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Special Section on Moral Distress

Harnessing the Promise of Moral Distress: A Call for Re-Orientation

Alisa Carse and Cynda Hylton Rushton

ABSTRACT

Despite over three decades of research into the sources and costs of what has become an "epidemic" of moral distress among healthcare professionals, spanning many clinical disciplines and roles, there has been little significant progress in effectively addressing moral distress. We believe the persistent sense of frustration, helplessness, and despair still dominating the clinical moral distress narrative signals a need for re-orientation in the way moral distress is understood and worked with. Most fundamentally, moral distress reveals moral investment and energy. It is the troubled call of conscience, an expression of fidelity to moral commitments seen as imperiled or compromised.

It is crucial that we find ways to empower clinicians in heeding this call—to support clinicians' moral agency and voice, foster their moral resilience, and facilitate their ability to contribute to needed reform within the organizations and systems in which they work. These objectives must inform creative expansion in the design of strategies for addressing moral distress in the day-to-day of clinical practice. We include suggestions about promising directions such strategies might take in the hope of spurring further innovation within clinical environments.

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INTRODUCTION

The challenges of moral distress have become a rallying cry for clinicians and a focal point in the clinical ethics literature. Although the term "moral distress" was originally coined to refer to the anger, frustration, and suffering of nurses who felt their integrity was threatened by institutional pressures and constraints,[1] moral distress is now recognized as a growing reality across clinical disciplines and roles,[2] contributing to escalating rates of burnout and turnover, challenging recruitment, and imperiling the quality of patient care.[3] An alarming number of clinicians report feeling besieged and disillusioned in healthcare systems that are riddled with moral failings they feel powerless to change. In this environment, moral distress is a pervasive problem, one that too often leads clinicians to experiences of helplessness and moral failure. Despite over three decades of research into moral distress, and widespread awareness of its costs, there has been little significant progress in effectively addressing its sources or diminishing its destructive impact.

There is no question that addressing moral distress will require multifaceted reform efforts, including vitally needed systems reforms.[4] Our focus here is on the direct support and empowerment of clini-

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cians in cultivating ways of working with moral distress that can mitigate its detrimental consequences in day-to-day clinical practice. As we will explore, this will require individual effort but also organizational innovation. To date, strategies on this front have included enhancing education in ethical analysis, encouraging interdisciplinary training and collaboration, and expanding ethics consultation, mediation, and conflict resolution.[5] These represent promising steps. At the same time, we believe the persistent sense of frustration, helplessness, and despair that still dominates much of the clinical narrative around moral distress signals the need for a basic re-orientation in the way we understand, think about, and work with moral distress, one that more fully recognizes and harnesses its positive promise and potential.

Most fundamentally, moral distress reveals moral investment and energy. It is the troubled call of conscience, an expression of fidelity to moral commitments seen as imperiled or compromised. Realizing the positive promise of moral distress will require finding innovative ways to empower clinicians in heeding this call—to support their moral agency and voice, foster their moral resilience, and facilitate their ability to contribute to needed reform within the organizations and systems in which they work. These objectives must inform creative expansion in the design of strategies for addressing moral distress in the day-to-day of clinical practice if we are to move beyond the sense of victimization, failure, and despair too often accompanying moral distress and better support clinicians' ability to practice with integrity. At the end of our discussion, we offer some suggestions about promising directions such strategies might take.

MORAL DISTRESS REVISITED

As the concept of moral distress has gained traction in clinical bioethics, it has been understood in diverse, and sometimes conflicting, ways.[6] We understand moral distress broadly as anguish or anxiety tied to a sense of imperiled integrity. Sometimes moral distress entails a judgment that one has violated a core value commitment, failed to fulfill a fundamental moral obligation, or in some other significant way fallen morally short under conditions of constraint or duress. Moral distress is not, however, always tied directly to an experience of personal or professional moral failure or shortfalling. Sometimes it consists in uncertainty or anticipatory anxiety in the face of constraints, pressures, or moral concerns that are experienced as challenging to, or threatening of, one's integrity.[7] It can also involve situations in which one is concerned about being complicit in wrongdoing, or uncertain or anxious about contributing to, or supporting, an ethical lapse—perhaps on the part of an organization in which one works or with which one is affiliated. The sources of moral distress are diverse, as we will explore. They can be both social and institutional and, as is increasingly recognized, psychological, including notably the psychological "residue"[8] of insufficiently resolved moral distress itself—affective states and emotions (for example, of anxiety, frustration, shame, anger) carried into new situations in ways that can diminish clinicians' moral resilience and responsiveness, leading to escalations of moral distress, now widely known as the "crescendo effect."[9] We will discuss the cumulative and dynamic nature of moral distress in some detail later. Crucially, moral distress emerges in the dynamic relationship between the individual clinician and the context in which he or she practices. Addressing moral distress will thus require an approach that constructively engages a multiplicity of relational, organizational, cultural, and psychological factors as they dynamically interact in supporting (or eroding) clinicians' moral agency and integrity in particular contexts.[10]

While much attention has been given in the literature to the negative impact of moral distress on the psychological well-being of clinicians and the quality of patient care, most fundamentally at stake in moral distress is the experience of effective moral agency, the sense of trust and confidence in one's ability to sustain integrity—to live and act with fidelity to one's own deeply held, enduring standards and value commitments, including those central to one's professional identity and role. The epidemic of moral distress invites us to think more fully about what is entailed in sustaining moral integrity in challenging conditions and how clinicians might be supported in doing so. As we will argue, moral distress is often an expression of moral integrity rather than a sign or symptom of moral failure. The challenges of moral distress point to the limitations of individual agency and control; we can do our best to act with utmost integrity and yet find ourselves disempowered and silenced—unable to effectively uphold the moral standards to which we are committed or to give effective voice to moral concern or protest. Too often when this happens, the moral distress experienced is inflected by a sense of personal deficiency and failure, despite the constraints and pressures encountered. It is therefore urgent that we think more fully, both about the distinctive kinds of chal-

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lenges generating moral distress and about ways clinicians might be better supported and empowered in addressing these challenges.

To this end, we begin with reflections on an understanding of moral distress given especially systematic articulation in a recent analysis of moral distress by Thomas and McCullough.[11] While Thomas and McCullough's analysis is in many respects clear and insightful, it reinforces a troubling view of moral distress on which it is too readily associated with individual moral weakness and deficiency. It thus contrasts in stark ways with the understanding of, and approach to, moral distress we seek to characterize here.

Thomas and McCullough's "Taxonomy" of Moral Distress

In a recent analysis, Thomas and McCullough develop a "philosophical taxonomy" of what they call "ethically significant moral distress."[12] Their taxonomy represents one of the most systematic accounts of moral distress to date. On Thomas and McCullough's account, moral distress is a response to impediments encountered in clinical circumstances that incentivize *akrasia* or "moral weakness," introducing considerations of "self-interest" that "weaken the self-discipline and commitment to the care of others required by professional and individual integrity."[13] These impediments fall along a spectrum: the more formidable the impediment, the higher the level of self-sacrifice required to act with integrity.

Impediments that "challenge" integrity can be withstood, given sufficient self-discipline. Impediments that "threaten" integrity introduce incentives that are powerful enough to "undermine" the self-discipline needed. Impediments that "violate" integrity are "so powerful that one finds oneself completely unable to do the right thing." In cases that "violate" integrity, "the self-discipline required to sustain the commitment to scientific, clinical, and moral excellence that define the healthcare professional's role" is "destroy[ed]."[14] When clinicians are aware that they have acted in self-interest, "against considered moral judgment," they experience moral distress, which "manifest[s] psychologically" in a range of states, including "anxiety, frustration, anger," "burnout [and] depression," all of which can negatively impact the quality of patient care.[15]

In developing and defending their taxonomy, Thomas and McCullough expand on a case first presented by Epstein and Delgado.[16] In the case, a patient in the intensive care unit (ICU) of an academic medical center who is suffering sepsis and multi-organ failure goes into unstable ventricular fibrillation. The nurse and resident physician begin cardiopulmonary resuscitation (CPR) and are joined by medical interns who respond to the resuscitation attempt. It is believed that the patient is dying, so, at the request of the nurse, the resident calls the patient's family members. The family are directed to the waiting room. Given the patient's condition, the nurse believes CPR must stop so that its utility and the patient's wishes can be discussed with the family. The resident agrees, but continues to run the code, telling the interns to switch off in doing compressions "so everyone gets a chance to learn" and all will get some practice in a real code situation. The nurse attempts to intervene and stop the exercise, but is persistently overridden by the resident. The situation escalates as the resident physician continues the exercise and the nurse's intensifying efforts are dismissed. Finally, at her "wit's end," the nurse tries unsuccessfully to physically stop the resuscitation and, refusing to participate in the code, threatens to leave and call the nurse manager and attending physician who have authority to override the resident physician's orders.

In analyzing the case, Thomas and McCullough describe the nurse's integrity as initially "challenged" as she witnesses the code exercise undertaken on her dying patient, then "threatened" as her escalating efforts to intervene are ignored, and finally "violated" as she refuses to participate in the code and threatens to leave the scene. At this point, they write, the nurse is in full-blown moral distress; she confronts impediments to moral action so "formidable" that her "self-discipline" is "destroy[ed];" she has never before "abandoned her clinical duties, commitment to teamwork, or doing what is best for the patient."[17]

Thomas and McCullough don't specify what "self-interested incentives" are in play in this case, or why they believe the nurse's self-discipline is "destroyed." Perhaps they interpret the nurse's threat to leave the scene as a self-interested effort to soothe her own rattled emotions. If so, this is a troubling interpretation at best. Indeed, one might wonder why it is the nurse's conduct alone that is assessed, given the complex dynamics characterizing the situation. It is understandable, in one sense, as the example is intended to illustrate the spectrum of escalating stages of moral distress. The resident and others are a kind of "foil" used to generate an analysis of the nurse's escalating moral distress as it exemplifies the stages of Thomas and McCullough's spectrum.

But in focusing on the nurse without attending to other facets of the situation, Thomas and McCul-

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lough effectively assign disproportionate moral responsibility to her, marking her as the locus of moral deficiency and weakness.[18] This deflects attention away from a number of significant factors that are in play in the situation, including the power imbalance between the nurse and the resident physician, the authority of the resident physician over the medical residents and interns at the patient's bedside, the complete breakdown of effective communication within the "team," or the potential ways the resident physician's own conduct might be incentivized within the organization. It puts the focus of moral appraisal on the individual who is experiencing moral distress, rather than considering a broader array of relational and institutional factors that are contributing to moral distress.

Moreover, the description of the nurse as "abandoning" her patient because her "self-discipline" is "destroyed" frames her conduct as morally defective, tying her moral distress to her awareness of her own (alleged) moral deficiency. Thomas and McCullough's spectrum analysis is insightful in highlighting that moral distress can be a response not just to failures (or "violations") of integrity, but also to perceived challenges and threats to integrity. At the same time, framing the spectrum of moral distress itself in terms of *akrasia* or "moral weakness" reinforces a deeply problematic understanding of moral distress, one too often reflected in the sense of moral deficiency and failure that are felt by clinicians experiencing moral distress.

Consider a different understanding of the nurse's case, one that shifts the narrative. On this understanding, the nurse is not abandoning her patient or her team; she is resisting participation in what she sees as an ethical violation of her patient, protesting this violation, and attempting to do everything in her power to put an end to it. She is herself unable to succeed in protecting her patient because she lacks the institutional authority to override the resident's orders. In preparing to leave the scene, she is not seeking to soothe her own rattled emotions (her "distress"), but to locate staff with the requisite authority to protect her patient from further violation. Leaving is thus not an act of self-interest or a failure to undertake the "self-sacrifice" necessary to meet her clinical obligations; it is an attempt to meet her obligations—to act on her "considered moral judgment"—in a situation in which time is urgent, her own power and authority are limited, and her concerns and protests are ignored.

On this understanding, the nurse is attempting to cut moral losses in a challenging situation. No amount of self-discipline and willpower can secure the outcome she deems morally optimal; nevertheless, she resolutely fights for her patient as best she can. In an important sense, her actions are an expression of her integrity, not a failure (or "violation") of integrity.

We can, to be sure, imagine the nurse might herself emerge from the resident's use of her patient to practice CPR feeling emotionally distraught about what she experiences as her own failure to effectively protect her patient. She might even feel as though she is "abandoning" her team in leaving the scene. Like many clinicians who struggle to effectively uphold their own moral standards in the face of pressures and constraints, the nurse's moral distress may carry a sense of personal moral failure and shame. But if so, this is troubling, for it would take insufficient account of what this case so poignantly captures, namely, the susceptibility of individual moral agency to the power and authority of others, the way others' treatment and regard can limit what we can effectively do, including the outcomes we can effectively achieve, and the moral concern and protest we can effectively voice.

We believe that this case signals a more general need for a complex understanding of the relationship of moral distress to moral integrity, one that recognizes that it is sometimes in acting with integrity that one experiences moral distress, precisely because one's powers are limited or one's efforts are thwarted or dismissed.

This is not to deny that moral distress can itself sometimes be a moral liability. Acute or unresolved moral distress can take a toll; it can diminish emotional and moral resilience, introducing significant internal, psychological impediments to moral responsiveness and integrity. Forms of "self-related distress" can also accompany moral distress and motivate self-protective action that may be harmful to patients. In their broader analysis of moral distress, Thomas and McCullough rightly highlight the well-documented negative repercussions of cumulative and escalated moral distress in generating painful states, including states of "anxiety, frustration, anger . . . burnout [and] depression," that can imperil patient care.[19] While exertions of self-discipline and will can, on occasion, enable clinicians to power through states of suffering and distress in service to their patients, the kind of emotional and moral fortitude and resilience that are needed to sustain moral responsiveness and integrity in morally distressing environments cannot simply be willed "on a dime," but must be fostered and supported over time. As we will explore, the systems in which clinicians practice can play an important role both

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in supporting and in eroding the clinicians' internal resilience.

In their positive recommendations, Thomas and McCullough highlight institutional and systemic sources of moral distress, urging healthcare leadership to implement institutional mechanisms for the ongoing review and reform of potentially integrity-imperiling "challenges and conflicts" that are created by organizational practices and policies; they also emphasize the need to clamp down on clinicians who, perhaps like the resident physician in their example, abuse their power and authority in ways that imperil their colleagues' ability to work with integrity.[20]

These forms of organizational oversight and accountability can be essential in addressing sources of moral distress. They point beyond the individual clinician who is experiencing moral distress to the broader conditions generating the distress. At the same time, moral distress is not always a response to problematic organizational incentive structures or institutionally tolerated abuses of power or authority. Its sources also reflect the real and inescapable moral complexity of many clinical situations, including the fact that conscientious and thoughtful clinicians, patients, and families can struggle with uncertainty, feel constrained by the pressures and limitations of time and resources, and disagree about ethically appropriate interventions and optimal outcomes. We have good reason to expect moral distress to be an ongoing challenge in clinical practice, even when troubling incentive structures or abuses of power are not an issue.

In understanding and addressing moral distress, we must shift away from the prevailing negative narrative, in which moral distress is too often tied, at the individual level, to "moral weakness"; this reinforces a troubling tendency to regard moral distress as evidence of personal moral deficiency, an inability to withstand the challenges and demands of clinical work. The experience of moral distress is not itself a symptom of moral deficiency or failure; it is a sign that one is attuned to ethical pressures or concerns, "an alarm signal when a conscientious person is required to practice in challenging contexts."[21] More fully understanding the challenges generating moral distress can help rehabilitate our relationship to it.

In the next section, we explore four challenges we believe are key: the experiences of moral powerlessness, frustration, and anger; of voicelessness and isolation; of diminished moral responsiveness; and of shame. We highlight the dynamic and cumulative character of moral distress, the way it can itself diminish psychological and moral resilience, impairing the capacity of clinicians to respond with composure and clarity to new morally distressing situations, thereby compounding the experience of moral distress, and often, too, the sense of deficiency and shame in the mix. Making positive and lasting headway in addressing the crisis of moral distress will require finding ways to address these challenges.

THE CHALLENGES OF MORAL DISTRESS RECONSIDERED

Powerlessness, Frustration, and Anger

In a personal narrative, Susan McCammon, a surgical oncologist, describes her "helplessness and outrage . . . immense, and frightening in its unfamiliarity" when she learns that the institution where she practices has, in the wake of a damaging storm, "terminated" care for uninsured patients.[22] McCammon questions this decision, moving up the "increasingly reticent and then elusive" line of authority, only to discover she is powerless to combat it. "While this decision was made by the administration," she writes, "its enactment was delegated to the physicians. Thus, not only were the physicians not involved in the decision to terminate their patients, they shouldered the burden of telling their patients that they would no longer be treated."[23]

Carrying out a decision she deems immoral, McCammon bears the brunt of her patients' terror, grief, and rage. Like many clinicians, she must navigate a situation she has not designed, confronting choices resulting from institutional practices and policies she lacks authority to change. She is expected to acquiesce to, and carry out, decisions that are at odds with her own moral convictions. Continuing to work within the system is the price she pays to remain connected to her patients and true to her values of service. But it is a steep price, one McCammon experiences as morally compromising.

The experience of powerlessness, of being "caught" and pressured to do what one believes to be wrong, or impeded in meeting moral commitments one takes to be fundamental, is a key theme in narratives of moral distress.[24] This powerlessness has many faces—the nurses and physicians mandated by their hospital to treat a catastrophically brain injured child even when they believe doing so to be "cruel," who "observe their own hands engaged in what they perceive as the unconscionable act of harming a child"; the clinician so overwhelmed by her patient load she cannot provide what she regards as safe and adequate care;[25] the neonatal intensive care unit team that, for lack of

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alternatives, releases a still fragile infant into a social environment it deems inadequate and perilous; the ICU nurse who lacks authority to stop a practice code that she believes is violating her dying patient.

When moral distress is tied to a sense of powerlessness, clinicians often feel helpless, frustrated, and angry, trapped in situations they are unable to alter or exit without undue moral cost.

Voicelessness and Isolation

The sense of powerlessness, frustration, and anger is often connected to an experience of voicelessness, especially when one's moral concerns are devalued or disregarded. Thomas and McCullough's ICU nurse protests, but her protests are ignored by her team and are dismissed by her superior. McCammon's questions and concerns about her institution's policies in the wake of the storm meet with administrative resistance and evasion. In a different kind of case, a clinician reflects on the "strong wall of silence" he experiences in response to administrative bullying and abuse, of the "fear of retaliation" that "prevents professionals from doing what is right—speaking up."[26]

Even when no direct retaliation is feared, institutional hierarchies can have a profound impact. A nursing student describes obeying her teacher's commands to remain silent about an act she witnessed: "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."[27] The inability to give an effective voice to moral concern or to protest can be alarming and humiliating; if persistent, it often leads to silent suffering and a keen sense of moral isolation.[28]

The contours of morally distressing situations are diverse: Clinicians may experience their integrity as imperiled by resource constraints, by others in authority, by conflicts with patients or colleagues that stymie resolution or progress, or by policies they lack the authority to override. Sometimes moral distress is an anguished response to direct participation in perceived wrongdoing under duress, such as providing painful treatments whose complications degrade the human body and prolong dying, sometimes to witnessing wrongdoing one lacks the power to stop. One may not, of course, be as powerless and voiceless as one believes oneself to be. But the experience of moral distress highlights our vulnerability, as individual moral agents, to the power and authority of others, to systems that we neither design nor control, and to the way others' treatment and regard can limit what we can effectively do—including the moral concern and protest we can effectively voice.

Diminished Moral Responsiveness

The moral demands of clinical work can make the toll of moral distress especially poignant and concerning. Patients and their loved ones are vulnerable to the quality of the technical knowledge and skill of the clinicians who care for them, but also to the expressive quality of the care they receive—the sense that their experience of illness is understood and honored, and that those caring for them are respectful, compassionate, and trustworthy. Empathic understanding and communication can play critical roles in the discernment and responsiveness at the heart of the clinical excellence, enabling clinicians and patients to communicate effectively and to build and sustain the trusting alliances that are often essential for effective treatment.[29]

More generally, navigating ethically challenging clinical situations requires an ability to detect and interpret the morally salient dimensions of the situation one is in; to identify justified responses to ethical challenges, even when they sometimes entail moral cost or compromise; and to execute action in an emotionally balanced, morally grounded, and compassionate manner.[30] Clinicians in whom these capacities are compromised may overlook morally salient factors, missing occasions for moral action. They may carry unreflective assumptions and projections into new situations, in ways that distort perception and impede their ability to sensitively track the impact of their decisions on patients and others, including clinical colleagues.[31] They may find it difficult to work constructively with conflict or to engage collaboratively in forging shared resolutions to ethical challenges.

In clinical environments, the same factors that make moral responsiveness crucial make it difficult to achieve. Persistent exposure to suffering can lead to empathic overarousal and secondary trauma. Time pressure, exhaustion, uncertainty, conflict, and limited ability to effect desired outcomes often challenge emotional fortitude and resilience. A clinician who carries unresolved moral distress into the clinical encounter may find it doubly difficult to achieve the mix of flexibility, openness, emotional equanimity, and compassion called for. Negative emotional arousal can become overwhelming and unbearable, leading to self-protective patterns of "flight," avoidance and/or abandonment of patients, colleagues,

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and others; "fight," expressions of anger, contentiousness, cynicism, and other forms of aggression and resistance; and "freeze," emotional disengagement, shutting-down, numbing, and disconnecting, sometimes in ways that produce a "robotic" task-orientation.[32] All of these reactions can lead to conduct that is morally disengaged, even callous, risking communication breakdowns, entrenched conflicts, and damaged trust. Clinicians suffering from persistent moral distress often lament that they have "lost heart," are "simply going through the motions," or "just don't care anymore." In such conditions, one may also cease to see ethical avenues that are open and within reach, or grow numb to injustices or infractions of important principles.

Shame

Chronic, unmitigated, or repeated experiences of moral distress often generate an ongoing sense of deficiency—of what Sandra Bartky identifies as a form of shame, "manifest in a pervasive sense of personal inadequacy . . . a species of psychic distress occasioned by a self or a state of the self apprehended as inferior, defective, or in some way diminished."[33] Crucially, shame need not entail the belief that one has done something wrong. Too often, clinicians feel shame when they are not able to resolve difficult situations, secure desired outcomes for patients, or prevent others' wrongdoing. The experiences of moral powerlessness, frustration, and anger, of voicelessness and isolation can, if sustained, become manifestations of shame when they are tied to a sense of personal or professional moral deficiency. Conscientious clinicians may respond with especially acute shame to signs of their own diminished resilience, apparent in mounting disengagement or diminished responsiveness, considering these to be moral failings. Bartky highlights the "profoundly disempowering" drive for "secrecy and concealment" induced by shame, which can undercut the possibility of solidarity with others—even with those who may be struggling in similar ways—and further intensify experiences of helplessness and isolation.[34] Often in the grip of moral distress, especially when it is chronic or sustained, one becomes the victimized person, the "walking wounded," as a sense of moral injury or grievance takes over. Experiences of helplessness, voicelessness, emotional depletion, and shame can induce a sense of loss and disillusionment—alienation from aspirations that once informed one's professional identity and grounded engagement in purposeful and trusting collaboration with colleagues. It can be increasingly difficult to sustain confidence, courage, and hope.

The Cumulative Dynamic of Moral Distress

It is important to appreciate the cumulative and dynamic character of moral distress. Short-term, moral distress is associated with states of frustration and anger, but also of rage, grief, and guilt, among others. Longer-term consequences include anxiety, emotional exhaustion, depersonalization, burnout, depression, and a range of chronic physical ailments.[35] When unresolved or persistent, moral distress can erode resilience, leaving clinicians vulnerable to disruptive and disabling escalations of distress. Jameton distinguished "initial moral distress" from "reactive moral distress,"[36] the long-lasting painful emotions or "moral residue,"[37] carried in the aftermath of morally distressing situations. Empirical evidence reveals that when triggers of distress are repeated, or new morally challenging situations are encountered, the impact is often cumulative, elevating the residual baseline of somatic and emotional disregulation, producing a "crescendo effect" that increases with intensity as new situations are encountered.[38] This is exacerbated when new distressing situations resemble earlier ones, thus activating memory, heightening the sense of frustration and powerlessness, and generating anxiety as one anticipates new distressing situations around the bend.

Crucially, moral distress does not always trace to discrete and identifiable crises or conflicts. It can emerge more insidiously, beginning with vague moral discomfort, or the dawning awareness, for example, that resource-driven pressure to cut corners and curtail costs—to discharge patients before they are ready or to perform interventions for which one is insufficiently trained—has become morally intolerable; or an anguished realization that the exhausting daily demands of one's understaffed and under resourced facility have eroded the safety and quality of the care one is able to provide, and perhaps led to a loss of the sense of connectedness, generosity, and compassion once present in one's work. While moral distress is sometimes triggered by identifiable crises and conflicts, it can also escalate more gradually, through a cumulative erosion of one's sense of moral effectiveness and integrity. This is important because it can make it more challenging to notice and address moral distress before it escalates in destructive ways.

Whether dramatic or gradual, moral distress can itself disrupt composure, diminish resilience, and impede effective moral agency. It is an inherently cumulative, dynamic phenomenon that can spiral in destructive ways. This is a dynamic that we believe it is essential and possible to interrupt and re-

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direct. Doing so will require recognizing and honoring the moral energy and investment revealed by moral distress so it can be worked with and directed in ways that support clinicians' moral empowerment and voice, and foster the psychological and moral resilience clinicians need in navigating the complex challenges of their work.

MOVING FORWARD: RE-ORIENTING OUR APPROACH TO MORAL DISTRESS

Despite the extensively documented costs of moral distress, it is possible to navigate morally distressing circumstances in positive and constructive ways. It is also possible to grow in the wake of morally distressing experiences—to find meaning, to reconnect to one's original commitments and aspirations, and to release the negative and destructive residue so often fueled by frustration, anger, despair, and shame.[39] Realizing these positive possibilities on a broad scale will require a re-orientation in the way moral distress is understood and worked with. In particular, we must find ways within clinical practice to more fully recognize, and harness, the positive promise of moral distress. We highlight the value of "moral resilience" in addressing moral distress, and urge a shift away from the harsh perfectionism that often informs understandings of moral integrity. Re-orienting our approach to moral distress will require practical recognition of the profound embeddedness of individual moral agency and both the real limitations on individual power and control this entails and the positive potential it represents. We must seek to empower individual moral efficacy and support individual integrity through creative innovation within clinical organizations and shared systems of practice.

Fostering Resilience, Supporting Integrity

Resilience is a concept that has gained traction in various disciplines concerned with managing the effects on individuals of adverse situations, including natural disasters, war, crime, and other potentially damaging and disabling experiences.[40] Generally, resilience refers to the ability to adapt to or recover, in healthy ways, from stress, trauma, loss, and other challenges, to be buoyant in adverse circumstances. A hallmark of *moral resilience* is the ability to restore or sustain integrity under morally challenging circumstances.[41] Moral resilience entails *conscientiousness*—the diligent, resolute, and thoughtful ongoing effort to live in alignment with one's own principles and value commitments, even in the face of challenges and obstacles. Morally resilient individuals do not buckle under adversity or fear; they are buoyant, able to "bounce back," to recall their commitments and to re-orient themselves in ways that work constructively with the possibilities available, and in some instances to grow and learn from adversity. Morally resilient people draw upon inner strength and fortitude in encounters with moral adversity; they are also able to work effectively under conditions in which the possibility of moral adversity or threat is realistically anticipated. While moral resilience requires fortitude and perseverance, it is not simply or centrally a matter of individual exercises of discipline, willpower, or resoluteness, which are of limited value at best in navigating the kinds of integrity-challenging constraints and pressures that often generate moral distress.[42]

Moral distress in all its forms confronts us with the brute limitations of our own power, authority, and control. To acknowledge limitation is to face, head-on, our vulnerability to the choices and conduct of others, and to institutional structures and policies and systems of practice that frame the situations in which we act. This requires abandoning what the philosopher Norman Care calls the "myth" of the "in-control agent."[43] This "myth" and the pressures to be "heroic" can render clinicians especially susceptible to moral distress. In morally challenging situations, it is crucial to accept that the effort exerted can be more important than the outcome achieved, and that compromising wisely can be integrity-preserving. Perfect fidelity to one's own principles and value commitments is simply not always possible. This is not to counsel moral complacency or apathy, but to emphasize the importance of thoughtful and principled consideration of the limits of our own power, control, and understanding. In a positive sense, sustaining integrity must, as Wendy Austin writes, "involve more than a single-minded focus on one's own moral agency." Especially in contexts that are inherently collaborative, as clinical contexts characteristically are, Austin writes, "being ethical . . . involves perpetual responsiveness to others," a "recognition of the messy . . . interdependence of decisions, interests, and persons."[44]

In such contexts, exercising resilient moral agency is not centrally a matter of independent, individual effort, but of collaborative engagement in forging paths that are walked together, and shaped in ongoing ways through shared, collective effort. Moral resilience thus requires flexibility and responsiveness in the ongoing, conscientious process of interpersonal moral negotiation, a willingness to

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revisit and reevaluate one's perceptions and choices with honesty and openness, and both awareness of, and self-compassion in the face of, the inherent finitude of one's own moral power and control. Yielding a perfectionistic, insular understanding of personal accountability and moral integrity is an important step in addressing moral distress.

This is not to deny that moral compromise can constitute moral self-betrayal, especially when it is significant or persistent, or that repeated limitation and constraint on our ability to act as we believe we ought can erode meaningful integrity, leading to a sense of moral deficiency and failure or troubling moral complicity, however hard we try to make the best of a bad situation. We need to dismantle the impediments to integrity in day-to-day clinical practice. This will require finding ways to empower clinicians and secure them meaningful moral voice in addressing the sources of their moral distress. It will also require devising innovative approaches that support clinicians' ability to work directly with their moral distress itself—with the somatic and affective dimensions of distress—thus bolstering their psychological and moral resilience. In what follows, we offer reflections about promising strategies we might take on each of these fronts. Our reflections are largely suggestive and programmatic; we make them in the hope that they will spur further thought, contributing to concrete innovation and experimentation within clinical environments.

Moral Empowerment, Moral Voice

As we have emphasized, moral distress is, most fundamentally, an expression of conscientious moral concern, of fidelity to moral commitments that are seen as imperiled or compromised. It is a troubled call of conscience. Heeding this call—sustaining integrity—under conditions of moral pressure, conflict, and constraint requires being able to stand for, and give voice to, one's commitments and values, choosing whether, when, and how to resist, protest their compromise, or speak for them—even in cases when moral disagreement persists or one's own position will not hold sway. Having a voice—being able to assert appraisals, raise concern, protest meaningfully, with background trust that one's perspective counts and can have an impact—is crucial to overcoming the sense of moral powerlessness and isolation so often tied to moral distress.

Understanding this can provide insight into how we might support clinicians' effective moral agency and integrity—namely, by creating safe and responsive environments in which clinicians can give voice to conscience in meaningful ways. We believe clinical organizations and institutions can significantly mitigate moral distress by creating what Margaret Walker has (broadly) called "moral-reflective spaces," in which clinicians are provided the opportunity to meet and explore the sources of moral distress in their day-to-day practice.[45] Crucially, these reflective "spaces" would be formally instituted and facilitated, with regular, designated times and places, providing ongoing (rather than crisis-driven or *ad hoc*) opportunities to engage in collaborative ethical reflection and exploration. They would provide a safe and responsive forum in which clinicians can speak to ethically troubling challenges, lodge concerns and suggestions, express moral anger, share stories, and propose reforms without fear of retaliation or other negative repercussions.[46] They would also invite clinicians across roles and disciplines into active engagement in thinking, querying, and reflecting together about the ethical challenges they encounter in their day-to-day work,[47] thus enhancing clinicians' understanding of diverse ethical perspectives and concerns as they are attached to distinct roles and responsibilities within clinical practice.[48]

In meeting regularly on equal terrain to explore ethical challenges and concerns in an environment of curiosity, trust, and respect, clinicians representing different disciplinary and clinical perspectives might carry a more egalitarian sensibility of mutual respect and understanding back into the clinical "trenches," feeling that their voices have been heard and valued and that their moral views can have an impact.[49]

In addition to providing opportunity for shared ethical reflection and trust building, moral reflective spaces can be locations of valuable ongoing ethical skill-building, including skill in constructive moral reflection and communication. There is a standing risk that expressions of moral distress will be construed in a reductive way (both by speakers and hearers) as mere lamentations or reports of inner states—for example, of frustration, anguish, anger, discomfort—rather than as assertions of moral appraisal, concern, or protest. There is also a risk that both the conflicts generating moral distress and the solidarity arising from shared distress can lead to a damaging intensification of negative energy, a litany of reasons to feel hopeless, that further entrench resentment or deflate efforts to seek needed reform. We thus envision an important role for skilled facilitators in cultivating ongoing engagement in "narrative repair," guiding the development of "counter stories"—through which themes of victimization, powerlessness, guilt, and shame might,

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over time, yield to empowered discourse, in which integrity-preserving and restoring strategies are identified, energizing moral courage and hope.[50] It is also important to encourage movement beyond impoverished moral vocabularies or cryptic, shortcut, disguised claims—pleas and "complaints"—that get easily dismissed ("Why are we doing this?" "We've been down this road before." "Nothing will ever change."), so that observations and concerns are framed in ways that invite constructive and robust ethical analysis: What is ethically at stake here? What features of the situation are amenable to compromise and further exploration? What assumptions are we making? Are they true? What interim steps might we take to shift our understanding or change the situation? Crucially, clinicians' expressions of moral distress would be offered into "a space of reasons" in which they could be explored—analyzed, contested, debated, emended, and checked against diverse perceptions and perspectives. They would be heard not as just laments, but as a call or appeal to others with whom there is hope of achieving greater shared moral understanding and alignment in practice. A crucial piece of this may involve the acknowledgment of moral anger, and the creation of space in which anger can be witnessed and constructively worked with in a respectful and safe context. A context like this might, for example, afford an opportunity for the ICU nurse, resident physician, and medical residents and interns in Thomas and McCullough's case to carefully hash out and explore what happened in the practice-code situation, and identify ways to proceed, should a situation like that arise again.

The pragmatics of integrating such "spaces" into clinical environments is something that must be decided in the concrete, within actual organizations and institutions—and it will take experimentation. They might, for example, be integrated into daily clinical rounds, ongoing patient care conferences, morning reports or clinical hand-offs, regular, structured debriefing sessions, facilitated "ethics conversations," or dedicated ethics rounds.[51] What we are proposing would include an expansion of formal, facilitated, interprofessional ethical engagement beyond consultation models, making constructive and inclusive reflection an integral part of clinical practice. It would involve a shift away from a quandary-centered orientation that is tied to discrete and identifiable conflicts, crises, and choice points, to a more inquiry-based, open-ended, model of ethical reflection, that includes, but does not focus on, solution seeking and decision making. This, in turn, would invite the extension of ethical exploration to include systemic issues—for example, power dynamics, communication breakdowns, interdisciplinary tensions, and other matters of practice and protocol that trigger moral distress in the daily life of clinical work.[52] The emphasis would be placed on appreciating diverse ethical perspectives and orientations, thereby encouraging clinicians to examine their own ethical assumptions and biases, to extend their moral imaginations, and to develop comfort with the idea that there may be more than one interpretation of, and viable resolution to, the challenges they confront.[53] Especially if a premium is placed on achieving insight into others' perspectives, rather than on agreement, there would be potential to enhance mutual understanding and develop both greater respect for complexity, and greater comfort with ethical uncertainty.

There is no question that "moral-reflective spaces" of the kind we are envisioning are best joined with broader reforms within healthcare practice and policy, which protect clinicians' freedom to question and protest, empower and authorize clinicians to contribute to needed practice and policy reforms, and commit resources to the support of innovative ethical education and consultation.[54] While moral-reflective spaces represent just one piece of a bigger picture, we believe they hold significant promise as a way to help stem the escalation of moral distress. They would offer clinicians a consistent, ongoing opportunity to exercise constructive moral agency, to see themselves as members of a larger moral community that provides a safety net of support in response to morally distressing or ethically complex situations. Joining others in grappling with the sources of moral distress can enhance mutual understanding and respect and set a shared ground for proposing and experimenting with changes in practice and protocol. This can diminish the sense of helplessness, isolation, and despair so often tied to moral distress. More positively, such "spaces" would offer promising opportunities to harness the moral energy and investment revealed by moral distress, and direct it in ways that support clinicians' empowerment and voice.

Tapping into the Promise of Mind/Body Connection and Mindfulness Practice

In addition to creating moral reflective spaces in which clinicians can speak to, and explore, sources of moral distress, we believe it is important to find ways to support clinicians' ability to work constructively with their moral distress itself, with the somatic and affective states of "distress." As noted above, moral distress can, if insufficiently ad-

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dressed, disrupt composure, diminish resilience, and impede moral responsiveness. The ability to cultivate mental and emotional fortitude, to maintain greater inner stability and resilience, can be crucial in the face of morally distressing clinical realities that often lead to reactivity and outrage, numbness, and withdrawal.

We know, for example, that sometimes, when mired in heightened emotional states, we can be impeded in our ability to remain open and curious, able to engage in inquiry, reflection, or constructive exchange. We can feel stuck, and react with anxiety, anger, or fear that close down imagination and flexibility, and lead to narrow and rigid views of what is possible, obscuring creative, integrity-preserving compromises and unforeseen options. In heightened states of emotion, we can hold on to convictions by selectively honing in on confirming evidence, while remaining immune to disconfirming evidence. The capacity to identify the morally relevant aspects of a situation and to weigh their significance realistically, to give room to different moral perspectives, and to work flexibly, creatively, and collaboratively in envisioning possible ways forward can all be impaired.[55] Thus the ability to work skillfully with somatic and affective dimensions of distress is not just a way to address the physical and psychological "fallout" of moral distress, to secure greater well-being, it is also a way to strengthen moral efficacy and integrity, to foster capacities that ground the moral discernment and responsiveness that are at the heart of moral integrity.

We thus urge the development of approaches within clinical training and practice that offer clinicians ongoing ways to work skillfully with the emotional and somatic disregulation generated by moral distress. Here we must experiment creatively. Among the strategies we believe hold great promise are techniques directed to cognitive, affective, attentional, and somatic awareness and self-regulation, including approaches derived from contemplative traditions used for stress reduction and resilience training. Mindfulness is an awareness of the present moment that emerges by purposefully paying attention to and not judging one's unfolding experience.[56] Mindfulness practices to stabilize emotion and focus attention can enable clinicians to perceive the context of their moral adversity with more clarity, curiosity, and openness. "Awareness" practices can assist clinicians in recognizing emotional triggers and states of negative arousal, including symptoms of over-aroused empathy.[57]

There is emerging evidence that mindfulness practices offer promising methods for the support of psychological and moral resilience.[58] Research suggests, for example, that mindfulness-based interventions can decrease rumination and avoidance of experiences, enhance emotional stability, and help sustain equanimity under conditions of stress.[59] These changes, in turn, correlate with the reduction of anxiety and depression and the enhancement of positive emotions, including self-compassion.[60] Mindfulness, in tandem with skillful self-regulation of affect, can enhance clarity and composure, and enable clinicians to be more resilient and flexible in the fray of clinical pressures, less at risk of making clinically poor decisions aimed at alleviating their own distress, better able to address conflict, and more able to engage empathically with patients and colleagues.[61] While some may doubt the practicality of integrating mindfulness practice and other contemplative approaches into clinical work environments, pointing to the already overwhelming work loads and time pressures clinicians juggle, we believe that finding ways to introduce insights and practices from contemplative traditions into the clinic can encourage the institutional creation of time and space for taking stock, for pausing. This can serve as a meaningful antidote to the sense of urgency that is so often a factor in moral distress.[62]

It is also important to note that some forms of mindfulness practice, once learned, offer highly portable techniques clinicians can use to secure greater self-regulation and focus in just moments,[63] and that even brief mindfulness meditation training has been reported to have significant positive effects.[64] New approaches to building such capacities have been proposed[65] and, although further research is needed to evaluate their effectiveness, we believe these efforts hold significant promise as powerful, practical, and scalable means of fostering clinicians' resilience in clinical environments.

CONCLUSION

While it is unlikely that moral distress can be eradicated, it can serve as a valuable catalyst for moral progress. What is needed are productive, integrity-preserving, growth-enhancing strategies for working with and channeling the moral energy and investment that moral distress reveals. There is no question that the positive strategies we recommend must be a part of a robust, ambitious, multifaceted endeavor—a "full-spectrum" approach to developing a culture of ethical practice across healthcare institutions, policies, and networks.[66]

The challenges posed by moral distress in day-to-day clinical practice reveal the limitations of ap-

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proaches within clinical ethics that are cognitively focused and organized around discrete crises and decision points. Although it is sometimes triggered by crises, moral distress can also escalate in gradual, more insidious ways, especially when it is rooted in deeper organizational and systemic challenges. As it consists of disregulated somatic and emotional states, moral distress shapes the way clinicians perceive, frame, and respond to moral problems. If not detected and worked with in an ongoing and proactive way, it often takes on a dynamic of its own. When it does, it can itself further disrupt moral composure, diminish compassion, and threaten clinical collaboration and trust. Too often, by the time an ethics consult, mediation, or other support resource is sought, moral distress has escalated precipitously; emotions are at their height, narratives and conflicts are locked in, and the patient, family, and treatment team have spiraled into full-blown crisis. The challenges of moral distress thus call on us to design interventions that are ongoing, proactive, and integrated into clinical practice in thoughtful ways.

Moral distress itself is not the enemy. If properly worked with, it can heighten awareness that an occasion calls for careful moral consideration and prompt fruitful reflection and action. It is essential that we find new ways to support the effective moral agency of clinicians, at all levels of power and authority, so they can stand for, and give courageous voice to, matters of conscience without fear of resistance, dismissal, or reprisal, and with realistic hope that their constructive protests and creative ideas will be heard and taken seriously. There is also an urgent need for the design of innovative approaches that will support clinicians' ability to work constructively with the somatic and affective dimension of moral distress, and to learn skills that can foster moral resilience and enhance moral efficacy. Constructively working with and redirecting the energy consumed by moral distress can help clinicians to restore their commitment to the people they serve, practice with moral integrity and compassion, and take action to reform the systems in which they work.

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