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*Original*

What Is Moral Distress? Experiences and Responses / Batho, David; Pitton, Camilla. - ELETTRONICO. - (2018).  
[10.13140/rg.2.2.25797.76003]

*Availability:*

This version is available at: 11583/2991036 since: 2024-07-19T11:13:38Z

*Publisher:*

*Published*

DOI:10.13140/rg.2.2.25797.76003

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# What Is Moral Distress? Experiences and Responses Green Paper (February 2018)

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# What Is Moral Distress? Experiences and Responses

Green Paper (February 2018)

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THE ETHICS OF  
POWERLESSNESS

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## 1. What is Moral Distress?

The term 'moral distress' entered nursing literature in 1984 when Andrew Jameton first described the phenomenon. According to Jameton, moral distress occurs '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). As we shall see, this brief statement has come in for criticism, led to some confusion, and spurred subsequent attempts at refinement. Our aim in this Green Paper is to present a critical review of discussions of moral distress, propose a phenomenologically grounded analysis of the phenomenon, and sketch an array of possible ways of responding to experiences of moral distress as described.

By way of initial orientation toward the phenomenon, we can begin by following Jameton in contrasting moral distress from the experience of moral dilemmas. When an individual faces a moral dilemma she is confronted with two mutually exclusive courses of action, one of which she must choose but neither of which appears to present decisive moral reasons for action. Moral dilemmas thus present a distinctive challenge that requires a distinctive response: the agent has somehow to make up her mind over a moral matter in the apparent absence of clear guidance. In contrast, Jameton's description of moral distress focuses attention on those cases in which an individual has already determined for herself what she considers to be the morally correct course of action, only to perceive that she is prevented from undertaking that course of action. Moral distress is thus taken to present a distinctive challenge to those who experience it, since it does not involve a difficulty in making up one's mind but the difficulty in dealing with one's perceived inability to undertake the action that one has determined to be best.

Moral distress has been a highly influential concept in nursing literature in the US (Oh & Gastmans 2010), is beginning to see application in discussions of healthcare in the UK (Morley 2016), and has even found application in literature concerning the state of academia (Ganske 2010). The literature on moral distress is, however, subject to a great deal of confusion concerning the meaning of the concept and, therefore, which phenomena are supposed to be under examination. To illustrate the confusion of the concept, we can consider a number of putative examples of 'moral distress' presented across several studies. One study invited nurses to define 'moral distress' and received the following responses:

"Perhaps (...) [moral distress is] the feeling of discomfort (...) not feeling able to do something or (...) that feeling of leaving work and not being able to do what you should have done, either because of (...) an institutional technical matter or your own technical matter, I think this is what makes me more (...) upset."

"I think it's the emotional damage caused (...) by your own perspective in relation to the patient"

"Some sort of negative feeling (...) I think that is what weighs heavily regarding working in the ICU"

“Some situations in which we feel powerless (...) to make some decisions, which leaves you so in the middle of a situation when it is difficult for you to choose what you are going to do.” (Fachini et al.)

Plainly, there is significant variation in how these nurses understand moral distress. For one, it is to be identified with emotional damage caused by the agent’s perspective on the patient; for another, it is a particular sort of situation in which agents feel powerless; for another still, there is some sense of its being a negative feeling, but with little clarity on the precise character of that feeling; and finally the last nurse seems to have in mind a phenomenon closer to a moral dilemma, the phenomenon in contrast to which Jameton described moral distress.

These nurses can hardly be blamed for providing apparently inconsistent definitions of a phenomenon that they have been asked to define on the spot, not least because a lack of clarity on the issue is also to be found within the studies themselves. In the work cited, for example, the authors use ‘moral distress’ to refer also to the experience of complicity with an institution that allocates resources in a way that is perceived to be unjust. In another study, one nurse reports moral distress upon having witnessed ‘personal (dating) relationships between a supervisor and their employees impacting the team’ and another describes a situation in which ‘a patients (sic) brother had died in the same car accident. When the patient asked about him they lied for fear the bad news would impede the patients recovery. Family wanted staff to do likewise’ (Mukherjee et al.).

While each of these situations is surely distressing in its own right, it is not clear that each corresponds to Jameton’s definition or presents a case of the same phenomenon. Witnessing an inappropriate relationship is quite different to perceiving oneself to be prevented from undertaking a course of action that you believe to be morally appropriate. I might, after all, find out that there is something I should and can do about the effect of the relationship on the working environment. In a similar vein, to be asked by a family to lie to a patient seems much closer to an experience of a moral dilemma, rather than a clear-cut case of moral distress, since we can imagine someone in this situation feeling torn between two moral options: fulfilling the wishes of the family and being honest with the patient. The cases presented in the literature, then, do not all conform to Jameton’s initial definition and do not consistently refer to the same phenomenon.

In view of the range of examples of moral distress offered in the literature, some authors have opted for an umbrella definition, designed to encompass all the proposed definitions under one master concept. Campbell, et al. (2016), for example, define moral distress 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’ (p.6). To be sure, this definition covers all of the examples described above. But it is also considerably, indeed indefinitely, broader than Jameton’s initial definition. This is problematic, since instead of drawing our attention to a specific phenomenon, Campbell et al. are suggesting that moral distress should be taken to refer to any situation in which one is involved and which leads to negative self-

directed emotions. As Lucia Wocial puts it, the definition offered 'reduces the experience of moral distress to feeling bad because one is caught in a morally undesirable situation' (Wocial, p.21).

The confusion over the meaning of moral distress is nothing new; conceptual problems with the definition reach as far back as Jameton's initial presentation of the phenomenon. As we have seen, Jameton defines moral distress as occurring 'when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action'. There are four broad problems with this definition:

- Firstly, the definition entails that moral distress can only occur in those cases in which individuals have correctly identified the appropriate course of action. This sets the threshold for moral distress unacceptably high, since it excludes those cases in which the individual's sense of what is morally appropriate is either indeterminate or misguided. There are, however, plausibly many such cases: I might have no clear sense of what I should do but nonetheless feel that I am not acting appropriately, whatever the morally appropriate action turns out to be. Moreover, I might be misguided in my sense of right and wrong, but it would seem moralistic to suppose that I must be immune to the possibility of moral distress simply because I am mistaken in my beliefs.
- Secondly, the definition entails that it is as a matter of fact 'nearly impossible' to act upon one's understanding of the correct course of action. Once again, the bar is set too high and cases to which we should give consideration are ruled out of hand. It might be, for instance, that there is much that the individual could do, but she simply lacks the time to discover these available possibilities. In such situations, the problem is not that morally appropriate action is objectively nearly impossible but rather that the morally appropriate actions that are in fact available are unseen.
- Thirdly, the definition as stated makes no reference to the subject's affective condition. Jameton's brief statement allows for the possibility that an individual may as a matter of fact be, *unbeknownst to herself*, in a situation in which it is nearly impossible for her to act on her moral knowledge. On Jameton's definition, such a person would be in moral distress without feeling any distress at all.
- Finally, Jameton's definition draws an essential connection between moral distress and institutional constraints. While moral distress may quite plausibly occur under conditions of great institutional pressure, we should be reluctant to suppose that it could only occur as the result of such conditions. Why should we rule out in advance the possibility that one might feel moral distress in situations made demanding by 'internal' issues, such as fear or anxiety, rather than the unjust imposition of institutional constraints? It might be, for example, that I know what I should do and can see a way of doing it, but find myself too afraid to act. In sum, then, there are four problems with this definition:

1. ***Epistemic Threshold***: It requires the individual to have knowledge of the right course of action;

2. *Objectivity Condition*: It requires that it must as a matter of fact be ‘nearly impossible’<sup>1</sup> to pursue a morally appropriate course of action;
3. *Absent Affectivity*: It is compatible with the absence of any feelings of distress;
4. *Narrow Aetiology*: It is too narrowly focused on cases in which the individual is suffering from institutional constraints.

These problems are often repeated in subsequent attempts to refine Jameton’s definition:

- Webster and Bayliss, for example, describe moral distress as the objective situation in which one ‘fails to do the right thing (or fails to do it to one’s satisfaction)’ (Webster and Bayliss, 2000). The first half of this definition is subject to the problem of *Absent Affectivity* sketched above: I might actually be in that situation without being aware of it at all, since I might be unaware of having failed to do the right thing or having failed to do it to my satisfaction. On this definition, then, I could count as being in moral distress without experiencing any actual distress. The second half of the definition seems to miss the mark in another way: it is one thing to fail to do something to your satisfaction, but nonetheless think that your efforts will have to do, and quite another to feel that you have fallen profoundly short of your understanding of morally appropriate action, which appears to be closer to the experience of moral distress.
- Austin, Rankel, Kagan, and Lemermeye take a step in the right direction by defining moral distress as “the state experienced when moral choices and actions are thwarted by constraints” (Austin et al. 2005 p.197). In contrast to Webster and Bayliss, there is some reference to the subject’s experience of her situation. The definition offered, however, is subject to the second criticism raised above (*objectivity condition*): to be in a situation of moral distress, on this account, your moral choices or actions must in fact be ‘thwarted’ by the circumstances. The definition thus rules out those cases in which the individual fails to see what possibilities are in fact open to her.
- Epstein and Delgado claim that ‘moral distress occurs when an individual identifies the ethically appropriate action but feels unable to take that action’ (Epstein & Delgado, 2010). While they make space for the possibility that the agent may be unable to see options that are nonetheless open to her (on their definition, the individual need only feel unable to act), they still require the individual to have identified the actual appropriate course of action: in the abstract of the cited paper, the authors claim that moral distress occurs when the individual *knows* what she should do. The account offered therefore falls foul of the first problem identified above, that of *Epistemic Threshold*.
- Finally, according to the American Association of Critical-Care Nurses’ guide to addressing moral distress, moral distress occurs when either a) ‘you know the ethically appropriate action to take, but you are unable to act upon it’ or b) ‘you act in a manner contrary to your personal professional values’.<sup>2</sup>

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<sup>1</sup> A unfortunately ambiguous turn of phrase since by definition a ‘nearly impossible’ event is, in fact, possible (but unlikely).

<sup>2</sup> [http://www.emergingnleader.com/wp-content/uploads/2012/06/4As\\_to\\_Rise\\_Above\\_Moral\\_Distress.pdf](http://www.emergingnleader.com/wp-content/uploads/2012/06/4As_to_Rise_Above_Moral_Distress.pdf)



In the first case, the threshold seems to be too high, in that individuals are required to have knowledge of the morally appropriate course of action (*Epistemic Threshold*); in the second case, there is no reference at all to the individual's experience, such that moral distress might occur without any feelings of distress (*Absent Affectivity*).

In Jameton's definition, as well as the subsequent attempts at refinement we have just reviewed, then, there are serious conceptual problems which seem to set the bar too high in various respects: each of the definitions fails to make room for a range of plausible cases of moral distress. We submit that many of the problems we have identified above have the same root cause: lack of emphasis on the individual's fallible understanding of the situation she is in. That is to say, many of the problems arise because the account in question does not recognise that *moral distress is primarily a function of how the world appears to the individual, which may be different from how world objectively happens to be*. To be sure, the world might appear to be a certain way because it actually is that way. But whether or not a person is in a state of moral distress should not depend on the world actually being as she understands it to be.

This diagnosis allows us to stipulate some desiderata that any convincing account of moral distress will have to meet. Firstly, any account of moral distress should allow for the possibility that the agent either has an indeterminate sense of what she should do or is mistaken in her assessment of the morally appropriate action. In other words, we should not restrict moral distress to those possibly very few cases in which the individual in fact knows what is the right thing to do; it may merely appear to the agent that a course of action that is out of reach is morally appropriate, or she may have a more or less indeterminate sense that something needs to be done, even if she does not know what that is. Secondly, any account of moral distress should allow for the possibility that the individual does not see all the possibilities that are in fact open to her, rather than requiring her to be in a situation that objectively excludes (or nearly excludes) the possibility of doing the right thing. In other words, it is possible that agent who experiences moral distress does not see all the options open to her; in such cases, she feels that she cannot act because she fails to see, perhaps for good reason, what possibilities for action are available to her. Thirdly, any account of moral distress should recognise that the painful feelings that arise in light of the individual's understanding of her place in the situation are an essential part of the phenomenon. One cannot experience moral distress without feeling bad, and any satisfactory account of moral distress should reflect this. Finally, any account should be broad enough to make room for a wide range of causes for moral distress, so as to avoid arbitrarily restricting focus on a subset of the cases of interest. In summary, any account of moral distress should:

1. Avoid the *Epistemic Threshold* by allowing for the agent's sense of what is morally appropriate to be fairly indeterminate (e.g. she feels that there is something she should do but she is not sure what) or mistaken. Consequently, allow for the agent's fallibility in assessing which of her available options is morally appropriate

2. Avoid the *Objectivity Constraint* by allowing for the agent's fallibility in assessing all options open to her.
3. Avoid the problem of *Absent Affectivity* by making essential reference to the agent's feelings of distress in light of her understanding of the situation and her place in it.
4. Avoid *Narrow Aetiology* by refusing to arbitrarily restrict focus on cases with a specific causal profile (e.g. institutional constraints).

In the next section, we shall turn to some testimonials of experiences of moral distress to help us refine an account that can meet these desiderata. Before we do so, however, we can add one further constraint that our account should be able to meet.

As we have seen, some definitions of moral distress are problematically ad hoc. Campbell et al., to recall, define moral distress in a maximally broad sense, driven by the attempt to capture as many of the proposed definitions as possible. Here, the work of definition is not in the first instance guided by how the phenomena present themselves, but rather by the desire to create parsimony in a conflictual discursive field. The result is highly unsatisfactory, precisely because of its generality and abstraction from the concrete cases that motivated the study of moral distress to begin with. If we are to make progress on the question of the nature of moral distress, then, we should do so in a way that we keep our eye trained on the relevant phenomena and allow them to guide us. Are we, then, able to account for moral distress in such a way that meets our four desiderata and is grounded in the phenomena themselves?

#### Section Summary:

- The concept of moral distress is often confusingly defined.
- Any successful account of moral distress will have to meet four desiderata:
  - Allow for the agent's sense of what is morally appropriate to be fairly indeterminate (e.g. she feels that there is something she should do but she is not sure what) or mistaken.
  - Allow for the agent's fallibility in assessing all options open to her.
  - Make essential reference to the agent's feelings of distress in light of her understanding of the situation and her place in it.
  - Refuse to arbitrarily restrict focus on cases with a specific causal profile (e.g. institutional constraints)
- Further, any successful account of moral distress should be grounded in the phenomena themselves

## 2. The Phenomenology of Moral Distress

### A: Methodology

What, then, is moral distress? In order to answer this question, we propose to return to examples of moral distress themselves and allow them to guide us in our analysis of the phenomenon. In this respect, our

approach shall be phenomenological: our aim is to describe the relevant phenomena as they show themselves and thus allow our theory to be guided by and grounded in the things themselves. This proposal brings with it some methodological complexity, however. We have just said that we lack any precise definition of moral distress. How, then, are we to identify the relevant cases that we will then use to guide our analysis? It would seem that we are faced with a dilemma: either we must presuppose a definition of moral distress that will work implicitly in guiding our selection of relevant phenomena, or we lack any criteria for selection. In the first case, we will simply choose those phenomena that confirm our prejudices and thus make no progress at all; in the second case we will be unable to move in a principled way towards a better understanding.

There is, however, a way out of this dilemma. We can begin with a formal, stipulated, but preliminary description of a phenomenon of interest. We can then look at examples that fit the bill exactly and others that are in the same ballpark, that is, other examples that suggest themselves as similar to those that meet the stipulated definition. We can then ask whether any similarities emerge between the phenomena in the ballpark. We need not presume that there is any one phenomenon here: it might be that we find only a rag-bag of similar cases that overlap in some respects but which cannot be subsumed to any one definition. But we might also discover a structural homogeneity that we had not anticipated. If so, then we would have found a principled way of describing a range of phenomena as of a piece that is grounded in the phenomena themselves. To be sure, there is some circularity here, since we begin with stipulating a rough area of interest and then only pay attention to those phenomena that appear within that area of concern. But it is not the problematic circularity with which we were concerned, since our aim is to revise the merely stipulated definition in terms of what is revealed by analysis of those examples that show up within the same ballpark, rather than as simply matching our prejudice.

To this end, we propose to begin with the following preliminary, formal, stipulated definition, in light of the constraints we have described above:

**Moral Distress:** an agent experiences moral distress if she experiences painful feelings through understanding herself to be unable to realise an action that she perceives to be morally appropriate to the situation as she understands it.

This definition meets our desiderata since it allows for the fallibility of the individual's understanding of right and wrong; allows for the individual's fallibility regarding her assessment of which options are open to her; makes essential reference to the affective dimension of moral distress; and finally makes no reference to institutional constraints as a necessary causal factor. Note that it is preliminary, since our aim is to revise it in light of whatever saliences emerge once we turn to the phenomena it describes and those similar to them. It is also formal in that it leaves a number of important issues open for refinement. In particular, this definition makes no initial description of the character of the distress that is experienced in these cases. Now that we have a preliminary definition, we can turn to a number of case studies before analysing them so as to attempt a revision of our preliminary definition.

## B: Testimony

### Case 1

An elderly woman is in the advanced stages of cancer and is entering the last hours of her life. She and her family have expressed the wish that the medical staff should not attempt to resuscitate the patient. However, the patient codes (enters cardiopulmonary arrest) before the attending staff have completed the formal 'Do Not Resuscitate Order'. Consequently, the interns and residents that arrive on the scene quickly begin to attempt to resuscitate the patient. An attending nurse, aware of the situation, attempts to intervene and stop the resuscitation but is overruled by the attending physicians and is physically removed from the bedside.

She died, and of course it was awful. They broke every rib in that poor woman's body and she was left like this, and then they walked out. I went to my manager and to the Director of Nursing and I got no support for what I'd done, to try and intervene in this hopeless situation, and it was a matter of paperwork. Everyone in that unit knew... There was one family member there saying, "No, no, no! We made her a DNR." That was my final night in a hospital. I never went back to a hospital after that.<sup>3</sup>

### Case 2

An intoxicated man arrives in hospital by ambulance having fallen down some stairs and hit his head. The man loudly and aggressively asks why he has been admitted to hospital and dismisses the nurse's explanation that, since he may be suffering from concussion, the staff are not permitted to let him leave before he has received a CT scan. He becomes louder and more aggressive, at which point a member of security calls for backup. A number of security guards arrive, ask an attending student nurse to hold a bag of restraints, and try to calm down the man. This does not work. The student nurse is asked to hand over the restraints so that the man can be tied to a stretcher in the hallway.

After the incident, the student nurse feels as though the man had been poorly treated and wishes to raise her concerns with the head of psychiatry in the hospital. Her teacher, however, does not believe that anything was done wrong and blocks the student from raising the concern, insisting that the student is merely naïve and idealistic, ignorant of the realities and daily life of the psychiatric ward. She is told that being a student is 'mutually incompatible with activism'.

To my lasting regret, while I chafed at her claims of the student vs. activist mismatch, I did end up keeping quiet. She reported my outrage and my questioning to the director of my program. And though my program director privately agreed with my assessment that something was wrong about

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<sup>3</sup> <http://moraldistressproject.med.uky.edu/mdp-get-involved>

what I had witnessed, she asked me not to rock the boat. I finished out my rotation without a peep. But in doing so I feel I betrayed the people in my life who have mental illnesses. I betrayed the belief in human rights, which had led me to healthcare in the first place. And I betrayed the patients who come to that hospital seeking help and compassion and are instead treated like criminals. (Hensel, 2013: p100)

### Case 3

A physician involved in organ donation is presented with a difficult case: a woman has suffered brain death while carrying a premature and yet still viable foetus. Although the foetus is too young to be delivered immediately, the physician wonders whether options for preserving the pregnancy had been reasonably considered and explored. She also questions whether the attending doctors have considered the wishes of the parents. The physician has not been alerted in advance to the nature of the case and is not provided with support in thinking through what options are open to her. Due to the nature of organ donation, the time to think through the situation is severely limited. The physician attempts to raise concerns with the ethics team, asking whether a proper assessment of consent had been conducted, but is denied an ethics consultation. She believes that this is the result of having miscommunicated her concerns, due to a lack of experience in filling in the request form for an ethics consultation.

The decision-making in this instance felt rushed and failed to solicit the advice of the broader team. The result was that many clinicians that day felt morally distressed. What was my reaction to that moral distress? It best can be described as isolation, although I was active member of the care team to be involved, I felt I was relegated to being a quiet bystander, a technician expected to provide the skills, but not the critical reflection, which I still feel makes us physicians. I wasn't the only healthcare worker on the team that day that felt distress, but the circumstances that day made me feel rather alone. A few of us removed ourselves from the care team that day. My decision to do so stemmed from my uncertainty but also from my belief that my actual distress would impact my ability to provide care, my feelings of isolation from the team impede communication in some critical fashion. My actions certainly registered very publically my distress and some probably felt it was unprofessional, but I believe going forward to provide care under such circumstances would have been truly unprofessional. (Mack, 2013: pp.106-7)

### Case 4

A healthcare professional has been involved for the last decade in the care of a patient with a degenerative musculature disease. His patient has authored a healthcare directive, which has legal weight in directing the care of the patient once competency has been lost. Despite the presence of the directive, the attending physicians are not willing to grant that the directive has legal force, preferring to pursue a direction agreed

by all of the patient's family. The professional who insists on the importance of the directive believes that neither the family nor the healthcare team want to take responsibility for putting the patient's wishes into practice.

The health care team was no more eager to address the issue than the family. I had produced specific state statutes regarding the health care directive of a previously competent person and even in light of this information, some individuals continued to believe the surrogates decision took precedence over the directive. This growing tension left me feeling angry and ineffective, questioning my role in the organization, while watching A. J. [the patient] linger in a state not chosen. I believed I had failed in my obligations as a professional. (Shuhan, p.121)

### Case 5

A child was previously born prematurely and addicted to opiates. 'After several months in the Neonatal ICU, he was sent home, ventilator-dependent but with a high likelihood of survival and a low chance of severe, lasting disability.' His prognosis has now deteriorated, despite frequent trips to the hospital. The ICU team believe that the continuation of aggressive treatments is no longer in the child's best interests, but the parents are unwilling to remove the child's life-support, believing that all possible support should be given and that it should be God's decision alone whether the child dies. An ethics consultant reviews the case and, through the process of compiling a case for the ethics board, comes to the conclusion that the morally appropriate action is to withdraw life support. Despite this conclusion, however, the internal ethics committee overrules the consultant, stating that the decision whether to continue the treatment lies solely with the parents. The consultant is obliged to communicate to the ICU team a directive with which he profoundly disagrees.

On a personal level I agreed with the ICU team: it wasn't right to continue to treat Jay aggressively. But from a professional perspective, there didn't seem to be a lot of wiggle room. I hit the books, checked state law, and worked with in-house resources, but everything I learned confirmed what I already knew intellectually: this was the parents' decision. I told the ICU team, "This isn't what I would want for my child, but . . ." It was incredibly difficult to try to persuade the medical team—who were becoming angry that I was not telling them what they wanted to hear—of something that I personally didn't agree with. I was advocating for a route that I found personally repugnant. (Volpe, p.122)

### Case 6

A baby has been born at 35 weeks of gestation. She experienced hypoxia at delivery, required resuscitation and ventilation to keep breathing, and had brain damage whose severity could not be determined. The

parents of the child decide to withdraw care. She subsequently starts to breath without the help of the ventilator and her condition becomes more stable. Protocol would normally require that feeding is maintained, but since the parents have decided to withdraw care, doctors and nurses decide to remove the feeding tubes. A Roman Catholic nurse, involved in the baby's treatment, believes that the child should continue to receive treatment. She comes to the conclusion that she should attempt to foster the child. Her attempts seem to her to fall on deaf ears, or to be rebuffed by those who insist that 'the parents' wishes should be respected'. On the day that the baby's feeding tubes are removed, the nurse is prevented from seeing the baby and told that 'religious hang ups' should not interfere with medical procedure.

I was working that day in an office by myself and there was-no one to talk to - no support. One of the nurses I was working on the project with came by - I thought I would feel her out about the no cuddle order and her response was: "it's too bad that we couldn't give something to hasten the death." I couldn't believe the words that I heard. I felt so alone, I felt fear, deep sadness, anger and helplessness. It is difficult to be a prolife nurse - the distress I have felt this past week is more than I thought it would be.<sup>4</sup>

The baby subsequently dies of starvation. On the day of the baby's death, the nurse is invited to visit the child.

I prayed for her and her parents. She was very quiet and still and her breathing was shallow but I knew that it was a graced moment. The next day she died - she lived for 27 days. God gave me consolation by providing the opportunity to give her my love.<sup>5</sup>

## Case 7

A patient is brought in to hospital suffering from an overdose. As the hospital is short-staffed, the administrative coordinator enters the trauma room to assist. The patient is a First Nations woman who is very upset and strongly resisting medical care. She is in restraints and is being verbally abusive towards the staff. The emergency physician several times tells the patient to 'shut up', before stuffing a flannel in the patient's mouth in order to silence her. Although many of the staff laughed at this behaviour, the administrative coordinator is distressed. Feeling frightened and isolated, she does not intervene, even though she has a strong sense of what she should do.

My feelings on that night remain with me to this day. I now wish that I had found the courage to walk over to the patient, remove the washcloth and say why I believed the doctor's act was wrong, but this action did not seem to be open to me at the time. The culture of the emergency room in

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<sup>4</sup> <http://www.consciencelaws.org/background/procedures/assist010.aspx>

<sup>5</sup> <http://www.consciencelaws.org/background/procedures/assist010.aspx>

that hospital was such that I set aside deeply held (and publicly professed) beliefs, values and principles. Here was a very vulnerable person in our care, and we were removing the last vestige of her autonomy and, on top of that, laughing at her! I was not facing moral uncertainty in this situation: I knew there was a moral problem, and I knew what it was. I didn't have a moral dilemma (in the classical sense): I knew what the right thing to do was. I simply did not have the courage to do it. (Hardingham, p.129)

## C: Analysis

What do these examples tell us about our preliminary definition of moral distress? Recall that this definition is as follows:

**Moral Distress:** an agent experiences moral distress if she experiences painful feelings through understanding herself to be unable to realise an action that she perceives to be morally appropriate to the situation as she understands it.

To begin with, we should note that several cases appear to correspond to our definition. Cases 1, 4, 5, 6, and 7 each describe experiences of understanding oneself to be prevented from carrying out an action that the agent had identified as morally appropriate to the situation as she comprehends it. We should also note, however, that cases 2 and 3 do not so neatly fit this description. In these examples, the individuals have not identified anything as an appropriate course of action but, rather, experience distress at a perceived lack of institutional support for the kind of thinking that would lead to the identification and implementation of morally appropriate option. Our selection of cases, then, provides a range of examples which extend beyond the preliminary definition. Not every case describes a situation in which an individual understands herself to be prevented from realising what she has already determined to be a morally appropriate course of action. Are there any key commonalities between the cases that suggest a unified account of a phenomenon?

There is some reason to suppose that a unifying account may be out of reach. Consider, for example, the variety of the feelings reported across these cases: individuals report feeling a sense of betrayal, hopelessness, guilt, isolation, uncertainty, anger, impotence, disaffection with their chosen career, fear, sadness, helplessness, cowardice, and even consolation. On first glance, the case studies thus may appear to present too rich a variety of human feeling to be faithfully reduced into an overarching description. A second look, however, may give us pause for thought. For while the various feelings expressed may differ from case to case, the significance of those feelings may be more continuous. To see what we have in mind, consider Varcoe et al.'s definition of moral distress: 'the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards' (Varcoe et al., 2012, p.59). To be sure, this definition, as stated, does not capture all the cases we have surveyed: not every individual we have looked at acted in accordance with accepted professional



values and standards; some felt distressed and isolated through the failure to conform to such values and standards. Nonetheless, the first half of the definition does seem to point to a recurrent theme: these individuals appear to report moral distress when their feelings amount to a sense of being morally compromised:

Case 1: the nurse felt unable to carry on working within the hospital;

Case 2: the student nurse felt that betrayed people with mental illnesses and the beliefs that led her to healthcare;

Case 3: the physician found it so hard to be within the situation that she removed herself from the context in which the decisions and actions had to be made. She believed that she could not be a professional in the immediate context from which she removed herself;

Case 4: the individual believed that he had failed as a healthcare professional through being unable to put into effect his patient's wishes;

Case 5: the consultant's personal beliefs were inconsistent with the demands of his job such that he felt pushed into putting into practice a course of action that he found repugnant;

Case 6: the nurse felt pushed out of the context of care in which she had to accept a decision she strongly disagreed with on moral and religious grounds;

Case 7: the administrative coordinator felt that the situation was such that she failed to express her deeply held beliefs; these were put aside while she allowed the situation to unfold.

In each case, we submit, the individual experiences herself to be compromised by her involvement in the situation as she understands it. In this respect, we endorse the claim made by a number of authors that central to moral distress is the experience of loss of moral integrity (Varcoe et al.; Rushton, 2016; Epstein and Delgado, 2010; Cox, 2008). While we endorse this claim, we note that the concept of 'moral integrity' tends to receive very little attention in its own right. While Hylton claims, for example, that moral distress 'ensues when clinicians [...] are unable to translate their moral choices into ethically grounded action that preserves integrity' (Hylton 2016, p.111) she does not provide a detailed analysis of either 'ethically grounded action' or 'integrity'. Other authors claim that the experience of moral distress involves a sense of a loss of integrity. Epstein and Delgado, for example, claim that 'moral distress involves a threat to one's moral integrity' (Epstein and Delgado, 2010 p.3). But what this really amounts to is not subjected to extended discussion, such that the relationship between the definition of moral distress presented (of which we have made some critical comments above) and the loss of integrity adverted to is left unclear. In what follows, we attempt to address this lacuna by providing an extended analysis of the experience of being compromised in experiences of moral distress, grounded in the testimony we have presented above. We thereby hope to contribute to the literature by pursuing an analysis of a concept that is central to what we take to be a compelling account of moral distress.

To begin with, we can note that while many of these cases might involve a sense of being unable to perform a particular action, the sense of being compromised seems to go far beyond this. We can

see this most clearly in those cases in which the agents explicitly claim to have suffered a crisis in the ability to *be* a particular sort of person in a specific situation: in case 1, the individual experienced herself to be unable to continue to *be* a nurse, such that she left the profession; in case 3, the physician literally removed herself from the particular context in which she felt that she was unable to *be* a professional; case 4 similarly involves the experience of having been unable to *be* a healthcare professional; in case 6, the nurse found that she struggled to be a 'prolife' nurse within the healthcare context. In each of these cases, the experience of moral compromise goes beyond being unable to perform this or that action; the experience is one of being unable to *be* this or that sort of person.

While this reflection takes us a step further in understanding the experience of being compromised, it is not sufficient. In watching a concert, I might experience myself to be unable to be a virtuoso. This might manifest a sense of awe at the performing musicians, rather than a sense of being compromised. Why does the experience of not being able to be this or that sort of person manifest an experience of compromise in some cases but not others? We can turn back to the case studies to glean an answer. In case 2, the student nurse understands herself as someone who cares deeply about issues in mental health and human rights and attempts to live out this self-understanding through a career in nursing. In her training, however, she finds that her chosen career inhibits her ability to be herself, since it appears to block the expression of the values that she acknowledges as her own. In case 5, the consultant found that he was unable to be himself in his role, since his personal views of right action were diametrically opposed to the requirements of the position. Again, in case 6, the nurse understood herself in terms of her commitments to Roman Catholicism and her commitment to prolife practice, which she struggled to effectively express within the treatment context. She consequently felt isolated from the setting, unable to be herself easily within her working environment. In each of these cases, we submit, the individual experiences herself to be compromised insofar her *ability to be herself* is severely constrained and placed in a state of crisis, since there appears to be no clear way of living out the roles or values with which she identifies within the context.

While this takes us closer to understanding the distinctive character of experiencing oneself to be morally compromised, it still does not take us far enough. This is because we have so far said nothing about the distinctively *moral* character of these experiences. There are many different ways in which you might experience yourself to be unable to be yourself. Those who experience debilitating medical conditions, for example, often report experiencing themselves to be unable to fulfil a variety of roles integral to their sense of self as a result of their loss of capacity:

One participant explained that she had not been able to be fully a grandmother because of her fear that she might drop her grandchildren while trying to hold them in her arms when they were babies. [...] One male participant felt particularly distressed, as he felt he could be neither a proper spouse nor a proper father, and maybe not even a proper man. (Aujoulat et. al., 2007 p.781)

In these cases the individuals plainly feel unable to be themselves because they feel that they cannot be a particular sort of person: grandmother, father, man. And yet these cases do not look like examples of being morally compromised. To be sure, these experiences are surely distressing for those who undergo them and these individuals do indeed appear to experience themselves to be compromised. But these examples lack a distinctive moral character. Being unable to be yourself, then, is not sufficient for an experience of being morally compromised. How, then, are we to account for the distinctively moral character of the sense of compromise we have found in the cases reviewed above, in such a way that distinguishes these cases from other experiences of being unable to be a particular sort of person?

We suggest that in each case the individual experiences herself to be unable to be herself because she feels that she should have been (but was not) able to do the right thing. On this suggestion, the distinctively moral character of the sense of compromise is explained as follows: the individual experiences herself to be unable to be herself through feeling that she should have been able to do the right thing as herself. We can state the proposal formally: *in cases of moral distress, an individual feels morally compromised by a situation S when she takes it that she was unable to be herself in S, because she should have been (but was not) able to do the right thing in S.* To help see what we have in mind, we can see how this formal proposal helps us to describe those cases we have discussed above:

1. The individual experiences herself to be unable to be a nurse because she experiences herself to be unable to act in a morally appropriate way as a nurse.
2. In the context of the psychiatric ward, the individual experiences herself to be unable to be a friend to those people close to her with mental illnesses because she experiences herself unable to act in a morally appropriate way as someone who is committed in that way.
3. The physician finds herself unable to be a professional within a particular situation because she feels unable to act in a morally appropriate way.
4. Similarly, the individual experiences himself to be unable to be a carer through experiencing himself to be unable to act in a morally appropriate way with respect to his client.
5. The individual experienced himself to be unable to be himself because he experienced himself to be unable to act in a morally appropriate way: he is limited to acting 'as a professional'.
6. The Roman Catholic nurse experienced herself to be unable to be a 'prolife' Christian because she experienced herself to be unable to act in a morally appropriate way as a Christian.
7. Finally, the individual experienced herself to be unable to be a good person, since she experienced herself to be unable to act upon what she nonetheless understood to be the correct course of action.

Thus our proposal allows the distinctively moral aspect of the distress experienced by the agent to come to the fore in an intelligible manner. Note, however, that our proposal does not entail that in each situation of moral compromise the individual understands herself to be prevented by external factors from acting in a morally appropriate way. I might be unable to win at chess because I lack the concentration to follow through my plan, rather than because someone is stopping me from acting. Similarly, I might feel that I am unable to do the right thing because I believe myself to lack the requisite foresight or courage for the challenging circumstances. Our proposal, then, is neutral on the question of the cause of the lack of the ability to do the right thing.

This neutrality, however, leads to a central ambiguity to our formulation: in what sense does the agent feel that she 'should' have had the ability to pursue a morally appropriate course of action? Are we claiming that she must feel personally responsible for her inability? Or are we claiming that she must feel that she has been disempowered by her circumstances? *Is the 'should have' in this formulation a recognition of institutional injustice or personal failure? Or both?* In the first case, the individual might understand herself as a victim of moral distress. In the second case, her moral distress might be experienced as a symptom of guilt.

We submit that this question is central to feeling morally compromised, and that in most cases it cannot be answered by the individual in a straightforward manner. This, in turn, makes moral distress very ambiguous because the individual is torn in two opposite directions: her feeling of being a victim on the one hand, and her feelings of responsibility and guilt on the other. If you feel as though you should have been able to pursue a morally appropriate course of action, you face the difficult challenge of reckoning with the extent of your own complicity in your perceived inability. Suppose, for example, that an institution requires you to make a difficult decision within challenging time constraints. You find yourself to be incapable of identifying a morally appropriate course of action within that timeframe, and consequently feel compromised by the situation. Even if we grant that the fault lay with the institution for throwing you into an overly demanding situation, and even if you are very much aware of the injustice of the circumstances, the situation into which you were unfairly thrown showed you to be incapable of it and this can be a difficult realisation to bear. This realisation is difficult not least because of its deep ambiguity. While you might recognise that the institution forced the crisis on you, you would still feel that the crisis revealed something about *you*, namely, that *you* were incapable of it. Concomitant with that realisation is the nagging sense of the possibility that there is something more you could have done within that situation, and which you simply failed to do. Perhaps if you had had an earlier night you would have been sharper; perhaps if you had paid more attention to your supervisors over the years you would have been better prepared. Questions such as these are likely to emerge with the sense of being morally compromised by the situation. Part of the difficulty of living with moral distress, we propose, is dealing with this ambiguous sense of your own complicity in your inability to do the right thing: no matter how challenging the circumstances, they reveal you to be incapable of them.

This distinctive feature of moral distress presents particular challenges, not least because the experience seems to further inhibit the individual's ability to pursue the practices to which she remains

committed. Under normal conditions, if you have made a mistake in the course discharging a commitment, then maintaining that commitment is likely to involve identifying what you have done wrong, owning up to it, and seeing how you can improve in light of the mistakes you have made. If I have hurt a friend, for example, then it behoves me to find out what I did wrong, take responsibility for that, and try to live better in light of my understanding of how I went awry. Where there is no straightforward way of identifying either whether you have done something wrong or what it is that you have done wrong, however, there is no obvious way of going forward with your commitments in a responsible manner. This seems to be the situation of moral distress: those who remain committed to those practices in light of which they feel moral distress may find no straightforward way to identify what they did wrong or even *if* they did anything wrong, and so find no immediate way of taking responsibility in the practice in light of what they (may) have done. Moreover, the very experience of oscillation between feeling as if you are a victim and feeling as if you are a perpetrator is likely to provide a distraction, at least, and an obstruction, at most, to a lucid vision of the moral situation in which you are required to further act. If I am painfully confused about my role in events previously, it will be harder for me to press on with the continuing demands I am required to address. In summary, then, the unstable oscillation between seeing oneself as a passive victim, on the one hand, and seeing oneself as a perpetrator, on the other, is likely to generate painful feelings of paralysation of the sort we have just described.

To be clear, our aim here is not to determine in the abstract the moral responsibility of any individual in any concrete case. Our aim is not to apportion blame or cast aspersions. We are not claiming that those who experience moral distress really are to blame for not doing the right thing. Rather, we hold that in order to capture the particular psychological, felt character of moral distress—that is, if we are to articulate what is so distressing about the experience—we have to recognise that the feeling of being morally compromised involves the difficulty of coming to terms with your sense of the ambiguous status of your own complicity in your perceived inability to pursue a morally appropriate course of action. In feeling morally compromised, it is difficult to attain consolation simply by apportioning blame to the institution that brought on the compromising situation. Even if you believe, truly, that the institution is at fault, it remains the case that that *you* were incapable of the circumstances, which realisation is hard to bear.

We have suggested that, in each of the cases we described above, there is an abiding sense that the individuals felt morally compromised by the situations as they understood them. We have suggested the following analysis of the experience of being morally compromised: to feel morally compromised is to feel incapable of being yourself within a particular situation because you should have been (but were not) able to do the right thing in that situation. This feeling is likely to be accompanied by a felt sense of deep ambiguity regarding the extent of your own complicity in your inability. We have suggested that this description maps on to the seven case studies we presented above. For this reason, we are now in a position to make the following hypothesis: the feeling of being morally compromised, as we have just described it, is the central experience of moral distress. Does this suggestion meet each of the constraints on any account of moral distress that we identified above?

Firstly, our account allows for the possibility that the individual may have erred in her assessment of the moral value of those options that she experiences as being open to her. Our account therefore avoids the problem of *Epistemic Threshold*. Secondly, our account allows for the possibility that the individual may have failed (for whatever reason) to identify a course of action that was in fact open to her. In this way, an individual need not in fact have no appropriate course of action open to her to experience moral distress; it may merely seem to her that way. Accordingly, our account avoids the *Objective Constraint* problem. Thirdly, our hypothesis makes essential reference to the painful feelings involved in understanding yourself to be unable to undertake a morally appropriate action; it is the painful feeling of being morally compromised. Thus, our account avoids the issue of *Absent Affectivity*. Fourthly, our account is neutral on causes of the experience of moral distress: our account is broad enough to accommodate those cases in which the individual feels moral distress because of institutional constraints as well as those cases in which the individual feels moral distress because of 'internal' constraints, such as fear or anxiety. Therefore, our account avoids the problem of *Narrow Aetiology*. Finally, the hypothesis we have developed has been constrained by the testimony of a number of individuals who report moral distress and so, for that reason, is not ad hoc and abstract but principled and grounded. In this way, we have provided a grounded analysis of moral distress as the experience of the loss of moral integrity or, in our preferred terminology, the experience of being morally compromised that supports and complements those accounts of moral distress that emphasise the importance of integrity in understanding moral distress but which do not provide an extended analysis of this key concept.

If our suggestion is to be a viable hypothesis for an account of moral distress, however, it will have to do more; it must be able to accommodate a number of important features of moral distress that we have so far not discussed, in particular 'moral residue' and the 'crescendo effect'. Before we move on to discuss how one might respond to an experience of moral distress, as we have described it, we shall briefly discuss these two features and suggest how our hypothesis can accommodate them.

#### Section Summary:

- Many examples of moral distress appear to display this common feature over variations: the experience of being morally compromised.
- We suggest that the experience of being morally compromised is the feeling of being unable to be yourself in a situation in which you feel that you should (but are not) able to do the right thing.
- The feeling of being morally compromised, so described, is central to the experience of moral distress.
- We suggest that this feeling brings with it a sense of ambiguity over your own responsibility for your perceived inability to do the right thing in those circumstances.
- This is likely to be accompanied by a sense of premonitory guilt, in half-anticipation of a verdict to which one suspects oneself to be subject, but cannot rule out.
- This suggestion meets all four desiderata and is grounded in an analysis of the phenomena themselves.

## D: Moral Residue and the Crescendo Effect

Jameton's initial description of moral distress distinguished two aspects: initial distress and reactive distress. According to him, initial distress occurs at the moment of crisis, while reactive distress lingers, after the occasion that gave rise to the distress initially has passed. In light of this distinction, Epstein and Hamric (2009) have described what they call the crescendo effect of moral residue. 'Moral residue' is their term for 'reactive distress', that is, the lingering effects of moral distress after the initial crisis is over. They argue that repeated exposure to situations that give rise to moral distress leads to a 'crescendo effect'. This effect has two features: 1) a particular episode of moral distress becomes increasingly distressing the longer it lasts; 2) the resulting moral residue amplifies the distress of subsequent experiences of moral distress. Together, these two aspects combine to describe a crescendo of distress over the course of time. Each new experience of moral distress is more distressing than the last and lays the ground for subsequent experiences to be more distressing still. Can our proposed framework accommodate the crescendo effect of moral residue?

We submit that our proposal provides a natural explanation for these phenomena. Indeed, our account is in line with, but provides a substantial extension of, Epstein and Hamric's suggestion that the crescendo effect should be understood as 'a result of repeated threats to moral integrity' (Epstein and Hamric, 2009, p.340). Let us begin with moral residue. According to the proposal we have sketched here, to experience moral distress is, among other things, to feel unable to be yourself in a situation because you feel that you should be (but are not) able to do the right thing in that situation. This is, quite plausibly, an experience that is likely to stay with you, not least because understanding yourself to have been incapable of a morally demanding situation raises deep questions regarding your character, which are not easy to either dismiss or resolve. The extent of your own complicity in your inability to have acted morally is not an easy question to answer, even if you rightly believe the institution to be at fault. In this way, we suggest, our proposal has a natural place for moral residue. Consider, for example, the sense of being morally compromised through your involvement in a situation in which a patient has died in pain because a 'do not resuscitate' form was not filed in time. We have suggested that situations like this are likely to lead you to question what more you could have done and bring with it a sense of guilt. These questions are not easy to answer and hard to avoid. Consequently, the pain of having been morally compromised stays with you. What about the crescendo effect?

Here too it seems that there is a natural place for the crescendo effect within our description of moral distress. To recall, the crescendo effect has two aspects: 1) an increase in distress the longer a morally distressing situation continues; 2) the amplification of subsequent experiences of moral distress by moral residue. The first aspect can be given a relatively brief explanation: if a situation is painful to be in, then the longer it goes on the more the individual will experience pain. If a situation of moral distress involves the painful realisation of being incapable of a morally demanding challenge, as we have suggested, then the longer one is forced to bear that fact at the forefront of one's mind, the longer it will remain painful. On our account, then, we should expect experiences of moral distress to exhibit the first feature of the

crescendo effect. Let us move on to the second aspect: why should moral residue as we have interpreted it lead to an amplification of distress in subsequent experiences of moral distress? We have suggested that moral distress is situation specific: it is the feeling of being unable to be a particular sort of person within a given situation, because you feel morally compromised. We have suggested that the sense of being compromised is likely to linger, since the questions it raises regarding your own character and responsibility with regards to your incapacity are difficult to resolve or dismiss. We can also add that the more experiences of this nature that you have, the more likely it is that your sense of incapacity will spill out of the specific situations that occasion it and transform into a sense of being generally incapable. To take a mundane example, if I lose one or two games of chess, I am unlikely to think myself incapable of chess; I may reasonably feel that those games got the better of me. But if I keep on losing, I may start to feel as though I am not up to the game as such, rather than a few cases. Similarly, if I experience myself to be unable to be a nurse in a specific context, I may nonetheless experience myself to be able to be a nurse in other contexts. But the more times I pass through situations in which I experience myself to be morally compromised, the greater the possibility of experiencing myself to be unable to be a nurse in any context. I may experience myself to fall short of nursing as such, rather than simply not being up to a handful of difficult cases. In this way, we suggest, our account makes room for the second feature of the crescendo effect, since we should expect it to be harder to hold on to the sense of being capable of being a particular sort of person the more times you are exposed to situations in which you feel morally compromised as that sort of person.

We have, then, proposed that moral distress is the feeling of being morally compromised by a specific situation. We suggested that the feeling of being morally compromised is the feeling of being unable to be a particular sort of person in a specific context because of your (perceived) inability to pursue a morally appropriate course of action as that sort of person, which ability you feel you should have had. This suggestion meets each of the desiderata we identified at the end of the previous section and is grounded in testimony. Furthermore, we have suggested that our proposal is able to accommodate moral residue and the crescendo effect. If this hypothesis does accurately describe moral distress, however, what might it mean to live well in light of such experiences? In the final section of this Green Paper, we shall review a number of possible ways of responding to experiences of moral distress.



#### Section Summary:

- The crescendo effect of moral distress has two features:
  - The distress of a situation of moral distress increases the longer the situation lasts;
  - The residue of moral distress amplifies the distress of subsequent experiences of moral distress.
- Our proposal makes room for the possibility of the crescendo effect.
- On our account, it will be increasingly painful to be confronted with the sense of being incapable of an action.
- Further, on our account the more times you experience being morally compromised in particular situations, the more likely you are to feel morally compromised as such.

### 3. Living in Light of Moral Distress

#### A. The '4 A's' Model

Perhaps the most prominent model for addressing moral distress is presented in 'The 4A's to Rise Above Moral Distress'<sup>6</sup>. According to this model, those who experience moral distress should respond in four steps:

1. **Ask:** the individual should ask whether her symptoms are consistent with those associated with moral distress. The goal of this step is to become aware that moral distress is present, if it is present.
2. **Affirm:** Once moral distress has been identified, the individual is recommended to affirm her distress and commit to taking care of herself; validate her feelings and perceptions with others; and affirm her professional obligation to act. The goal of this step is to make a commitment to address moral distress.
3. **Assess:** Once the individual has made a commitment to address moral distress, she is recommended to begin to assess the sources of her experience, be they personal or environmental. She is encouraged to 'contemplate [her] readiness to act'. Here the goal is stated as follows 'you are ready to make an action plan'.
4. **Act:** This step involves preparing to take the action set out in your action plan, to implement 'strategies to initiate the changes you desire' and to anticipate possible set-backs. The goal of this step is the preservation of moral integrity and authenticity.

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<sup>6</sup> [http://www.emergingmleader.com/wp-content/uploads/2012/06/4As\\_to\\_Rise\\_Above\\_Moral\\_Distress.pdf](http://www.emergingmleader.com/wp-content/uploads/2012/06/4As_to_Rise_Above_Moral_Distress.pdf)

This model is severely problematic. Consider, for example, step one. To be sure, it is important that individuals are encouraged to gain a deeper understanding of their situation. But we submit that treating moral distress as a sort of disease that can be diagnosed third-personally by comparing one's own 'symptoms' to a list of diagnostic criteria, risks distorting the phenomenon in the eyes of those who experience it: it goes against the aims the model espouses, namely the preservation of moral integrity and authenticity, to treat moral distress as a condition from which individuals passively and third-personally suffer, rather than a moral crisis in which they are first-personally implicated, in the ways we have highlighted above. The attempt to come to a better understanding of your own moral distress should not be modelled on the attempt to identify what disease you are suffering from.

The second step also has considerable problems. As we have seen, this step involves acknowledging that one has an obligation to act. This presupposes that the best way to address moral distress is to make a commitment to act for the best. We have just seen, however, that moral distress involves the feeling of being unable to be yourself because you feel that you should have been (but were not) able to do the right thing. In other words, the experience of moral distress involves a sense of being compromised in one's ability to act for the best. It is unclear how someone who feels that they are suffering such a compromise could simply commit to act for the best, since their ability to make such commitments is precisely what may be experienced to be undermined through moral distress.

The third and fourth steps inherit this problem from the second: by setting the goal of the third step as the development of an action plan, the model once more presupposes that the individual understands herself to be capable of acting for the best; here we are presented with a strategy for exercising that ability. And yet it is precisely this sense of one's own capacity for right action which is experienced to be compromised in cases of moral distress. When the model states, then, that the goal of step four is the preservation of integrity and authenticity, and that this is to be met through putting into action one's sense of what is best, it is presupposed that the individual to whom the model is addressed already has the capacities that the model is supposed to help cultivate.

In summary, then, the '4A's' model is severely problematic, since it both frames moral distress as a kind of disease with characteristic symptoms (and so distorts its character as a crisis in your first-personal experience of your own moral agency) and moreover presupposes that individuals already unproblematically possess the very capacities that are supposed to be cultivated by the model. This model is not the only prominent suggestion as to how we might respond to moral distress. Recent years have, for example, seen the emergence of the concept of 'moral resilience'. Does moral resilience provide a more compelling model than the alternative we have just surveyed?

## B: Moral Resilience

'Moral resilience' refers to the character profile of individuals who appear best able to resist burnout as a result of continued exposure to situations that give rise to moral distress. Cynda Rushton's work is prominent in this area and has largely been directed to the attempt to provide a description of this character

profile, demonstrate the effectiveness of moral resilience in protecting individuals from burnout, and surveying possible ways to cultivate moral resilience in nurses. According to Rushton, those with moral resilience demonstrate the following characteristics (Rushton 2016, pp.112-116):

1. Knowledge of who you are and what you stand for in life
2. A commitment to ongoing exploration, refinement, or in some cases revision of one's values, ideals, and point of view
3. The cultivation of capacities such as 'mindfulness' that allow the individual to 'fully experience' moral distress and 'release its grip on them more easily';
4. Responsivity and flexibility in complex ethical situations
5. The capability to discern the boundaries of integrity, including the exercise of conscientious objections
6. The ability to be resolute and courageous in one's moral action despite resistance or obstacles
7. The ability to discern when one has exerted sufficient effort to fulfil one's ethical obligations and to be realistic about one's limitations and the constraints and pressures of the situation
8. The attempt to seek meaning in the midst of situations that threaten integrity or cause dissonance with one's moral sensitivity and reasoning

This list presents an intriguing and richly suggestive description of various character traits that may protect individuals from burnout. There are, however, a number of issues with this description as a presentation of a viable response to moral distress. To begin with, we should note that none of the items on this list has been accompanied by an extended analysis on the basis of which systematic distinctions and relations could be drawn between the other items on the list. This is problematic for a number of reasons. Firstly, it may be that there is substantial overlap between the enumerated items: how are we to distinguish between, for example, the capability to discern the boundaries of integrity (item 5) and the ability to discern when you have exerted sufficient effort (item 7)? What grounds are there to warrant this distinction at all? Secondly, the absence of any systematic analysis of the relations between the features of moral resilience means there is no real explanation as to why these and only these items have been included. Might there be other items we are missing? Might we have captured features that are mere contingent accompaniments to the phenomenon of interest? Thirdly, through the absence of a systematic analysis we lack any account of the relation between the items on the list and the contribution of each to the constitution of the phenomenon of moral resilience. What is it about the attempt to seek meaning, for example, that is important to resisting burnout? How does the attempt to seek meaning relate to the exercise of courageous action? Can one seek meaning through courageously enacting one's plans? Is the attempt to seek meaning prerequisite of this action? If progress is to be made in pursuing the cultivation of moral resilience, we should first attempt to be clear about the phenomenon, both in identifying the relevant examples and systematically elaborating their features in a way that explains how the features relate to each other and contribute to the phenomenon of which they are a feature.

Besides the lack of systematic analysis, however, there is a more general issue with focusing on moral resilience as a response to moral distress. As we have seen, Rushton conceives of moral resilience as that character profile that protects individuals from feeling profoundly compromised in distressing situations. It therefore looks to be directed, primarily, at the prevention of the worst cases of moral distress, in which the individual feels that she cannot go on at all. The aim is to cultivate in nurses those virtues which allow them to best resist a loss of integrity in situations of great moral strain. Does moral resilience, however, provide a viable way of addressing those cases in which the individual has already reached a point of crisis? It is not obvious that the virtues that are supposed to protect an individual *from* being compromised will be appropriate to those cases in which the individual is *already* compromised. Perhaps, in these cases, we need an altogether different approach; since the aim is not to battle on through difficult circumstances so much as to, so to speak, recover from defeat. To be clear, we are not suggesting that 'moral resilience' is not a viable account of how to best respond to moral distress. Rather, we indicate some of the difficulties faced at this early stage of thinking through the concept that will have to be dealt with if the idea is to come to fruition.

#### Section Summary:

- The '4 A's' model of addressing moral distress is highly problematic for two reasons:
  - It encourages individuals to relate to their moral distress as a condition with symptoms that can be third-personally diagnoses, rather than a crisis in your first personal experience of yourself in your situation.
  - It presupposes that individuals already have the very capacities that are experienced to be undermined in cases of moral distress and which are supposed to be cultivated by following the model.
- The 'moral resilience' model of addressing moral distress presents an interesting and rich range of character traits that may be involved in protecting the individual from burn out as a result of moral distress.
- This model is also problematic, however:
  - It is not systematically developed
  - It is not clear that the virtues that are helpful from protecting against burnout must be the same virtues that you need to cultivate in the response to a crisis.

### C. Alternative Responses to Moral Distress

There are, then, some major issues with some prominent models of responses to moral distress. How, then, should we respond to moral distress? In conclusion, we once more turn back to our case studies. We shall identify a number of ways of addressing moral distress that are exemplified in these examples. Our aim is to identify a range of possible responses to moral distress and present a brief analysis of them in light of our discussion of moral distress. We do not aim to adjudicate the value of any of these responses:

we present them here to raise the question of the respective value of each and how these examples might better help us refine our understanding of what it might mean to live well in light of moral distress.

## i. Rebellion

If moral distress is the experience of being morally compromised within a given situation, as we have suggested, then a natural way of resolving the experience would be to remove oneself from the situation in which one feels compromised. We can distinguish between two ways in which one might pursue this strategy, in response to moral distress.

### *1. Leaving the immediate context*

Firstly, you might decide to leave the immediate context which has given rise to the experience of moral distress while nonetheless remaining committed to the overarching context. You might, for example, decide to rescind responsibility for a particular treatment decision while nonetheless remaining committed to professional healthcare. In this way, you would resolve an experience of moral distress by evacuating the compromising situation that gave rise to it. This response appears to be exemplified by case 3 above: the physician felt that she could not continue in a morally appropriate way within the immediate context in which a treatment decision needed to be made, and so vacated that context.

### *2. Leaving the broader context*

A more radical way of pursuing a similar strategy would see the individual not only removing herself from the immediate context, but also the overarching context to which she had been committed and within which the immediate situation of moral distress arose. Rather than simply leaving a particular treatment decision to others, for example, you might decide to quit healthcare altogether. This response appears to be exemplified by case 1 above. To recall, the nurse states that after witnessing the unnecessarily painful death of a patient in a situation within which she could not intervene, she never returned to the hospital.

## ii. Acquiescence

Rather than attempting to remove yourself from the situation that you find compromising, you might undertake an alternative approach. In the situation we have in mind, the agent goes along with the situation irrespective of her moral scruples about doing so. In this way, the situation of moral distress is resolved by not allowing your moral principles to stop your work from proceeding. We can identify two varieties of this approach.

### *1. Choosing your battles*

On this approach, the individual so to speak concedes defeat on a number of fronts in order to maintain her commitment to the overarching context and allow herself to be steadfast in situations in which she may be more insistent. This approach appears to be exemplified by case 5 above. To recall, in this example the ethics consultant reports relays instructions to the treatment team even though he finds repugnant the course of action the instructions recommend. He does so, it appears, in view of his commitment to professionalism.

## *2. Full surrender*

On a more radical form of pursuit of a similar strategy, the individual gives up any attempt to act in accordance with her moral beliefs and, rather, decides simply to go along with whatever is asked of her. In this case, the individual does not decide to strategically concede defeat, as it were, to continue to fight another day; she more generally abandons her moral principles as restraints on her conduct at work. Although none of the cases above seem to exemplify this approach, there may be references to such a response in case 2. In that example, the student nurse makes reference to a number of professionals who seem to her jaded and relaxed with the situation which she perceives to be extremely morally problematic.

## *iii. Rediscovery*

We have, then, reviewed two broad ways of responding to experiences of moral distress: in the first case, the individual more or less radically rejects the context that gives rise to moral distress, while holding on to her moral principles; in the second case, the individual more or less radically accepts the context that gives rise to moral distress, while letting go of her moral principles. In the final set of cases we shall examine, matters are more complicated, since they seem to involve both accepting and rejecting the apparently morally problematic context in a complicated way.

### *1. Rediscovery of possibilities of moral self-expression*

Consider case 6, in which a Roman Catholic nurse initially finds no way of being able to be a Christian within the immediate context of care. She does not remove herself from that context; she continues to attempt to find a way to care for the child, despite the distressing sense of her inability to do anything. But nor does she simply accept the context; she holds herself in that distressing situation until she is able to find a way of being a 'prolife' nurse that she had not previously envisaged: in praying for the child, she found a way of being able to be a 'prolife' nurse within the context. We might call this a rediscovery of the possibility of moral self-expression within the context, made possible by accepting the difficulty of the situation as presented it and letting go of her sense that there was only one morally acceptable course of action open to her, which was foreclosed. In other words, the nurse had believed that the only morally appropriate course of action within this situation was to save the life of the child. Only by letting go of belief

in that action as the solely morally appropriate was she able to see her way to another possibility of caring for the child.

## *2. Rediscovery of commitment to practice*

Although none of our examples exemplify the approach we have in mind, we can nonetheless imagine a plausible case along the following lines. Imagine a nurse who finds that she can no longer remain at the frontline of care. Accordingly, she decides to remove herself from the hospital permanently. This need not amount to a rejection of her commitment to caring, however, since she may seek to find a new avenue for the expression of the commitment to that practice. She might, for example, decide to work for a healthcare charity. In this respect, the nurse rediscovers her commitment to a practice of care by first letting go of her previous sense of what is involved in following through that commitment but nonetheless accepting being bound by that commitment despite her sense of being unable to continue as she had before. In other words, the nurse had believed that the only way of being committed to care was to remain working within a hospital. Only by freeing herself from this conception was she able to find her way to another way of maintaining that commitment outside of the nursing profession.

We have, then, surveyed a number of different responses to moral distress as we have understood it. Each example represents a different way of living in light of moral distress and several are exemplified in the case studies we have presented. The first set of examples involved more or less radically letting go of the situations in which moral distress arose, so as to hold on to one's moral principles. The second set of examples involved more or less radically letting go of one's moral principles, so as to hold on to one's commitment to the practice. The third set of examples involved a more complicated relationship between holding on and letting go. In the first example of this cluster, the individual remains in the tense situation but lets go of her previous judgement as to what options are open to her so as to find a new way of expressing her moral principles within that context which she had not seen hitherto. In the second example, the individual holds on to her commitment to care but lets go of her sense of how to play out that commitment, so as to find a new way of being committed to care despite her inability to carry on before. We do not claim that this list is exhaustive.

### Section Summary:

- Our case studies demonstrate a number of different ways of responding to moral distress:
  - **Rebellion:** individuals may more or less radically remove themselves from the context that gives rise to moral distress;
  - **Acquiescence:** individuals may more or less radically submit to courses of action to which they disagree.
  - In the first case, individuals *hold on* to their moral principles and *let go* of those contexts in which they cannot be expressed.
  - In the second case, individuals *hold on* to the contexts and *let go* of the principles which cannot be expressed in those contexts.
  - **Rediscovery:** individuals may find ways of *both* holding on and letting go:
    - You might let go of your preconceptions of the correct moral action to hold on to the possibility that another option may emerge;
    - You might let go of your specific practice in order to hold on to the possibility of another way of expressing your commitment to care.

## F. Summary

To conclude, let us briefly sum up and raise some questions that remain outstanding. We began by reviewing the literature on moral distress. We identified four desiderata any successful account of moral distress would have to meet and one methodological constraint: any account of moral distress should avoid the problems of a) *Epistemic Threshold*, b) *Objectivity Constraint*, c) *Absent Affectivity*, and d) *Narrow Aetiology*, while developing an analysis that is grounded in the phenomena themselves. We then turned to testimony of experiences of moral distress and developed an analysis of the cases we presented. We argued that each case presented an example of an individual who has experienced him- or herself to have been morally compromised. We offered an analysis of moral compromise: to experience yourself to be morally compromised is to feel that you are unable to be yourself within a given situation because you feel that you should be able to do what is right (but are not) within that situation. On the basis of this analysis, we raised a hypothesis: moral distress is the ambiguous and painful experience of feeling morally compromised, as described. We showed how this hypothesis meets the desiderata and constraints we identified and how it is further able to accommodate the crescendo effect of moral residue. We then explored a range of possibilities of what it might mean to live well in light of moral distress. A number of questions, however, remain unanswered. We submit that the pursuit of these questions would be fruitful in coming to better understand how to address moral distress:

- How should we assess the appropriateness of each of these responses?
- How far can we generalise any of these responses?
- Are there further responses to moral distress, if so, how are we to understand and assess their effectiveness?



- How are we to understand the ambiguity between feeling like a victim and feeling like a perpetrator?
- Are there other ways of experiencing this ambiguity in different areas of moral life that are experienced as *empowering*, rather than paralyzing?
- Is there a role for resilience in the *rediscovery* of one's practice or commitment in light of moral distress?
- What would it mean to live with moral distress and would this involve resilience in a new role?
- In previous Green Papers, we found that a pattern of 'letting go' and 'holding on' may be central to living well in light of experiences of powerlessness. Could such a dynamic be helpful in response to moral distress? If so, what would this look like?

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