that one does not have one of these. It therefore allows for cases of delayed distress, as well as cases in which one does not experience reactive distress or moral residue (which might happen in cases of mild distress). Interestingly, our definition

even allows for the possibility of *anticipatory distress*. If a health care worker believes that, in the future, he or she *will* be involved in a morally undesirable situation, this can lead to distress in the present. This phenomenon may not be all that uncommon. Health care workers who have routinely found themselves entangled in morally undesirable situations can reasonably assume that they will find themselves in such situations in the future.[8] This can be a source of distress in their lives.

Lastly, the traditional understanding of moral distress implies that moral distress only arises from serious violations of one's values and therefore does not acknowledge instances of mild moral distress that, even if not terribly important on their own, can have a significant cumulative impact. In contrast, on our definition even mild forms of negative emotions and attitudes could constitute moral distress.

4.3 Is It Too Broad?

It might be thought that seeking a broader characterization of moral distress is a misguided goal. As we ourselves acknowledged in the first section, moral distress has gained such attention over the past several years primarily because it is a serious problem in actual health care practice. Bioethicists and health care practitioners want to understand what moral distress is in order to identify and remedy it in real-life contexts. However, our broader definition might seem to thwart that goal. Just think of the wide range of negative self-directed emotions individuals might feel, or the innumerable ways in which an individual might perceive herself to be "involved" in a situation, or the countless ways in which a situation might be judged to be morally undesirable. As Joan McCarthy and Rick Deady once observed, we do not want a definition of moral distress to be "so broad … as to be diagnostically and analytically meaningless" [10, p. 259].

This is a reasonable worry, but we think it admits of a satisfying response. Although it might prove difficult to conduct research on moral distress in general when it is so broadly conceived, it seems perfectly possible for researchers to overcome this problem by specifying a particular type of moral distress and making that their object of study. Could such a strategy prove fruitful? Thankfully, we need not resort to mere speculation here, for there is a prominent concrete case that sheds light on this question. The extant literature on moral distress is itself an in-depth investigation of one narrow (and important) type of moral distress—namely, moral distress that (1) results from the perception that one failed, due to internal and external constraints, to behave in the morally right way, (2) in a way that represents a compromising of one's moral integrity or core values, and that (3) involves both initial distress and reactive distress. Feature (1) represents one way in which an individual can perceive herself to be involved in a morally undesirable situation. Feature (2) will tend to involve or be correlated with very intense negative self-directed emotions and attitudes. Feature (3) concerns the time at which the distress

[8] It is conceivable that anticipatory distress will play some role in the best explanation of the so-called "crescendo effect." See Epstein and Hamric [11].

is experienced. If the existing research on moral distress represents a worthwhile endeavor (as we believe it has), then it is clear that investigating a particular type of moral distress can be worthwhile. Working with a broader understanding of moral distress is no impediment to focusing our research and interventions on narrower, context-pertinent forms of moral distress. In fact, our proposed definition of moral distress can support the investigation of particular forms of moral distress insofar as it lends itself to developing a taxonomy of moral distress, which serves to illuminate the full range of varieties of moral distress.

4.4 Toward a Taxonomy of Moral Distress

Given our broad definition, a taxonomy may be organized around three components of moral distress: the negative attitudes that one experiences, one's perceived involvement in the situation, and the perceived moral undesirability of the situation. While it is beyond the scope of this essay to work out this taxonomy in detail, the following is a rough sketch of the general form it might take and the practical, conceptual, and empirical implications:

The Negative Attitudes
- The type of negative attitudes.
- The appropriateness or fittingness of the attitudes.
- The intensity of the attitudes.
- The time at which the attitudes occur.
- The positive and/or negative consequences of the attitudes (e.g., on one's job satisfaction, job performance, personal life).

The Perceived Involvement
- The type of involvement.
- The degree of involvement.
- The accuracy of the perception of involvement.

The Perceived Moral Undesirability
- The source of moral undesirability (i.e., what makes the situation morally undesirable).
- The degree of moral undesirability.
- The accuracy of the perception of moral undesirability.

In a fully developed taxonomy, each of the subcategories will be attached to a list of options. For example, the time at which the attitudes occur would include the following: before the time of one's perceived involvement, during the time of one's perceived involvement, after the time of one's perceived involvement, or some combination of these. For any given instance of moral distress, it can be asked how it should be classified within each subcategory.

Developing a taxonomy of moral distress can be beneficial. From a practical and conceptual perspective, it can open our eyes to the many varieties of moral distress, preventing us from becoming narrowly focused on a particular type that

does not have moral priority over various other types. Empirically, it can also stimulate new lines of thinking about how to deal with moral distress by examining, for instance, the relationship between clinicians' degree of involvement in morally distressing situations, the source and degree of the moral undesirability of these situations, possible mitigation strategies, and clinician- and patient-related outcomes. To illustrate, consider this question: Should a hospital seek to prevent the occurrence of situations that will be perceived as morally undesirable by its staff, should it seek to ameliorate the moral distress experienced by the staff after such situations occur, or should it attempt to do both? Reflecting on the outlined taxonomy, it is evident that the choice between different interventions will depend crucially on the type of moral distress in play. If the kind of situation that gives rise to moral distress involves a violation of patients' rights or serious harm to them, clearly there should be efforts to prevent such morally undesirable situations from occurring. However, suppose instead that we are focusing on moral distress that arises from patients or their families making cool-headed, informed, and legally protected medical decisions that the medical staff considers to be foolish or immoral. With moral distress of this kind, it seems far more plausible that the hospital should focus its effort on mitigating moral distress in its staff without trying to prevent the occurrence of the situations that give rise to that distress. Thus, different forms of moral distress will call for different types of responses and interventions.

Importantly, we are not claiming that all forms of moral distress require or merit intervention. The envisioned taxonomy of moral distress will reveal instances of moral distress that are plausibly best left to individuals to address on their own. These might include cases where the moral distress is mild, the distress springs from obviously misguided moral views or unreasonable beliefs about one's involvement, the intensity of moral distress is much greater than the situation warrants, or individuals are having normal and appropriate self-critical responses to their own moral failings. Working out a taxonomy of moral distress can help us systematically explore whether and how we should intervene to address moral distress.

4.5 Conclusion

In this essay, we have sought to motivate the need for a broader definition of moral distress, propose a broader definition, and gesture toward a taxonomy that might be developed from this definition. While the appeal of our proposed definition partly depends upon the success of our case for favoring a broader understanding of moral distress (presented in the first section), the success of our case for a broader definition does not depend on the appeal of our definition. Thus, some readers might be convinced by the considerations in the first section and yet find some reason to reject the definition presented in the second section. We welcome this. If our proposed definition of moral distress proves to be unacceptable for reasons we have not foreseen, we hope that our attempt will inspire others to discover a better one.

Disclaimer The views expressed in this essay are the authors' own. They do not represent the positions or policies of the National Institutes of Health, U.S. Public Health Service, or Department of Health and Human Services.

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4.6 A Broader Understanding of Moral Distress Revisited

Stephen M. Campbell, Connie M. Ulrich, and Christine Grady

Our essay "A Broader Understanding of Moral Distress" was published in the December 2016 issue of *American Journal of Bioethics* alongside a guest editorial and twelve commentaries from colleagues working in bioethics, medicine, nursing, and philosophy. The responses were largely favorable. The guest editorial—written by two physician-ethicists from Stanford—welcomed the expansion of the moral distress concept to make space for "the lesser known, more nuanced relatives" of traditional moral distress that are "not quite destructive to moral integrity and not intractable in the situation, but unsettling enough that they deserve thoughtful attention, exploration and, when possible, mediation and resolution" [26, p. 2].

A majority of the commentators were also sympathetic to, if not persuaded by, our case for broadening the definition of moral distress in order to make it more inclusive. Many of these same authors took the opportunity to explore interesting dimensions of this topic. Stephen Latham [27] highlighted parallels between our definition and the Catholic doctrine of complicity with wrongdoing. Andrew McAninch [28] drew connections between the concepts of moral distress and moral injury and explored the implications of recognizing distress in cases of luck. Markus Christen and Johannes Katsarov [29] thoughtfully examined the relationship between moral distress and moral sensitivity. David Resnik [30] offered some pioneering reflections on the presence of moral distress in the context of scientific research. Sven Nyholm [31] convincingly argued that there is much good in a person's propensity to experience appropriate moral distress and that we should not lose sight of this fact. Carolyn W. April and Michael D. April [32] brought Rawlsian considerations to bear on our discussion and highlighted practical advantages of our approach. These contributions have enriched our own understanding of various facets of moral distress.

However, some respondents were critical of our proposal, and we would like to briefly address what we regard as the two most important objections to our proposal. The first comes from Epstein et al. [33]. These authors raised worries about the practical effects of abandoning the traditional understanding of moral distress

in favor of a broader definition. In particular, their concern was that a broader definition "dilutes the concept to such a degree as to render it impractical—too nebulous to be effectively taught, studied, used in practice, or, frankly, respected any longer as a powerful phenomenon in bioethics." This is an understandable concern, but to repeat a point that was explicitly presented in our essay and merits repeating here, our broader definition of moral distress is in no way incompatible with recognizing and researching specific context-pertinent forms of moral distress. Indeed, our definition with its accompanying proposed taxonomy facilitates the identification of specific forms of moral distress and positions us to better understand and appreciate their various dimensions and to assess their ethical significance. Hence, the authors' emphasis on the importance of "naming the moral distress experienced by staff" seems misplaced. Our definition is no obstacle to telling people, "You're experiencing a kind of moral distress." (In fact, this is precisely what should be said even on the traditional narrow definition since that definition also admits of different subspecies of moral distress.) Furthermore, as Carina Fourie [34] has helpfully suggested, it is possible that there are ways to justify the special importance of the traditional definition's "constraint-distress" in nursing contexts. If its special importance can be justified, our broader definition should not be so worrisome. Finally, we feel that this line of criticism misses the immense practical benefit and importance of recognizing a wider array of relevantly similar phenomena.

The second important line of objection was presented in the commentary from Moti Gorin [35]. Gorin introduced the following hypothetical case:

> Sexual Harassment: A female nurse enters the break room for coffee. Two of her male colleagues are sitting at a table and eating. As the woman is leaving with her coffee, one of the men makes a lewd comment to his lunch partner about the appearance of their female coworker. He makes the comment openly, clearly with the intention that she will hear it. The other man responds with laughter. As she exits the room the woman is overcome with feelings of annoyance, anger, and fear, which are directed at her colleagues. She also feels acute shame and embarrassment as a result of being crassly objectified. Even when the passage of time has reduced the intensity of these emotions, she can't help feeling less confident whenever she's at the hospital.

Gorin's case reveals a flaw in our proposed definition. On the one hand, it does not seem intuitively correct to say that the woman in this case experiences *moral* distress or that she herself feels *morally* compromised or tainted by this interaction. She can walk away from the exchange with a clear conscience, despite whatever other feelings she may have. On the other hand, her emotional response does qualify as moral distress on our definition, which identifies moral distress with "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" Campbell et al. [37, p. 6]. In Gorin's imagined case, the woman does indeed have

negative self-directed emotions (shame, embarrassment) in response to her involvement (victim) in a situation that she perceives to be morally undesirable (an instance of sexual harassment). We concede that this is a case where our proposed definition overgenerates or, we might say, delivers a false positive.

The question is: how do we adjust the definition to handle this problem? Gorin rightly notes that the problem has to do with our underdeveloped notion of "involvement." He suggests that we modify our definition by replacing "perceived involvement in" a morally undesirable situation with "perceived [moral] responsibility for" a situation thought to be morally undesirable. This would avoid the implication that the woman in his case has moral distress provided that she does not perceive herself as being morally responsible for the harassment she suffers. We agree with Gorin that one's involvement needs to have a moral dimension, but we also think that a modification phrased in terms of responsibility is too strong. There are cases of bad moral luck and distress by association where a person might be fully convinced that she is *not* morally responsible for the morally undesirable situation with which she is involved and yet still feels morally compromised by her association with the causal consequences of her actions or with other parties. Our preferred solution is to modify our definition so that one who has moral distress must perceive her involvement in a morally undesirable situation to be itself morally undesirable:

> Moral distress = one or more negative self-directed emotions or attitudes that arise in response to one's perceived morally undesirable involvement in a situation that one perceives to be morally undesirable.

This modification retains the spirit of our original proposal and addresses Gorin's objection by screening out cases where one has a morally unproblematic involvement in a morally problematic situation. We are optimistic that our definition can be successfully tweaked to handle new counterexamples that emerge.

Moral distress is a global phenomenon that is widely experienced by those working in health care. Our essay outlining six example cases was meant to broaden the dialogue on this valuable and pervasive problem. We are pleased that our proposed definition of moral distress welcomed such an engaging dialogue on what it is and what it is not. Future work is now needed to develop a taxonomy around the three critical components of our definition: the negative attitudes that one experiences, one's perceived involvement, and the perceived moral undesirability of the situation. This type of work is bound to open up new areas of normative and empirical bioethics research, further refining the depth, dimensions, and significance of this important topic for all those who face the everyday ethical challenges of caring for patients and families.[9]

[9] This essay is adapted from Campbell et al. [36].

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