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The Standard Account of Moral Distress and Why We Should Keep It

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Abstract In the last three decades, considerable theoretical and empirical research has been undertaken on the topic of moral distress among health professionals. Understood as a psychological and emotional response to the experience of moral wrongdoing, there is evidence to suggest that—if unaddressed—it contributes to staff demoralization, desensitization and burnout and, ultimately, to lower standards of patient safety and quality of care. However, more recently, the concept of moral distress has been subjected to important criticisms. Specifically, some authors argue that the standard account of moral distress elucidated by Jameton (AWHONN's Clin Issues Perinat Women's Health 4(4):542–551, 1984) does not refer to a discrete phenomenon and/or that it is not sufficiently broad and that this makes measuring its prevalence among health professionals, and other groups of workers, difficult if not impossible. In this paper, we defend the standard account of moral distress. We understand it as a concept that draws attention to the social, political and contextual determinants of moral agency and brings the emotional landscape of the moral realm to the fore. Given the increasing pressure on health professionals worldwide to meet efficiency, financial and corporate targets and reported adverse effects of these for the quality and safety of patient care, we believe that further empirical research that deploys the standard account moral distress is timely and important.

Keywords Moral distress · Moral constraint · Nursing · Health professional · Moral emotion

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Introduction

The philosopher, Andrew Jameton, first deployed the term "moral distress" in 1984 in order to capture what he then perceived as an emerging feature of the professional role of nurses—that they were unable to act in a way that was consistent with their moral values and beliefs because of institutional obstacles. While empirical researchers initially described and analysed the experiences of moral distress among critical care nurses (Rodney 1988; Corley 1995), the intervening years have seen an increase in research based in a wide variety of settings including: paediatric care, psychiatry, gerontology, oncology and hematology (Hamric 2012; Oh and Gastmans 2013). Journals directed at medical as well as nursing professionals have also begun to include theoretical and empirical papers on moral distress, such as *The American Journal of Bioethics, Bioethics, Bioethical Inquiry, Hastings Center Report, Journal of Medical Ethics* and *HEC Forum*. The notion of moral distress has also received attention in the media, e.g., a *New York Times* article on moral distress, published in 2009 by Pauline Chen, elicited 299 comments on the blog, *Medicine and Moral Distress,* and most of these were posted in the first month after the initial article was published (Chen 2009; Parker-Pope 2009). In sum, research on moral distress now refers to a wide range of nursing professionals as well as other health professionals and allied workers, e.g., doctors, pharmacists, midwives, social workers and students. Qualitative and quantitative research with these various groups of health professionals indicates that moral distress negatively impacts the well-being of health professionals, staff burnout and retention as well as the quality and safety of patient care (Dodek et al. 2016; Hamric et al. 2012; Huffman and Rittenmeyer 2012; Lamiani et al. 2015; Oh and Gastmans 2013).

Alongside the growing body of empirical research on moral distress, increasing attention has also been paid to the way in which moral distress has been defined and understood. This paper engages primarily with those authors who have critically considered the way in which the concept of moral distress has been originally delineated and successively operationalized. Firstly, we describe and explain Jameton's original definition of moral distress and we briefly outline the way in which this standard definition has been deployed in empirical research. Secondly, we explain and respond to a key challenge that has recently been proposed in relation to Jameton's account of moral distress—that it should be more broadly defined. Finally, we recommend that Jameton's account of moral distress could be strengthened if greater attention were paid to the emotional dimension of the moral realm that we believe Jameton's account draws attention to.

The Standard Definition of Moral Distress

Jameton's now familiar definition of moral distress describes it as arising "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984, p. 6). His original account of moral distress focussed on the way in which institutional policies and

practices as well as co-workers can prevent nurses from acting in ways that they are convinced is morally appropriate—they are unable to do what they know to be the right thing. He later expanded the definition when he distinguished between "initial" and "reactive" distress:

> Initial distress involves the feeling of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values. Reactive distress is the distress that people feel when they do not act upon their initial distress (Jameton 1993, p. 544).

Here, Jameton explicitly refers to the psycho-emotional responses that may accompany the failure to act in a morally appropriate way. The following report of a nurse's experience of moral distress is a hybrid case drawn from the first piece of empirical research on moral distress that deploys Jameton's definition. It indicates that nurses face institutional obstacles and collegial resistance leading to moral wrong-doing and, ultimately to feelings of anxiety, self-doubt, helplessness, hurt and anger:

> I have to Do Things I Think are Wrong
>
> I was always taught to do as written. I have gone to the "powers that be" and complained. I have talked to the physician about it. Their response is to do nothing. Jobs are hard to come by … It's not like I could just quit, although I'd like to. And … I *like* nursing. I was thinking I might be wrong – that maybe I'm biased … What if I'm wrong? Maybe I didn't have the backbone to refuse … I'm really tired of that whole system … it hurts too much to have to spend a lot of time with those patients because you know you're helpless to change the situation for them … I think what it's done is make me decide to get out of nursing because I don't like being in a situation where I feel helpless or continually have to deal with situations where I have to do things I think are wrong (Wilkinson 1987/88, pp. 23–24).

In the three decades since Jameton first introduced it, his particular delineation of moral distress has, for the most part, been the standard definition deployed in the qualitative (Huffman and Rittenmeyer 2012), quantitative (Lamiani et al. 2015; Oh and Gastmans 2013), and argument-based literature (McCarthy and Gastmans 2015). This research has generally addressed the following dimensions of moral distress:

(1) clinical settings (e.g., critical care) and clinical circumstances (e.g., aggressive interventions in conditions of medical futility or at the end of life) that give rise to moral distress (Corley 1995; Lamiani et al. 2015);
(2) the nature of external constraints (e.g., staff shortages, institutional policies and asymmetries of power and authority) and internal constraints (e.g., lack of resolve and ethical incompetence) that prompt individuals to act, or desist from acting, in a morally appropriate way (Varcoe et al. 2012; Wilkinson 1987/88);

(3) the normative meaning of moral distress involving moral judgement, moral agency, conscience, moral, personal and professional integrity (McCarthy and Gastmans 2015);
(4) the short and long term psychological, emotional and physiological effects on individuals that follow on their failure to do what they believe to be the morally right thing (Epstein and Hamric 2009; Webster and Bayliss 2000);
(5) the (usually negative) impact on patient care, on the personal and professional lives of health professionals and their retention in practice (Austin 2012; Dodek et al. 2016; Pauly et al. 2012).

Definitional Challenges

Despite the general consensus as to the phenomenon of moral distress and its relevant features, some authors have also found fault with Jameton's conceptualization of moral distress, and the empirical research studies that have operationalized it (Fourie 2015; Hanna 2004; Johnstone and Hutchinson 2015; Morley et al. 2017; McCarthy and Deady 2008; Repenshek 2009). One worry is that the term *moral distress* does not pick out a discrete phenomenon or set of phenomena; in essence, that it is not possible to carve the moral realm up at the joints so that some experiences can be distinguished as genuine expressions of moral distress (Johnstone and Hutchinson 2015; McCarthy and Deady 2008). Critics point to the absence of any agreement on the key features of the concept and, in turn, the difficulties involved in devising tools to measure it adequately (Campbell et al. 2016; Fourie 2015; Johnstone and Hutchinson 2015; Morley et al. 2017; McCarthy and Deady 2008).

In a recent article, Carina Fourie goes to the heart of the problem, when she claims that Jameton's definition of moral distress is unsatisfactory because it refers both to the cause of distress as well as to the distress itself:

> Jameton's discussion prompts the question – what kind of phenomenon is moral distress then? Is it a psychological response to an ethical phenomenon? Or is it the phenomenon that prompts the response? Another way of asking this is, is it meant to be an outcome or the possible cause of that outcome? Although Jameton does not make this clear, his discussion of moral distress implies that it is both (Fourie 2015, p. 93).

On Fourie's view, Jameton understands moral distress as a "compound phenomenon" which includes both the *aetiology* and the *symptoms* of moral distress: the ethical cause (e.g., institutional requirements that constrain moral agency) and the psychological states of distress that may follow when a person feels compelled to act against their core moral beliefs and values. As Fourie suggests, "combining" the ethically relevant cause—institutional constraints—with psychological responses is confusing and muddies the waters for empirical researchers. Moreover, for Fourie, positing institutional constraint as a necessary condition of moral distress, is needlessly narrow. It implies that other morally relevant experiences are

not counted as legitimate causes of moral distress. Fourie argues that there are a range of "morally relevant" experiences of distress in addition to those caused by moral constraint such as those that may be prompted by moral conflict and uncertainty about how to act in a morally appropriate way. In effect, she rejects the distinction that Jameton makes between situations involving ethical dilemmas or conflicts and situations involving moral constraint and moral distress. Her revised definition posits moral distress as a single phenomenon that is triggered by a range of possible causes:

> Moral distress is a psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both (Fourie 2015, p. 97).

In a similar way, a recent target article in *The American Journal of Bioethics* by Campbell et al. (2016) takes the reader through six cases involving ethical challenges that the authors suggest give rise to a kind of moral distress that is not captured by Jameton's definition. They describe them as "a wider range of cases that can sensibly be framed as moral distress" (Campbell et al. 2016, p. 2). In brief, these cases relate to situations involving moral uncertainty, ethical dilemmas, moral bad luck as well as the moral constraint that Jameton pays attention to and are claimed to give rise to different kinds of moral distress such as mild and delayed distress. They argue that the definition of moral distress should be broadened so that it covers these scenarios:

> 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 (Campbell et al. 2016, p. 6).

However, we suggest that any broadening of the causes of moral distress collapses the very important distinction, between situations involving ethical dilemmas where health professionals must choose between established but conflicting ethical principles such as autonomy and best interests, and those involving ethical constraints, that Jameton was anxious to make. Critically, for Jameton, the morally relevant cause of moral distress is any situation involving the constraint of moral agency, whereas the morally relevant cause of moral puzzlement and/or uncertainty is being in situations involving moral dilemmas (Jameton 1984; 1993). In contrast to situations of moral distress, moral dilemmas do not hinder (or impede), but challenge moral agency until a morally preferable option is determined. Granted, Jameton's definition conflating cause and response has led to some confusion. However, it is important to retain his distinction between the cause(s) of puzzlement and uncertainty and the cause(s) of moral distress. There might well be situations that give rise to both—a person might feel uncertain as to how to respond to competing moral obligations that an ethical dilemma gives rise to *and* they may also experience moral distress if they perceive themselves to be compelled to opt for one solution to the moral dilemma rather than the other. However, Jameton's point is that feeling compelled or constrained is a necessary condition of moral distress. By contrast, feeling uncertain or hesitating about ethical principles and values in a given situation is not. For Jameton, situations involving moral constraint and moral

distress prompt questions about moral responsibility and agency that moral agents *cannot* evade more than questions about balancing principles or values. In such situations, we might ask, e.g.,

> What is possible for me to do?
> What is the extent of my responsibility?
> What personal risks are health professionals obligated to take for patients?
>
> [T]o what extent should I share the blame? [for shared decisions that lead to harm?] (Jameton 1993, p. 545).

Jameton is mindful of the way in which moral responsibility can be understood. As he puts it, "The moral questions of responsibility in a bureaucratic setting are central to ethics, so moral distress deserves close attention" (Jameton 1993, p. 543). An exemplary application of this perspective comes from Mary Corley, one of the early empirical researchers to operationalize Jameton's account of moral distress and assess its prevalence in nursing practice. Corley saw her research as an antidote to what she viewed was the overly attentive gaze of traditional ethics approaches on the process of ethical decision making without due regard to the institutional context within which ethical decisions are made (Corley 2002).

Unlike Fourie and Campbell et al., we believe that it is important to retain the narrow focus of Jameton's definition; i.e., that the term "moral distress" should be applied to the psycho-emotional-physiological responses of an individual who feels unable to act in a way that they believe to be consistent with deeply held ethical values, principles or moral commitments because of institutional or other constraints. In situations involving moral distress, the moral agent believes that moral norms are being violated and, at the same time, feels unable to act otherwise. In sum, both "belief in moral wrongdoing" and "constraint" are necessary conditions of moral distress. Waiving either one of these two conditions—and thereby "broadening" the definition—fails to acknowledge the normative and epistemological difference between, on the one hand, a *constrained* moral agency (the moral agent holds a belief about what the right thing to do is but feels unable to do it) and, on the other hand, a *challenged* moral agency (the moral agent does not hold a belief about what the right thing to do is because they are unsure or conflicted). Admittedly, in the moral realm of clinical practice, it may not always be easy to clearly distinguish one from the other. Here, ethics consultation has been proven to support multi-disciplinary teams in this work of clarification and effective negotiation. In their rejection of Campbell et al.'s proposal to broaden the concept of moral distress, Epstein et al. (2016) draw on their experience as ethics and moral distress consultants to point out how a "broadened" concept of moral distress is also not as readily amenable to operationalization, empirical interrogation and possible resolution. They suggest that distinguishing the experiences of moral distress and compromised integrity from other kinds of moral challenges among health professionals prompts leaders and organisations to adopt different strategies for repair and resolution. In turn, they suggest that interventions to address moral

distress among health professionals are likelier to be more successful at measuring its impact on patient outcomes if its original narrower definition is retained.

This albeit "narrow" view gets at a particular feature of the lived experience of many health professionals and it is a particular strength of Jameton's account of moral distress that it brings this feature to the fore. Fourie's and Campbell et al.'s definitions of moral distress, on the other hand, obfuscate precisely this experience. Other authors, who take a similar approach to Fourie and Campbell et al. such as Morreim's earlier target article in *The American Journal of Bioethics* (Morreim 2015) and several of the commentaries on it (Shelton and White 2015; Spike 2015), also cast moral distress in very broad terms, e.g., "Moral distress is best understood as a clash of 'bedrock' values and/or bedrock beliefs" (Morreim 2015, p. 39). Like Fourie, these authors are concerned about moral distress among health professionals, however, they pay little attention to the way in which institutional and/or sociopolitical structures enable or undermine their moral agency. There is a danger then, that unless theoretical and empirical research pays explicit attention to the role of these external constraints, they will be rendered invisible and the opportunity for research on moral distress to identify "morally uninhabitable workplaces in which incoherent understandings and unsustainable practices exist" would be lost (Peter and Liaschenko 2013, p. 339).

Moral Distress and Moral Emotions

We agree with Fourie, in the interests of clarity, that we need to distinguish between the phenomenon of moral constraint from the emotions that it prompts. The standard view of moral distress that we want to retain represents the emotional suffering of health professionals who feel compelled to compromise their moral integrity in clinical contexts and in response to institutional and other external constraints that manifestly hinder moral agency. By describing moral distress in this way, we do not contend that situations involving moral uncertainty or moral dilemmas cannot be stressful also. However, such stress may manifest itself quite differently and should be carefully addressed by ethics educators in the clinical and educational context, prompt further self-reflection, dialogue and interprofessional learning with the aim of deepening understanding of the situation.

The extant research on moral distress generally links it with emotions, such as guilt, regret, shame and anger, and to related feelings such as frustration and anxiety as well as physiological responses, such as crying and sleeplessness (Huffman and Rittenmeyer 2012; McCarthy and Gastmans 2015; Oh and Gastmans 2013; Wilkinson 1987/88). It might be helpful to explicitly describe these emotions as "moral emotions" as they have been associated with moral failure since they were first mooted by Aristotle in his account of *akrasia*, or "weakness of will" (Aristotle 1941 [c. 340 BCE]). The idea that emotions such as guilt and shame may accompany moral decision making has also been articulated by several more contemporary philosophers (Greenspan 1995; Taylor 1985; Williams 1993). Williams, for example, links these emotions with what he calls *anangkē*, or

"constraint exercised by the power of others" (1993, p. 45), a view that bears more than a passing resemblance to the standard account of moral distress.

The literature on moral emotions is vast and it is beyond the scope of this paper to engage with it in any meaningful way. However, it is important to note the link that philosophers and empirical researchers make between moral emotions and moral judgement and action. As early as 1759, for example, Adam Smith suggested that moral emotions, such as guilt and shame, motivate people to pay more attention to other people's interests (Smith 1982). While the individual who experiences these feelings may find them uncomfortable, research indicates that they function to stimulate prosocial behaviours (de Hooge et al. 2008). Haidt (2003) defines moral emotions as "other-centered" and as: "those emotions that are linked to the interests or welfare either of society as a whole or at least of persons other than the judge or agent" (Haidt 2003, p. 852). His work also lends weight to the claim that particular moral emotions are elicited by specific situations such as witnessing unnecessary suffering or the unjust actions of colleagues and that, in turn, these emotions can prompt both reparative and avoidance responses. Research on moral distress also supports this view. Exploring what they call, "moral stress" Lützén et al. suggest that it can be understood as an "energizing factor(s) resulting in a satisfactory feeling of accomplishment of professional goals" (Lützén et al. 2003, p. 315). The experience of moral distress makes individuals more aware and reflective about the limits put to their moral agency by external constraints, but it also raises the awareness about, their own moral, spiritual and philosophical beliefs and it can strengthen their resolve to do better next time (Corley et al. 2005; Hamric et al. 2012; Hanna 2004; Lützén et al. 2003).

Conclusion

The standard view of moral distress, supports and foregrounds the role of moral emotions in moral decision-making and signals the variety of ways in which moral agency can be enabled or limited in institutional settings and socio-cultural contexts. The definition of moral distress by Jameton may be imperfect, but, it seems to us to be a good "fit" with the working lives of today's health professionals, indeed many workers, whose moral agency is increasingly hostage to the exigencies of economic efficiencies, corporate management structures and limited resources. No doubt many people are successful in negotiating the challenges of contemporary healthcare systems with their moral integrity intact. However, it seems clear that the moral terrain they must traverse is becoming increasingly more treacherous. This necessitates broadening the theoretical and empirical remit of traditional medical/healthcare ethics and calls for an explicit integration of accounts of moral distress in ethical frameworks and policies. In addition, professional bodies should provide through their regulations and codes orientative knowledge that support professionals in responding to the kind of constraints that lead to moral distress and in restoring moral agency and equanimity in situations where moral integrity and wellbeing is threatened or lost (see, for example, the Canadian Nursing Association 2017). Including concepts such as moral distress and developing professional,

educational and institutional strategies and policies that are socially, emotionally and politically more intelligent and informed would make acting ethically more achievable and the personal cost of doing so to the well-being of health professionals and the patients in their care more bearable.

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