Health Management Forum

Contemporary Healthcare Practice and the Risk of Moral Distress

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Abstract

Healthcare professionals are moral agents whose fiduciary relationship with the public is animated by responsibility and the promise to use knowledge and skills to aid those in their care. When their ability to keep this promise is constrained or compromised, moral distress can result. Moral distress in health care is defined and outlined. Constraints and factors that lead to moral distress are identified, as are the means that individual professionals and organizations employ to address it. A call made for transformative change to overcome a culture of silence and to sustain a healthcare system that is morally habitable.

"… cumbersome, incapacitating, joy-killing, insomniogenic moral responsibility."
Zygmunt Bauman, Postmodern Ethics[1]

Healthcare professionals are moral agents, their practice necessarily grounded upon disciplinary standards, codes of ethics, the values of empathy and compassion, and the ongoing demand for conscientiousness and integrity. Their fiduciary relationship with the public is animated by responsibility and the promise that knowledge and skills will be used to aid those in their care. Their ability to keep this promise, however, can be constrained and compromised. When this happens, moral distress can result.

Moral distress is a term that originated in nursing ethics but has become common across the disciplines that share responsibility for health care in Canada, including those in management, whose roles— particularly in priority setting and resource allocation— make them vulnerable to moral distress.[2] Moral distress manifests physically, can generate relational changes, and may

encompass a loss of meaning and purpose affecting the heart of one's professional and personal identity. The practice environment and its culture play a role in this phenomenon although strategies and interventions to deal with it have been primarily aimed at the individual. Concerns exist about the conceptual clarity of the concept[3] but a useful definition of moral distress is:

> the embodied response (e.g., sleeplessness, headache, nausea, anxiety) of an individual to a moral problem for which the individual assumes some moral responsibility, makes a moral judgment about the appropriate ethical action to be taken but, due to real or perceived constraints, participates by act or omission in what s/he regards as moral wrongdoing.[4,5,6,7]

Moral distress that remains with a healthcare professional (and may trouble them for years) is termed *moral residue*.[8] Each unresolved episode builds upon previous ones, creating a *crescendo effect*.[9] Moral distress has motivated professionals to leave their position, their organization, and their discipline.

Healthcare environments are moral communities[10] where difficult ethical decisions and issues arise daily. This being so, ethical sensitivity, attentiveness, and questioning are essential to its climate. The risk of moral distress is ever present so the means to address and resolve it should be, too. If they are not, levels of moral distress can rise and, like an 'ethical canary, [11, 12] reveal that the environment is becoming unsafe and toxic.

Factors Leading to Moral Distress

Factors which lead to moral distress have been categorized as internal (e.g., fear, lack of knowledge) and external (e.g., system characteristics, team conflicts). Yet such designation is not clear-cut. While failure to voice one's ethical concerns may be due to lack of self-confidence or courage, reluctance to speak out may exist due to real external jeopardy. In some settings, the

expression of moral distress can be taken as weakness, an inability to tolerate the inherent stress of health care ("Can't take the heat?") or lead to a reputation as 'troublemaker' ("Why do you have to make a fuss?").[13] Either reaction by colleagues, management or both can result in a sense of alienation, of isolation, of being 'cut adrift' from the team or organization. [This can occur quite literally as when the person becomes unwelcome in the staff lounge or at the cafeteria table.] Fear of disconnection motivates silence. Lynn Musto's Paddy Rodney's, and Rebecca Vanderheide's identification of moral distress as a form of "relational trauma"[14] is well-grounded.

Empirical studies indicate that patient/family suffering and conflict between the family and the team, and among team members are strong contributors to moral distress. [15] The most cited factor, however, appears to be resource allocation (human and material), particularly if staff believe that safe staffing and/or necessary treatment and equipment are unavailable. [16,17] Documented discussions on moral distress with healthcare professionals disclose that lack of time or structures for improving team dynamics and/or the belief that one lacks voice and influence on policy (i.e., management has a 'my way or the highway' attitude) are also factors.[18]

Addressing Moral Distress

Healthcare professionals' personal attempts to cope with the anguish of moral distress include: focusing on positive aspects of their role and past successes in making a difference; seeking time away from their workplace; sharing distress (but not details) with a spouse, friend, or colleague; self-care (exercise, journaling, humour, mindfulness, spirituality); and choosing to leave their position (the 'exit' option). [13, 19]These strategies do give some relief, but damage to integrity is not easily repaired. Moral distress has been called a "dirty experience" and its dirt lingers.[20]

Occasionally, the notion is raised that the antidote for moral distress is greater moral courage on the part of the healthcare professional. This notion needs to be rejected. It is an oppressive expectation in which the cost is borne by the lone individual; further, it cannot address moral distress created by dysfunction in teams and systems.[21]

If healthcare professionals' efforts to query incongruences between organizational values and their disciplinary ones have been met with silencing and charges of 'resistance,' a collective sense of impotence and hopelessness can occur[22] and a culture of silence be perpetuated. Transformational change involving organizational efforts will be required to sustain a more positive ethical climate.

Sustaining Morally Habitable Environments

Professional responsibilities need to be aligned with power. When it is, professionals are able to use discretionary judgement while enacting their roles; feel safe to express moral uncertainty and raise ethical questions, and find that conflicts are addressed collaboratively. This type of power flows from the social structures and relationships in which practice occurs, along with intersecting personal, professional, and organizational values. [14]

Empowerment for ethical practice can be supported by the encouragement of inter-professional contributions to ethical decision-making and by ensuring opportunities for the processing of difficult care situations (e.g., formal/informal ethics debriefing, ethics consultations, ethics committees) and for ethics education (e.g., ethics rounds to learn from cases, ethics training).

Leaders should not be hesitant to raise questions such as: what are the most common sources of moral distress in *this* care facility? and, is moral distress a significant factor in staff absenteeism and turnover? There are tools available that allow moral distress levels to be

measured, focusing on context [e.g., Moral Distress Scale (MDS) [23] MDS-Revised[24]] or time (Moral Distress Thermometer[25]). They are useful as a means to assess effectiveness of interventions.

Arts-based resources to promote dialogue and insight into aspects of health ethics are increasingly common. An example of a moral distress resource is the film, *Just Keep Breathing*. [26] Based on Canadian research, it is the dramatization of the stories of pediatric intensive care unit (PICU) teams, showing how moral distress arises and advances. Use of the film has been successful in helping healthcare professionals speak about moral distress and their own experience; it is being used in staff orientation, in-services, and medical education.

The most important strategy for an organization may be acknowledgement by leaders that moral uncertainty and distress are ongoing risks in health services—risks that they share with 'frontline' staff. As Jennifer Gibson argued in a 2012 issue of this journal, organizational ethics cannot be "the elephant in the room." [27] Health leaders need to explicitly acknowledge their concern for staff crises of conscience and admit that they experience similar struggles.[27] Speaking out about the latter may be initially difficult, given that recognition and understanding of healthcare leaders' moral distress has been slow to evolve. There is little to be found regarding it in the research literature, although a 2011 Canadian exploratory study, using interviews and focus groups, revealed that mid- and senior-level health system managers experience moral distress related to managerial functions (e.g., implementing policy they do not wholly support) and that differences existed which related to place in organizational hierarchy.[28] There is a pressing need for further study of leaders' moral distress.

Moral distress needs to be recognized as a risk component of the heavy responsibility of healthcare provision. It indicates ethical sensitivity to one's role and commitment to public trust.

As ways are found to address and resolve it by stakeholders working together, our healthcare systems will be more fully sustained as moral communities.

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