Tessy A. Thomas and Laurence B. McCullough, "Focus More on Causes and Less on Symptoms of Moral Distress," *The Journal of Clinical Ethics* 28, no. 1 (Spring 2017): 30-2.

Focus More on Causes and Less on Symptoms of Moral Distress

Tessy A. Thomas and Laurence B. McCullough

ABSTRACT

In this commentary on Carse and Rushton's call for reorientation of moral distress,[1] we state agreement with the authors that the discourse of moral distress should refocus on the moral components of integrity. We then explain how our philosophical taxonomy of moral distress,[2] mentioned by the authors, appeals to moral integrity. In this process, we clarify our taxonomy's appeal to Aristotle's concept of *akrasia.* We conclude by offering support of Carse and Rushton's challenge to organizations to strengthen moral integrity by fostering resilience.

Carse and Rushton's call for reorientation of moral distress is a welcome and important addition to the ongoing discourse of moral distress. They underscore the limited progress in effectively addressing moral distress that has resulted from an incomplete understanding of the fundamental elements of moral distress. We agree that if one does not focus on what is *really* going on, the causes of moral distress, one will focus only on its symptoms. The latter is important work, to be sure, but it is not enough and, we fear, will prove inadequate in the long run. We therefore need to curtail our time, energy, and resources fixing the wrong problems with the wrong solutions.

In their appeal for the reorientation of the moral distress narrative, Carse and Rushton adopt our focus on the moral component of *integrity* as the main fundamental element of moral distress that is constantly stressed within a system, and call for reforms that support moral agency and moral resilience. We welcome their characterization of our focus on the *moral* in moral distress and our resulting philosophical taxonomy of moral distress as "the most systematic account to understanding moral distress."

Our proposed philosophical taxonomy of moral distress appeals to the core concept of moral integrity.[3] In the current moral distress literature, too often the exploration of the underpinnings of moral distress has primarily focused on understanding the *distress* component of moral distress. The *distress* component of moral distress centers on the psychological responses (anxiety, anger, frustration, burnout, *et cetera*) of those experiencing moral distress. The study of the psychological manifestations of

Tessy A. Thomas, DO, MBE, is Assistant Professor of Pediatrics, Section of Critical Care Medicine at Texas Children's Hospital, Baylor College of Medicine in Houston, Texas. *tathomas@bcm.edu*
Laurence B. McCullough, PhD, is Adjunct Professor of Ethics in Obstetrics and Gynecology and of Medical Ethics in Medicine in the Department of Obstetrics and Gynecology at Weill Medical College of Cornell University in New York, New York; and is Distinguished Emeritus Professor at the Center for Medical Ethics and Health Policy at Baylor College of Medicine. *Laurence.McCullough@bcm.edu*

moral distress is an important endeavor, since it is well documented that experiences of moral distress generate and involve tangible feelings and responses. However, focusing only on the psychological manifestations and the *distress* component of moral distress is to focus only on symptoms and not the underlying cause. A major accomplishment of our proposed taxonomy is to shift the focus back to the *moral* component of moral distress and thereby its causes. The moral component explicitly emphasizes the interconnection between moral distress and moral integrity; moral distress occurs when moral integrity is challenged, threatened, or violated.[4] These, in turn, cause the psychological manifestations that are well documented in the moral distress literature.

Our taxonomy also appeals to Aristotle's concept of *akrasia,* usually translated as "moral weakness." Why do we sometimes do *precisely* what we ought not do? Moral philosophy has long debated the underpinnings of good and wrongdoing, and much of the scholarship documented is the deep analysis of Socrates and Aristotle's classical account. Aristotle understood *akrasia* to name the intrinsic tendency in some circumstances to act against one's considered right judgment and thus lose self-mastery. This can happen deliberately, when someone in authority uses his or her organizational power to force a healthcare professional to act against considered professional judgment. When resisting such power comes at a very high price, ordinary human beings may sometimes elect to lose self-control and go along, even though they know that they should not. This is not a matter of character, but of behavior and action that can damage character by damaging moral integrity.

Our taxonomy appeals to Aristotle's concept of *akrasia* to raise awareness of the powerful organizational forces that influence behavior and action. The awareness and/or mindfulness that behavior and action may generate discordant judgments in response to challenges, threats, and violations of moral integrity—thereby generating moral distress that manifests with significant psychological sequelae[5]—may help moral agents to better understand their experiences and to identify opportunities for improvement that are based on such mindfulness. Carse and Rushton thus misread *akrasia* as "moral deficiency and failure felt by clinicians experiencing moral distress," and "as evidence of personal moral deficiency, an inability to withstand the challenges and demands of clinical work." It is, instead, the ordinary human behavior of not acting heroically and, therefore, sometimes not having self-mastery. In this view, Aristotle analogizes an akratic moral agent to "a city that votes for all the right decrees and has excellent laws, but does not apply them."[6] We agree with Carse and Rushton that "sometimes in acting with integrity that one experiences moral distress" and the "experience of moral distress is not itself a symptom of moral deficiency or failure." We treat the experience of moral distress as a symptom of the challenges, threats, and violations to moral integrity that originate such behavior, and not in some character flaw. In this respect, the translation "moral weakness" is misleading.

In our view and embraced by the taxonomy, all moral agents have the capacity for moral integrity, but that capacity is sometimes limited by *akrasia* thus understood. It is a mistake to treat this as being morally deficient or a failing. Simply stated, the experience of moral distress occurs when an agent's fundamental sense of sound and strong moral integrity is challenged, threatened, or violated. Thus, being aware of inherent *akrasia* that potentially influences judgments, behaviors, and actions is not a negative narrative of moral distress as suggested by the authors. In fact, mindfulness of actions that are discordant with moral integrity may offer further understanding of the strong psychological manifestations of moral distress that include powerlessness, loneliness, and shame that express injury to moral integrity, and to that extent, loss of self-mastery. Such mindfulness can then guide a moral agent's judgment, behaviors, actions, and self-assessment before, during, and after a distressing situation.

For example, [A] is a new employee in a group practice. [A] finds out that his/her boss [B] has the office manager overbill for services provided by [A] in order to cover office overhead costs to pay ancillary and co-employee salaries. [A] knows that this is not the right thing to do and acknowledges the situation is now challenging his/her moral integrity. [A] wants to speak to the office manager and to [B] about this situation, to seek clarity and express dissent to [B]. [A] does not know if other colleagues are aware of the overbilling practice, and is concerned that speaking up will risk immediate job termination and labeling as a non-team player. [A] feels powerless and lonely. [A] reflects that he/she usually speaks up when he/she sees injustice, but also recognizes that the consequence of following through with usual behavior is higher than prior experiences. [A] decides to wait for six months before committing to a particular course of action: speak up or remain silent.

While Carse and Rushton reiterate the importance of focusing on the moral integrity component

of moral distress in their prelude, they are at risk for falling into the trap of psychologizing *moral* distress. Subsequently, their reconsideration of moral distress falls short. Emphasizing powerlessness, voicelessness and isolation, diminished moral responsiveness, and shame echoes the psychological manifestations of moral distress that have already been identified. These four aspects presented by Carse and Rushton have been well documented in the literature.[7] This psychologizing of moral distress and its resultant focus on its affective symptoms distracts focus on their causes, the *moral* in moral distress. Loss of conceptual clarity impedes the task of reconsidering moral distress that Carse and Rushton propose to undertake.

While it likely impossible to eliminate moral distress altogether, it is possible to curtail some of its dangerous effects on individual healthcare professionals and on healthcare organizations. To this end, Carse and Rushton make the important contribution of identifying innovative practical strategies to address moral distress. The strategies accounted for by the authors appear to focus on bolstering support of the moral agent and preserving moral integrity within complex organizations and their cultures. Organizations formulate mission statements to embody the values of an organization. The mission statements usually include what leadership expects and discourages, as well as what leadership rewards and punishes. Organizational culture influences what leadership tolerates and, crucially for prevention of moral distress, what leadership should not tolerate if it is committed to the sustained moral integrity of healthcare professionals in the organization and thereby to patient safety and quality care. Leadership should tolerate neither the causes of moral distress nor their psychological manifestations.

Carse and Rushton call for healthcare organizations to focus on fostering resilience features and supporting the moral integrity of their clinical staff by creating healthier workspaces. To create a healthy work environment that emphasizes moral empowerment and moral voice, the authors encourage facilitated reflection and narrative sharing in the day-to-day clinical realm. We agree that facilitated discussions/debriefs can invite different frameworks to improve moral understanding and perceptions. Such a focus on moral reflection may empower clinicians to use shared ethical language and maintain the healthy workspace environment needed to improve team dynamics. Additionally, encouraging mindfulness practice can further deepen each moral agent's connectedness to his or her individual goals, values, and feelings, and identify larger connectedness to the organization and colleagues. All these potential interventions, when focused on the causes and the symptoms of moral distress, have the potential to promote resilience, which is essential for sustained moral integrity as a powerful antidote to moral distress.

NOTES

1. A. Carse and C. Rushton, "Harnessing the Promise of Moral Distress: A Call for Reorientation," in this issue of *JCE,* volume 28, number 1.

2. T.A. Thomas and L.B. McCullough, "A Philosophical Taxonomy of Ethically Significant Moral Distress," *Journal of Medicine & Philosophy* 40, no 1. (February 2015): 102-20.

3. Ibid.

4. Ibid.

5. Ibid.

6. Aristotle, *Nicomachean Ethics*, 2nd ed., trans. T. Irwin (Indianapolis, Ind.: Hackett, 1985), 5, 1152a20.

7. E.H. Elpern, B. Covert, and R. Kleinpell, "Moral distress of staff nurses in a medical intensive care unit," *American Journal of Critical Care* 14, no. 6 (2005): 523-30; M.C. Corley, R.K. Elswick, and T. Clor, "Development and evaluation of a moral distress scale," *Journal of Advanced Nursing* 33, no. 2 (2001): 250-6; J.M. Wilkinson, "Moral distress in nursing practice: Experience and effect," *Nursing Forum* 23, no. 1 (1987): 16-29; E.G. Epstein and A.B. Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," *The Journal of Clinical Ethics* 20, no. 4 (Winter 2009): 330.