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IN THE LITERATURE

Who Is Experiencing *What* Kind of Moral Distress? Distinctions for Moving from a Narrow to a Broad Definition of Moral Distress

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Abstract

Moral distress, according to Andrew Jameton's highly influential definition, occurs when a *nurse* knows the morally correct action to take but is *constrained* in some way from taking this action. The definition of moral distress has been broadened, first, to include morally challenging situations that give rise to distress but which are not necessarily linked to nurses feeling constrained, such as those associated with moral uncertainty. Second, moral distress has been broadened so that it is not confined to the experiences of nurses. However, such a broadening of the concept does not mean that the kind of moral distress being experienced, or the role of the person experiencing it, is morally irrelevant. I argue that differentiating between categories of distress—e.g., constraint and uncertainty—and between groups of health professionals who might experience moral distress is potentially morally relevant and should influence the analysis, measurement, and amelioration of moral distress in the clinic.

Introduction

According to Andrew Jameton's influential definition, first published in 1984, moral distress occurs when a nurse "knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" [1]. According to this definition, moral distress occurs under specific conditions: there is moral certainty—the nurse *knows* the morally correct action to take—and there is something, commonly referred to as a "constrain[t]" [2] or "obstacle" [3], which prevents the nurse from being able to take the morally correct action. Although this definition and variants of it remain popular, there are at least two ways in which critics have attempted to broaden it. First, it has been argued that morally challenging situations that give rise to distress but which are not necessarily cases of certainty and constraint—such as those associated with moral conflict, moral dilemma, and moral uncertainty—should also be seen to result in moral distress [4, 5]. Second, moral distress is not restricted to the experiences of nurses; a range of health professionals, such as physicians, are being included in research on moral distress [6, 7].

While I have argued that we should broaden the definition of moral distress [4, 8], we need to guard against the neglect of morally relevant differences in the forms and experiences of moral distress. In this paper, I will highlight the significance of two sets of distinctions that might seem to be in danger of being blurred by broadening the definition of moral distress: first, categories of moral distress and, second, groups experiencing distress. Accepting a broader definition runs the risk of blurring these distinctions if moral distress is examined, measured, and addressed solely *as an aggregate*—in other words, as a sum or total. Regarding moral distress as an aggregate blurs what could be major morally significant features of distress, such as the unequal distribution of distress among groups of health professionals, because it would not take the experience of these different groups into account. These distinctions could be significant for identifying and ameliorating the specific causes and impacts of moral distress in the clinic.

What Is Moral Distress? The Difference between Narrow and Broad Definitions

For the purposes of this discussion, let's limit ourselves to the kind of moral distress that is experienced *by health professionals* in decisions taken about *patient care*, as this is the kind of moral distress often discussed within the clinical and nursing ethics literature [3]. Within these limits, and as a starting point for this analysis, moral distress can be described as a psychological response to morally challenging situations [4]. Jameton's definition [1], as well as many of the definitions used in the literature [3], can be viewed as examples of a type of narrow definition of moral distress because they limit moral distress to only one major kind of morally challenging situation—that is, situations in which a person is constrained from taking the correct action, as some obstacle (e.g., an institutional rule or a physician's decision) stands in the person's way [1, 4]. I will refer to these kinds of situations as cases of moral constraint. Advocates of the narrow definition of moral distress not only associate distress with moral constraint but also explicitly claim that cases of distress that stem from other morally troubling situations, such as a moral dilemma or moral certainty, are *not* moral distress [1, 4, 5].

I claim that Jameton's definition of moral distress should be seen as a definition of a category of moral distress, i.e., *moral-constraint-distress* (for short, *constraint-distress*) [4]. An example of constraint-distress is the distress felt by a nurse caring for a terminally ill child in a situation in which the parents insist on the child receiving aggressive life-extending treatment, although it is in the best interest of the patient for health professionals to stop treating her and to arrange for the provision of palliative care to avoid prolonging her suffering [1, 4]. Applying the terminology and form of the narrow definition to this case, we could say that the parents' decision is a constraint on the nurse's action.

While constraint is often treated as if it were a necessary condition of moral distress [1-3, 6, 9], I have argued that constraint-distress should not be considered the only form of

moral distress that is significant in the clinic [4]. I recommend adopting a broad definition of moral distress, which means recognizing that constraint is not a necessary condition of moral distress and that such distress can arise from morally troubling situations other than those of moral constraint. When health professionals experience distress due to a moral conflict, dilemma, or uncertainty, this should, I claim, also be referred to as moral distress [4]. Imagine that we change the previous example—the case of the child and the aggressive life-extending treatment—to reflect moral uncertainty. In this revised example, it is morally unclear both to the parents and the nurse which of the two actions—treatment or stopping treatment—should be taken, and the nurse experiences distress at the moral uncertainty of the situation. Instead of treating this distress as something other than moral distress, which Jameton has explicitly advocated [1, 9], I recommend that it be considered moral distress and that we call it a specific kind of moral distress—*moral-uncertainty distress* (for short, *uncertainty-distress*), as opposed to constraint-distress.

There are a few reasons why it is important to use a broader definition of moral distress rather than confining moral distress to constraint-distress as Jameton and others have done [4]. For the purposes of this paper, a particularly significant reason for using the broader understanding is the following: I assume that at least one reason, if not the primary reason, that we care about distress associated with morally troubling situations is because these situations are often likely to stem from or lead to violations of significant moral values—or both. It seems difficult to justify why we should then care only about those categories of moral distress that are related to constraint rather than those related to conflict or uncertainty if, indeed, these are also likely to stem from or lead to violations of the same or similar values.

There are at least three independent moral values that are relevant to moral distress: (1) the well-being of the patient, (2) the well-being of the health professional experiencing moral distress, and (3) the distribution of moral distress among groups of health professionals [8, cf. 10]. While values one and two are fairly intuitive, it might be helpful to specify that the distribution of distress could be unfair when greater burdens of distress are placed on particular groups of health professionals through no fault of their own [8]. If moral uncertainty, moral conflict, and moral constraint are all associated with moral concerns about the well-being of the patient and can all lead to psychological distress, why should that distress only be described as "moral" in the case of constraint? Additionally, if the well-being of health professionals and the distribution of moral distress are negatively impacted by any of these kinds of morally troubling situations, then why exclude cases of uncertainty and conflict from moral distress?

A concern that could be raised by advocates of the narrow definition of moral distress is that if we broaden the definition we might downplay the distinct experience of nurses, who are much more likely to experience constraint-distress, at least in comparison to

physicians, because they tend to have less decision-making power regarding patient treatment and thus are more likely to experience moral constraint via others' decisions. I suspect that one of the primary reasons why the definition of moral distress is often confined to constraint-distress is because of moral concerns about the "additional" burden of distress that might be experienced by nurses [4, 8, 11]. Any health professional could suffer distress due to concerns about patient care, which can lead to the well-being of that professional being negatively impacted. In these kinds of cases, only the moral values of patient well-being and professional well-being are likely to be violated. However, implicit in the possible objection to the broad definition of moral distress is the concern that certain groups of professionals, such as nurses, will suffer moral distress related not only to "typical" patient-care situations but also to the nature of their job and the constraints that they face as part of that job. In these cases, all three moral values are likely to be violated—patient well-being, professional well-being, and a fair distribution of moral distress among groups of health professionals.

I am willing to concede that situations in which all three moral values associated with moral distress are being undermined are likely to have a special moral urgency, precisely because so many values are at play. However, this is no objection to broadening the definition of moral distress. It would only work as an objection to broadening the definition if doing so meant that moral distress was necessarily considered to be an aggregate. Moral distress would be treated as an aggregate if, for example, it were measured in such a way that no distinctions could be made between categories of moral distress such as constraint-distress and conflict-distress or between the different kinds of professionals experiencing moral distress, thus leading to particular concerns associated with constraint-distress and with nurses being overlooked. However, there is no need to treat moral distress solely as an aggregate even if one accepts a broader definition, and indeed there is good reason not to—because we will neglect important morally relevant features of moral distress if we do so. While I am claiming that there is enough in common between cases of moral conflict, uncertainty, and constraint that distress stemming from them should be referred to as "moral," I am not claiming that they should be considered to have precisely the same morally relevant features either.

Comparing Constraint-Distress and Uncertainty-Distress

Let's consider a brief moral assessment of the examples of constraint- and uncertainty-distress discussed in the previous section in order to highlight some of the specific morally relevant features that may be associated with them. As a reminder, these are the cases of constraint-distress wherein the nurse is constrained by the parents' decision to pursue aggressive treatment for the child and the cases of uncertainty-distress wherein the nurse is morally uncertain whether or not aggressive treatment should be pursued.

Take the first moral value identified in the previous section: the well-being of the patient. In the example of constraint-distress, the distress experienced is a signal that something has definitely gone morally wrong in terms of patient care; the treatment is not to the benefit of the terminally ill child (assuming the nurse is correct in his moral assessment of the case). Now compare this to the case of uncertainty-distress wherein the nurse experiences moral distress due to moral uncertainty—he might not know what is in the best interest of the patient because he is uncertain of the moral implications of his actions. The difference between the two kinds of moral distress, constraint and uncertainty, does appear to have moral relevance, although each stems from concern about a similar primary moral value—the well-being of the patient. If possible, additional action needs to be taken in cases of moral uncertainty so that the implications of interventions for patient well-being are determined before intervening. Unlike our case of constraint-distress, for example, this kind of case of uncertainty-distress may require an ethics consult to determine what the morally ideal course of action is likely to be.

The second relevant moral value is the well-being of health professionals. This value is relevant in the examples of both constraint-distress and uncertainty-distress; the well-being of health professionals is being undermined by their experience of distress, which can, in turn, have negative implications for the organization and the patient. For example, moral distress is associated with staff turnover intent [12]. What could be of further moral relevance and be fruitful for empirical research to determine is whether moral distress is experienced more acutely if it is of a certain category. For example, is constraint-distress more likely to negatively impact health professionals' well-being than uncertainty-distress because the health professional is blocked from being able to perform the correct action or the perceived correct action? Or does the experience of different kinds of distress tend to influence the same health professionals similarly? Here the answers to these empirical questions have moral relevance because if a particular category of distress is more harmful than another kind, then ameliorating the more harmful kind should be a greater priority, all other things being equal.

The third relevant moral value has to do with the distribution of moral distress among different groups of health professionals. We might find that certain kinds of health professionals, such as nurses rather than physicians, or those working for certain departments, such as the Emergency Department, or in certain specialties are more likely to develop moral distress. If this is the case, then they would carry a greater moral and psychological burden than other health professionals. As mentioned in the previous section, it seems reasonable that nurses on average would be more likely to experience constraint-distress than physicians because of their position in decision-making hierarchies [11, 12]. More research would need to be conducted to indicate which groups are most vulnerable and to which categories of distress they are most vulnerable; however, what is important to emphasize here is that making morally relevant

distinctions is related not only to the *categories* of distress experienced but also to *who* is experiencing the distress.

Conclusion

In this paper, I have highlighted the difference between a kind of narrow and a broad definition of moral distress. I claim that among the reasons why we should adopt a broad definition is that distress that arises from a variety of morally troubling situations related to patient care stems from and leads to similar violations of core moral values, and thus it would seem strange to single out only one of these types of situations—of certainty and constraint—as being wholly constitutive of moral distress. However, although there are primary moral similarities among these situations, there are also some additional morally relevant distinctions that should not be blurred by treating a broad notion of moral distress as an aggregate. In the final section of the paper, I emphasized how differentiating between categories of distress and the groups of health professionals experiencing distress is significant for determining morally relevant features of specific cases of moral distress.

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