

HISTORY OF MEDICINE

What Moral Distress in Nursing History Could Suggest about the Future of Health Care

Andrew Jameton, PhD

Abstract

The concept of *moral distress* was defined in 1984 as (a) the psychological distress of (b) being in a situation in which one is constrained from acting (c) on what one knows to be right. A substantial literature on the subject has developed, primarily in nursing ethics. The aforementioned elements of distress are applied here to areas of clinical and organizational significance: (a) distress from causing intimate pain during care of the dying, (b) constraints stemming from proximate and background challenges of health care organizations, and (c) changing perspectives on therapeutic technologies derived from global environmental perspectives. Although moral distress may be increasing in clinical settings, nursing advocates are developing positive ways to cope with it that can help clinicians in general.

Introduction

After its first use in nursing over 30 years ago, the concept of *moral distress* has proven applicable to a growing range of problematic situations. This essay outlines a few motifs in the development of the concept in nursing ethics and then considers some current applications of the concept. Starting with the bedside care of the dying, it sets moral distress in successively wider contexts, concluding with some morally problematic global environmental challenges that health care services will need to address during the next decades.

Coining a Concept

My 1984 book, *Nursing Practice: The Ethical Issues*, introduced moral distress as the experience of knowing the right thing to do while being in a situation in which it is nearly impossible to do it [1]. I was responding to students' stories related during classroom discussions of bioethical dilemmas, such as appropriate care for dying patients, limits to life support, and communication and decision making with patients and families. Some of the students were senior nursing clinicians. A few recalled with regret hospital incidents in which they were required to perform uncomfortable or painful procedures on patients when, in their experience, curative efforts were futile. A common flash point was the suctioning of patients on respirators who had been in intensive care units for weeks and

who were not going to live to discharge. Similarly, providing intensive care to premature infants with expectably poor outcomes disturbed some neonatal nurses [2].

Although standard bioethics texts at the time emphasized cognitive moral reasoning and appeals to abstract moral theories [3], nurses' ethical concerns were heartfelt. Thus, I thought it was important to address the emotional side of moral problems. In so doing, I shared the concerns of educators cultivating the moral development of clinical professionals [4-7]. Nurses were professionally concerned about the role of emotions in providing compassionate care to patients [8-11]. And feminist moral theory was foregrounding emotional factors in ethical theories based on care, compassion, and empathy [12, 13].

As originally conceived in *Nursing Practice*, the authority of nurses as professionals in organizations was also important to the development of the concept of moral distress. Feminist ethics stressed the equal moral standing of women with men, and nurses, in a traditionally women's profession, were building on a more than 80-year struggle to establish a fully autonomous profession with substantial control of their work [1, 14, 15]. The aspiration of equality encouraged nurses to assert their professional judgments and to confront others when they had objections [16, 17].

In situations in which nurses had ethical concerns, secondary ethics questions arose, generally falling under the rubric of "organizational ethics" [18, 19]. Assertive nurses wanting to speak with authority on ethical problems in a timely way faced questions and challenges [20]. Examples include: Should a nurse express doubts about the wisdom of a course of therapy? Whom should he or she first approach—the family? The attending physician? Other nurses? A nursing supervisor? If ethical questions recur, should he or she question persistently? What is a nurse's standing as a professional to raise ethical questions in a clinical context [21]? When is a medical order so problematic that an ethical nurse should refuse to cooperate [22, 23]?

Development of an Idea

Defining moral distress. A diverse literature about moral distress has grown [24, 25], which rightly notes the vagueness of the concept and its relationships to similar concepts [26-32]. Significant questions have arisen that reflect three facets of the definition:

1. What does the power of moral distress derive from? Why is it being labeled as "moral" distress and not simply as psychological distress? Are we really talking about something more like conscience, guilt, shame, or regret [27, 33]?

2. Is it really ever “impossible” to act? Isn’t this something that depends on the perceptions of the nurse [26, 30, 34]? Or are there institutional factors that restrict ethical action by clinicians?
3. Do nurses really “know” the right thing to do, or is this simply about their opinion or firm belief [26]? Have moral judgments about the wisdom and aims of care shifted over time?

Increase and spread. A quick review of *PubMed* reveals that more articles about moral distress were published in the last three years ending 2016 than in the prior three decades, and a bibliometric analysis of articles published on moral distress between 1984 and 2013 revealed a sharp yearly increase in publications on the topic after 2011 [28]. The concept is spreading to other fields including pharmacy, social work, psychiatry, veterinary care, administration, long-term care, organ donation, surgery, palliative care, and managed care [28, 35, 36].

Growth in publication may simply reflect the natural spread of an idea or a trend in academic interest. But the scale of publication may also reflect an increase in the frequency, intensity, or extent of distress among health professionals [28]. I will take this possibility seriously here and in the remainder of the paper discuss some reflections on the rise in distress. Even if the literature proves to be misleading, it is worthwhile to reflect on potential causes of an increase in distress, since the discussion may suggest lines of research that prove fruitful in reducing the rates of distress.

Factors Contributing to the Spread and Increase of Moral Distress

If moral distress is indeed increasing and spreading to other fields, several explanations might plausibly be offered. The themes identified here grow out of *Nursing Practice's* paradigmatic case of moral distress—when a clinical professional is required to perform uncomfortable procedures on a patient during overextended terminal care. Each theme emphasizes one of the three facets of moral distress outlined in the previous section—the nature of distress, the possibility of action, and the extent of knowledge.

The nature of distress. Most people, including trained professionals, who work with the dying and those close to death react with feeling [37, 38]. A patient dying in a hospital setting seldom experiences an easy passage from rescue with the possibility of recovery to “comfort care only.” So when patient, staff, and family are traversing the ordeal of a steepening rise in discomfort to eventually futile care, stressful ethical disagreement is common. In such circumstances, nurses conducting uncomfortable procedures are likely to experience distress [32]. Consequently, a compassionate response to clinicians’ feelings will continue to be needed, whatever the frequency of other background issues of health care organizations.

Obstacles to moral action in health care organizations. If moral distress is increasing and spreading among health professionals, one simple explanation may be that many hospitals provide care at higher levels of acuity than in the 1980s. Moreover, morally distressed nurses often identify problematic incidents at the organizations in which they work [39]. Their views deserve respect, and, as some studies show, the frequency of distress is positively correlated with organizational problems [2, 28, 39, 40]. Such problems include short-staffing, inflexible policies, complex documentation, clumsy staff changeovers, poor communication, overly complex technology, mistakes, and other organizational and resource challenges [24, 25, 28, 41]. Some of these problems are local to the institution in which nurses work; others derive from broad challenges of the health services system. Background features, such as ownership by large organizations, profit-oriented management, and complex coding and record-keeping, are putting pressure on the professional autonomy of a variety of professions.

Finding solutions. There is a consensus in the research that moral distress is too frequent and that something should be done to alleviate it [42–44]. At one end of the spectrum, proposed solutions focus on the feelings of individual nurses and seek to comfort and heal them [45]. At the other, solutions address the topical content of the distress and so include organizational and policy measures intended to reduce the frequency of ethically problematic incidents [41, 46–49]. Many proposals combine elements of both. One approach is to support nursing staff in speaking to ethical issues. Some suggest encouraging nurses to be more resilient and courageous in speaking up [44]; others recommend improving nurses' ethical reasoning through education [50]. At another level, hospitals have created committees, such as moral distress consultation services, wherein problems can be discussed in depth [51–53]. Other approaches include involving staff in improvement of interdisciplinary communication and amending organizational culture [54, 55]. With or without institutional support, clinicians who identify distressing organizational problems can [advocate creative ideas](#) for improving their organizations and the health care system either within hospitals and clinics or by speaking publicly and in professional circles [14, 25, 41, 56, 57].

Looking Ahead: Larger Problems and Possible Solutions

At a third, more conceptual level—deeper, wider, and harder to discuss in clinical settings—perceptions of the global situation of human life on earth are changing in ways I will discuss below. Although at this point I cannot show that these concerns have begun to affect how clinical professionals feel about their work or challenges in it, I am willing to argue that these concerns ought to affect ethical judgments about clinical care. A good starting point for introducing these general concerns is the cost of care.

Changing moral judgments about health care costs. Two major concerns about health care costs are now converging. First, the financing and affordability of health care has been a public concern for a century. Many now regard health care as overly expensive and

health care spending as comprising a disproportionate share of the GDP [40, 58-60]. Second, concerns about the contribution of health care materials to [toxic waste](#) and other [environmental impacts](#) of health care have been growing for about two decades. Increasingly, health professionals and organizations are participating in greening programs to reduce the environmental damage done by health care [61-63].

Accelerating global change is adding weight to these financial and environmental concerns [64]. Levels of consumption in developed nations are decreasingly sustainable on a limited earth [65-68]. In the next decades, US per capita material and energy consumption needs to be scaled down to a terrestrial scale [66, 68, 69-71]. Since US health care already comprises a significant proportion of GDP, if the economy is to be scaled down, so must health care [72, 73]. It needs to be materially less ambitious, more modest, simpler, and more manageable [74].

Climate change. Climate change is emerging as one of the most—if not the most—significant long-term [risk to human health](#) and biodiversity [75-78]. The major health professions have expressed grave concerns about the health consequences of climate change [79-83]. And many health care organizations have begun to include clean energy, energy efficiency, and other climate change mitigation methods in their greening programs and building designs [84, 85]. Some health professionals are beginning to realize that in order for health care to adapt to environmentally driven shifts in long-term health risks, health services need to adapt to a potential global decline in population health status, climate refugees, disasters, and disruptions to the supply chain [73, 86].

Philosophical trends. As environmental practices enter hospitals, principles derived from environmental philosophy are being seen as increasingly applicable to health and health care [87-93]. A dominant message of environmental philosophy is that all humans are biologically interconnected in the great web of life [94-97]. This sense of interconnection is beginning to challenge the strong commitment to individual autonomy seen in traditional bioethics [3, 73, 98]. Technologically extensive and intensive care of the dying, as I observed above, is emotionally challenging to clinicians. It is also expensive and therefore environmentally costly [68, 99]. Thus technologically extending an individual's life is diminishingly meaningful in the face of the long-term need to maintain the human and nonhuman biosphere. Arguably, some of the proximate moral distress over technological dying reflects a changing moral perspective. It is likely that those who see things in this light will, to their distress, evaluate overtreatment more negatively than those around them.

Conclusion

As the literature indicates, moral distress may be spreading to medicine and other professions [28, 35, 36, 100-103]. This may reflect that a variety of health professionals are increasingly finding themselves in moral binds similar to those experienced by

nurses. By studying the literature on nurses' moral distress, physicians and other clinicians may learn something useful from nurses about coping with similar problems they may face now and in the future.

Current nursing thinking about moral distress is more positive than my 1984 formulation of the concept. It emphasizes that the cure for moral distress consists in taking action with others to tackle problems both great and small. A recent nursing symposium proposes to replace moral distress with *moral resilience* [44]. The intention of the rephrasing is to turn clinicians' awareness of problems into courage, cooperative speaking up, and persistent action to address the background problems that foster health care failures.

Yet we must consider that we might become even more distressed as we realize that solving the ethical problems of health care now urgently includes global social and environmental advocacy.

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Andrew Jameton, PhD, is professor emeritus at the College of Public Health at the University of Nebraska Medical Center in Omaha. He is also on the affiliate faculty of the Center for Bioethics at the University of Minnesota. He has been working as a philosopher in health care since 1972 and now studies the environmental aspects of health care and the risks to health and civilizations from climate change.

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