



Moral Distress in Health Care Professionals

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As the coronavirus pandemic rages on, it is becoming increasingly evident that many on the frontlines are, understandably, distressed. Distressed by the high volumes of patients and the lack of personal protective equipment (PPE). Anxious about not having enough ventilators as they face unprecedented resource allocation decisions. Grieving from watching patients die alone. Health care workers, first responders and chaplains may experience moral distress due to the COVID-19 crisis, and this can affect them psychologically, morally and spiritually. It is incumbent on Catholic hospitals and long-term care facilities to care for their personnel, with particular focus on the frontliners who are experiencing more of this kind of harm.

VOICES OF MORAL DISTRESS

The psycho-moral-spiritual toll of the coronavirus pandemic is borne out in various narratives in hospitals across the United States. For instance, Dr. Adam Brenner speaks from Brooklyn, New York, describing the likely long-lasting effects of his current work: “I don’t know how long I can keep doing this for. In my mind, I’m going to do it, I’m going to be there until this is done, but it’s going to be very hard to come back to work after this is over.”¹ Dr. Sadath Sayeed writes from Boston about the mental and moral harm of rationing decisions: “Nevertheless, I also cannot help feel that a crucial part of our humanity will be chipped away each and every time such decisions are actually made.”² Rev. Sharon Codner-Walker, also in Brooklyn, grieves the inadequacy of end-of-life chaplaincy amid social distancing measures: “Whatever sacred sign happens in the doorway, we can’t connect in the same way.”³ These are some of the many voices of moral distress.

UNDERSTANDING THE ORIGINS OF MORAL DISTRESS

Moral distress was first defined by Andrew Jame-

ton in the 1980s to describe the mental and moral repercussions experienced by nurses prevented from providing proper care, usually due to institutional restrictions. According to Jameton, “*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.”⁴

The term took hold. After further study and clarification, a consensus emerged that moral distress involves the following elements: the impossibility to do the right action, stages of distress, and harm to “moral integrity.” Moral distress can occur in two stages: “initial distress” occurs at the time of the problem, while “reactive distress” occurs later.⁵ Even after the reactive stress dissipates, it can leave a “moral residue” causing a cumulative negative stress effect. The way moral distress undermines moral integrity is somewhat vague (perhaps intentionally), but it points to the ways in which transgressing moral values undercuts one’s sense of self.

Nurses and scholars Cynda Rushton and Melissa Kurtz offer a salient example of moral distress, pre-coronavirus.⁶ Doctors’ orders pre-



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vent a nurse, Maria, from giving her patient much-needed pain medication. The difficulty of the situation is exacerbated by the fact that the patient's family is also resisting pain medication for the patient because they regard suffering as spiritually edifying. Maria is very troubled by witnessing her patient's ongoing pain. Repeatedly experiencing this kind of event damages Maria's sense of effectiveness and causes her to question her career choice. Maria knows what to do — give pain medication — but isn't allowed to do it. She is distressed during the event and experiences troubling reactive distress later. The moral distress builds up inside her in problematic ways.

EVOLUTION OF THE CONCEPT OF MORAL DISTRESS

The definition of moral distress continues to evolve and has been applied to many facets of health care. Philosopher and ethicist Stephen Campbell and co-authors argue for a "broader" view of moral distress that they define as "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."⁷ Importantly, while Jameton's original definition limited moral distress to situations where nurses were unable to perform the actions that they knew were right, the expanded definition by these authors argues that moral agents can experience moral distress even when they think they acted in the best way possible given the circumstances, or when moral agents are unsure of what the best action is. They contend that one can experience "distress by association," which can occur even if one does not consider oneself directly morally culpable for the action that is causing distress.⁸ Also, in this view, one can experience reactive distress without initial distress, and vice versa. This expansive definition encompasses almost all situations that cause moral discomfort and thus extends beyond Jameton's original focus on moral distress caused by institutional constraints.

HARMFUL EFFECTS OF MORAL DISTRESS

The harmful effects of moral distress are multifaceted. Rushton and Kurtz explain that "[m]any nurses experience physical, emotional, behavioral, and spiritual symptoms in response to moral distress."⁹ They assert that this distress can mani-

fest itself in ways including fatigue, exhaustion, frustration, anger, guilt, anxiety, depression, withdrawal from patients, avoidance, abandonment, spiritual distress, loss of meaning, and can even lead to "burnout."¹⁰ The pain of moral distress is very real and potentially destabilizing for those who experience it, which is why it is crucial to identify and treat it.

Harm to moral integrity is a critical component of moral distress. This is primarily what differentiates moral distress from emotional stress and PTSD. While someone may experience moral distress with emotional stress and/or PTSD, moral distress homes in on the ethical nature of a distressing incident (or incidents) and the subsequent effects it has on one's self-understanding as a moral being. This is notably distinct from PTSD, which is about fear, as well as different from emotional stress, which is not necessarily related to morality.

There have been various iterations of scales to measure moral distress. Recently, nurse and scholar Elizabeth Epstein and co-authors developed and studied the "Measure of Moral Distress

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for Healthcare Professionals," or the MMD-HP.¹¹ The scale uses 27 items to assess the moral distress of health care professionals in a variety of fields. And, as Rushton points out, moral distress can also be measured by "proxy" through surveys that ask questions such as, "Over the past year I have never been asked to do something that compromises my values."¹²

WAYS OF DEALING WITH MORAL DISTRESS

Moral resilience has generally been put forward as the antidote to moral distress. This is defined by Vicki D. Lachman as "the ability and willingness to speak and take right and good action in the face of an adversity that is moral/ethical in nature."¹³ There are different approaches to building moral resilience, but many of those involve recognition of moral agency (one's ability to intend and to act

on a moral decision), ethics education, meditation, opportunities to process distressing events and institutional efforts to reduce future moral distress.

The Schwartz Rounds — interdisciplinary rounds that focus on the emotional side of health care — often address moral distress by providing a space for practitioners to share difficult personal stories about patient care, but the focus of the rounds is not necessarily ethics or moral resilience. A more in-depth approach to dealing with moral distress is the Mindful Ethical Practice and Resilience Academy developed by Rushton, which builds moral resilience over the course of six sessions.

In light of moral distress during the coronavirus, Rushton and colleagues started “Moral Resilience Rounds,” where practitioners meet virtually to discuss ethical issues, as well as the “Frontline Nurses WikiWisdom Forum,” where nurses can connect online to share their stories from the crisis.¹⁴

These important approaches to caring for moral distress are not built upon the Catholic moral tradition or Catholic spirituality. As such, they can be bolstered and nuanced by additional considerations from Catholic understandings about the common good, the preferential option for the poor, solidarity, sacramental theology, theodicy (attempts to resolve the problem of evil) and God’s goodness.

MORAL DISTRESS DURING THE CORONAVIRUS PANDEMIC

Based on accounts given so far, many health care professionals and chaplains are likely facing moral distress during the coronavirus pandemic. While these professionals can rely on the *Ethical and Religious Directives for Catholic Health Services* (ERDs) and the guidelines of the Catholic Health Association to ensure sound ethical decision making, moral distress can still occur. As Campbell and coauthors argue, moral distress can occur even when moral agents believe they acted in the best way possible. The fact that such hard decisions even had to be made will be morally distressing for many. Rationing might be morally distressing even for those who do not make the decisions themselves but who witness hard choices and/or their effects. Some will experi-

ence moral distress from providing care that falls short of ‘normal’ care standards, even though it is the best option in the circumstances. Jameton’s emphasis on moral distress as a result of institutional constraint may take a new form during the coronavirus pandemic as situational constraints affect care. For many, the lack of enough essential resources, such as PPE and ventilators, will seem unjust or unfair and can generate moral distress. Working with the threat of contracting COVID-19 and spreading it to patients or family

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members may cause moral distress. Some might find their sense of God’s justice challenged by the magnitude of the pandemic or by the loneliness and isolation for patients at the end of their lives. The intensity of this time period might prevent some people from experiencing initial moral distress, only to find themselves later experiencing significant reactive distress. Moral distress may be amplified by the large number of patient cases, thus increasing moral residue and creating a cumulative destructive effect.

The pain and suffering of moral distress can manifest in the caregiver in numerous ways. It also can affect patient care, sense of self-worth and the drive to do the work. This may explain why Dr. Brenner does not think he will be able to practice after the crisis subsides. This is surely what Dr. Sayeed means when he describes that his humanity is being chipped away.

NEW WAYS FOR CATHOLIC HEALTH CARE TO TREAT MORAL DISTRESS

In light of the COVID-19 crisis, moral distress will be far more widespread than ever before. Tools previously used may have to be adapted to the broader definition of moral distress, its manifestations during the coronavirus pandemic, and the challenges of social distancing. The effects are likely to be cumulative and significant. Hence, treating moral distress in this context will require new and intensive efforts.



Since moral distress is a system-wide issue rooted in moral events, it makes sense for system ethicists, ethics committees and hospital ethicists to lead the charge in organizing and coordinating responses to moral distress. In my view, the following are necessary to properly treat moral distress during the coronavirus pandemic and beyond:

1. Recognize that moral distress is likely to be experienced across the board for those professionals and chaplains working in health care during the pandemic;
2. Recognize that moral distress occurs on three levels: moral, psychosocial and spiritual;
3. Responses should involve interdisciplinary teams of mental health specialists, spiritual advisers and ethicists;
4. Implement both immediate and long-term responses and action plans to address moral distress;
5. Take immediate action in these ways:
 - moral distress education (such as webinars, web resources, pamphlets, etc.);
 - assess moral distress levels (with the MMD-HP or through surveys, etc.);
 - regular, frequent interdisciplinary opportunities to discuss moral distress with an interdisciplinary support team (weekly virtual moral health rounds, virtual communication boards, etc.);
6. Prepare a long-term action plan that includes:
 - regular moral distress assessments;
 - multi-session moral health workshops;
 - implement structural changes where appropriate.

No one is immune to moral distress — it can be experienced by nurses, chaplains, physicians, first responders, administrators, support staff, home health aides, nursing home staff and others. As the voices from the frontlines suggest, and as the symptoms of moral distress indicate, this is a multifaceted psycho-moral-spiritual issue that requires an interdisciplinary team of mental health specialists, chaplains and ethicists. The psychological aspects and their behavioral and emotional expressions will need the expertise of mental health professionals. Chaplains or spiritual directors can guide the spiritual yearnings of moral distress. And, ethicists can provide education to clarify sources of moral distress, encourage moral agency and use the insights of health

professionals to suggest institutional changes when appropriate. Ethicists can rely on the Catholic moral tradition to illuminate important moral issues at stake.

Urgently, there should be educational support such as webinars, pamphlets and web resources to provide information about how moral distress may manifest during the coronavirus pandemic and what ethical issues are at play. There should also be frequent assessments of moral distress levels. This could be done using the MMD-HP or through monthly online staff surveys that ask whether staff members' moral values have been challenged. Importantly, health care providers and chaplains should be invited to discuss moral distress and ways to build moral resilience. This can be done through weekly, virtual cross-disciplinary rounds focused on ethical issues and led by an interdisciplinary team. This can be a new type of meeting or rounds, such as Rushton's Moral Resilience Rounds, or what I would call "moral health rounds." It can be done through rounds already in place, adapted to meet virtually and with a special focus on moral distress. Chat forums or blogs are ways that all staff can share experiences of moral distress and begin to process them.

Even after the coronavirus crisis subsides, hospitals should remain focused on dealing with moral distress because the effects from the pandemic will be long-lasting. Furthermore, moral distress will persist as health care workers continue to confront the regular ethical challenges of health care. As such, hospitals should continue to monitor moral distress through the MMD-HP or other staff surveys. In the long-term, there should be workshops to process moral distress and to build moral resilience. These should be available to all health care professionals and chaplains, and the programs should be intensive, performed over a series of sessions with an interdisciplinary team.

CONCLUSION

Offering care to health care providers is embedded in the charge of the first ERD to be "a community that provides health care to those in need of it."¹⁵ This means attending to the health needs of those who work in Catholic health care. Healing moral distress is important — it can get many of the Dr. Brenners of the world back to the work they once found fulfilling, it can offer the Dr. Sayeeds a pathway to hope, and it can buoy the Rev.

Corner-Walkers blessing patients from the doorways. Our health care professionals have cared for many patients, and now it is their turn to be cared for too.¹⁶

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ADDITIONAL RESOURCES:

American Nursing Association, "Ethics Topics and Articles," "Moral Courage/Distress," <https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/>

American Nursing Association, "Code of Ethics for Nurses," <https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/>

The Hastings Center, "COVID-19: Supporting Ethical Care and Responding to Moral Distress in Public Health Emergency," <https://www.thehastingscenter.org/guidancetoolsresourcescovid19/>

The Schwartz Center for Compassionate Healthcare, <https://www.theschwartzcenter.org/>

Cynda Rushton, National Academy of Medicine, "Clinician-Well-Being-July-14-Meeting-Cynda-Rushton-Promising-Approaches-to-Reducing-Burnout," *Mindful Ethical*

Practice and Resilience Academy, <https://nam.edu/wp-content/uploads/2017/08/Clinician-Well-Being-July-14-Meeting-Cynda-Rushton-Promising-Approaches-to-Reducing-Burnout.pdf>

NOTES

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2. Sadath A. Sayeed, "The Psychological Toll of Health Care Rationing Should Not Be Underestimated," *Newsweek*, Opinion, April 6, 2020, <https://www.newsweek.com/2020/04/24/psychological-toll-health-care-rationing-should-not-underestimated-opinion-1496321.html>.
3. Emma Goldberg, "Hospital Chaplains Try to Keep the Faith During the Coronavirus Pandemic," *New York Times*, April 11, 2020, <https://www.nytimes.com/2020/04/11/health/coronavirus-chaplains-hospitals.html>.
4. Andrew Jameton, *Nursing Practice: The Ethical Issues*, (Englewood Cliffs, NJ: Prentice-Hall, 1984), 6.
5. Stephen M. Campbell, Connie M. Ulrich and Christine Grady, "A Broader Understanding of Moral Distress," *The American Journal of Bioethics* 16, no. 12 (December 1, 2016): 2.
6. See Cynda H. Rushton and Melissa J. Kurtz, *Moral Distress and You: Supporting Ethical Practice and Moral*

QUESTIONS FOR DISCUSSION

Kate Jackson-Meyer describes moral distress as a term for the mental, spiritual and moral repercussions experienced by health professionals who are prevented from providing proper care, usually due to institutional restrictions or insufficient resources. She discusses occasions of moral distress and offers ways to avoid or prepare health care professionals for situations that could lead to it.

1. Are there any immediate changes due to COVID-19 in your health care facility that could cause your staff to experience moral distress? Would any of the changes proposed in this article be beneficial in your workplace?

2. For care providers, are there any healthy steps you've been able to take in your own life that can help lessen any stresses of providing care? What do you find helpful that others may find helpful? Does your ministry have a system in place where you can advocate for change if a policy or approach may cause moral distress to you or others?

3. For leaders, how are you assessing the moral distress that may be occurring within your organization? What multi-disciplinary resources within your institution might help address moral distress? What will you do or continue to do to provide the right people and resources to address moral distress in your organization?

4. The antidote to moral distress is considered to be moral resilience, that is, the ability and willingness to speak out against moral dilemmas and carry out the right action instead. Discuss ways how you might develop moral resilience in yourself and how your ministry could support you in that.



- Resilience in Nursing*, ANA's You Series (Silver Spring, MD: American Nurses Association, 2015), 2.
7. Campbell et al., "A Broader Understanding," 6.
 8. Campbell et al., "A Broader Understanding," 6.
 9. Rushton and Kurtz, *Moral Distress and You*, 8.
 10. Rushton and Kurtz, *Moral Distress and You*, 9.
 11. Elizabeth G. Epstein et al., "Enhancing Understanding of Moral Distress: The Measure of Moral Distress for Health Care Professionals," *AJOB Empirical Bioethics* 10, no. 2 (April/June 2019): 113-24.
 12. Anne Herleth, "How Johns Hopkins University Improved Nurse Resilience by Addressing Moral Distress," *Advisory Board*, Post-webconference Q&A with Johns Hopkins Hospital's Cynda Hylton Rushton, <http://www.advisory.com/research/nursing-executive-center/expert-insights/2018/moral-distress>.
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 16. Special thanks to Andrea Vicini, SJ, for his feedback on this article.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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