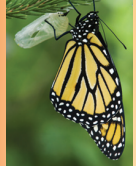


By Patricia A. Rodney, PhD, RN

What We Know About Moral Distress

Looking over three decades of research and exploring ways to move the concept forward.

ABSTRACT: This article provides an overview of moral distress, including the existing research on the concept, and a discussion of ways to evolve our understanding of moral distress in order to meet current and future practice challenges.
Keywords: moral distress, moral resilience, nursing

Moral distress arises when nurses are unable to act according to their moral judgment. The concept is relatively recent, dating to American ethicist Andrew Jameton's 1984 landmark text on nursing ethics.[1] Until that point, distress among clinicians had been understood primarily through psychological concepts such as stress and burnout, which, although relevant, were not sufficient. With the introduction of the concept of moral distress, Jameton added an ethical dimension to the study of distress.

BACKGROUND

In the 33 years since Jameton's inaugural work, many nurses, inspired by the concept of moral distress,[2] have continued to explore what happens when nurses are constrained from translating moral choice into moral action,[3] and are consequently unable to uphold their sense of integrity and the values emphasized in the American Nurses Association's *Code of Ethics for Nurses with Interpretive Statements*.[4] Moral distress might occur when, say, a nurse on a busy acute medical unit can't provide comfort and supportive care to a dying patient because of insufficient staffing.

The causes of moral distress in nursing have been found to be varied and include conflict with other clinicians, an excessive workload, and challenges with end-of-life decision making.[2,5] In addition, as nurses morally disengage—by, for example, blaming and alienating junior colleagues for not working "efficiently" enough—they may further contribute to their own moral distress and to that of their coworkers.[3]

Although Jameton's research initially focused on nursing, the concept has since been observed among diverse groups,[6] including physicians and psychologists.[3,5,7-16] In one study, a broad range of health care workers providing home-based palliative care—nurses, social workers, and rehabilitation therapists—all reported moral distress that was most commonly triggered by informal caregivers, challenging clinical situations, and service-delivery issues.[8]

Research related to moral distress has been both quantitative—generating numerical or measurable data—and qualitative—providing rich descriptive information obtained from such exploratory methods as focus groups and interviews. Quantitative initiatives have provided an understanding of the scope of moral distress within and between health care provider groups in various practice contexts.[9-11,14,16,17] For example, according to some Canadian and American research, the moral distress in nurses in critical care settings may be higher than that in physicians.[10] Qualitative inquiry has further explored the scope and complexity of the phenomenon and its implications in nursing and beyond.[7,8,12,15] For instance, in one qualitative study of physicians, nurses, psychologists, and nonprofessional aides practicing in mental health care, nurses indicated that shortages of resources, such as shortages of time and staff, led to dispiritedness, a lack of respect, and an absence of recognition for both patients and staff, all of which severely diminished the ability of staff to provide high-quality care.[18]

The consequences of moral distress for nurses and other health care providers include feelings of anger, frustration, guilt, and powerlessness.[3] Moral distress has also been associated with staff attrition, deterioration of morale and teamwork, decreases in the quality of care, and challenges related to patient safety.[3,6]

More recent research has focused on the significant moral distress experienced by health care managers.[13,19] In one study, nurse leaders from California, who had responded anonymously to an online questionnaire

Patricia A. Rodney leading a discussion of the symposium findings.

about the distress they felt in relation to such administrative challenges as poor work environments, reported being particularly concerned about the signs of moral distress that they noticed among staff nurses.[19]

Another well-documented aspect of the experience of moral distress is its nonlinearity. Canadian ethicists George Webster and Françoise Baylis have pointed to the long-term "residue" clinicians carry after facing morally distressing situations that, in the clinicians' own assessment, caused them to seriously compromise themselves or allow themselves to be compromised.[20] Other researchers have echoed this finding, arguing that the accumulation of moral distress has a cumulative effect, also known as a "crescendo effect," that may escalate progressively over time.[21]

Given the complexities of the health care system, the incidence of moral distress is likely to continue to rise.[22] As the aforementioned studies indicate, nurses and other health care providers are working with constrained resources that consistently prevent them from acting according to their moral values.

CRITICISM

The concept of moral distress provides nurses, other health care providers, managers, and researchers with an important lens through which to observe ethically challenging situations and initiate positive changes in practice. Yet the evolution of the concept of moral distress has not taken place without some ongoing—and thoughtful—criticism.[5, 14, 23, 24] Major points of consideration include the following:

- The concept of moral distress needs to be better defined and explained.
- The idea of moral distress may distract clinicians from ethical responsibilities if they focus on their own feelings and not what they ought to do.
- Researchers should focus on the responsibilities of nurses and other clinicians, not just on emotional responses, so that ethical practice overall can be improved.
- Researchers ought to better understand how nurses can act with constructive moral agency within complex organizational structures.

Despite these concerns, most scholars continue to believe in the importance of the concept of moral distress, even as they agree that it should be clarified and further defined so that it can be applied more effectively toward positive change in practice. Increasingly, researchers are discovering that moral distress need not be a purely negative experience; it can also be perceived as a path to positive growth, prompting nurses and other health care providers to engage in self-reflection and to be effective advocates for their patients, their patients' families, and their communities, thereby improving the quality of health care in their practice settings, and beyond.

MOVING THE CONCEPT FORWARD

Significant progress has been made in the study of moral distress. At the same time, there is ample room for additional exploration.

Increasing investigation of moral distress in diverse practice areas. Although the scope of research on moral distress has broadened,[6] the focus has largely been on acute practice contexts, such as critical care. More attention needs to be paid to practice areas such as mental health, community care, and long-term care.[3]

Moving beyond external constraints. Jameton's initial focus was on external constraints, and many subsequent studies have since echoed his focus. However, as noted above, more recent research has shown that moral distress can also occur when clinicians internalize external constraints to such a point that their own moral values begin to shift, causing them to disengage morally, compromise their integrity, and possibly engage in harmful practice.[3] Additional investigation of the effects of internalized constraints and ways to prevent them could help our understanding of moral distress.

Letting go of the narrative of powerlessness and despair. Too often, when nurses and other health care providers internalize constraints, they view themselves as "victims" of moral distress rather than as individuals with moral agency capable of responding positively to ethically challenging situations.[2, 3, 22]

Focusing on the skills and characteristics that allow nurses and other health care providers to respond healthfully to moral distress—instead of solely examining the pain they experience—can advance their ability to prevent or lessen their level of moral distress. To this end, important new writing has emerged on the idea of *moral resilience*,[22] which can be understood as "the capacity of an individual to sustain or restore [her or his] integrity in response to moral complexity, confusion, distress, or setbacks."[22] (See "Cultivating Moral Resilience" by Cynda Hylton Rushton, PhD, RN, FAAN, in this supplement.)

Exploring reciprocity between organizations and individuals. People and systems don't exist in isolation from one another. The examination of moral distress through a *relational* ethical lens—which allows for a deeper appreciation of the interconnectedness between people and structures—can help researchers and policymakers to further develop effective interventions to address moral distress at all levels.[2, 5]

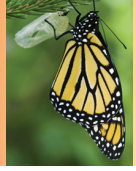
Health care providers, patients, their families, and those in leadership positions are individuals who act in relation to one another within complex—and often disempowering—organizational structures.[5, 25] Moral distress therefore needs to be addressed at various levels, from the individual all the way to larger systems and structures. For example, at the individual level, nurses and other health care providers may begin by paying attention to the anger, frustration, guilt, or powerlessness that they may be feeling when faced with a morally distressing situation, and pause and attempt to connect with their initial intention and sense of integrity.[3] They can also encourage open communication with colleagues, as well as with patients and their families, in order to foster more-ethical treatment choices. Such reflection and openness could nurture the conditions necessary for addressing each patient's unique needs and providing the best possible care in a nonjudgmental and equitable manner.[26] Seeking support from others within the institution—chaplains or ethicists, for example—may also be helpful. By cultivating moral resilience, individuals will be better prepared to take some or all of the aforementioned actions.

At the organizational level, nurses and other health care providers can participate in the formulation of ethical policies and practices.[25] For instance, they can address the need for integrating palliative approaches to care in diverse practice contexts, including acute care, home care, and long-term care.[27] At regional, national, and global levels, nurses and other health care providers can work through councils, community groups, and professional associations to promote equitable access to health care resources and to acute, chronic, long-term, and palliative care programs.

With proper support—including the opportunity for self-reflection and for true collaboration with other clinicians and with colleagues in management—nurses can create a climate that promotes safe, competent, and ethical care.

CHALLENGES

A number of challenges—particularly epistemological and political—remain. At the epistemological level, we need to continue to work toward a better understanding of *how* to support health care providers as individuals operating in relation to complex organizations and systems in order to move forward with meaningful change.[2, 3, 5, 28] For example, in order to address the moral distress of a nurse on a busy acute medical unit who can't provide comfort and compassionate care to a dying patient because of insufficient staffing, we need to better understand what kind of support will allow the nurse to cultivate moral resilience so that, along with colleagues, she or he can speak up and help change the organizational structures that are limiting her or his ability to provide ethical care. With proper support—including the opportunity for self-reflection and for true collaboration with other clinicians and with colleagues in management—nurses can create a climate that promotes safe, competent, and ethical care.[29]



At the political level we need to better understand *how* to foster fair processes and democratic ideals—locally, nationally, and internationally—in order to support health care providers as well as the organizations and societies in which they work and the communities they serve.[30, 31] This means intentionally cultivating our practice environments as moral communities[32] where ethical values drive practice at all levels. ▼

Patricia A. Rodney is an associate professor in the School of Nursing and a faculty associate at the W. Maurice Young Centre for Applied Ethics at the University of British Columbia, Vancouver, British Columbia, Canada. She is also a research associate at the Providence Health Care Ethics Services in Vancouver. Contact author: paddy.rodney@nursing.ubc.ca. The author has disclosed no potential conflicts of interest, financial or otherwise.

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