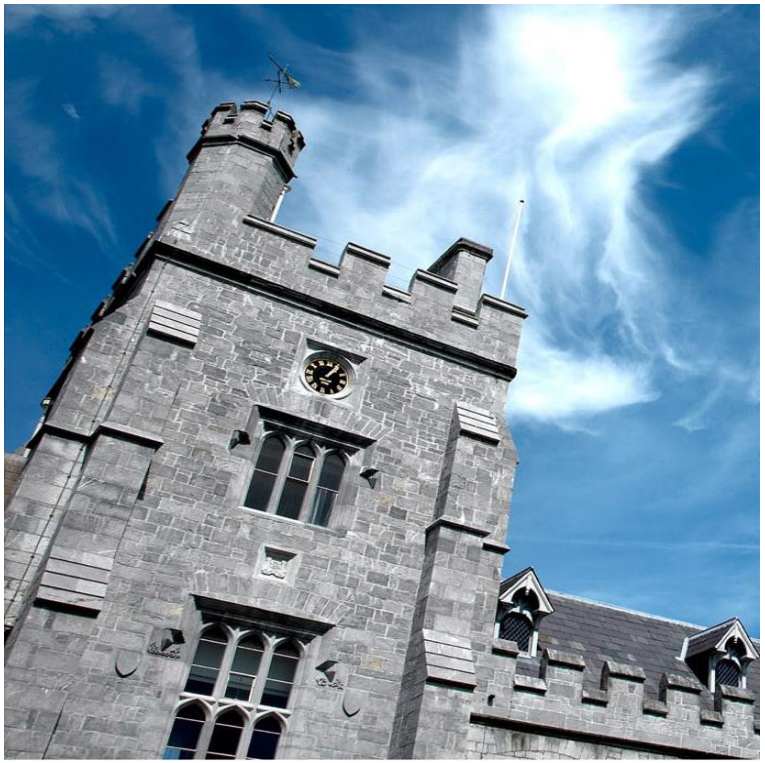

Moral Distress of Health Professionals: What it is and why it matters

Caregiving: a Commitment Without Borders?

Conference of the Belgian Advisory Committee on Bioethics, **13 April 2016, Brussels**

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A TRADITION OF INDEPENDENT THINKING

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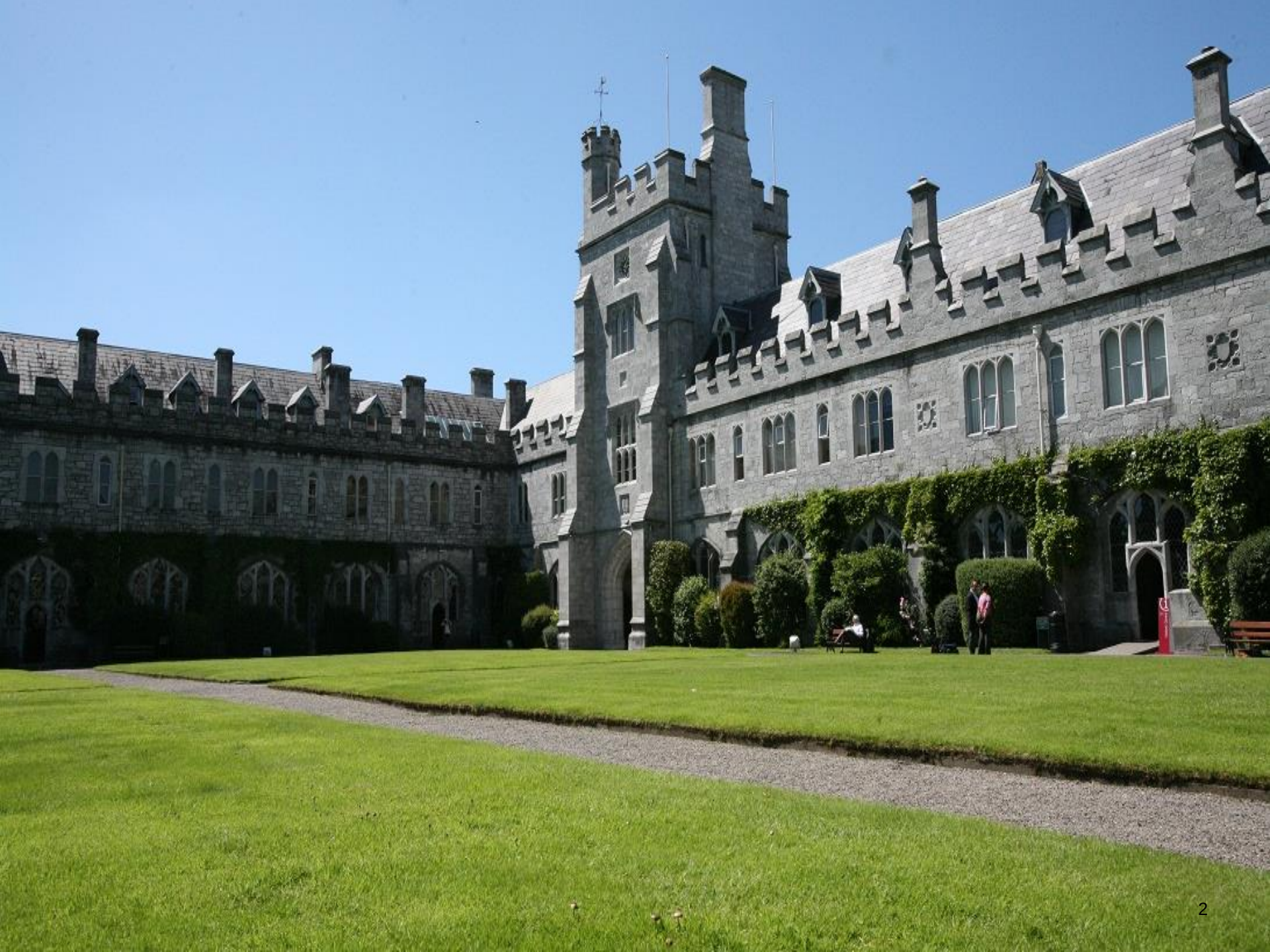
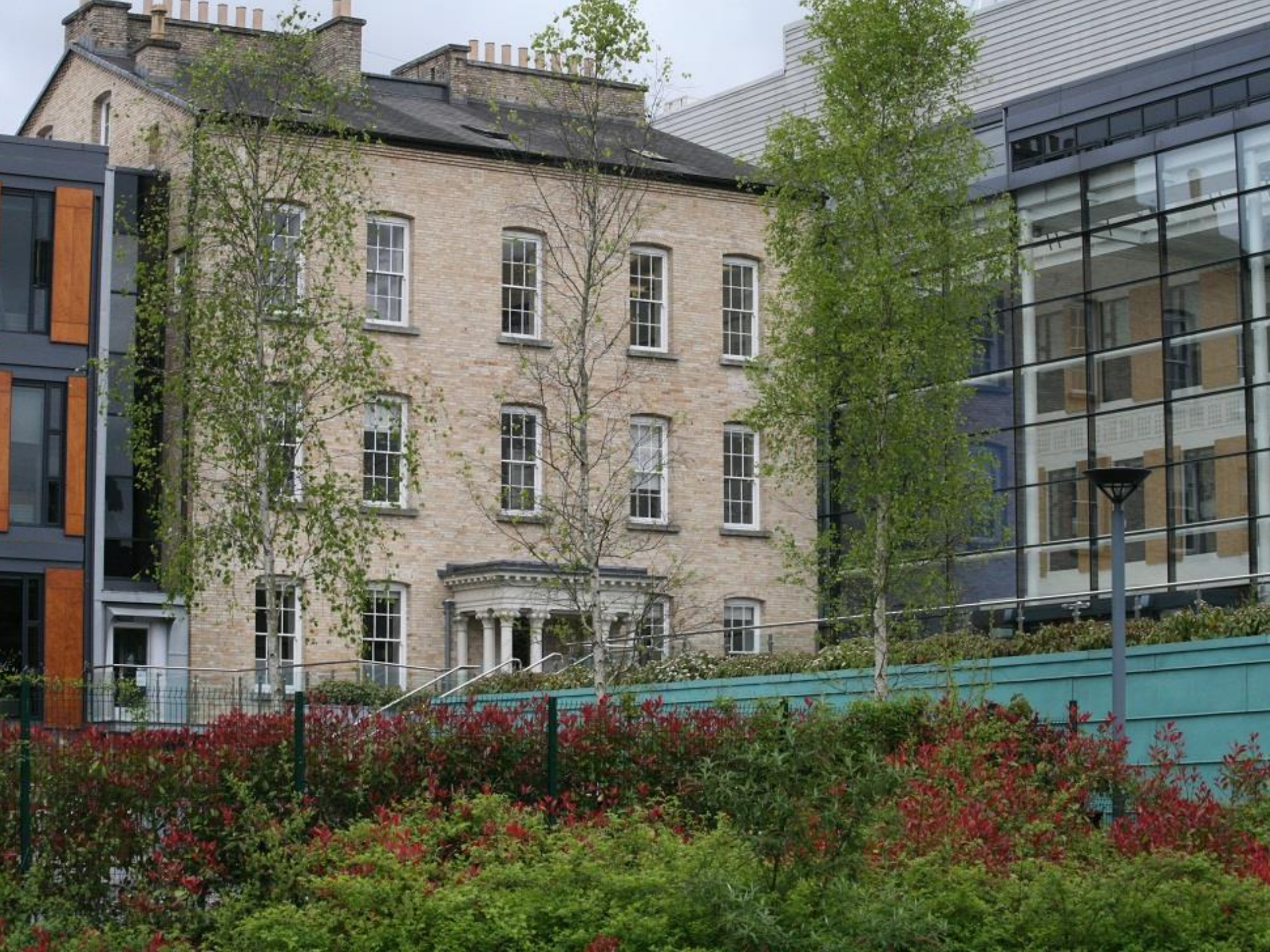




What I am going to talk about

- Background
- Examples
- Standard definition of moral distress (MD)
- Empirical and theoretical research
- Challenges with research
- The way forward - strategies

Background

Jameton J (1984); **Wilkinson J** (1987/88)

Nursing Ethics 1995 (1 abstract); 2012 – 2014 (16 abstracts); Special Online Issue, Jan 2013; Special Issue, Jan 2015

Range of Journals e.g. *Hastings Center Report, AJOB, Bioethics, Clinical Ethics, JME, NY Times* 2009

Critical care and nurses – doctors, nursing and medical students, pharmacists, managers, psychiatrists, psychologists, educators, physical therapists, podiatrists, researchers, veterinarians, patients' family members (Lamiani et al 2015)
US (70%), Europe (15%), Middle East, South America, Oceania, Africa, Asia

Tired of the system

‘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: 21, 23-24)

When doctors and nurses can't do the right thing

I feel so conflicted on a daily basis, almost repulsed at my profession…..dealing with pressures from insurance companies, medicaid, the administration, drug companies, and the patients per se. How can medicine be practiced when it is run by financial interests? how can I help anyone I do not know (I am not allowed to spend the time I need with my patients and yes, I have become a machine)? What happens when the patient's best interest is not the patient's best interest but avoiding a lawsuit? … After all these years I know that the patient-doctor relationship is the most important thing, but current policies, practices and dynamics do not allow for such a thing to exist…

(Cat 2009, Blog Response to Chen, NY Times, 5 Feb, 2009)

Standard definition of moral distress (MD)

‘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.’

(Jameton 1984: 6)

‘Moral distress […] **the psychological disequilibrium and negative feeling state** experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision.’

(Wilkinson 1987/88: 16)

[MD involves] situations in which nurses cannot fulfil their ethical obligations and commitments (i.e. their moral agency), or they fail to pursue what they believe to be the right course of action, or fail to live up to their own expectations of ethical practice, for one or more of the following reasons: **error in judgment, insufficient personal resolve or other circumstances truly beyond their control**. … They may feel guilt, concern or distaste as a result.'

(Code of Ethics of the Canadian Nurses Association 2002: 6)

Qualitative research

Mainly small descriptive/exploratory studies

(Review: Huffman and Rittenmeyer [2012])

Initial and reactive moral distress

Initial distress: anger, frustration and anxiety
Reactive distress: powerlessness, guilt, self-criticism and low self-esteem, as well as physiological responses such as crying, loss of sleep, nightmares, loss of appetite

Internal and external constraints

External constraints: e.g. institutional constraints; inabiity to influence medical decisions; staff shortages

Internal constraints e.g. ‘being socialized to follow orders, futility of past actions, fear of losing their jobs, self-doubt, and lack of courage’ (Wilkinson 1987/88: 21)

Quantitative research

Survey instruments

(Review: Oh and Gastmans 2013; Lamiani et al 2015)

Moral Distress Scale (MDS) (Corley et al 1995; 2001)

Initially, 32-item Questionnaire/ Likert scale for levels of moral MD of little/almost none (1) to great (7).

Measures **frequency and intensity** of MD

Focused on moral concerns in **critical care settings,**

Adapted by Corley and others; Hamric and Blackhall (2007) and Hamric et al (2012): **MDS-R**: broader range of sources/settings/professionals

– multi-site, multi-disciplinary, replication

Other tools e.g. Sporrong et al 2006; Wocial 2013

Settings contributing to moral distress e.g.

Critical care or acute: aggressive treatment of terminally ill patients, unnecessary tests and deception, incompetent or inadequate treatment by colleagues, long waiting lists, cost controls

(Corley et al 1995, 2001; Dodek et al 2016; Førde and Aasland 2008)

Psychiatric: professional and legal conflict, unnecessary use of coercive practices (medical interventions late, insufficient, prescribed for non-medical reasons), poor standard of care, limited treatment choices for clients

(Deady and McCarthy 2010; Hem et al 2016)

Geriatric: a lack of involvement in end-of-life decisions, a lack of ethical debate (Piers et al 2012:

20 nursing homes and 3 acute geriatric wards in Flanders, 222 nurses using modified MDR)

Sources of moral distress

1. **Clinical situations:** harm and disrespect to patients

1. **Difficult working conditions and limited resources:** organisational policies and poor staffing

2. **Structural conditions:** asymmetries of power (MD is 'powerlessness by any other name'; 'uncertainty about who is in charge' [Crippen 2016]; 'a cardinal characteristic' [Dodek et al 2016]); poor team support, interprofessional conflicts, epistemic injustice (Reed and Rischel 2015)

1. **Moral sources:** moral sensitivity, value conflicts, unhealthy ethical climate, professional role, personal failings

Impact of moral distress

Negative (mostly):

- Psychological, emotional, physical well-being; long term legacy - morally desensitized, loss of moral integrity
- Retention: 27%(doctors) - 52% (nurses) consider and/or leave position (Dodek et al 2016)
- Distancing from patients, poor patient care (Pauly et al 2012)

Positive:

- Facilitates learning, personal and professional growth; greater self-awareness and resilience
- Clearer ethical commitments, advocacy, resistance

So far – standard account of MD

The standard account of MD focuses on **settings and circumstances** that give rise to MD;

the **internal and external constraints** that influence individuals to act or desist from acting in a morally appropriate way;

the **short and long term psychological and emotional effects** that follow on the failure to act;

as well as its subsequent **impact on patient care** and on the **personal and professional lives** of health professionals

Theoretical or argument-based Literature:

articles that analyse concepts and present arguments to draw conclusions about what ought to happen

Broad Consensus on standard definition of MD

MD as a **discrete entity** – a set of experiences – characterized in psycho-emotional-physiological terms

External and Internal constraints

Alternatives to standard definition of MD
e.g.

- **‘relational concept** … 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.’**
  (Varcoe et al 2012: 56)

- ‘a negatively-valenced feeling state where one perceives a conflict between what one is expected to do and what is morally right.’ (Weber 2016: 248)

  For Weber, MD is intrinsically harmful to the sufferer and challenges moral integrity.

‘Reactive MD’ = ‘Moral residue’

- ‘[T]hat which each of us carries with us from those times when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised’ (Webster & Bayliss 2000)

- Failure to act, due to perceived constraints, may compromise one’s personal integrity: ‘In the deepest part of yourself, you feel you will never be the same and you carry this with you for the rest of your life.’ (Webster & Bayliss 2000)

- Over time, higher levels of moral residue contribute to increased levels of MD. Left unaddressed, ‘crescendos can erode care providers’ moral integrity, resulting in desensitization to the moral aspects of care’ (Hamric 2012; Epstein and Hamric 2009)

Normative meaning of MD – moral terms/components

1. Conscience: an intellectual faculty or mode of knowing that enables individuals to discern right from wrong and good from evil and in cases of wrongdoing - accuses, rebukes and torments

(Hanna 2004)

2. Moral judgement: Most accept Jameton's (1984) distinction between

'dilemma' - torn between the demands of competing ethical principles and unsure what to do; and

'judgement' - knowing what she ought to do.

3. Moral integrity and professional role:

Most distinguish MD from psychological and emotional distress by seeing it as a result of a threat to, or loss of, moral integrity.

Obligations of **professional role** viewed as a source of MD:

a) the demands of professional practice (e.g. to assist with euthanasia; being unable to offer the option of euthanasia) may be contrary to an individual's own conscience

b) 'the routine moral burden of occupying a professional role and having to negotiate tensions between the normative expectations attached to that role and one's own personal moral compass.' (Cribb 2011: 119)

Balancing act :
do the jobs expected, even though that may sometimes make them ethically uneasy, and also discern the tipping point where that uneasiness requires challenging the status quo (Cribb 2011)

Some MD is normal;

'We expect reasonable, competent, caring clinicians to disagree sometimes about important aspects of patient care. […] A realistic expectation is that stakeholders be heard, their experiences, expertise and insights thoughtfully considered – not that moral angst or suffering be altogether prevented.' (Dudzinski 2016: 1)

c) 'The **'sustained proximity'** to patients distinguishes nursing practice and compels nurses to experience their moral responsibilities […] acutely.'
(Peter & Liaschenko 2004: 221)

d) the **constitution of the professional role** itself:

'As roles are constructed – for example, through processes of regulation, the development and dissemination of policy and professional norms [...] we are, **more or less deliberately and self-consciously, changing** the frequency of, and kinds of, moral stress experienced by professionals.' (Cribb 2011: 127)

With **increasing social and health inequities** and dwindling healthcare resources around the globe, nurses will be less able to provide the care needed or confront discriminatory and marginalizing social processes that perpetuate inequity. In this way, the demands of a profession that they view as 'rooted in social justice' will, inevitably generate MD which will, in turn, be viewed as an 'acceptable' feature of the professional role. (Austin 2012; Varcoe et al 2012)

4. Moral competencies: several authors refer to moral sensitivity; moral imagination; moral responsiveness; moral comportment; moral virtues; principled compassion; moral courage; moral knowledge; moral empathy and resilience

5. Moral responsibility: all authors address responsibility in varying ways e.g.

a)The 'responsible actor' is limited (Jameton 1984)

b)Focus on what nurses can do with the right mix of knowledge, skills and attitude:

'[I]t is not the case that all nurses feel or perceive themselves to be powerless to act. Whether they do or not is **very much a matter of personal character and aptitude**, not 'other' constraints.'

(Johnstone and Hutchinson 2013: 5)

c) **Moral responsibilities** are divided out and experienced in the context of particular socio-cultural and structural arrangements and understandings – people have different levels of authority, credibility and accountability:

‘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’’.’

(Varcoe et al 2012: 57)

So far …

Empirical + Theoretical Literature:

Consensus on the **Standard Definition** of MD and some **alternatives**

Consensus on **Sources** and **Impact** of MD

Focus in theoretical lit. on **normative meaning** of MD:

1. Conscience
2. Moral Judgement
3. Personal Integrity and Professional Role
4. Moral Competencies
5. Moral Responsibility

Challenges with research on MD

1. Definitional problems

a) Is MD a 'discrete entity'?
Is classification of the properties of MD possible?

(Johnstone and Hutchinson 2013)

b) Is Jameton's starting point a worry? – that nurses '**know** the right thing to do'?

Assumes the high moral ground – but patients', families', other professionals' views count also

(Repenshek 2009; Johnstone and Hutchinson 2013)

2. Limited explanatory rigour

Reliability? Self-reporting through interview or questionnaire

Representational? Small samples largely from US and Europe

Little attention has been paid to those who do not seem to suffer from MD or who cope well or better with it than others e.g. Hamric (2012) 49% nurses vs 19% doctors – what of 51% and 81%?

3. Disempowering

Does research on MD perpetuate traditional narratives of nurses' victim status and powerlessness?
(McCarthy and Deady 2008; Johnstone and Hutchinson 2013)

The Way Forward
1. Accept the definitional challenges

a) MD is not a 'discrete entity' as such

• Moral realm of healthcare is complex
• Concepts are tools that orient us
• Different definitions of MD foreground e.g. moral constraints, the role of emotions, the transgression of moral norms and the effects of socialization

b) Jameton explains starting point

•The claim that nurses 'know' or 'are clear' about the right thing to do distinguishes ethical dilemmas from dilemmas of distress
•Nurses' views are not the only ones that count
•MD was a means of 'putting a nursing perspective across in a stratified bureaucratic environment' where they hold strong moral views but express them indirectly in order to avoid conflict.' (Jameton 2013: 298)

2. Strengthen explanatory rigour

- **Link with research on moral emotions -** guilt, shame, regret and remorse
- **Philosophical** literature e.g. Aristotle and Bernard Williams
- **Empirical research** in psychology and anthropology (Fontaine 2006: 277-8)
- **Undertake** multi-site, multi-disciplinary, replication, intervention studies. **Targeted interventions** to reduce MD and foster moral resilience

(Monteverde 2014; Peter 2015; Rushton 2016)

3. Address disempowerment

- **Politicize the concept** of MD by foregrounding the **relationship** between individuals, institutions and underlying socio-political structures.

- View MD as a ‘critical concept’ that draws attention to hitherto invisible/silent moral experiences of nurses and other health and allied professionals.

- Need to look harder and from different perspectives to notice what is too ‘familiar’, or ‘natural’, to see.

- MD is a window that makes the **social-moral space** of health professionals expressible. (Peter 2015)

‘Root and branch’ strategies

More education? Counselling? Acceptance of what cannot be changed? More research?

‘[T]hese responses are not solutions: they are merely means of accepting the state of being in moral distress and feeling better about it.’ (Crippen 2016: 271)

a)A ‘system-oriented preventive approach’ will make healthcare organisations morally ‘safe’ places (Johnstone and Hutchinson 2013)

a)A ‘structure-oriented approach’ foregrounds the socio-political context within which moralizing takes place

Moral Distress Map

Case	Emotions	Source(s)	Constraints	Conflicting Responsibilities	Possible Actions	Final Action(s)
	what emotions? e.g. sadness, anger, frustration	precise sources of MD	internal and external obstacles to taking action e.g. lack of knowledge or limits on care	value/ obligation/ responsibility X conflicts with Y	to improve patient outcomes and to cope with MD	what action(s) should you take?

(Source: Dudzinski 2016)

13 Steps of the Recovering Caregiver

1. Any expertise or skill I offer is based, first and last, on offering my presence as a fellow human being.
2. My words and gestures, and the attitudes I project through my actions, affect the healing of my patients, the morale of my co-workers, and the moral self I become.
3. I am responsible for how I offer care, but I do not work in conditions of my own choosing.
4. I forgive myself for doing what my working conditions require, but forgiveness requires working to change whatever is detrimental to care.
5. If I ever feel my work is out of my control, then I have ceased to be an effective professional and need either a day off, or to lead a protest, or both.
6. I refuse to blame patients when their troubles reveal inadequacies of either professional institutional capacity to care or professional ability to treat.
7. I will recognize who — patient, co-worker, or myself — pays what price in which currency — money, time, physical risk, dignity — to keep the institution running.

13 Steps of the Recovering Caregiver contd.

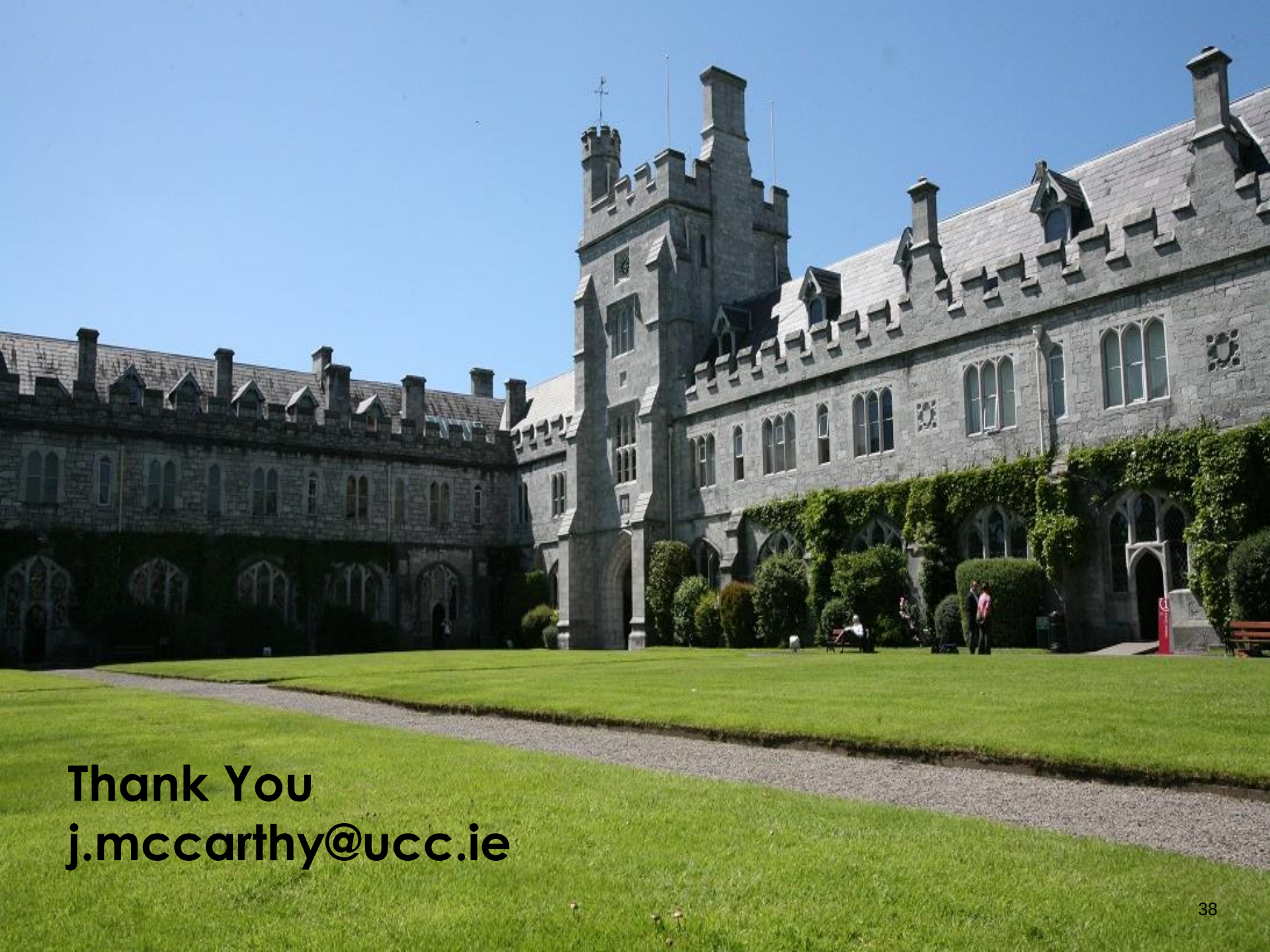
8. I ask myself: By telling or not telling a truth at this moment, whom is that serving?
9. I refuse the self-defense of blindness to the gap between my patients' needs and what care I can offer.
10. When I reach the limit of my ability to provide care, I will recognize what remains uncared for and offer appropriate expressions of regret.
11. Faced with patients or co-workers whom I find difficult, I will first ask myself what difficulties they confront, and how they are struggling to hold their own. If recognizing their struggle fails to bring resolution, I will protect myself.
12. I will never forget that any person's suffering is every other human's vulnerability, including my own.
13. I will seek, in each person, what is most admirable, enjoyable, and soulful. I choose to respond to these qualities with what is best in me.

Frank, A. (2007). 'Practical Generosity: The Professions and the Recovering Caregiver.' US President's Council on Bioethics Retrieved April 2016 http://bioethics.georgetown.edu/pcbe/transcripts/nov07/session1.html.

References

- Austin W (2012) Moral distress and the contemporary plight of health professionals. *HEC Forum* 24(1): 27-38.
- Cat (2009) Medicine and Moral Distress http://well.blogs.nytimes.com/2009/02/05/medicine-and-moral-distress/ Accessed 20 September 2012.
- Corley MC (1995) Moral distress of critical care nurses. *American Journal of Critical Care* 4(4): 280-285.
- Corley MC, Elswick RK et al. (2001) Development and evaluation of a moral distress scale. *Journal of Advanced Nursing* 33(2): 250-256.
- Cribb A (2011) Integrity at work: managing routine moral stress in professional roles. *Nursing Philosophy* 12: 119–127.
- Crippen D (2016) Moral distress: powerlessness by any other name, *Journal of Critical Care* 31: 271-272.
- Deady R, McCarthy J (2010) A study of the situations, features, and coping mechanisms experienced by Irish psychiatric nurses experiencing moral distress. *Perspectives in Psychiatric Care* 46(3): 209-220.
- Dodek PM et al (2016) Moral distress in intensive care unit professionals is associated with profession, age, and years of experience. *Journal of Critical Care* 31: 178-182.
- Dudzinski DE (2016) Navigating moral distress using the moral distress map. *Journal of Medical Ethics* 1-4.
- Epstein EG, Hamric AB (2009) Moral distress, moral residue, and the crescendo effect. *Journal of Clinical Ethics* 20(4): 330-342.
- Fontaine JR et al. (2006) Untying the Gordian knot of guilt and shame. *Journal of Cross-Cultural Psychology* 37(3): 277-8.
- Førde, R, Aasland OG (2008) Moral distress among Norwegian doctors. *Journal of Medical Ethics* 34(7): 521-525.
- Hamric A (2012) Empirical research on moral distress: issues, challenges, and opportunities. HEC Forum 24(1): 39-49.
- Hamric AB et al. (2012) Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB* Primary Research 3(2): 1-9.
- Hanna DR (2004) Moral distress: the state of the science. *Research and Theory for Nursing Pratice: An International Journal* 18(1): 73-93.

- Hem MH et al (2016) Ethical challenges when using coercion in mental healthcare: a systematic literature review. *Nursing Ethics* 1-19.
- Huffman, DM, Rittenmeyer L (2012) How professional nurses working in hospital environments experience moral distress: a systematic review. *Crit Care Nurse Clin N AM* 24: 91-100.
- Jameton A (1984) *Nursing Practice: The ethical issues*. Englewood Cliffs, NJ, Prentice Hall.
- Lamiani et al (2015) When health professionals cannot do the right thing: a systematic review of moral distress and its correlates. *Journal of Health Psychology* 1-17.
- Monteverde S (2014) Caring for tomorrow's workforce: moral resilience and healthcare ethics education. *Nursing Ethics* (10)2.
- Oh Y, Gastmans C (2013) Moral distress experienced by nurses: A quantitative literature review.' *Nursing Ethics* 2013; 3:3.
- Pauly B et al. (2012) Framing the issues: moral distress in health care. *HEC Forum* 24(1): 1-11.
- Piers RD et al (2012) End-of-life care of the geriatric patient and nurses' moral distress. *Journal Of The American Medical Directors Association* 13(1): 80.e7-80.e13.
- Reed PG, Rishel CJ (2015) Epistemic injustice and nurse moral distress: perspective for policy development. *Nursing Science Quarterly* 28(3) 241-244.
- Repenshek M (2009) Moral distress: inability to act or discomfort with moral subjectivity?*Nursing Ethics* 16(6): 734-742.
- Rushton C (2016) Moral resilience: a capacity for navigating moral distress in critical care. *AACN Advanced Critical Care* 27(1): 111-119.
- Sporrong SK et al (2006) Measuring moral distress in pharmacy and clinical practice. *Nursing Ethics* 13(4): 416-427.
- Thomas TA, McCullough LB (2015) A philosophical taxonomy of ethically significant moral distress, *Journal of Medicine and Philosophy*. 40: 102–120.
- Varcoe CB et al (2012) Moral distress: tensions as springboards for action. *HEC Forum* 24(1): 56.
- Weber E (2016) Moral distress, workplace health, and intrinsic harm, *Bioethics*, 30(4): 244-250.
- Webster G and Baylis F (2000) Moral residue. In S B Rubin and L Zoloth(eds) *Margin of error: The ethics of mistakes in the practice of medicine*, Hagerstown, MD: University Publishing Grp.
- Wilkinson J (1987/8) Moral distress in nursing practice: experience and effect. *Nursing Forum* 23(1): 16-29.
- Wocial LD, Weaver MT (2013) Development and psychometric testing of a new tool for detecting moral distress: the moral distress thermometer. *JAN* 69(1):167-174.


Thank You
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