Moral Distress: A Different Perspective

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Over the past three decades, a literature has emerged identifying, defining, and addressing the phenomenon of moral distress in health care professionals. Since the concept was originated in 1984, many writers have discussed moral distress as a nursing ethics issue, or more broadly as a clinical ethics issue, but there has not been literature addressing moral distress in health care professionals as an organizational ethics issue. In this paper, I will begin the process of doing precisely that.

First, I will discuss the nature of moral distress and why it ought to be considered an organizational ethics issue. Second, I will review several ways health care organizations currently address moral distress and why they are ethically insufficient. Third, I will propose a different way to think about moral distress that is based on the moral equality and moral acquaintanceship of health care professionals. And, finally, I will offer a few practical recommendations for ways health care organizations can address moral distress.

There is no one hard and firm, standardized definition of moral distress in the literature of the health care professions.[1] However, for the purposes of this paper, I will define moral distress as a situation in which "you believe you know the ethically appropriate action to take, but you are unable to act upon it" and, therefore, "you act or refrain from acting in a manner contrary to your personal and professional values, which undermines your integrity and authenticity."[2] This occurs most frequently for reasons related to accepted organizational structure, social roles, and power dynamics. Also important to keep in mind is that, as contemporary medical care is most often team care, moral distress can occur when the medical team, or the authoritative party in charge of the team (say, the attending physician) acts in a way that one of its members believes to be ethically inappropriate, and that person does not have the power to effectively raise objections to the decision.

Though the literature on moral distress grew out of, and continues to primarily focus on, moral distress in nursing, I choose to look at the phenomenon across the health care professions, given that the empirical data show moral distress affects "nurses, pharmacists, social workers, physicians, health care managers,"[3] psychologists[4] and psychiatrists.[5] In other words, moral distress occurs in all corners of the health care professions and wherever caregivers provide professional care together. Consequently, it is necessary

to broaden the study of moral distress beyond nursing.

There is no doubt that moral distress is an important clinical issue in health care, but I want to argue that it should also be seen as an organizational ethics issue. The effects of moral distress on health care professionals are diverse and damaging, affecting not only the individual with symptoms like "depression, nightmares, headaches and feelings of worthlessness,"[6] but also the institution. "Moral distress has implications for satisfaction, recruitment and retention of health care providers and implications for the delivery of safe and competent quality care."[7] Ultimately, unmitigated moral distress leads to professional burnout and, at times, departure from the profession altogether. In addition, given that contemporary medical care is necessarily team care, moral distress can cause rifts in team cohesiveness, especially when the distress situations arise due to differences in ethical judgments among team members. These effects are a direct affront to the mission undertaken by health care organizations, in that it conflicts with the two main priorities of such organizations: the health of the patient, and professional expertise as the basis of decisions in clinical matters.[8]

What is Currently Being Done by Health Care Organizations

Though I believe that they are ethically insufficient, some proposals for reducing or alleviating moral distress among health care professionals can be found in the literature, and even some examples of

actual hospital policy. For example, we could interpret unilateral DNAR orders to be a hospital's attempt to provide institutional backing for the decision of a medical team to not act in a potentially morally distressing way by attempting resuscitation on a medically untenable patient. Another proposed institutional response comes from Judith Daar,[9] which she calls a "treatment evaluation board", or TEB. The TEB would be used as a forum in which physicians could: 1) discuss their disagreements over the course of treatment requested by patients, 2) determine how to meet the needs of the patient, and 3) decide how to transfer the patient to another physician or hospital, as needed.[10] While I agree that at least the first two tasks that Daar assigns to her TEB are potentially useful steps for resolving moral distress (though I will explain later why they are not ideal), Daar's proposal includes a recommendation for how the TEB is to be composed. This recommendation is troublesome. Daar states, "Ideally, a TEB should be composed of two members from the full-time medical staff, one member who represents the hospital administration (this member should serve as the chair of the board), and one member who is a hospital social worker."[11] Note, however, that *not* included on this board is the health care professional that is experiencing the moral distress—not even as an ad hoc invitee. Instead, the situation is handled hierarchically—it is handed up to hospital administration to be dealt with via the TEB. This seems to be the wrong approach to resolving moral distress. It takes away the voice of, and the proper

share of the decision making from, the morally distressed person.

Equality in Moral Distress

I would like to propose an alternative approach. In order to deal properly with moral distress, procedures that emphasize and support the moral equality of health care professionals are essential and ought to replace hierarchically based responses. I believe that no one health care provider is more of an expert on the individual experience of moral distress than another, and this means that all health care professionals are to be viewed as equally qualified to contribute to the resolution of morally distressing situations. Moreover, the experience of moral distress carries equal ethical weight for whomever it affects, and for this reason also any response to such distress must recognize all parties involved as moral peers, as opposed to subordinates negotiating with superiors on the organizational chart. In other words, there is something seriously wrong with an organizational solution to moral distress if a superior is tasked with solving a subordinate's personal experience of moral distress.

The experience of moral distress is a personal, individual, and, in important ways, a unique experience – even when several people are distressed at the same set of events. Taking participation in the resolution of a morally distressing situation away from those experiencing the distress marginalizes their experience of the situation in a way that is not ethically appropriate, given that the morally distressed person is feeling the

distress in a potentially unique way. Organizationally speaking, one's superior (or a TEB or a hospital policy) can neither fully understand nor completely fix one's experience of moral distress without one's being engaged as a full and equal collaborator in addressing it. Furthermore, even if only one health care professional is experiencing distress in a given situation, it is in the nature of moral inquiry and reflection that it is accessible to all the health care professionals involved and all are capable of moral reasoning and therefore of contributing as moral equals to the discussion. In addition, given that differing ethical judgments among team members may be the catalyst for moral distress within the team, all those team members involved in the case are causally or contextually related to the moral distress experience, and thus have a contribution to make to discussing it and should participate in its resolution.

I am arguing, therefore, that all health care professionals have the ability to discuss moral distress experiences as equals with important contributions to make toward resolution of distress situations. To support this, it is necessary to understand the kind of moral framework in which such a discussion and resolution by the group of moral equals can occur. Thus, in addition to moral equality, I also want to suggest that health care professionals already have a moral framework within which to express themselves as moral equals in their efforts to address situations of moral distress.

Among health care professionals there is, I maintain, a mutually agreed-upon (to

some extent explicitly, but also to a great degree tacitly) "common moral framework" within which health care professionals routinely operate.[12] This is a "thin" moral framework because it admits of many kinds of variation of moral views and standards from profession to profession, institution to institution, and person to person. But this thin common moral framework is "thick enough" to do two things. First, it delineates what we mean when we discuss "reasonable" experiences of moral distress that an ethically serious health care organization would want to resolve, even when the experience itself is, as shown above, variable and subjective in an important sense. Second, because this much of a moral framework is common to all health care professionals, it can provide the means for creating a peer-to-peer non-hierarchical forum in which to discuss morally distressing situations. By this, I mean that because the assumption is that all health care professionals are in basic (though at times, *very* loose) agreement about what is meant by ethical practice – due, for example, to similarities in training and professionally assumed moral commitments – then in any discussion of a moral distress situation it is reasonable to accept as a starting point that each participant is equipped with a health care professional's moral compass that is, very broadly speaking, the same as everyone else's in the conversation.

My defense of the validity of this notion will rest on what I will call a "professional common morality." The starting point from which I will build my discussion of this framework is Tom Beauchamp's and James Childress' notion of "common morality", though they use the phrase more broadly than I do.[13] As the authors state, "All persons who are serious about living a moral life already grasp the core dimensions of morality. They know not to lie, not to steal property, to keep promises, to respect the rights of others, not to kill or cause harm to innocent persons, and the like…Because we are already convinced about such matters, the literature of ethics does not debate them. Such debate would be a waste of time."[14] I think there is something intuitively correct in what they say, although it is a tougher sell to then justify the claim that this common morality gives us four principles from which to begin medical ethical deliberation. The point is, however, that at the very least broad agreement exists amongst "morally serious" people regarding some paradigm issues.

Turning back to professions specifically, by the very nature of what it means to be a professional (as opposed to, say, a member of a trade), those who become professionals are obligated to be "morally serious" about their profession. This means that upon entering a profession, the newly-minted professional is expected to take up certain moral obligations, a commitment often sworn symbolically by oath. Though these professional moral obligations may be vaguely articulated or blandly stated in standard codes, they are understood to be, and expected to be, substantive when practiced. This much common understanding about professional commitments is characteristic of the professions in general. When we focus more narrowly on the health care

professions, I argue that the moral obligations undertaken by health care professionals provide even more of a common moral framework – though still a thin one rather than anything more than that – which identifies patterns of acceptable health care practice or behavior; and it is because of this common moral framework that calling a stressful situation an instance of **moral** distress makes sense in the first place. Thus, we cannot justifiably exclude a particular health care professional from the discussion or resolution of a moral distress situation by claiming he or she doesn't have the ethical background to be involved in it. For all health professionals have this basic grounding in what I am calling a "thin" but genuine "common moral framework."

It should be noted that I am not claiming that all health care professionals share the exact same set of ethical commitments. For example, bioethics literature traditionally states that doctors have healing as a primary obligation (with different specialties even having differing notions of what that means), while nurses have caring as their primary obligation. However, if we focus on a notion of a "thin" degree of mutual understanding, then I claim that all health care professionals are committed to a set of overlapping convictions that include the aforementioned healing and caring, among other various moral concepts that are a part of the common moral framework. A person from one health care profession could be understood by a person from another health care profession when using these concepts,

even if their rank order differs from profession to profession. Other obligations, then, that might be offered for this shared moral framework might include such things as respect for autonomous decision-making, biological health, avoidance of harm, equitable use of resources, promotion of patient well-being, compassion, empathy, and knowledge of and expertise in one's specialty. Clearly, this is not an exhaustive list, but it stands to reason that any one of the above obligations could be understood in a "thin" sense by all health care professionals.

Supporting This Equality-Based Approach

In order to explain this idea of a "thin" but genuine common moral framework for health care professionals, I want to summarize two different strains of philosophical thought that support it. The first builds on a proposal found initially in H. Tristam Engelhardt, Jr.'s, *The Foundations of Bioethics*,[15] and further developed by Kevin Wm. Wildes. The second, which I draw from Jürgen Habermas' theory of discourse ethics will lead us to a description of the kind of forum in which what I will be calling "moral acquaintances" can work together to address their moral distress.

Engelhardt's project in *The Foundations of Bioethics* is to find a viable health care ethic given his declaration that there is not, and cannot be, a content-full common morality in this world because of its multitude of ethical viewpoints and lack of a universally agreed-upon moral

authority. There is simply not enough moral agreement, he holds, for us who inhabit this world to be "moral friends" who share common ethical commitments or moral authorities. Instead, he says, we are necessarily "moral strangers" who lack those commitments and authoritative ethical judges.

Obviously, there is an important difference between Engelhardt's concern for a lack of a content-full morality and my belief that health care professionals are committed to a common moral framework included in their professional obligations. For this shared framework precludes them from continuing to be moral strangers with one another in Engelhardt's sense, as the common moral framework alluded to above ensures that there is an overlapping conception of ethical practice (though perhaps a thin one) among them as health care professionals. Health care professionals do not start from a "moral square one", as it were, and thus we need not be stuck with a *content-less* procedural morality. Certainly, though, it does not follow that health care professionals must be moral friends, as not all moral content can (or necessarily should) be shared by all health care professionals. Here, Kevin Wm. Wildes' theory of moral acquaintanceship,[16] can be helpful because it provides a fuller conceptual basis for describing the kind of forum that is needed for health care professionals to resolve instances of moral distress.

Wildes seeks to find middle ground between the distaste of moral relativism that comes with accepting radical

pluralism as a fact, and the lack of moral choice that comes with enforcing a single ethical system on all people. Believing that Engelhardt's polarized labels of moral friends and moral strangers are not sufficiently comprehensive, Wildes introduces the term "moral acquaintances" to fill in the gap. "Moral acquaintances" exist when "the parties involved understand another's moral world and share it in part."[17] Wildes believes it is this vision of acquaintanceship that is most often at work in secular bioethics. It is why there is often consensus when it comes to basic ethical principles about health care and why even wildly divergent viewpoints can be discussed in a common bioethical language. Thus, Wildes argues, while "moral friends may agree strongly on content; moral strangers may be satisfied with procedural agreements; and moral acquaintances may develop limited, overlapping, substantive, and procedural agreements."[18]

Given Wildes' description of these categories, I believe that health care professionals ought to be considered moral acquaintances. Like Wildes, I maintain that moral acquaintances share *part* of each other's ethical world, namely, the common professional moral obligations I have discussed. Even if these shared obligations are broad and thin, health care professionals understand that their colleagues have also, by the very nature of professionalism, adopted these same professional obligations. They will often understand the obligations a little differently, and might have differing moral backgrounds or personal ethics. But

they also know that important parts of their moral worlds are intertwined because they are health care professionals together. As moral acquaintances, they have enough overlapping training and language that, even when shared answers to ethical questions have not been identified, the participants in the discussion at the very least ought to have understood each other within the framework professionalism creates. They can couch their explanations in terms of adherence to obligations and in a language that is shared, though not necessarily in terms of conformity to a deep moral foundation.

A Practical Organizational Proposal

I turn now to some insights from Jürgen Habermas' discourse ethics that can contribute to some practical solutions. Some of the theoretical underpinnings of Habermas' work can, in light of the groundwork I have laid out, act as signposts for a practical solution to moral distress in a health care organization. This is due to the fact there are some important parallels between Habermas' discourse ethics and Wildes' moral acquaintanceship.

First, Habermas insists that all affected parties in a moral conflict have an equal chance to hear and be heard; the equality of health care professionals in moral distress situations demands this as well. Second, for Habermas, true consensus is reached through real dialogue among affected subjects; this avoids the problems presented by a hierarchical response to moral distress (including the distressed party being denied a say in the resolution

process, or the inability to have a constructive, real dialogue regarding the situation before it is taken over by an organizational entity removed from the conflict at hand, which makes the discussion theoretical rather than practical). Third, Habermas does not ask for a deep moral bond between parties; he seems to realize that understanding the other's moral world and sharing a part of it is enough to negotiate a consensus under the rules of discourse ethics.

In this way, Habermas provides what could be useful guidelines for addressing situations of moral distress. A resolution would be considered reached when all affected parties are included in the discussion, and though individual interests will have to be modified to be harmonious with other individuals' interests, the process itself would be judged as fair, and the outcome judged as one mutually agreed-upon by all parties as being, minimally, an *acceptable* solution. This is because all parties will have heard and been heard, and, ideally, understand and be understood, even if agreement on every aspect of the relevant moral question is out of reach.

Given the above, I propose, in no particular order of importance, several avenues that a health care organization might pursue in order to address moral distress. First, the organization might pursue a moral distress intervention process in which the focus is on procedural facilitation. Second, the organization could establish a body focused on uncovering the systemic causes of moral distress and providing

educational opportunities to health care professionals. Finally, the organization should work toward the creation of an ethical workplace climate with an emphasis on a non-hierarchical moral culture.

Given the inadequacy of a hierarchical response to moral distress, the equality of health care professionals who all share a thin common morality, and the Habermasian forum in which moral acquaintances can meet and engage in dialogue, it seems clear that neither a clinical ethicist nor an ethics committee ought to be granted power to arbitrate resolutions to moral distress. Rather, the ethicist(s) called to the moral distress situation ought to be charged with bringing about the circumstances in which the participants are treated as equals, given a chance to speak openly and have the opportunity to both understand, and be understood by, all other parties in their articulation of their distress. My own recommendation would be for the organization to employ a full-time ethicist that is known to have autonomy from the organization itself, perhaps analogous to how a newspaper ombudsman is employed by, but editorially separate from, his or her employer. I also advocate against an ad-hoc committee whose independence from the institution may be less clear. I believe that an autonomous ethicist acting as facilitator for discussion would most likely alleviate fears of the organization's sending a committee to "fix" the problem, which in turn removes the worry of a possibly hierarchical response (especially if the cause of moral distress is institutionally-based).

Another recommendation is that health care organizations set up a standing body to study the situations that cause moral distress in order to better understand them, and provide educational opportunities on how to respond to them (or eliminate them when possible). Root-cause analyses of morally distressing situations, as explained by Rushton, could be a way to achieve this that would fall under the purview of the appointed body. Such a body could, as Rushton explains, "use a systems analysis…to explore the systems that have contributed to moral distress. Root cause analysis is a process for identifying what, how, and why an event happened in order to prevent its reoccurrence. Using a neutral process, [the analytic body would] identify interpersonal factors, interdisciplinary dynamics, policies, or practices within the system. This type of process can lead to documentation of institutional constraints that lead to moral distress and identify workable solutions."[19] This body could compile the ethicist notes/reports of moral distress consultations in order to perform such an analysis, and then create educational programs for health care professionals on how to resolve cases of moral distress. Ideally, this would be empowering to health care professionals, as opposed to reinforcing hierarchies—the organization would have to take great care to ensure that health care professionals understand that moral distress resolution can be achieved without "going up the ladder," while still being the source of education.

Of course, it is not a stretch of the imagination to picture an attending

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physician or someone else with decision making authority within the institution being uninterested in moral distress education, or refusing to join in moral distress discussions, whether due to perceived time, autonomy, authority, or patterns of practice constraints. The question is how to bring such individuals on board with these institutional changes.

A third recommendation, then, is the creation of an ethical climate in the health care organization. Also known in the business ethics literature as "moral culture," the goal here would be to create a workplace in which any morally distressed individual would feel—and be correct in feeling—that her concerns were valued and addressed by an organization that is legitimately focused on creating a non-threatening, equality-based atmosphere in order for its employees to be able to morally thrive. Given the above discussion, an ethical climate alleviating moral distress would be one in which: 1) those experiencing distress see themselves as being heard and their distress as being taken seriously by their peers and a supportive administration;[20, 21] 2) the existence of organizational mission discernment and a mission statement to match;[22, 23] 3) open communication strategies;[24, 25] and 4) as noted above, moral distress education. Such an ethical climate would hopefully be one in which any health care professional experiencing moral distress would feel comfortable asking to have it addressed, knowing that the organization had created an environment conducive to doing so, based on the background of equality of health care professionals, moral

acquaintanceship, and discourse ethics that I have discussed.

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[1] Bernadette M. Pauly, Colleen Varcoe, and Jan Storch, "Framing the Issues: Moral Distress in Health Care," *HEC Forum*, 24(1) (2012): 1-11.

[2] American Association of Critical-Care Nurses (AACCN) Ethics Work Group, "The 4A's to Rise above Moral Distress," (N.P: n.p.: 2004). Accessed 8/19/11. http://www.aacn.org/WD/Practice/Docs/4As_to_Rise_Above_Moral_Distress.pdf, 1.

[3] Pauly et al. 2012, 2.

[4] Wendy Austin, Marlene Rankel, Leon Kagan, Vangie Bergum, and Gillian Lemermeyer, "To Stay or to Go, to Speak or Stay Silent, to Act or Not to Act: Moral Distress as Experienced by Psychologists," *Ethics and Behavior*, 15(3) (2005): 197-212.

[5] Wendy Austin, Marlene Rankel, Leon Kagan, and Vangie Bergum, "The Balancing Act: Psychiatrists' Experience of Moral Distress," *Medicine, Health Care and Philosophy* 11(1) (2008): 89-97.

[6] Sofia Kälvermark, Anna T. Höglund, Mats G. Hansson, Peter Westerholm, and Bengt Arnetz, "Living with Conflicts-Ethical Dilemmas and Moral Distress in the Health Care System," *Social Science & Medicine* 58(6) (2004): 1075-84, 1077.

[7] Pauly et al. 2012, 1.

[8] These are the two most important priorities of health care organizations according to: David Ozar, Jessica Berg, Patricia H. Werhane, Linda Emanuel, and the AMA Working Group on the Ethics of Healthcare Organizations, "Organizational Ethics in Health Care: Toward a Model for Ethical Decision Making by Provider Organizations," (Chicago: American Medical Association: 2001), 9-11.

[9] Judith F. Daar, "A Clash at the Bedside: Patient Autonomy vs. a Physician's Professional Conscience," *Hastings Law Journal* 44(6) (1993): 1241-89.

[10] Daar 1993, 1285.

[11] Daar 1993, 1285-86.

[12] This is not a "common moral framework" in any strong or "thick" sense. I am decidedly not claiming that this framework is THE answer to all moral quandaries. This is a looser shared

understanding, based on the shared moral obligations of health care professionals. In fact, "common moral framework" may not be the most exact term—if a different, more explicative term can be thought of, it will be used. One possibility is "shared convictions". In addition to removing the objection that health care professionals do not, in fact, explicitly use a moral framework, this phrase implies that health care professionals are imbued with the same convictions about their role in health care, for example, respecting patient autonomy, healing the sick when possible, providing comfort, and so forth.

[13] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics: Fifth Edition* (New York: Oxford University Press, 2001).

[14] Beauchamp and Childress 2001, 3.

[15] H. Tristam Engelhardt, Jr. *The Foundations of Bioethics: Second Edition* (New York: Oxford University Press, 1996).

[16] Kevin Wm. Wildes, *Moral Acquaintances: Methodology in Bioethics* (Notre Dame: University of Notre Dame Press, 2000).

[17] Wildes 2000, 139.

[18] Wildes 2000, 144.

[19] Cynda Hylton Rushton, "Defining and Addressing Moral Distress: Tools for Critical Care Nursing Leaders," *AACN Advanced Critical Care* 17(2) (2006): 161-68, 166.

[20] Wendy Austin, "Moral Distress and the Contemporary Plight of Health Care Professionals," *HEC Forum* 24(1) (2012): 27-38.

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[22] Stanley Joel Reiser, "The Ethical Life of Health Care Organizations," *The Hastings Center Report* 24(6) (1994): 28-35.

[23] John A. Gallagher and Jerry Goodstein, "Fulfilling Institutional Responsibilities in Health Care: Organizational Ethics and the Role of Mission Discernment," *Business Ethics Quarterly* 12(4) (2002): 433-50.

[24] David O. Renz and William B. Eddy, "Organizations, Ethics, and Health Care: Building an Ethics Infrastructure for a New Era," *Bioethics Forum* 12(2) (1996): 29-39.

[25] Cindy H. Rushton and JoAnn Brooks-Brunn, "Environments that Support Ethical Practice," *New Horizons* 5(1) (1997): 20-9.