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Looking at the Positive Side of Moral Distress: Why It's a Problem

Elizabeth G. Epstein and Ashley R. Hurst

ABSTRACT

Moral distress, is, at its core, an organizational problem. It is experienced on a personal level, but its causes originate within the system itself. In this commentary, we argue that moral distress is not inherently good, that effective interventions must address the external sources of moral distress, and that while there is a place for resilience in the healthcare professions, it cannot be an effective antidote to moral distress.

In their article, "Harnessing the Promise of Moral Distress: A Call for Re-Orientation," Carse and Rushton refocus our collective attention on the need for multifaceted strategies to address moral distress in day-to-day clinical practice.[1] While we heartily agree with their call and believe that sustained attention to practice and research that impact clinical practice is certainly needed, we are concerned that their arguments re-orienting moral distress back towards the self (as opposed to the system) are problematic in two ways. One, their re-orientation asks that moral distress be cast in a more positive light—being morally distressed serves as reassurance that the clinician is morally attuned. We agree that morally distressed clinicians are morally attuned, but the experience of being morally distressed is not a necessary condition for moral attunement or for its awareness. Additionally, calling moral distress a positive, for whatever reason, obscures that moral distress fundamentally is a grave problem within a system. Two, part of their call is that moral resilience can be an effective antidote to moral distress—that re-orientation to resilience will allow clinicians to let go of their "perfectionistic" and "heroic" tendencies, be less likely to "buckle under adversity or fear," and be less morally distressed. These suggestions give us pause because the ability to convince healthcare organization administrators to take clinicians' moral distress seriously is predicated on the fact that moral distress is a serious systems problem—an alarm bell that some aspect of the situation has gone awry, not that staff are under-resilient. And, although early in their article Carse and Rushton rightly decry the clinician-blaming implied when moral distress is equated with moral weakness, their call for clinicians to learn to be "buoyant," not to "buckle" under to morally adverse situations, and to make lemonade from their morally distressing lemons continues the clinician-blaming they wish to avoid.

We argue that moral distress is a phenomenon of the industry. It is experienced on a personal level,

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but it reflects systems-level problems. As such, a systemic commitment to addressing the common sources of moral distress is the necessary cure. There is a place for resilience, in that it may help clinicians tolerate the problems, separate self from the problems, or bring problems forward, but, in the end, resilience cannot cure moral distress. In this commentary, we offer some insights on the systemic nature of moral distress based on our experience as moral distress consultants, and we expand on the potential place for resilience in the context of moral distress.[2]

MORAL DISTRESS IS A SYSTEMS PROBLEM —NOT A POSITIVE

At a recent annual conference of the American Society for Bioethics and Humanities, several colleagues were gathered in a hotel lobby discussing a presentation on moral distress they had just heard. One physician told of her frustration at the lack of administrative attention to a persistent problem at her institution that negatively impacted patient care. She turned to the others and said, "Moral distress is exactly what I'm experiencing. How many times must I bang my head against the wall before I just stop trying? When am I going to learn that I will not be heard?" This physician's statement draws attention to some of the key background conditions of moral distress; lack of voice, external causes, and moral hazard (being made to bear the burden of another's decisions), and each of these conditions draws attention to why moral distress cannot be couched as a positive sign, but is and must remain a systems problem to be solved, not merely endured.

LACK OF VOICE

The problem this physician and others face is not that they lack moral agency or are unaware of the wrongness of situations. Clearly, this physician is highly aware of the wrongness and is willing to speak up. The problem is that she has a legitimate claim to know that what is happening is wrong and is not being heard by those with the power to evaluate and fix the situation. This is not a problem with her, but with the system that does not hear her or value her potential as a useful informant or co-operant. We agree with Carse and Rushton when they state, "Having a voice—being able to assert appraisals, raise concern, protest meaningfully, with background trust that one's perspective counts and can have impact." However, having a voice goes beyond trust that one's perspective counts. Having a voice requires a corresponding act of the party with power—an act of hearing. And by hearing, we mean not only listening, but being willing to evaluate and address the situation given what is heard.

EXTERNAL SOURCES OF MORAL DISTRESS

The key sources of clinicians' moral distress are fairly consistent. Following the family's wishes to continue life support measures that are not in the best interest of the patient, witnessing a diminished quality of patient care due to poor team communication, watching patient care suffer due to a lack of careproviders' continuity, working in conditions where staffing levels are unsafe, working with colleagues who are not as competent as care requires, and providing less than optimal care due to pressures from administrators to reduce costs have been shown, over and over, to be the root causes of moral distress for physicians, nurses, social workers, chaplains, and others.[3] All of these sources reflect problems of healthcare systems such as unclear avenues of communication, power structures that inhibit frank dialogue about clinical problems, resource shortages, fear of litigation, and scheduling or staffing routines that undermine accountability. Further, all of these sources clash in some way with professional obligations such as to reduce risk and harm, to avoid unnecessary suffering, to respect patients' dignity, to work as a team for the sake of the patient. And because clinicians must take care of patients in this milieu, their ability to carry out what is in the best interest of patients is, at times, difficult, and optimal care may be compromised. Clinicians understand the realities of healthcare—resources are scarce, multiple opinions are involved, and sometimes what they see as best for patients may be unachievable. Clinicians are also able to recognize when the system is unnecessarily failing them or their patients. It is these situations, and the resultant feeling of being trapped in having to do something that violates professional obligations, that is so problematic. And, although positive changes can and do occur in response to these situations, they reflect a core negative state, not a positive challenge.

MORAL HAZARD

Moral hazard occurs when the one making decisions does not bear the burden of those decisions.[4] Administrators who decide to cease providing oncology care for patients who cannot pay for it do not bear the burden of that decision, but patients surely do, as do the clinicians who are left to explain the

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mess to patients.[5] A physician who decides to continue to aggressively treat a patient, despite the disagreement of the rest of the team, does not bear the burden of carrying out the orders, but the residents and nurses surely do: "I got put in the middle . . . the nurses coming to me and saying why are we doing this and . . . I was quite opposed to doing anything to begin with . . . yet the [attending] is saying to do another thing."[6] Administrators in Winnipeg, Manitoba, who ignored pediatric intensive care nurses' concerns about a surgeon's professional competence did not bear the burden of that decision, but the 12 children who ultimately died as a result of that incompetence surely did.[7]

This is not to say that there must be consensus on every decision or that administrations should not make unpopular decisions. In fact, thank goodness for the clear-minded administrators who are able to make well-informed (even if unpopular) decisions based on a varied set of data. And thank goodness for the keen eye of the attending physician who sees a ray of hope that the team does not see (yet), for this wisdom has certainly saved many a patient's life. The problem is that administrators, physicians, nurses, and other healthcare providers do not practice in a vacuum or disconnected silo, but in a moral community—"a group of people united by a shared common end with moral implications; in this case, the well-being of patients."[8] To function as a moral community is to acknowledge the impact of decisions on others, and to recognize that the insight and expertise of team members makes for better decision making and better patient care.

Given that moral distress arises from external factors, involves a lack of voice despite those voices having a legitimate claim to be heard, and tends to be felt by those carrying out another's decision, moral distress is an alarm bell that there are problems with what is happening at the patient, unit, or organization level, and not problems with clinicians' goals, expectations, or values. The presence of moral distress should, therefore, serve as the impetus to demand systematic change. That one can use moral distress as a reason for change does not alter the nature of moral distress as an unalloyed negative. We need not recast moral distress in a positive light to see that good can come from those whose internal moral alarm bell caused them to raise their voices against morally wrong situations. Their acts of resistance should be celebrated, but that they had to resist in the first place should not. The positive promise Carse and Rushton desire comes from organizational interventions to resolve moral distress, not from the experience of moral distress itself.

MORAL RESILIENCE AS POSITIVELY STATED CLINICIAN-BLAMING

In the beginning of their article, Carse and Rushton offer a thoughtful critique of Thomas and McCullough's taxonomy of moral distress;[9] highlighting that their taxonomy misattributes moral distress to individual moral weakness, and misperceives moral distress as a failure of personal moral resolve and self-discipline. We readily agree with their critique. Carse and Rushton also underscore that experiencing moral distress is the sign of an attuned conscience, not a weak will. We agree. However, their subsequent call for enhanced moral resilience in clinicians in response to morally distressing situations, whether acute or cumulative, is problematic. Although they avoid calling morally distressed clinicians weak or lacking in moral resolve or self-discipline, Carse and Rushton's positively framed language of moral resilience can have a similar impact—blaming the clinician for not bucking up, not being buoyant, or not looking at morally distressing situations as a growth opportunity. Learning to reframe situations to see previously unseen potential avenues or even positive aspects is a valuable tool and skill. Unfortunately, the language of fortitude and perseverance that Carse and Rushton associate with moral resilience echoes the traditional "keep a stiff upper lip" or "suck it up" ideologies foisted for so long on clinicians, which much of the recent research on moral distress is trying to undo. Therefore, our concern is that in attempting to affirm clinicians' moral antennae for detecting moral distress, we are careful not to gloss over the wrongness of the situation or send the message that a way to address moral distress is to be more resilient, when the root causes of moral distress are external and system-oriented and have nothing to do with inner resolve.

This is not to say that resilience has no place in confronting moral distress. It does. But resilience born out of naming moral distress as categorically wrong is very different than resilience born out of being encouraged to "bounce back" from it. To avoid clinician-blaming, we must empower them with language that fully reflects the wrongness of the situation they are experiencing. And as with other injuries, we must avoid trying to move them through the recovery process from moral injury too quickly. "Buck up" and "bounce back" language can encourage clinicians to cover up or hide their moral injury, instead of naming it and taking actions necessary to recover from it. Strategies for helping clinicians to re-enter the trenches after a moral injury are abso-

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lutely essential. But an overly positive spin on resiliency, in light of its myriad of contemporary usages and definitions, runs the real risk of labeling those who do not buck up or bounce back as morally weak.

This blaming concern is further highlighted by Carse and Rushton's claim that clinicians make themselves vulnerable to moral distress by being "perfectionistic" or "heroic." Here, the clinician-blaming is direct. They argue that if clinicians can learn to accept their inability to change a situation and accept compromise, they will be less morally distressed and may even find that they were being unreasonably perfectionistic and morally self-righteous. The moral distress they describe here is considered to be self-inflicted, which is addressed if clinicians relax their moral rigidity and listen to other perspectives. Being open to other perspectives and listening within one's moral community are incredibly important actions, which can positively impact a clinician's experience of a difficult clinical situation. These acts may indeed help address the experience of moral distress by showing clinicians they are not alone in their moral distress, that others feel the same way, that they may be mistaken about or missing important information related to the situation, or that there is indeed more grey than first thought about the situation, lessening their sense that there is a clear right and wrong. But to link moral distress, as Carse and Rushton argue, with clinicians' perfectionism and their need to be heroic shifts the source of moral distress to the shoulders of clinicians, and not on the shoulders of the system where it belongs.

The value of moral distress consults (as we have seen) or other opportunities to discuss and reflect on difficult clinical situations (as Carse and Rushton suggest) is that they create a moral space to learn more about the situation, be informed by other's views, and, especially for clinical leaders, understand the impact their decisions are having on others (moral hazard). None of this, however, is dependent on or directly related to clinicians first relaxing their moral integrity.

CONCLUSION

Carse and Rushton's call to refocus on strategies to address moral distress in day-to-day clinical practice is a positive one. But their call focuses primarily on how an individual should handle moral distress (that is, by enhancing moral resiliency) when moral distress is a systems problem that mere perseverance and fortitude cannot solve. Their recasting of moral distress in the positive glow of personal resiliency reads too much like a coach sending an injured player back into the game for the good of the team, but at the expense of the player. The gravity of moral distress should not be downplayed as a step towards addressing it. Instead, recognition of its fundamental negative nature should be preserved. This does not mean there are no short-term strategies for addressing the personal experience of moral distress while attempts at systemic change are sought. These strategies, however, are rooted in teams, not individuals. Team meetings to develop goals for pain management while a family comes to grips with a difficult outcome may be enormously helpful for staff. Patients with complex discharge needs may require regular multidisciplinary meetings with clinicians, risk management, administrators, case managers, and social workers to effect an appropriate plan. Although resilience is generally good for clinicians, it is not the cure, either in the short or long term, for moral distress.

NOTES

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