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Moral Distress: Tensions as Springboards for Action

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Abstract In the previous four papers in this series, individual versus structural or contextual factors have informed various understandings of moral distress. In this final paper, we summarize some of the key tensions raised in previous papers and use these tensions as springboards to identify directions for action among practitioners, educators, researchers, policymakers and others. In particular, we recognize the need to more explicitly politicize the concept of moral distress in order to understand how such distress arises from competing values within power dynamics across multiple interrelated contexts from interpersonal to international. We propose 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 health care providers for the problem of moral distress. Grounded in a critical theoretical perspective of context, definitions of moral distress are re-examined and refined. Finally, recommendations for action that emerge from a re-conceptualized understanding of moral distress are provided.

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The four papers in this collection (by Pauly et al.; Lützén, Austin and Hamric) serve as a synopsis of the state of the art of inquiry related to moral distress in health care. The papers, and the symposium from which they arose, identify key tensions in this inquiry and offer clear directions for the future. The tensions are interrelated across three domains: contextual, conceptual, and definitional. In what follows, we summarize these tensions and offer suggestions for practitioners, educators, policy makers and the public.

Contextual Tensions

Across the papers in this series, which are reflective of wider debates, it is evident that the extent to which context is considered in understanding moral distress is crucial. Contexts from the local interpersonal context to global political contexts must be considered in developing our understanding of what constitutes moral distress as well as action and responses to moral distress. Lützén's work highlights the importance of global socioeconomic and political contexts. In the symposium, upon hearing the examples of situations giving rise to moral distress in Canadian, American and other contexts in contrast to more social democratic political systems, Lützén wondered whether differences in political economies, with consequent differences in health care systems, health outcomes and health care inequities would be associated with different levels of moral distress in different countries. An understanding of international differences helps to understand the emergence of different and related concepts in moral distress. For example, different socio-political contexts may partially explain the origins of the concept of moral stress as discussed by Lützén in this issue, a less overtly political notion. In turn, we have recognized the need to more explicitly politicize the concept of moral distress in order to understand how such distress arises from competing values within power dynamics across multiple interrelated contexts from interpersonal to international.

Indeed, Bryant and others have shown the marked differences in health and inequities in access to healthcare across different sociopolitical systems (Bryant 2006). Different levels of inequity and different pressures within health care systems likely create contexts with different types and levels of pressure for health care providers. We hypothesize that there are different outcomes for health care providers in relation to moral distress as well as in other factors that contribute to well-being and functioning of health care providers across different health care systems.

In concert with this reasoning, Austin (this issue) argues that, in Canada, health care restructuring and cutbacks are demoralizing. We would add that they are reflective of a political economy that is based on neo-liberal values that underpin shifts to more business focused and efficiency models of health care. Repeatedly we have seen in our own work how challenges to ethical nursing practice and increased

moral distress are shaped by a neo-liberal socio-political contexts (Doane et al. 2009; Doane and Varcoe 2007; Rodney and Varcoe 2001; Storch et al. 2002, 2009; Varcoe et al. 2003, 2004). Different approaches to, and rates of health care reform, a global phenomenon with varied features internationally, have led to different rates of liberalization.

Neo-liberal reform, which emphasizes deregulation, market control and competition, has spread beyond economic systems, and permeated political systems (Coburn 2000, 2004; Read 2009). Neoliberalism has become an ideology that governs daily social relations in a variety of ways that constantly reinforce and reproduce dominant discourses as to the responsibility of individuals and society. Health care systems are increasingly privatized in both funding and delivery of care through deregulation with increasing erosion of social systems that impact access to resources for health. Implicit in neoliberalism is the importance of the self-interested and autonomous individual with implications for individual responsibility for personal and family health. As such, discourses of responsibility have become entrenched in systems and emphasis on personal responsibility for health has obscured the role of systems as health inequities proliferate. There has been some attention given to the importance of context and the impact of neo-liberalism in relation to marginalizing discourses in health care that blame individuals for poor health outcomes and further stigmatize individuals for behaviors such as drug use or poverty, or on the basis of gender or ethnic associations (e.g., Anderson et al. 2009; Bungay et al. 2009; Klodawsky et al. 2006; Pauly et al. 2009; Pulkingham et al. 2010).We suggest that these same conditions are impacting providers and the development of moral distress. In the same way that individuals are blamed for their poor health so are health care providers found to be weak or failing when moral distress is constructed as primarily an individual concern. Further, situations that give rise to moral distress are changing as health care contexts continue to shift, moving from situations concerning the treatment of individual patients to increasing awareness of systemic situations—including health inequities and inequities in health care access and treatment stratified by poverty, stigma related to ability, mental illness and substance use, racism and other forms of discrimination.

As social and health inequities widen globally, inequitable health outcomes and health care access for individuals, families and communities is and should be of increasing ethical concern. Indeed, health inequities have been identified clearly by the World Health Organization as ethical issues and the goal of health equity as an ethical imperative (World Health Organization 2008). We anticipate that moral distress will increase as these dynamics escalate. In all areas of practice (public health, homecare, acute care) nurses may be confronted increasingly with responsibility for providing care or responding to health needs when the prerequisites for health are not available, where marginalizing social processes such as stigma and discrimination impact opportunities for health, and health care resources and access to resources for health and health care dwindle. Such situations include poverty and the attendant issue of homelessness, in which individuals do not have access to nutrition or shelter adequate to support health. Racism and gender bias and other forms of stigma and discrimination, dynamics that also permeate the delivery of health care services, shape these inequities. In Canada, for example, such

dynamics have been demonstrated in relation to Aboriginal people (Bourassa et al. 2004; Browne 2007; Browne et al. 2011; Kubik et al. 2009), racialized immigrant groups (Henry et al. 2006; Jiwani 2000; Johnson et al. 2004) and people who use illicit drugs (Bungay et al. 2010; Pauly 2008a, b; Smye et al. 2011). Nurses will have to challenge such inequities and negotiate practice within the confines of ideological, political and economic systems that tend to blame, victimize and in some cases criminalize people who face constraints and limited choices in relation to health and wellbeing. In predominantly neo-liberal socio-political environments, nurses and other health care providers, whose professions are rooted in social justice, consequently will face increasing tensions and resultant moral distress. Manifest moral distress may, in turn, be individualized and health care providers seen as 'bleeding hearts' who need to toughen up and accept such distress as an occupational hazard.

We argue that analysis of socio-political and economic contexts in all future research is crucial to developing understandings of, and global responses to moral distress. Research and policy development must account for the dynamics of moral distress within particular contexts at the organizational, regional, national and international levels. Moral distress is not merely a problem of individuals but as Wendy Austin highlights, it is the canary in the coal mine that alerts us to broader contextual factors that impact the abilities of nurses and other health care providers to enact ethical practice in the best interests of those for whom they care. So, too are the solutions to moral distress located in the contexts of health and health care practice. Rather than offering local and individualized solutions such as critical incident stress debriefing, and helping health care providers to "manage better"; promising solutions lay in the creation of social contexts in which health is viewed as a right for all, and health care contexts in which health care is viewed as a right for all, with widespread understanding that social position and the conditions in which people live shape health and access to health care resources. Just as there are limits to individual agency in attaining health within adverse conditions, there are limits to ethical practice within adverse conditions that cannot be addressed at the level of the individual. This becomes even more prevalent if we look across international boundaries to the conditions in which nurses and other health care providers may face socio-political challenges that impact their ability to implement even basic care for patients. For example, nurses working in war zones and impoverished areas of the globe may not be able to complete their work because of lack of staff or resources; they may have to leave work early so as not violate curfews or place themselves at risk of harm (Harrowing and Mill 2010).

Conceptual Tensions

There has been varied attention to the role of context in the development of moral distress. In the papers presented in this special issue, there is a conceptual tension within understandings of moral distress regarding the extent to which moral distress and its causes are located within the individual or within contexts of practice. At one extreme, the causes of moral distress are seen as entirely contextual, with the

individual being absolved of responsibility; at the other extreme moral distress is anchored solely to the individual's ability to practice ethically. In this paper, we seek to propose an integration of attention to both individual and contextual perspectives.

We argue that an interaction of individual and structural factors is at play in the development and unfolding of moral distress. While there are many individual experiences of moral distress, we must look to root causes that operate within systems at the same time as we enhance our capacity as organizations and individuals to prevent and respond to moral distress. Here we draw attention to the culture of the professions that populate health care, the wider "health care culture" experienced by patients, families and health care professionals, and the wider socio-political cultures that are coextensive with health care. This has important implications for research, education and policy.

Previous research (see Pauly et al. in this issue) has attempted to examine associations between organizational context and individual experiences by examining organizational moral climate (e.g., the Hospital Ethical Climate Survey) in relation to individual moral distress measured using the Moral Distress Scale (MDS). Further work in this direction is required, extending beyond organizations to examine the relationship between moral distress and broader sociopolitical contexts. For example, a multi-country study of moral distress in contrasting socio-political contexts would permit examination of the relationship between the context, social and health inequities and levels of moral distress.

In the development of future research on moral distress, it is imperative that the theoretical frameworks chosen to underpin and guide such research be grounded in a conceptual understanding of moral distress that reflects both moral agency and structural relationships, and the interactions between the individual's experiences and the structural features. In this series, Lützén has proposed a relational framework for exploring the dynamics among various aspects of both individual and structural components that contribute to moral distress. In her framework, moral agency and the ability to enact moral agency are proposed as mediating moral stress and moral distressing situations within particular ethical climates. Moral stress highlights the importance of the way that ethical situations give rise to stress that lives in the body and is experienced emotionally. How is moral distress experienced both emotionally and physically? Such frameworks need to be made explicit and operationalized in future research if we are to engage an understanding of the context in the development and experience of moral distress in practice. Toward that goal, Hamric has proposed the development of research tools (e.g., Wocial's moral distress thermometer) that integrate organizational factors into assessment and understanding of moral distress. More methodological work is needed in relation to instrument development. Further such frameworks, and the measures and research based upon these frameworks are essential to policy discussions of moral distress at the organizational level. Such inquiry will help move beyond understanding moral distress solely as an individual experience for practitioners and students who need to either endure such distress or develop individual coping skills.

A question essential for health professional education is "how do we prepare new practitioners to recognize, respond and challenge structural factors rather than

simply learning to navigate these conditions?" In keeping with the emphasis on the relationship between individual moral agency and broader structural features, this question moves concern beyond "professional education" to propose examining broader systemic organizational ethics in ways that may expose particular professional practices, management practices, and organizational processes/customs for resolving ethical difference (or not) that can nurture or contribute to occasions of serious compromise and moral distress. Examples might include deception, non-disclosure or, in end-of-life cases, unilateral decision making.

One of the presenters at the Symposium, Dr. Shafik Dharamsi (Dharamsi, personal communication, September 2010), highlighted the problems of teaching empathy and compassion within the current context, and argued that without attention to the contextual factors that create a dissonance between stated professional values and actual behaviors, we are more likely "turning lambs into lions". Dissonance between the espoused and "hidden" curriculum encountered in the clinical experiences of new physicians, nurses, social workers and even ethicists must be acknowledged and addressed. In our symposium, participants recognized that concepts related to moral distress need to be included in the curriculum and inform the development of competencies and standards for beginning practitioners. However, we argue that beyond simply including moral distress, curricula must address this dissonance. New practitioners can be sensitized to "moral distress" but if what is modeled by attending physicians, nurses, social workers, supervisors, management and others, is in stark contrast to what was learned in the curriculum, new professionals will work to "fit in", creating tensions and fostering compromise, cynicism and further de-sensitization.

Definitional Tensions

The papers in this series all underscore the importance of critically evaluating and refining definitions of moral distress. We argue that moral distress must be defined as a *relational concept*. That is, moral distress must be seen as a phenomenon that is experienced by individuals, but shaped not only by the characteristics of each individual (e.g., moral character, values, beliefs), but also by the multiple contexts within which the individual is operating, including the immediate interpersonal context, the health care environment and the wider socio-political and cultural context.

Here we draw upon the papers in this issue, and the various bodies of literature we have reviewed throughout our programs of research to offer some thoughts about what moral distress is not; followed by parameters to be considered in a definition and conceptual framework of moral distress.

Moral distress is not…

1. The daily pressures or stress of work: There are natural daily pressures or stresses of work in any job but they do not necessarily constitute 'moral' distress.
2. Compassion fatigue or post-traumatic stress disorder (PTSD): These are situations commonly placed alongside moral distress, but arise from different

root causes (e.g., witnessing suffering) and have their own courses of action to address. Individuals may experience PTSD or compassion fatigue and moral distress simultaneously.

3. Burn-out: Burn-out easily becomes a medical diagnosis to be treated by time off work for rest. Burn-out can be caused by workplace difficulties such as continually working in overload. Burn-out may be experienced concurrently with moral distress.
4. An excuse to avoid work or avoid dealing with challenging situations: The organizational pressures to silence voices claiming moral distress as a concern may foster assumptions that expressing such concern is a way for health care practitioners to avoid the difficult work they are doing. Health care leaders who understand moral distress as an individual issue solely may interpret concerns related to moral distress as ways to avoid work or avoiding challenging situations. Such an individualized understanding and dismissal of concerns may camouflage ethical issues.
5. Disagreements amongst colleagues: Such disagreements may lead to conflict, but they are not always synonymous with moral distress. A disagreement with a colleague, for example, may not be experienced as a compromise but rather the expression of different value commitments.
6. A pathological diagnosis of the inadequacy of a health professional: Locating the locus of moral distress as an individual failing is misattribution, and ignores the influence of organizational structures on an individual's practice. When we see moral distress as just an "individual's problem" we pathologize the individual and our gaze shifts from a broad systemic lens to one that is narrowly focused on an individual who is somehow upset or "not coping". This deflection away from organizational and systemic factors can camouflage the unethical features of organizational life and can often perpetuate questionable practices.

Moral distress includes the following parameters.

1. Moral distress can be a solitary or communal experience.
2. Moral distress is characterized by a personal experience of serious moral compromise that often originates in broader systemic organizational practices and routines.
3. Moral distress can be experienced by all types of direct health care providers, as well as by people at all levels of the health care organizational hierarchy.
4. Moral distress threatens the identity and integrity of many who experience it because they believe they have either seriously compromised deeply held personal/professional value commitments, or they have allowed themselves to be compromised.
5. Moral distress is layered and complex.
6. Moral distress may be experienced emotionally, psychologically and/or physically.
7. Moral distress is a relational concept.
8. Moral distress when not addressed may lead to moral residue.

Webster and Baylis (2000)defined moral residue as "… that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised" (p. 218). Moral distress and subsequent moral residue may lead to desensitization and disengagement which in turn can lead to "moral silence, moral deafness and moral blindness." Drawing on the work of Bird, in particular, "*The Muted Conscience*" (2002), moral silence is defined as people being morally mute. That is, "…they do not recognizably communicate their moral concerns in settings where such communicating would be fitting" (p. 27). Webster noted that the "silence that often fills meeting spaces" in today's workplace environments may reflect unvoiced moral distress (Webster, personal communication, September 2010).

The categories of "silence", "deafness" and "blindness" may offer us a language and a "portal" or entry way, that will allow us to more fully understand and appreciate the complex human dynamics at work in a shared or group experience of moral distress in an organization. The questions we might have about the psychological complexities of moral distress experienced by individuals, seem to be only compounded when we explore this terrain in a more communal or systemic fashion—say, in the day-to-day life of a complex organization such as a hospital, long term care facility or community clinic. When we think about "silence" in a communal context such as a health care environment, does silence about an important matter or ethical concern reflect "support" of other colleagues or is it uncertainty or ambivalence? Is it fear? Is it exhaustion? Is it laziness? Is it prudence? Is it that others simply don't "see what you see"? Is it that others do "see what you see" but hold different value commitments? Is it the "path of least resistance"? Are some quite oblivious to the issues around them? Rather than too readily "bridge" or "link" or "map on" the individual experience of moral distress with what we might call a more "collective experience" of moral distress, further work must be done to tease apart these dynamics.

Moral Distress Further Defined

Jameton (1984) defined moral distress as arising "…when one knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). This has been taken up and understood as if health care providers do not pursue right courses of action. Yet, our own work (Varcoe et al. in press) indicates that nurses often do act and pursue right courses of action but are frequently not heard or silenced and their actions are dismissed. Hamric and colleagues point out that even when they are not heard, or their actions do not appear to have effect, nurses may continue to raise objections in morally distressing situations (Epstein and Hamric 2009; Hamric 2010). Kälvemark et al. (2004) nuanced Jameton's definition of moral distress to highlight this important aspect of moral distress, which arises when health care providers cannot preserve all of the interests and values at stake in situations where there is organizational dissonance between professional values and organizational norms and policies. In reflecting on Jameton's definition, Webster and Baylis suggested it was important to look not only at institutional constrains but also errors in judgment and/or patterns of personal behavior such as systemic avoidance. We suggest a further refinement to the concept of moral distress to account for social

political and contextual factors that limit the ability of health care providers to enact their professional and education standards in spite of repeated attempts. This is not simply individual failing or avoidance of responsibility, but an inability to *enact* standards in their practice in spite of attempts to do so as a consequence of the context including both institutional and broader socio-political contexts. In the face of such conditions, health care providers may withdraw, leave, or continue to voice concerns.

Building from Jameton, we propose that moral distress be defined in relation to influences beyond those that would be considered institutional to broader socio-political contexts, and not depend on the level of impossibility of action. Indeed, our recent work has suggested that nurses take repeated actions, with or without effect, in the face of moral distress (Varcoe et al. in press).Thus, we propose that moral distress is

> 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.

Such experiences of serious moral compromise and moral distress may actually clarify an individual's commitments and strengthen resolve, or these experiences may diminish a person on many levels to a point where she or he becomes increasingly ethically de-sensitized. In either circumstance it is important to note that the experience of compromise and moral distress can have a significant impact on both the individual and the workplace environment.

From Analysis to Praxis

Throughout the symposium and these papers, calls were unequivocal that it is time to move beyond theory and definitions toward action. What actions are required and where such actions should be taken depends on how the tensions described above are approached. To date most suggested actions have been aimed at individual practitioners through strengthening ethics education (e.g., Bell and Breslin 2008; Gutierrez 2005). In contrast, if a relational definition is used and context taken into account, then interventions toward lessening moral distress must address structures and systemic issues. Moral distress conceived in this way is a highly political concept; that is, moral distress is inherently about power and differences in power.

Rather than helplessness in the face of inequities, understanding moral distress as rooted in socio-political and institutional contexts points to directions for action. There is a need for increased understanding of the individual in relation to the institutional and broader societal context. For example, a particularly interesting area for future research might be to gain an understanding of whether or not nurses who engage in political advocacy and action have more or less moral distress.

Reflecting on Recommendations for Action

As a part of the moral distress symposium, recommendations for a "moral distress agenda for action" were identified through focus group discussions and included in

the final report (Pauly et al. 2010). Participants strongly recommended the development of a health care network on moral distress as a key strategy to facilitate movement and action in the four domains. Such a network could be virtual and would provide an important venue to communicate research findings, develop research priorities and undertake political action. To date, there are several ethics and nursing networks in which moral distress is no doubt an issue and area of concern. We strongly urge the specific development of a focus on moral distress within these networks and an increased emphasis in future nursing and health care conferences on moral distress to further the ideas presented here that arose from this first international symposium on moral distress.

At the symposium, recommendations were identified in relation to theory, education and practice, research and policy. One year later, in what follows we reflect on each of these areas and provide some conclusions regarding the future of a moral distress agenda for action. At the symposium, the need for a shared definition and language for talking about moral distress, distinguishing moral distress from related concepts such as compassion fatigue and vicarious trauma and the development of theoretical frameworks to explicate relationships between relevant concepts were identified as important. We believe that the papers in this issue contribute significantly to that discussion. Lützén's paper highlights proposed theoretical relationships between key concepts including moral stress, moral distress and ethical climate. Further conceptual analyses are required to distinguish and identify the relationships between PTSD, compassion fatigue, burn out and moral distress. In this paper, we draw together key conceptual features and elements that help to define moral distress. Addressing these key theoretical questions is fundamental to moving forward and taking action on moral distress.

Further, in this paper we have pushed to highlight the contexts of practice that shape the development and experiences of moral distress. In the symposium, recommendations related to education emphasized the development of resources and tools for educators, students and practitioners to enhance understanding, awareness and strategies for navigating moral distress. We think that the priority for educators at all levels is to move beyond strategies that support individuals, toward strategies that will foster understanding and improvement of the contexts in which moral distress arises. Symposium participants identified the need to undertake a review of policy and practice documents with a view to inclusion of moral distress as part of ethical practice guidelines. However, we extend that recommendation to suggest the need to better understand the relationship of social political and institutional contexts to individual experiences of moral distress rather than only to enhance individual capacity to respond to moral distress. Educational strategies must foster analysis of the importance of context in the development of moral distress and recognition of both individual and systemic responses.

The need to engage with all levels of policy in discussions about moral distress and the importance of getting moral distress on agendas at all levels was widely recognized by symposium participants. In fact, following the symposium, at least one participant took the symposium report to organizational leaders as a basis for discussion. At the symposium and through this series of papers, we encountered difficulties in pushing further in the development of a policy agenda. While it is

important to raise these issues, we believe that there needs to be a better understanding of moral distress as relational and structural concept in order to engage discussions of policy. Wendy Austin's paper as well as our own work brings to the fore the plight of health care providers and the demoralization that emerges in the absence of systemic responses.

Symposium participants recommended the need for synthesis of current research as well as better measurement tools and most importantly, research to develop and test interventions to address negative sequelae of moral distress. Without question, there is a need for additional research but not necessarily continuing in the directions set by previous scholars' important and pioneering work in moral distress. Hamric (see this issue) highlights important directions for future research. In particular, we underscore the need for a cross-national study to understand the relationship of moral distress and different socio-political contexts. Preliminary research has highlighted associations between moral distress and ethical climate but current measures of moral distress need to be examined and updated to reflect contextual factors that contribute to moral distress. This work will demand further interdisciplinary work—moral psychology may contribute to evolving conceptual clarity; sociology may contribute to evolving understanding of the cultures of professions and health care workplaces.

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