Moral distress: A problem for us all

(published in CPMC's Ethical Times)

Everyone is feeling pressure from the rapid changes the healthcare system is currently undergoing. Hospital based clinicians are particularly affected because of the impact of changing regulations and increasing social pressure for efficiency and cost containment on hospital practice. These changes in practice conditions and their impact on clinicians are being discussed ever more frequently in the literature under the rubric of 'moral distress.'

We all occasionally experience stress of various kinds in our job, whatever the setting--competing demands, and constrained resources, whether of materials, support or time. When our situation threatens our ability to do a job according to our own highest standards, stress is the result. Health care is no different. Working conditions are not always ideal; patient load--and patient condition--is always a variable. So when does "stress" turn into "distress," and what is "moral" about it?

The distressed professional

The answer lies in the nature of the work in health care, and the particular obligations of the professionals who bear the primary responsibility of delivering that care to the people in need of it, our patients. As part of their training for the positions they hold, health care professionals have internalized standards of what is expected of them as ethical practitioners, expectations that are foundational not only for their role in their institutions, but for their professional identity, and often their self-respect. The primary responsibility of the health care system is to provide competent, compassionate care to the people in need of it. To become a health care professional is to accept this obligation, a fiduciary relationship with society, on which the society's trust in the health care system is based.

The language of "moral distress' was first introduced three decades ago by a philosopher who distinguished carefully between three different kinds of ethical issues that confront clinicians in their daily practice: moral *uncertainty,* when it is unclear what's the "right" thing to do in a given situation; moral *dilemma*, or quandary, when there are competing or conflicting moral demands that must somehow be resolved in order to determine what the "right" course of action should be--and a third, termed moral *distress*, where it seems clear to the agent what the "right" thing to do is, but there is some obstacle or impediment to actually doing it. It is the intractable conflict between what one knows one *ought* to do and what one *can* do that turns stress into distress for conscientious professionals, and it is the importance of their obligations, to themselves, their patients, their profession and their institutions, that makes the distress a moral one, and an important subject for ethical consideration. In the last twenty years the concept has been extensively developed in the nursing literature, and more recently it is surfacing in connection with other professions involved in health care, from allied health professionals through physicians to managers and hospital administrators.

Clinical professionals work at the front lines of healthcare, and are the most visible face and hands of the institutions in which they serve. The primary responsibility of those clinicians is patient care. They are engaged for that work by healthcare organizations that are themselves subject to a number of pressures that determine their

obligations and how they meet them. As those institutions are embroiled in change, the requirements of any particular job can shift, creating in individual clinicians a conflict between particular institutional policies and responsibilities and their professional obligations-- a conflict between what their job in the institution asks of them, and what their internalized professional ethics expects of them as nurse, or as doctor. If they do not have sufficient time to talk to with, and listen to, their patients, they perceive it as a failure in their primary obligation.

The effect on the individual practitioner can be frustration, loss of self-esteem, anger or depression, demoralization, burnout. Patient outcomes suffer; staff morale suffers, with increasing absenteeism or sick days, and reduced efficiency and commitment. Health care professionals in distress transfer out of dysfunctional units, change their shifts or areas of practice, or move to different kinds of institutions. Or, as a last resort, they may choose to leave their professions for more satisfying work, depriving the health care system of its most valuable resource, and by their absence contributing to its problems, rather than to their solution.

What can stand in the way of "doing the right thing" in a clinical setting? The literature presents a litany of things that can present obstacles to excellent and autonomous professional practice. Economic or political structures may require (or restrict) some interventions. Changes in regulations may require changes in routines. A heavy workload, difficult working conditions, or onerous administrative tasks can imperil the quality of care of patients, as can lack of time, lack of authority, lack of support, legal considerations, or institutional policies.

The main problem with much of the early literature on moral distress was that it focused on the affected individual, and in an implicitly 'victim-blaming' approach, primarily addressed self-care and coping mechanisms, suggesting individual strategies for enduring what cannot be changed. But believing that a structural or systemic obstacle can be overcome by individual action, or negated by developing personal coping skills, just makes the problem worse, leading to cynicism or despair. In the years since the terminology was introduced in the nursing literature, it has come to be realized that individuals at all levels of the institution are equally at risk, and both causes and remedies are as much institutional as individual. Moral distress is not just a source of suffering for individuals--it is a problem for the whole organization.

The distressed organization

The primary professional obligation of the clinician is competent and compassionate patient care. That is the primary responsibility, the mission and greatest source of pride of the institution itself, as well. Why, then, since both agree, should there ever be any perception of obstacles to "doing the right thing" in clinical care? Whence the frustration?

The answer lies in competing responsibilities. Since they are the primary agents of care, in addition to their commitment to their patients, individual clinicians also have obligations to the institutions in which they serve--its efficiency, the quality of its service delivery, its financial survival. And health care organizations themselves have additional responsibilities as well. They may, and often must, serve as the proximate transmitter to clinicians of pressures arising from sources outside their control. Institutional policies are often drafted to accord with regulations or professional standards as defined by agencies

external to the institution, and are as little under the control of the institution as of the individual--an organizational analogue to the sources of distress for inidividual practitioners.

Excellent patient care must not only be delivered, but be seen to have been delivered--a demand for constant documentation, justification or verification that, if inadequately supported, can threaten the time needed to talk with and listen to patients. The challenge to the organization is not to avoid or ignore externally imposed requirements for quality measures, clinical metrics or measures of performance, but to integrate them appropriately with the mission and priorities of the institution, and to allow--and reward--flexibility and professional judgment in how to implement them.

As the system prepares for the healthcare needs of the coming decade, evidence is growing that the cadres of professionals so important to hospitals' function are feeling the impact of increasing demands for documentation of efficiency and cost containment that compete with patients for their attention. Individual strategies of self-care and stress management are not a long-term solution to moral distress. An organizational approach is an important supplement to and support for such individual efforts. The proactive healthcare organization recognizes the institution as a moral community, prioritizing excellent patient care and sheltering the professionals most responsible for delivering it.