Moral Distress and Institutional Responsibility

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In my time today I'd like to talk to you about some work I and my colleague Ruchika Mishra have been doing on one particular kind of job dissatisfaction, moral distress, in one specialized and idiosyncratic industry, health care.

This conference on the philosophy of management is more general than a healthcare management conference, but we hope that some of what we have to say will be of interest and possibly of use outside of that narrow domain. It does seem to be the case that the concept of moral distress has recently been spreading beyond its point of origin to prove useful in a number of different contexts. Maybe understanding it better might be of use to some of you in your various areas of endeavor.

I want to talk about

(1) what kind of thing moral distress is;

(2) the effect of an increase in its prevalence or intensity on the organizations in which it occurs;

(3) and maybe some recommendations of organizational approaches to avoidance or mitigation.

I: Definition of moral distress

The term was invented by a philosopher and introduced in a book on nursing ethics in 1984. Ethicist Andrew Jameton distinguished three different kinds of ethical issue in clinical practice: moral *uncertainty*, when it is unclear to the agent what the morally

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apropriate action might be; moral *quandary* or *dilemma*, when there are ethically valid justifications for each of several possible actions; and moral *distress*, which arises, Jameton suggests, "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."

This third category is a different kind of problem. In one sense it is not an *ethical* problem at all: the professional knows (or thinks s/he knows) what the right thing to do IS. It's just that there is a roadblock to moral agency--a kind of moral constipation. And in that sense it IS an ethical or moral problem, because it acknowledges an impediment or obstacle to my agency in a situation that calls to me to act in a moral or ethical way--to do the right thing in the situation I find myself in.

And when he introduced the term, Jameton qualified the obstacle as an institutional obstacle: something about the situation that causes my moral distress is something outside of the control of my agency--a situationally external obstacle or impediment imposed upon my ability to "do the right thing."

There are historical and sociological reasons why this potentially useful concept first surfaced in the nursing literature, which have been explored in some excellent books. As late as the '80s all the doctors were male, all the nurses were female, and instead of being viewed as fellow healthcare professionals (as they now are, or at least should be, seen), nurses were viewed (as canonized in the title of historian Susan Reverby's excellent book) "the physician's hand."

And the other problem is that because the injury involved is to *my* moral agency there was, and continued to be, a tendency to view moral distress through the lens of an individual, quasi-psychological, personal problem: one requiring coping skills and

individual support. If you stop there, it can turn into what I think of as the "suck it up, you wimp!" approach: "Maybe you're not tough enough for this job." That purely individual and personal approach degenerates into victim blaming.

In my first parsing of this intriguing moral anomaly I broke it up into a kind of Ven diagram overlap of two separable concerns: a professional ethics component and an organizational ethics component.

(1) Professional ethics

Moral distress is a professional ethics issue because the affront to the agency of the affected individual is a particular kind of affront: their ability to act appropriately in their professional role. The feeling that is the distinguishing mark, the identifier of this particular injury is "this is not what a *good* [doctor, or nurse, or chaplain, or manager] should do in this situation."

The "professional ethics" aspect is particularly salient in health care, in the medical-industrial complex, because it is an industry founded upon and socially justified in terms of the provision of services that depend upon the experience, expertise, skills and knowledge of the professionals who deliver those services: the clinicians at the interface between the institution and its "clients", or in a particularly invidious description, "customers"-- the patients. And most of my examples come from that domain. But perhaps with a little thought, managers in any knowledge-industry that involves professionals may be able to isolate analogous examples of professional affronts. A perusal of the headlines practically any week can generate examples of people placed by their superiors in invidious positions: consider the plight of a safety inspector at general motors, or an appointment scheduler at the VA....

I bumped into this concept in a particular context: my colleague Dr. Mishra and I were doing a job satisfaction survey among a particular subset of physician specialists: the hospitalist. These are medical professionals who collaborate with their out-patient colleagues to take responsibility for those patients when they are in the hospital. They are hired by or contract with the hospital to provide in-house care in a way that is satisfactory to their out-patient professional colleagues--a transpersonal professional responsibility. This job-satisfaction survey quickly dubbed itself 'doctors in distress', and the results gleaned revealed a variety of problems--a 40 year old medical record system that didn't interface with 4 other computers in the system, or inadequate staffing for crucial services--sources of distress that could only be addressed on an organizational, not an individual, level.

The professional ethics component is, as I have suggested, transpersonal in an important way: it involves a feeling of responsibility to others who share my professional identification. And it is at the same time personal and individual, insofar as an occasion can represent a threat to my professional integrity, something about myself in which I take the most pride, something often central to my sense of self--adding a personal insult to the situational injury of impeded agency. The effect on the individual, as documented in detail in the literature, can be frustration, anger or depression, guilt, demoralization, which in turn can lead to exhaustion, inefficiency, depersonalization--and potentially to exit: from the case, from the unit, from the institution or in some cases from the profession itself.

A lot of the literature about moral distress focuses on the individual: where moral distress is found, where it manifests, how it can be dealt with: coping skills and

mindfulness exercises, internal and external support. I don't want to minimize the importance of acknowledging and strategizing the individual impact: but I want to supplement that with a discussion of the other half of the puzzle that is moral distress: the organizational ethics component.

(2) organization ethics

I want to say at least three things about moral distress from the standpoint of the organization in which it occurs: (a) it is very bad, dangerous and damaging not only to the affected individuals but to the organization as a whole--its mission, its reputation and its viability; (b) it's a systems problem in several senses: it is a problem which can arise through inadequate function on any of several levels of the organization, and it is a problem that has implications throughout the system; and (c) it's a managerial problem.

(a) From the standpoint of an organization in which there is a high incidence of moral distress, in frequency or intensity, it's a disaster on many fronts. The distressed clinicians are parents and members of congregations and voters and neighbors, and the trust and respect of the community for the organization can be affected by the morale of its members. Quality of service may well suffer. Frustrated, demoralized, angry or depressed clinicians do not make for satisfied patients--and for some arcane reason "patient satisfaction" has become increasingly important to h/c organizations. And if you want to get serious about the impact of bad morale, follow the money: there will be an impact on the fiscal viability of the organization. Lower reimbursements, fewer physicians referring patients to your hospital---the list goes on, and many of you are better judges than a philosopher of what those implications might be.

(b) Systems. This is really interesting. There's been considerable empirical work on moral distress in health care, primarily in the professional nursing literature. Scales have been developed to measure in various nursing and physician populations the frequency and intensity of the occurrence of potentially morally distressing incidents in clinical situations. The scales present micro-scenarios. And the interesting result of scrutinizing these scale, this empirical work, is that you can see the situations of impact working out from the clinican-patient dyad in, as it were, onion-rings of concentric circles. In the most proximate circle there's the colleague who's disrespectful or incompetent (or both); then the disfunctional team that fails to communicate adequately or to coordinate with external colleagues. No doubt there is the under- or inadequately supplied unit or service somewhere in there that needs one more surgeon or a couple more case managers, but there is a sense in which that is par for the course in hospital employment--until there is a situation in which that gap becomes a real problem. On the next ring out there's the situation where legal or utilization or the insurance company draws a line in the sand and everyone gets a sinking feeling in their stomach.

In short: the context in which something can arise that is perceived by the moral agent on the front lines as an external or institutional *impediment* to excellent professional practice--is coextensive with the very conditions which enable and support that practice of contemporary health care. Hospital practice IS working with colleagues, typically in teams, within organizations that themselves operate, well or badly, within legal and regulatory and accreditation constraints and requirements. When everything goes well within those concentric circles it is a system that supports and enables excellent patient care. When something goes badly, goes awry in the interlocking mechanisms,

witnhin the organic body that is the hospital, then some individual-- sometimes lots of individuals-- suffer that injury and insult to professional integrity and excellent professional practice that opens the door to moral distress.

And that's why I think of it as a systems problem, for the system; and as an institutional responsibility--to the individual clinicians, the patients they serve and the society that supports (and that we hope will continue to support) our health system.

(c) Why is this a managerial problem? Are all organization ethics problems managerial ethics problems? And--who's the relevant manager?? Who are we making responsible when we say something is an 'organization' problem?

An organization is basically a collection of events, decisions and actions--a complex of interacting components and the relationship between them; they function on relationships, interdependence and reciprocal influence. And as organizations go, hospitals are particularly strange birds. Some Canadian researchers described healthcare as: "a pluralistic domain, involving divergent objectives (individual patient care, population health and cost control); multiple actors (professionals, administrators, community groups and politicians) linked together in fluid and ambiguous power relationships....leadership roles are shared, objectives are divergent, and power is diffuse." (Denis Lamothe and Langley 2001) Hospitals are hierarchical, para-military organizations; bureaucratic, with closed access, strict reporting lines, and codified role expectations. At the same time, the service they deliver depends upon discernment and autonomous judgment, flexibility, improvisation, collaboration. They're a both-and combination of hierarchy and participation, unity of purpose and diversity of ideas,

discipline and creativity: a learning community within a knowledge industry. (And—not a production line….)

"Management" is hard to isolate as an 'external' source of impediments, or as an internal solution to problems. Few clinicians do not have some administrative role. The hospitalists I interviewed spoke of themselves as being responsible not just for the care of the patient, but for the management of the care of the patient. Nurses do utilization review and case management and discharge planning; everyone takes part in "the life of the hospital," which means sitting on at least one committee--QA or IT or ER observation or (if they're lucky) the ethics committee. People with clinical preparation occupy roles throughout the administration, and ideally, there aren't too many administrators that don't have some clinical preparation, although that may change as you work up the hierarchy. Insofar as amelioration of moral distress is the responsibility of the institution in which the clinicians practice, it may be able to be addressed by the clinicians themselves when, and insofar as, they have managerial responsibilities.

My initial tendency to things, being a 'union maid' at heart, is to approach the question of what the organization should do about mitigating moral distress from the bottom up: working your way outward in the onion-ring of the conditions of practice by crashing though apparently 'eternal' or institutional obstacles to realign them as conditions supporting excellent professional practice. When I talk about this subject to clinicians in hospital grand rounds, I always want to close the session by asking them all to join me in a verse of "solidarity forever". But this approach, appealing as I find it, has two problems. First, it's unrealistic. To be in an organization, to be an employee in an organization, can limit collective agency as well as individual agency. And second, it

risks devolving into exactly the danger that first brought me to the subject: that approach risks being just another variety of victim blaming. If I stop with saying "exercising your moral agency is a way to avoid moral distress," then the fact that a particular obstacle, or kind of obstacle, remains or recurs, means that I have failed. Again. To point out the transpersonal and interpersonal aspects may just move it up to the level of being able to say "we failed" instead of "I failed"—although I consider that an improvement…

Top down, or bottom up?

Now that's all very well. But when I talk about these matters with people who actually have some experience with trying to work morally within organizations, the conversation often starts with "Rorty, you idiot…That's the trouble with philosophers and organizations. It's a question of leadership." Good leaders encourage the moral agency of organization members; bad leaders suppress it or interfere with it. A bad leader can thwart even the best individual--or collective--moral agency.

So: even given the difficulty of defining what an organization is, except in the vague and relational way I've specified; and given the additional difficulty of isolating one managerial or administrative agent to whom all blame can be deferred: What can we actually say about moral distress as an institutional responsibility? What strategies or reframings can help? Are there some thumb rules that might help?

(1) Alignment of values and a focus on the mission
(2) Systems-thinking
(3) Model and encourage communication
(4) Value employee morale and institute strategies to improve it

(1) Alignment of values:

So trying to think about moral distress from the top down, and acknowledging that bad morale is a disaster for any org that hopes to survive, what can we say? An organization

functions most effectively when there is an alignment of values: (a) between the leaders and their extra-mural constituencies; (b)among the leaders themselves; and (c) between the leaders and their constituencies.

(a) A car company that produces unsafe cars is in trouble. A hospital that does not provide excellent patient care is in trouble. To say that the healthcare institution exists for the sake of patient care seems to be mouthing a platitude. But institutions operate in an environment that includes laws, regulations, suppliers and provides services to a community. It is clear that the hospital is itself embedded in the macro-level of the greater society. If a hospital is the environment in which an individual clinician works, the organization itself is but one part of the health care system, and is subject to the pressures of that surrounding environment. An explicit mission and values statement that is very salient within the organization helps to bring that alignment of values with the external stakeholders, be they regulators, accreditors or the local community.

(b) And that same mission statement, if agreed upon by the various leaders among themselves, allows the 'leadership' to act in collaboration, instead of in conflict. Some of the stressors on the individual practitioner arise from the institution, or from co-workers; but others are as unavoidable for the institution as for the individual, and must be dealt with by national or state policy, regulation or legislation, by changes in reimbursement policy, or by social change.

We all know that your role in an organization determines the priority given to different values: even if they are, by virtue of a common mission, shared values. In practice any organization, and especially a hierarchical and bureaucratic one like a hospital healthcare organization can function more like a machine with discrete

functional parts than like an organic whole. The clinicians meet the patients' needs; the legal department addresses legal requirements and compliance; the administrators are the designated worriers about finances. Such compartmentalization of roles can contribute to internal conditions that produce moral distress. Just the salience of the mission and values gives a better chance of being able to talk to each other about possible distressing situations. Every role in the institution needs to be understood as a contribution to the goal of carrying out the mission of the institution: to provide care of high quality at a reasonable cost to the community it serves. Communication in a common language of shared values can make justification of unavoidable but distressing situations on the ground in clinical situations intelligible to participants.

Our crucial third alignment—between the leaders and their constituents—is something that can be measured and tracked. *Ethical climate* is a measure of the extent to which individuals within organizations feel their organization is living up to its own values. There are some excellent instruments out there—one developed by the VA and publicly available for replication or emulation, one put out by the AMA several years ago: they can be adapted to individual organizations, in or out of health care.

II: Systems thinking:

Moving the focus from specific roles, whether the role be one of manager or clinician, to the overall goal of the healthcare organization is an application of what some scholars are calling "systems thinking:" moving from the part to the whole, attending to relationships and patterns of interaction, rather than focusing on individual components of particular relationships. A truly systemic view of current health care considers how this set of individuals, institutions and processes operates in a system involving a

complex network of interrelationships, an array of individual and institutional actors with conflicting interests and goals, and a number of feedback loops. (Wolf, 1999). Systems thinking addresses perceived problems by asking questions like "What are the upsteam causes of this situation? How does it look from the perspective of others affected by it? What changes in the structures in which it arises can eliminate its future recurrence?" Organizational and professional structures decree that the attending physician has the final say in decisions about patient care, but professional (or personal) differences should be expressed and heard, whether or not they are determinative of the situation. Similar problems can arise in negotiations between hospitalist physicians and the primary care providers of hospitalised patients. The literature on moral distress properly encourages recourse to institutional ethics committees in cases where staff nurses feel unable to effectively advocate for their patients, and it is useful to recognize that repeated appeals of this sort from the same units are a signal to the institution that more adequate provisions for effective collaboration are needed.

III: Model and encourage communication

It will be a surprise to no one familiar with health care ethics that failures of communication lie at the root of practically every clinical and organizational ethics issue. Moral distress is no exception.

Some of the research on moral distress reveals that conflict between the professional perspectives of nurses and physicians is a rich source of moral distress for nurses. In rigidly structured units, subordinates may be very aware of the professional values and ethical perspective of their superiors, but the converse may not be true. Of course personalities enter into any interaction between individuals,

but a combination of authoritarian personalities and authoritarian structures is likely to prove a rich breeding ground for moral distress.

An institution that provides an ethical health care environment must pay attention to routines and mechanisms that encourage communication and collaboration, which allow all individuals who are affected by care decisions to have a voice. Organizational and professional structures decree that the attending physician has the final say in decisions about patient care, but professional (or personal) differences should be expressed and heard, whether or not they are determinative of the situation. Similar problems can arise in negotiations between hospitalist physicians and the primary care providers of hospitalized patients. The literature on moral distress properly encourages recourse to institutional ethics committees in cases where staff feel unable to effectively advocate for their patients, and it is useful to recognize that repeated appeals of this sort from the same units are a signal to the institution that more adequate provisions for effective communication and collaboration are needed.

Unexpressed—or, more importantly, *unheard* –values cannot be brought into convergence. Communication UP the institution—from the bedside to management, not just down—is a precondition for a healthy system. One of the most frequent complaints Ruchika and I heard in our interviews was that changes in process were being decreed 'from above' by people who had no idea of the situation 'on the ground.'

Instead of tolerating situations that set the institution against the individual, we need to marshal the resources and the moral agency of the individual. It is the

expertise and judgment of highly trained clinicians that is the major resource for the service. Clinical care, unlike manufacturing, demands a space in which that judgment can come into play. An organization that is striving for an ethical health care environment will develop strategies to minimize role definitions of care processes, and maximize opportunities for their skilled professionals to use their expertise and discretion to advance the objectives of their unit or institution.

IV: Value employee morale

Just as there are instruments to measure ethical climate, there are instruments available to measure moral distress in health care settings, and a responsible institution would be well advised to institute regular monitoring to figure out whether the changes that have been introduced in your organization lately have made things better or worse for the individuals who compose it. Moral distress, threats to the professional integrity of its members, is a real threat to the integrity of the institution itself, and needs to be taken seriously. Introduced in the context of health care, this concept may well be useful in the context of other industries as well; you folks are probably a better judge of that than I. It is the responsibility of the institution as a whole to ensure a culture in which moral distress is taken seriously, ameliorated where and how possible. Constant up and down communication, minimally hierarchical practices, and clinician driven policies may help the beleaguered healthcare industry to survive the changes that this century is bringing.