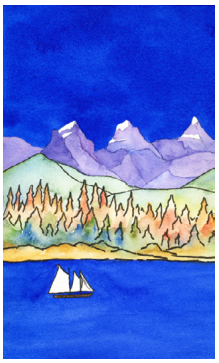


CHAPTER 6

Nurses and Health Care Providers as Moral Agents: From Moral Distress to Moral Action

Lynn Musto, Rosalie Starzomski, Patricia Rodney, and Peter Dodek

> *"It may be the case that the most challenging moral problem of the twenty-first century will be the relationship between the individual moral agent and the practices and institutions in which the moral agent is embedded."* **(Liaschenko & Peter, 2016, p. S18)**

THE WORDS FROM LIASCHENKO AND PETER, two leading North American nurse ethicists, emphasize the significance of the moral challenges that nurses and other health care providers (HCPs) often face as they work to fulfill their professional ethical responsibilities in health care practice. Liaschenko and Peter argue that feminist ethics provide a helpful lens from which to view the work of nurses in context because of the "inextricable relationship between ethics and politics" (p. S18). Our own thinking has also been informed by the work of diverse feminist ethicists, including Baylis, Kenny, and Sherwin.[1]

We begin this chapter with insights from Liaschenko and Peter (2016), which serve as a catalyst for us to analyze the means by which advanced practice nurse leaders and other HCPs can navigate ethical challenges, and promote positive ethical practice for individuals, families, and communities. Foundational to such practice is a relational approach, which "demands an explicit focus on the social and political contexts of individuals in its moral deliberations" (Sherwin, 1992, p. 40). By promoting and sustaining this commitment to a relational approach, nurses and other HCPs are enacting their *moral agency*—that is, engaging in deliberative action to make "self-determining or self-expressive choice" (Taylor et al., 1992, p. 57). However, when nurses and other HCPs are unable to enact their moral agency, they may experience *moral distress*, which is recognized as arising when they are "unable to act according to their moral judgment" (Rodney, 2017, p. S7).

The concept of moral distress originated with ethicist Andrew Jameton (1984) in his landmark text on nursing ethics. Until that point, distress among nurses had been understood primarily through psychological concepts such as stress and burnout, which, although relevant, were not sufficient to fully describe the moral phenomena that nurses were experiencing. With the introduction of the concept, Jameton added an important ethical dimension to the study of the distress experienced by nurses and other HCPs, which has had significant and longstanding impacts on scholarship in nursing.

In this chapter, we begin by defining moral distress, examining the basic assumptions underpinning the definition, and differentiating it from other related concepts. We then discuss the insights of leading ethical theorists, to explore the moral context of nursing practice and health care delivery. We highlight the importance of the moral reasoning and moral action of nurses and other HCPs—that is, their enactment of their moral agency—as foundational to the prevention of and responses to moral challenges in their practice. We explore situations where nurses and other HCPs experience moral distress because they are unable to enact their moral agency in the often challenging and resource-constrained moral climates where they practice (Austin, 2012; Jameton, 1984, 1993; Musto et al., 2021; Rodney, 2017). We present information about research on

moral distress and the debates about its evolving definitions, pointing to the importance of ongoing work in developing effective interventions to address the issue. Finally, we highlight the importance of moral leadership in fostering ethical clinical practice environments, providing recommendations at individual (micro), organizational (meso), and larger system (macro) levels for advanced practice nurse leaders to improve the moral climate of health care practice environments.

Differentiating Moral Distress from Overlapping Concepts

We initially focus on the debates surrounding moral distress and on differentiating moral distress from other closely related concepts such as moral residue and moral injury. Later in the chapter, we move on to tracking the contemporary arguments around broadening the definition of moral distress and weigh in with our own responses.

When Jameton introduced moral distress into the nursing literature, the concept resonated with nurses as a felt experience of something that had thus far not been named. Jameton described a phenomenon he observed as nurses recounted ethical situations that seemed to fit somewhere in-between the categories of moral uncertainty and moral dilemma (Jameton, 1984). As moral distress was a new concept, early researchers studied it, attempting to gain a greater understanding by delineating the parameters of the emotional, physiological, and psychological experience of moral distress, as well as the conditions that caused it (Wilkinson, 1987). Nurse researcher Wilkinson, the first to conduct research on the experience of moral distress, identified that indicators of moral distress have "cognitive, situational, feelings, and action dimensions" (p. 20). Other nurse researchers, including Liaschenko and Peter (2016), and members of our own research team (Varcoe et al., 2003), have also studied the concept of moral distress.

Over time, as research data accumulated, some scholars argued that the term "moral distress" was being used without critical examination of what the concept actually meant. They highlighted some significant concerns about the use of the term moral distress, such as conflating it with psychological distress, burnout, and other

closely related concepts (Hanna, 2004; Lutzen & Kvist, 2012; McCarthy & Deady, 2008).

The overlap of symptoms of moral distress with compassion fatigue, burnout, and vicarious trauma have also contributed to a conflation of concepts. Further, in the literature, overlapping concepts are discussed in the same articles but are not explicitly differentiated from each other. Conflation between moral distress and related concepts has led some researchers to identify what moral distress is *not*, while setting parameters for what it *is* (Varcoe et al., 2012). In Table 6-1, we describe concepts that overlap with moral distress. Our intent with the table is not to try and neatly categorize each concept. Rather, we hope to highlight some of the distinguishing characteristics of each concept to prompt deeper thinking about what HCPs are actually experiencing. It is important to note that HCPs may experience moral distress concurrently with compassion fatigue, burnout, and vicarious trauma.

As provincial and federal governments look to restructure and rebuild the health care workforce, it is imperative that nurse leaders (and other HCPs) distinguish between moral distress, burnout, compassion fatigue, and vicarious trauma. Conflation of these concepts carries at least two obvious risks: (a) failure to differentiate moral distress from burnout, compassion fatigue, and vicarious trauma will lead to overlooking the moral aspects of care in general, and overlooking the moral obligations unique to the professional identity of practitioners; and (b) while some interventions for moral distress, burnout, compassion fatigue, and vicarious trauma at the individual level may overlap at the organizational level, interventions need to be targeted at the specific root causes. For example, fostering moral community has been strongly recommended as a means of addressing moral distress (Epstein et al., 2020; Liaschenko & Peter, 2016; Traudt et al., 2016). If health care organizations fail to institute interventions specific to moral distress, there is a great risk that nurses and other HCPs, who experience moral challenges in practice, and "who feel a strong sense of responsibility to patients and for their own actions" (Wilkinson, 1987, p. 27), will leave their jobs or their professions altogether.

TABLE 6-1

Concepts Overlapping With Moral Distress

Concept	Definition	Differentiating Concepts
Moral Distress	Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action (Jameton, 1984).	Moral distress brings explicit focus to the experience of an HCP when they feel morally compromised when they fail to live up to the moral obligations of their profession. The experience of moral distress is linked to the health care context and whether having the necessary resources and supports are available to practice according to a professional code of ethics. The experience of moral distress is also connected to the concepts of moral identity and moral community.
Moral Injury	Moral injury is a betrayal of what's right by someone who holds legitimate authority in a high-stakes situation (Shay, 2014).	This definition of moral injury comes from Jonathan Shay, a psychiatrist working with soldiers in the American military. Central to Shay's definition of moral injury is the military's betrayal of the fiduciary relationship with soldiers. In health care, a fiduciary relationship exists between the health care organization and health care professionals. While there is conceptual overlap between moral injury and moral distress, in the military the experience of organizational betrayal/leadership malpractice leads to the *disintegration of character* (2011). The key distinction between moral injury and moral distress is the resulting disintegration of character in moral injury.

Moral Residue	Moral residue is that which each of us carries with us from times in our lives when we have seriously compromised ourselves or allowed ourselves to be compromised (Webster & Baylis, 2000).	According to Webster and Baylis, moral distress and moral residue are closely linked. Moral residue involves a form of moral compromise that results from moral failing, a betrayal of fundamental moral principles that weakens one's moral integrity or wholeness. Moral residue irrevocably changes a person "for good" or "for ill" (pp. 224–226); either by helping a person clarify their personal moral boundaries (for good) or by leading to error, becoming a "moral chameleon" (for ill) (p. 224).
Burnout	Burnout is a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity (Maslach et al., 1997).	The experience of burnout is currently understood to result from exposure to chronic organizational stressors such as excessive workload and understaffing. Interventions to address burnout are directed at improving organizational processes and creating a healthy work environment (Kelly, 2020).
Compassion Fatigue	Compassion fatigue is a state of exhaustion and dysfunction—biologically, psychologically, and socially—as a result of prolonged exposure to compassion stress and all that it evokes (Figley, 1995).	Figley identifies compassion fatigue as being a symptom of post-traumatic stress disorder (**PTSD**) but at a sub-clinical level (p. 24). Figley's definition of compassion fatigue centres on symptoms such as emotional and physical exhaustion, apathy, and desensitization to the needs of patients and others (Henson, 2020), which result from exposure to the trauma suffered by others. They refer to compassion fatigue as the "cost of caring."
Vicarious Trauma	Vicarious trauma is the transformation in the inner experience of the therapist that comes about as a result of empathetic engagement with clients' trauma (Pearlman & Saakvitne, 1995).	Pearlman and Saakvitne ground vicarious trauma in constructivist self-development theory, and describe it as a process that occurs over time, resulting in (potentially) permanent changes in a therapist's/**HCP**'s identity, worldview, and spirituality. There is an overlap of symptomology between vicarious trauma, burnout, and compassion fatigue; however, the authors look beyond symptoms to focus on the permanent and fundamental changes to therapists'/**HCP**s' perspectives resulting from repeated exposure to trauma experienced by others.

Basic Assumptions Underpinning Moral Distress

Jameton's (1984) description of moral distress reveals three basic assumptions: (a) nurses have the capacity to make a moral judgment about the rightness or wrongness of a particular action in the context of professional practice; (b) nurses experience institutional (external) constraints; and (c) nurses often do not act on moral decisions because of these constraints. However, as nurse researchers and scholars considered the definition, the ambiguity in each of these assumptions prompted recognition that moral distress lacked conceptual clarity (Varcoe et al., 2012; Wilkinson, 1987). Each of Jameton's assumptions has been critiqued, the result being a reworked definition offered by scholars and researchers in nursing and other disciplines, or the suggestion to abandon the concept altogether (Johnstone & Hutchinson, 2015). As well, these critiques raise other questions: (a) What exactly was Jameton describing when he identified moral distress—a situation or an experience? (Fourie, 2015; Hanna, 2004; Paley, 2021); (b) What is the nature and location of "constraints"? (Austin et al., 2003; Varcoe et al., 2012); and, importantly, (c) What is the impact of moral distress on patient care? (Wilkinson, 1987). Notwithstanding the critiques and questions, studying the concept of moral distress has opened up emerging possibilities for nurses and diverse HCPs to strengthen ethical practice. For more details about evolving definitions of moral distress, refer to Table 6-2 in the section "Evolving Definitions of Moral Distress."

As we continue to examine the evolution of the concept, we point to the disciplinary roots of moral distress. It is important to note that the concept of moral distress originated within the discipline of nursing. As such, the assumptions that underpin the definition arose from a specific disciplinary perspective of working in health care. The introduction of the concept heightened awareness of the challenges of moral agency in the presence of structural constraints in nursing. However, the singular disciplinary perspective from nursing has, at times, limited the understanding of moral distress (Musto & Rodney, 2018). For instance, the concept of moral distress has also been critiqued as perpetuating a disciplinary narrative of nurses as "victims," powerless to be moral agents in the

face of ethical challenges (Johnstone & Hutchinson, 2015; McCarthy & Gastmans, 2015; Paley, 2021). A second critique related to moral distress is that some have interpreted nurses "knowing the right thing to do," as though nurses have moral certainty about patient interventions. Some nursing scholars have pointed out that (a) a nurse's determination of the "rightness" of a particular intervention or approach to care cannot, and should not, supersede the decision making of other HCPs, such as physicians; and (b) that making a moral judgment is a complex operation that often occurs outside of conscious awareness and is based on a constellation of factors, including personal beliefs, education, and upbringing (Johnstone & Hutchinson). We agree with Johnstone and Hutchinson that the moral judgments of nurses ought not to take precedence over the moral judgments of other HCPs. However, we question whether the critiques above reflect accurate interpretations of what Jameton meant when he included the idea that nurses "know the right thing to do" in the definition of moral distress. Jameton does not qualify what he meant by "know," and assuming that nurses or other HCPs are certain in their knowledge would likely be unwise.

Health care researchers have examined how moral distress is experienced differently across professions in order to better understand the necessary and sufficient elements that comprise the experience of moral distress (Crane et al., 2013; Morley et al., 2019). For example, lack of autonomy in practice has been identified as a source of moral distress among nurses; yet, for physicians, autonomous decision making has been identified as a source of moral distress (Crane, et al.). This supports the recognition that although moral distress is experienced across health care disciplines, the root causes are influenced by specific disciplinary foci (Epstein et al., 2019). Overall, nurses experience higher levels of moral distress than HCPs in other disciplines (Dodek et al., 2016) due to their position within a hierarchical health care system, extensive engagement in patient care, and inadequate collaboration with physicians (Peter & Liaschenko, 2004).

Developing and implementing strategies for nurses, as well as other HCPs, to feel supported in the enactment of their moral agency are, therefore, crucial research and practice goals. Over time,

the three editors of this book, together with other colleagues, have had the opportunity to engage in and co-lead research programs focusing on these goals.[2] Throughout our research we learned that purposefully *listening to* and *learning from* nurses and others on the front lines of patient care is a prerequisite to addressing the sources of moral distress for nurses and other HCPs. We also learned that thoughtful engagement of nurses and other HCPs in improving the conditions of their work environment can strengthen the sustainability of the health care workforce.

Incorporating an understanding of the experience of moral distress across a range of health care disciplines has pushed examination of the assumptions regarding moral distress to a higher level of abstraction, so that scholars understand it as a violation of the ethical obligations specific to the professional identity of individual HCPs. For example, the definition of moral distress used by Dodek et al. (2016) in their multidisciplinary research is as follows: "Moral distress is the powerlessness, anger, and guilt health care professionals experience when they are unable to practice according to their ethical standards" (p. 179). Implicit in this definition is that HCPs across disciplines experience moral distress when they perceive that their professional codes of ethics are being violated. This focus on professional codes of ethics addresses the critique from some nursing scholars that nurses or other HCPs are presumed to somehow "know" the right course of action. Moral compromise is tied to disciplinary practice, not necessarily to decisions, about the direction of patient care interventions. Increasingly, researchers and scholars are recommending the development of moral communities as a means of fostering professional identity and moral agency, as well as mitigating the experience of moral distress (Epstein et al., 2020; Liaschenko & Peter, 2016).

Nurses as Moral Agents in Constrained Work Environments

Jameton's (1984) groundbreaking insight was to identify moral distress as "what nurses (or any moral agents) experience when they are constrained from moving from moral choice to moral action—an experience associated with feelings of anger, frustration, guilt,

and powerlessness" (Rodney et al. 2013b, p. 169). Nurses have fundamental ethical obligations to the individuals, families, and communities for whom they provide care. This has meant that the study of nursing ethics—including enactment of nurses' moral agency in fulfilling their ethical obligations—has become an increasingly relevant field of inquiry. The Canadian Nurses Association (CNA) (2017) has stated "*Nursing ethics is concerned with how broad societal issues affect health and well-being*. This means that nurses endeavor to maintain an awareness of aspects of *social justice* that affect the *social determinants of health* and *well-being* and to advocate for improvements" (p. 3, emphases in original). Further, based on their professional expertise, nurses are moral agents helping people who are in need of nursing care. Given the significance and complexity of the responsibilities nurses hold, support of nurses as moral agents ought to include attention to the socio-political, historical, and relational contexts in which they work (Rodney et al., 2013a, 2013b).

Several socio-political challenges have contributed to increasingly resource-constrained health care environments that are shaping the ethical context of practice, including moral challenges confronting nurses and other HCPs. These challenges include the application of neoliberal ideologies to social programs such as health care, as well as technological advances that have contributed to the increasing acuity of patient illness and the escalation of chronic illness. At the same time, the ongoing impacts of SARS-CoV-2 on HCPs have exposed deeply fractured health care systems in diverse countries, including Canada (Ness et al., 2021).

Although nurses as moral agents are committed to ethical practice, they, and other HCPs, face significant challenges in their practice. These challenges are exacerbated by neoliberal discourses of scarcity, where it is assumed that there will never be enough resources. This assumption can lead to rationing, the need for greater efficiency in health care services, and ongoing tightening of physical and human resources (Musto et al., 2021), all of which became particularly urgent during the COVID-19 pandemic. Austin (2011) tracked the consequences that could occur as organizations sought greater efficiency through rationalization of services based on corporate values. Importantly, they highlighted an unspoken

shift in values in the moral context of health care—from the patient as a vulnerable person, towards the patient as a consumer—and the impact this shift could have on nurses. Austin stated that nurses often experience a reduced sense of agency because they are constrained by market-driven health care decisions that reduce their ability to provide "safe, compassionate, competent, and ethical care. … [Such experiences] affect the way they perceive themselves *as* nurses" (p. 165, emphasis in original).

In the home care context, nurses may feel complicit in moral wrongdoing as they work in a resource-constrained program that limits the care they provide (Peter, 2013). For instance, home care nurses may have to allocate their time to a physical wound or dressing instead of providing holistic care that supports patients and their families' needs and preferences. Providing care at the end of life can also raise particular moral challenges and opportunities for nurses and other HCPs. Nurses provide end-of-life care in various practice contexts, from high acuity through to home care. Regardless of the practice context, the goal is to offer optimal care to patients, their families, and other members of the health care team. This is a goal that requires "a focus on the individual patient's well-being as a point of reference" (Doherty & Purtilo, 2016, p. 335), which has become increasingly difficult in resource-constrained health care environments.

Moral Agency, Nursing Practice, and Leadership

Foundational to all health care professional practice is a mandate to recognize and act on moral obligations to the individuals, families, and communities for whom nurses provide care. Being a nurse, therefore, entails being a moral agent, which Storch (2013) defined as "someone who has the capacity to direct his or her actions to some ethical end—in this case, good outcomes for patients" (p. 10). Traditionally, moral agents have been perceived as independent and rational individuals who made decisions based on self-interest and in isolation from outside influences (Sherwin, 1992). However, scholars in feminist ethics, such as Sherwin, have critiqued this view of moral agency as unrealistic, arguing for a relational perspective of moral agency that acknowledges the socio-political and contextual

influences on moral decision making. Researchers in moral psychology have conducted studies on moral decision making and also offer support for a relational perspective (Milliken, 2018).

In health care leadership, the moral agency of nurses and other HCPs needs to be understood in the current context of health care delivery. The emphasis on containing costs and increasing efficiency has shifted health care environments to places where HCPs are asked to be task-focused. The importance of structuring environments to promote or support the ethical aspects of practice has been overlooked (Austin, 2011). Consequently, an individual nurse or HCP may take up responsibility for the moral aspects of care that are, in fact, beyond the scope of their authority to address (Austin, 2016; Milliken, 2018). Milliken examined the concept of moral agency in light of current research and theory from moral psychology and moral philosophy. In refining our understanding of what it means for a nurse to a be a moral agent, Milliken stated that "[r]ather than focusing on the individual nurse, realistic considerations of moral agency must take into account what is possible of an individual in a highly complex system, and must examine what elements of the system and environmental context need changing" (p. 5).

In the Ethics in Practice scenario below, we describe a situation where a nurse experiences moral distress because they are unable to assert their moral agency and fulfill what they perceive as their responsibilities as a nurse, within a system characterized by staffing deficits, as well as poor leadership and teamwork.

ETHICS IN PRACTICE 6-1

Medical Assistance in Dying: Challenges to Moral Agency

Cindy is a nurse working on a community mental health team in an urban centre. Part of Cindy's job is to provide care for patients who have a chronic mental health condition and need monthly follow-up. Cindy went to visit Esther, a patient with a long history of psychosis and paranoia, who had missed her monthly appointment. Esther's mental illness had a severe impact on her relationships; she had no friends and had cut off contact with her family about 20 years before. Consequently, Esther was difficult to engage in treatment, and her only support people now were members of the community mental health team. When Cindy saw Esther, she was shocked to see how much weight Esther had lost since their last meeting a month before. Esther, unsteady on her feet, explained that she had food poisoning and had been unable to eat. She did not want to go to the local hospital to be checked out, but the two of them arranged for Cindy to bring some groceries and to check in the following week. At the subsequent visit Esther agreed to go to the local emergency department (ED), as she was very weak, having only been able to drink water. The ED physician discovered that Esther had cancer and that it had spread throughout her whole body. Esther was admitted to a medical unit to manage her symptoms and begin cancer treatment.

Esther stayed in the hospital, and Cindy made arrangements with the cancer agency for treatment. During her visits over a period of three weeks, Cindy noticed that the nurses avoided Esther, mostly leaving her to care for herself. Cindy recognized that the nurses didn't know how to engage Esther, and she was uncomfortable with the lack of care Esther received. One day Cindy called the unit to give details of an upcoming meeting with the cancer agency. During the call, Cindy was informed that the hospitalist had spoken to Esther, who had just agreed to MAID, which would take place within the hour. Cindy rushed to the hospital and found that preparations were in process for MAID. When Cindy asked Esther directly if she understood what was happening, Esther replied, "I don't want to die, I want to go to a boarding home." Cindy called her manager and together they halted the process. Esther died from her cancer a few days later.

As a result of her experiences trying to support Esther during her hospital care, Cindy described feeling morally distressed for several reasons. She felt angry when she would arrive on the unit and find that Esther had not received even basic care. On the day that MAID was to occur, Esther was filthy. She hadn't been bathed or given clean pajamas, had not had oral care, and had feces on her sheets. Cindy understood that Esther could be difficult to work with, but she couldn't understand why the staff on the unit failed to meet the bare minimum of care for her. Cindy was shocked that the hospitalist had arranged for MAID to happen without speaking to anyone on the community mental health team, the members of whom had been Esther's only

supports for the past 10 years. Cindy also questioned the informed consent process and wondered if Esther understood what she was agreeing to, or if she had felt pressured into signing the consent. Even though Cindy had stopped the MAID process for Esther, she doubted her actions had improved the care Esther received. She believed that as Esther was in the end stages of cancer, the health care team on the medical unit should have supported Esther to have a good death instead of trying to rush the process. Even now, several years after Esther died, whenever Cindy thinks about that situation, she continues to experience moral residue and feels distressed.

REFLECTIVE QUESTIONS

1. *How did the overlay of Esther's serious mental health challenges with her physical challenges confound the health care delivered to her?*
2. *Who should be considered to be in the "circle of care" or "care team" for this patient? How should that determination be made?*
3. *What elements of Esther's care caused moral distress for Cindy, and possibly other HCPs on the medical unit?*
4. *What is the role of nursing leaders, including advanced practice nurse leaders, in situations such as the one Esther and Cindy experienced? What actions/strategies might nurse leaders consider?*
5. *How should Cindy, as well as other nurses and HCPs, be supported as they advocate for this patient and others in similarly challenging situations?*
6. *What safeguards are, or ought to be, in place around MAID in situations that involve "difficult" and other vulnerable patients?*

Location of Moral Distress and Constraints

Early researchers on moral distress highlighted the problems and consequences of locating the experience solely within the individual HCP (the agent), or within health care organizations (structures). If moral distress is considered as an individual experience, then moral distress can be viewed as a flaw within the person (Varcoe et al., 2012), leaving the individual HCP to develop better coping strategies and become more resilient. Alternatively, if moral distress is seen as a result of institutional decisions and processes—for example, economically driven decision making—then the

organization becomes responsible for addressing the issues (Varcoe et al.). Both views reflect opposite ends of a spectrum of moral agency and are problematic because they overlook the *shared* responsibility of addressing the situations and contexts that create moral distress (Musto et al., 2015).

The nature of constraints on moral agency has also been debated. Initially, constraints on moral agency were identified as located solely within the organization; for example, hierarchical decision making, [limited] autonomy in practice, and constrained resources (Jameton, 1984). However, subsequent researchers identified that constraints on moral agency might also be "perceived" (Wilkinson, 1987), or arise from within an individual's fear or moral failure (Austin et al., 2003; McCarthy & Gastmans, 2015). Identifying constraints on action (either internal or external to the individual) as the root cause of moral distress is the source of much debate with the definition, which we discuss below. This identification also infers that moral distress is a linear process; either an HCP makes a moral judgment and acts on it and does not experience moral distress, or constraints inhibit the HCP from taking action and they experience moral distress.

From the first research initiatives on moral distress, the perspective of linear causality has been refuted, as Jameton (1993) noted when revising the definition to include "initial" and "reactive" distress (p. 544). In our view, constraints on action and moral agency are necessarily linked but not linear, because HCPs are situated within teams and organizations; as such, constraints on action, and taking action, occur in a relational context (Varcoe et al., 2012). Indeed, Varcoe et al. define moral distress as "a relational experience shaped by multiple contexts, including the sociopolitical and cultural context of the workplace environment" (p. 59). Currently, scholars and researchers express a nuanced perspective acknowledging the reciprocity between the organizational context and individual HCPs in the experience of moral distress, viewing it as an organizational issue that is reflected in individual HCPs (Epstein et al., 2020).

In Ethics in Practice 6-2, we describe a scenario where a nurse practitioner (NP) is working in an environment where the socio-

political and cultural context plays a significant role in leading to the NP's moral distress.

ETHICS IN PRACTICE 6-2

Outpost Nursing Practice and Regional Hospital Challenges

Rebecca Saunders is a registered nurse who has practiced in both hospital and community contexts in Ontario for eight years. She has just completed a two-year Masters in Nursing degree to become a nurse practitioner (NP). Rebecca studied relational practice in her NP program, and she has recently been recruited as an NP in a rural nursing station in northern Ontario. She is thrilled to have the opportunity to get to know the diverse community where the nursing station is located, and to learn from her colleagues there. However, she is also aware that she has a great deal to learn about primary care in an outpost context. Further, she knows that she must be cognizant of the unique cultural contexts of the diverse Indigenous and non-Indigenous people living in the community and the surrounding region.

After working for five months at the nursing station, Rebecca has come to appreciate the relational connections that she is making with diverse community members. She is able to practice to her full scope as an NP with mentorship from another NP and a physician who regularly visits the nursing station. However, she is concerned about what many of her patients relay to her regarding their experiences when they are sent for specialized treatment at city hospitals in Ontario or other provinces. Her patients speak of feeling "like a fish out of water" in these busy urban environments. Their appointments are often rushed, and they miss their usual family and community supports. Rebecca worries that these patients are not getting the quality of care that they need and deserve, and she feels helpless to initiate the intra-and inter-provincial system-level changes that she believes are required to make a difference.

REFLECTIVE QUESTIONS

1. *What socio-political inequities may be affecting Rebecca's patients when they are sent away from their home community for specialized treatment in city hospitals?*

2. *Rebecca studied relational practice and moral distress in her NP program. She is aware that her concerns about her patients' experiences may be creating moral distress for her and possibly for her colleagues in the nursing station. What are the possible implications for Rebecca and her colleagues in terms of ongoing moral distress?*

3. *How might the principles of relational practice guide Rebecca's leadership as a moral agent with her nursing colleagues and the population she is serving?*

4. *How might Rebecca find ways to engage with nursing and medical leaders in her community and at the city hospitals regarding the relational needs of the patients in her community? How might she involve colleagues, patients, and other community members in these activities?*

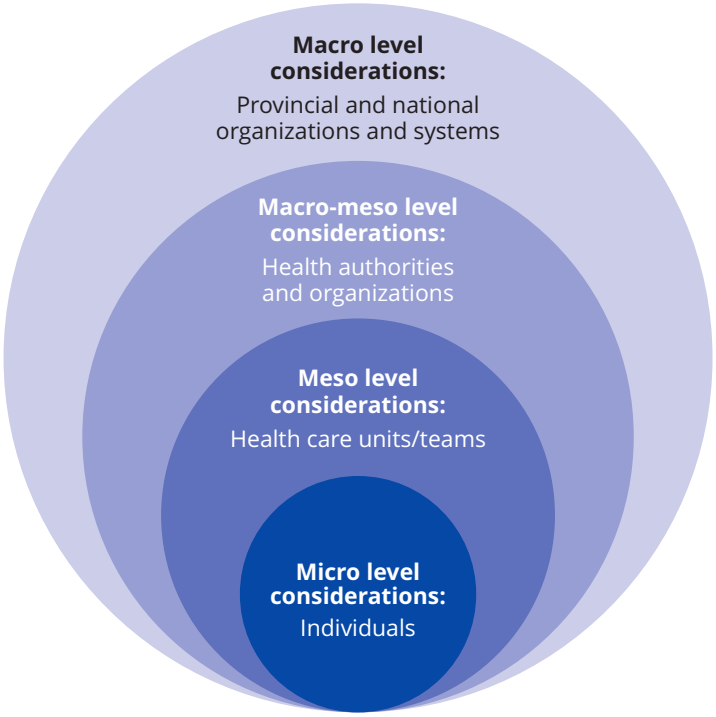
A Shared Responsibility for Addressing the Moral Context of Practice

What we have described are everyday examples of the moral challenges nurses confront in practice. We have used these examples to expose how socio-political and economic discourses create systemic vulnerabilities at the micro, meso, and macro levels of health care. Failure to connect limited resources, and regulatory bodies, to political and economic decision making gives the appearance that the moral context of health care practice is the sole responsibility of health care organizations. This neglects the reality that funding for health care organizations and regulatory bodies is determined at the macro level of the provincial and federal governments. We need to acknowledge that decisions at the macro level are made primarily by individual organizational leaders, which is also true of decisions made at the micro and meso levels of the health care system.

The responsibility to navigate ethical challenges, repair moral wrongdoing, and promote ethical practice is a shared responsibility. The moral context in which nurses practice shapes their ability to enact their moral obligations to patients. In turn, nurses' actions influence the context in which they work. Individuals at all levels of the health care system (micro, meso, and macro) have the capacity to enact their moral agency to varying degrees when they encounter ethical challenges in practice. Those in positions of leadership bear the preponderance of responsibility to foster a positive moral context of practice, because they hold the macro level authority for financial resources, decision making, and shaping organizational cultures. In Figure 6-1, we represent these relationships in terms of reciprocity between structures (health care environments) and agents (nurses and other HCPs).

FIGURE 6-1

Levels of Ethics Application



Research: The Influence of Context on Moral Agency

Drawing on the work of Milliken (2018) and others, we view moral agency as a dynamic and relational process that is influenced by the context(s) in which an individual works. The enactment of moral agency was the focus of research conducted by two authors of this chapter, Musto and Rodney, as well as their colleagues (Musto et al., 2021). As part of her dissertation work, Musto (2018) examined how HCPs working in mental health enacted moral agency in ethically challenging situations. The participants revealed that being a moral agent required balancing their own professional identity with the risk of having their professional reputation, their job, or their status on the health care team called into question. It is important to note that although all participants were able to describe how they enacted their moral agency, the contexts of participants' practice

environments at micro, meso, and macro levels played a significant role by either supporting or constraining their actions.

Musto (2018) found that the willingness of participants to take professional risks depended on the participant's context. The theoretical themes that Musto developed in her research appear in italics in the text that follows. In Figure 6-2 (from Musto, 2018), the outer portion of the diagram represents the socio-political context of HCPs' practice, and the inner segments represent key findings and related theorizing. As shown on the left side of Figure 6-2, offloading responsibility for care is part of the background context of this study and occurred between disciplines, hospital departments, and units, as well as between hierarchical levels of the health care organization. One of the consequences of government agencies offloading responsibility of care was that the acute care mental health programs took up responsibility for these complex patients. The result was that participants in the study noted a rise in the admission of two specific population groups into acute care psychiatric units: patients with a dual diagnosis and patients with a forensic history. As shown on the right side of Figure 6-2, safety and high-stakes situations permeated the background context of this study and refers to the increased levels of risk for significant harm, or aggression, including death.

Participants who described working with supportive colleagues and managers (*Working Through Team Relationships*) were encouraged by colleagues and their direct supervisors to raise and work through ethical issues. Team members supported participants by suggesting strategies or avenues for advocacy, and helping each participant to recognize the boundary of their responsibility. Participants who were supported described their growth as moral agents. For example, they developed strategies for advocacy and had increasing confidence in their ability to advocate; they carried forward these changes as they navigated subsequent ethical challenges; and they also discussed tipping in and out of moral distress, but not feeling "stuck" in the experience.

Musto also indicated that participants who described working in an unsupportive or toxic environment experienced a high degree of risk to their professional reputation—and their job, in some situations—if they attempted to address ethical challenges

directly, which she identified as *Struggling With Inhumanity* (Musto et al., 2021).

FIGURE 6-2

Risking Vulnerability: Enacting Moral Agency in the Is/Ought Gap

Participants often related situations of poor practice or bullying, but indicated that to speak up meant that a participant opened themselves up to retaliation. In some cases, the perpetrator of bullying was their direct supervisor or manager. Participants in these work environments perceived their direct supervisor or manager as providing ineffective leadership because leaders failed to intervene by holding practitioners accountable to their standards of practice or code of ethics. In these instances, to protect

themselves while also taking action, participants directed their moral agency towards the person in front of them—their patient or co-workers—in an attempt to mitigate [the experience of] ethical wrongdoing and the experience of moral distress.

A few participants in Musto's (2018) research described situations where they chose to be moral agents regardless of the consequences, because by *not* acting they were risking their own sense of integrity and perception of their professional identity—as described in Musto's framework, they were *Pushing Back*. Participants in this category discussed having developed personal strategies over time, such as spiritual practices, or developing a network of colleagues to go to for advice, that helped them to recognize when it was necessary to take what they described as "big actions" (Musto, 2018, p. 224) and advocate for system change. Some participants who took big actions either lost their jobs or moved on when no change was possible, but they acted in alignment with their professional identity, so their integrity remained intact. Other participants took big actions and were successful in creating the changes they sought. All participants who pushed back described that the strategies they had learned over time made it possible for them to live with the experience of moral distress that resulted from working in health care.

All participants enacted moral agency to different degrees depending on their context. They also described a range of individual and organizational strategies necessary to fully exercise their moral agency and live up to their professional and ethical obligations of practice, which highlights the dynamic nature of being a moral agent as described by Milliken (2018). Musto (2018) emphasized how the responsibility for ethical practice was shared, perhaps even entangled, between HCPs and health care organizations. This is depicted in Figure 6-2, with a particular emphasis on the need for leaders who support the enactment of moral agency.

In Musto's (2018) research on moral agency, participants explicitly linked moral agency to the experience of moral distress. As our understanding of moral distress evolves through the work of Musto and other scholars, there is growing consensus that a central source of moral distress is compromised professional identity (Epstein et al., 2019; Guzys, 2021).

Evolving Definitions of Moral Distress

Musto (2018), in her research, illustrated the significance and impact of moral distress on HCPs. In what follows, we review some of the scholarly debates that continue to evolve regarding the nature of and impacts generated by moral distress. While the experience Jameton (1984) described resonated with nurses, the actual definition he ascribed to the experience has been critiqued and debated over the past two decades, and these debates continue. In the initial description of moral distress, Jameton stated that "[m]oral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Several scholars have written thoughtful critiques of moral distress (see for example, Fourie, 2015; Hanna, 2004; Johnstone & Hutchinson, 2015; McCarthy & Deady, 2008). Our focus in this section is to provide an overview of the evolution of the concept as a response to critiques of the definition (see Table 6-2). This table is not intended to be an exhaustive list of definitions of moral distress; rather, we present a sampling of definitions that represent the debates surrounding moral distress over time. Earlier in this chapter, we identified some of the assumptions underpinning the original articulation by Jameton (refer to the section titled "Basic Assumptions Underpinning the Definition"). We continue here with a discussion of critiques and subsequent adjustments in our understanding of the concept of moral distress in response to these critiques. We end this section by pointing to how the definition of moral distress can be used in diverse areas of research and practice.

TABLE 6-2

Selected Definitions of Moral Distress

Authors	Definition	Critiques, Assumptions, and Subsequent Evolution
Jameton (1984)	Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action (p. 6).	Introduction of moral distress into the nursing lexicon. Captures the ideas of making a moral judgment, being unable to act on that judgment, and organizational constraints.
Jameton (1993) *Revised Definition*	Initial moral distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values. Reactive moral distress is the distress people feel when they do not act upon their initial distress (p. 544).	Amended the definition following Wilkinson's (1987) work to capture one of the assumptions, that moral distress has a linear trajectory, e.g. if a nurse took action in the face of moral challenge, they would not experience moral distress.
Wilkinson (1987)	Moral distress is the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision (p. 16).	Illuminates some of the gaps/assumptions in the definition. • Moral distress is a linear and binary experience hinged on action or non-action. • Moral situations can take other paths, e.g. moral outrage. • Identifies constraints as being real (institutional/external), or perceived (internal) by the nurse. • Speculates on the influence of moral distress on quality of patient care. • Attributes "distress" as psychological.

Authors	Definition	Critiques, Assumptions, and Subsequent Evolution
Austin et al. (2003)	Moral distress is the state experienced when moral choices and actions are thwarted by constraints. Responses to such constraints include frustration, anger, helplessness, despair, and/or betrayal (pp. 177–178).	Extended research to include other disciplines, and in the area of psychiatry. The word "betrayal" exposes the assumption of shared responsibility of ethical practice. The expectation that the HCP will practice according to their code of ethics, *and* that health care organizations will provide the resources for ethical practice.
Kälvemark et al. (2004)	Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the HCP feels she/he is not able to preserve all interests and values at stake (pp. 1082–1083).	Broadened research to include both HCPs in direct care and HCPs in non-direct care (pharmacists and pharmacy technicians, medical secretaries). Findings challenged original definition, i.e., moral distress *could* arise in situations of moral dilemmas.
Nathaniel (2006)	Moral distress is pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner he or she perceives to be morally wrong (p. 421).	Critiques the definition of moral distress as being *narrow*, and failing to explain the long-term processes that nurses experience; assumption that the nurse participates in the wrongdoing and is confined to the psychological implications setting up an "us-against-them" mentality. This critique is picked up by others as potentially perpetuating a *victim* narrative in nursing.
Mitton et al. (2011)	Moral distress is the suffering experienced as a result of situations in which individuals feel morally responsible and have determined the ethically right action to take, yet due to constraints (real or perceived), cannot carry out this action, thus believing that they are committing a moral offence (p. 108).	This was one of the first studies to examine moral distress in middle managers of health care organizations. Explicitly shifts research to meso level of health care organization by clearly identifying situations in which managers felt they were forced to violate strongly held moral/ethical principles.

Authors	Definition	Critiques, Assumptions, and Subsequent Evolution
Varcoe et al. (2012)	Moral distress is the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment (p. 59).	Explicit connection of moral distress to moral agency and violation of professional (not personal) values and standards. Introduces the idea of moral distress as a relational experience.
Crane et al. (2013)	*The experience of psychological distress that results from engaging in, or failing to prevent, decisions or behaviours that transgress, or come to transgress, personally held moral or ethical beliefs* (p. 6, emphasis in original).	Author critiques assumption of non-autonomous decision making causing moral distress, which may not be the case; and that for moral distress to occur one must knowingly contravene one's values, which doesn't allow for moral distress to arise as an unforeseen consequence of one's decisions. Draws on organizational psychology to explain moral distress.
Fourie (2015)	Moral distress should be understood as a specific psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both (p. 92).	Critique that the definition is a "narrow" and compound definition that requires constraints as a causal mechanism. Recommends removing "constraints" as a necessary condition of moral distress and including moral conflict as a potential cause.
Campbell et al. (2016)	*Moral distress=df* one or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable (p. 6, emphasis in original).	Present an argument for broadening the definition of moral distress to include other forms of moral distress not directly related to knowing the right course of action. Campbell et al. argue that moral distress arises when one feels morally compromised in some way.

Authors	Definition	Critiques, Assumptions, and Subsequent Evolution
Morley et al. (2019)	To be properly labelled moral distress it seems necessary that the distress is directly causally related to a "moral event." This would be a combination of (1) the experience of a moral event; (2) the experience of "psychological distress"; and (3) a direct causal relation between (1) and (2) are necessary and sufficient conditions for moral distress (p. 660).	Conducted a narrative synthesis of the literature reviewing 20 definitions of moral distress to determine the "necessary and sufficient conditions" of moral distress. Explicitly linking psychological distress to a moral event as a requirement of experiencing moral distress.

Note: All the definitions given in Table 6-2 are direct quotes from the references listed.

Broadening the Definition of Moral Distress

As research on and critiques of moral distress have opened up challenges with the original definition, some scholars have proposed new definitions or suggestions for responding to the critiques. We provide a brief summary of this debate here, and encourage readers to review the arguments from primary sources (see for example, Fourie, 2015; Hanna, 2009; Johnstone & Hutchinson, 2015; Morley et al., 2019). In our summary, we focus on two connected but separate aspects of the debates: broadening the definition beyond moral certainty (knowing the right course of action) to include a range of moral situations such as moral uncertainty and moral conflict (Campbell et al., 2016; Crane et al., 2013; Fourie), and removing "constraints" as a cause of moral distress from the definition (Fourie; Morley et al., 2019, 2021).

In 2016, the *American Journal of Bioethics* published an edition that included a debate on the pros and cons of expanding the definition of moral distress. Leading the edition, Campbell et al. (2016) argued for a definition of moral distress that could accommodate a range of situations that "can be sensibly framed as moral distress" (p. 2). The authors presented six ethical cases that potentially embodied the experience of moral distress and contributed to

a loss of provider well-being. The cases included situations of moral uncertainty, mild distress, delayed distress, moral dilemma, bad moral luck, and distress by association (pp. 4–6). Campbell et al. offered a new definition of moral distress as being "[o]ne or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable" (p. 6). This definition is broad enough to accommodate the range of situations that these researchers presented in their article.

Nonetheless, researchers on moral distress have pushed back on suggestions to broaden the definition, such as the one offered by Campbell et al. (2016), because the proposed definitions are so broad as to be "diagnostically and analytically meaningless" (Wocial, 2016, p. 21). As well, Hamric (2012) highlighted that the "problem of different definitions compounds the difficulty of developing adequate measures, since how a concept is defined matters greatly in measurement. Valid measures require a tight linkage between the concept and the items developed for the measure" (p. 44). Thus, developing a measurement tool for moral distress using a broad definition with ambiguous concepts would likely be impossible.

A second theme in the debate about broadening the definition of moral distress rests on removing the requirement of "constraints" on moral action. Fourie (2015) advocated for the removal of moral constraints from the definition as a necessary condition of the experience of moral distress. Fourie also identified Jameton's definition of moral distress as "narrow" because it "stipulates a particular cause, i.e., moral constraint" (p. 92), excluding other possible causes, such as moral uncertainty or moral conflict. Fourie offered a revised definition, stating that "[m]oral distress is a psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both" (p. 97).

While Fourie's argument for excluding constraints from the definition of moral distress has support (Morley et al., 2019), McCarthy and Monteverde (2018) provided a particularly convincing argument of the consequences of broadening the definition by removing constraints. These authors pointed out that "[f]or Jameton, situations involving moral constraint and moral distress prompt questions about moral responsibility and agency that

moral agents *cannot* evade" (McCarthy & Monteverde, p. 324, emphasis in original). Perhaps most important from our perspective is that McCarthy and Monteverde highlighted that broadening the definition of moral distress diverts attention away from "the way in which institutional and/or socio-political structures undermine [health care professionals'] moral agency. There is a danger then, that unless empirical research pays explicit attention to the role of these external constraints, they will be rendered invisible" (p. 325). Keeping constraints as a condition of moral distress invites both empirical research and critique of the socio-political and economic contexts that shape health care delivery. This kind of critique goes beyond examining constraints on moral agency to an exploration of contradictions between explicit societal values about equitable access to health care and political decisions related to resource allocation or funding models.

Broadening the definition of moral distress carries risks. The first risk is that the definition becomes so broad as to become meaningless. The second, related, risk is that it becomes difficult, if not impossible, to conduct research on such a broad topic. To overcome these risks, Campbell et al. (2016) suggested the development of a taxonomy of moral distress that could both identify specific forms of moral distress and accommodate research. Drawing on the extant literature, the authors suggested a taxonomy of moral distress that could be organized around "three components of moral distress: the negative attitudes that one experiences, one's perceived involvement in the situation, and the perceived moral undesirability of the situation" (p. 8). Other alternatives, such as developing a taxonomy for moral distress rooted in professional moral integrity (Thomas & Bruce, 2016), or in the specific causes of moral distress (Fourie, 2015), have been suggested as means of addressing the lack of conceptual clarity with the concept. The last risk of broadening the definition we highlight relates to Jameton's attempt to capture the embodied experiences nurses described when they were unable to live up to their moral obligations to their patients. McCarthy and Monteverde (2018) referred to this as "the lived experience of HCPs" (p. 325), and described it as a strength of Jameton's definition, reminding us that broadening the definition risks obfuscating the felt experience of moral violations.

Keeping a Narrow Definition of Moral Distress

Debates on the definition have moved scholars and researchers towards a greater understanding of moral distress, bringing the complexity of moral decision making and moral agency to the fore. Having said this, we land on the side of maintaining Jameton's "narrow" definition of moral distress. As noted above, maintaining constraints as part of the definition makes explicit that moral distress occurs at the intersection between the health care environment and moral agency. As such, we believe that addressing moral distress remains a shared responsibility among HCPs and health care organizations.

Guzys (2021) offered an example of understanding and addressing moral distress as a shared responsibility by describing a relational perspective of the experience. Guzys identified the fundamental cause of moral distress as being a "disorientation of professional identity resulting from conflict between a nurse's professional values and constraints imposed on professional practice" (p. 659). Recognizing the interplay between the individual's (agent's) professional values and organizational (structural) constraints, Guzys drew on theoretical work that acknowledges the reciprocity between top-down and bottom-up influences at the micro, meso, and macro levels. Thus, Guzys explicitly located moral distress at the intersection of structure and agency, so that addressing moral distress becomes a shared responsibility between HCPs and health care organizations.

In order to develop meaningful interventions for HCPs, researchers must be able to measure the phenomenon and the effectiveness of interventions. The shared responsibility for addressing moral distress requires that interventions be multifaceted and directed at the micro, meso, and macro levels of the health care system. As a concept, moral distress has received considerable attention, theoretically and empirically, both qualitatively and quantitatively. Nonetheless, there remains a need for ongoing and rigorous theoretical and empirical work. Over the past two decades, progress has been made regarding the measurement of moral distress, with a goal of informing action to prevent and ameliorate the experience. Hamric and colleagues (2012) revised Corley et al.'s

(2001) original moral distress scale by developing the Moral Distress Scale—Revised, and subsequently, (Epstein et al., 2019) developed the Measure of Moral Distress for Healthcare Professionals (MMD-HP). These are instruments in which respondents assess the frequency and level of distress that is associated with specific situations. The most recent measurement tool, the MMD-HP, is usable across HCPs and health care settings (Epstein et al.). Next, we describe a program of research on moral distress in critical care conducted by Dodek and his colleagues. The research conducted by Dodek's team, and their subsequent findings, are an example of the importance of empirical approaches to understanding moral distress and developing interventions that support the moral agency of HCPs at all levels of the health care system.

Moral Distress—Measurement to Action

The critical care setting is an appropriate place to explore moral distress because this is where many ethical issues arise. Considering the high stakes of critical illness and its treatments (such as mechanical ventilation, dialysis, vasoactive drugs, and extra-corporeal life support), there are many situations in which there is disagreement between what a critical care professional believes is "right" for the patient, and decisions that are made by others in the care team, including the patient's family. These disagreements may pertain to individual treatments or to the overall direction of care (for example, attempts to cure versus provision of comfort with an expectation of death). Furthermore, there may be differences between front-line critical care professionals and their supervisors about what is considered safe care, or adequate resources to deliver care. Such conflicts in values can cause moral distress.

In Ethics in Practice 6-3, we analyze the moral distress experienced by a nurse working in an intensive care unit (ICU), and consider the implications for their current and future practice, as well as the practice of other nurses.

ETHICS IN PRACTICE 6-3

Moral Distress Experienced by a Novice ICU Nurse

Jordan Singh is a 28-year-old registered nurse who works in an intensive care unit (ICU) in a large urban hospital. Jordan commenced ICU practice after completing his nursing education at a community college in Saskatchewan. He worked on an acute medical unit in Toronto for eight months, and then, most recently, completed a six-month-long ICU course.

Jordan greatly appreciates the learning he is acquiring as a new practitioner in the ICU, and finds the mentorship provided by the expert nursing and medical staff he works with to be helpful and inspiring. However, he also finds that he goes home after almost every shift feeling physically exhausted, and emotionally troubled by the serious and uncertain prognoses his patients and their families are often facing. He finds himself with less energy to engage with his family and friends or enjoy his favourite activity, horseback riding. He wonders if his feelings are normal, or if he might be "too sensitive" for the rigours of ICU practice. Jordan has heard some of his colleagues talking about moral distress, and he wonders if that is what he is experiencing. Yet, when he approaches the nurse educator to talk about moral distress, she tells him, "Hey, you'll get used to it."

REFLECTIVE QUESTIONS

1. *Do you think Jordan is experiencing moral distress? In what way(s) does Jordan's story reflect Jameton's definition of moral distress?*
2. *What do you think about the nurse educator's response to Jordan's concerns?*
3. *What preventative and supportive measures do you think could help Jordan now and as his career progresses?*
4. *What responsibilities do leaders in the ICU have to help Jordan and other HCPs to prevent them from experiencing moral distress?*
5. *How might advanced practice nurses, such as nurse educators and other nurse leaders, better prepare nurses at any stage in their careers to prevent, manage, and recover from moral distress?*

Impact of Moral Distress on Health Care Professionals and Patient Care

Dodek et al. (2016) explored the magnitude of moral distress in critical care professionals, by surveying all professional staff in 13 Canadian ICUs using the Moral Distress Scale—Revised.[3] The researchers found that the moral distress score was higher in ICU nurses and other non-physician professionals than in physicians; was higher in nurses with more years of experience but was lower with older age for other non-physician professionals; and was associated with a tendency to leave the job. The highest-ranked items associated with moral distress were related to end-of-life controversies and resource constraints. To examine concomitant issues and consequences of moral distress, they also surveyed the same professionals regarding general workplace distress (Dodek et al., 2018), and measured safety outcomes in the participating ICUs (Dodek et al., 2019c). After adjustment for demographic characteristics, higher moral distress in nurses was associated with lower decision latitude and social support, and with higher psychological stressors and psychological strain (Dodek et al., 2018). These relationships were similar for physicians and other professionals. Although moral distress in ICU personnel was generally not associated with errors or adverse events related to medications, or other adverse events, it might be associated with both hyper-vigilance in nurses and distraction in physicians (Dodek et al., 2019c).

To further explore these findings, Henrich (2016, 2017) conducted focus groups in three ICUs. The most commonly reported causes of moral distress were concerns about the care provided by other health care workers, the amount of care provided (especially too much treatment at end of life), poor communication, inconsistent care plans, and issues around end-of-life decision making (2016). All of these causes are amenable to improvement. Reported consequences of moral distress included frustration, perception of a negative impact on patient care, and thoughts about quitting work in the ICU (Henrich, 2017). These consequences indicate that moral distress is not just a psychological phenomenon—rather, it has grave potential consequences for both health care professionals and their patients.

Assessing Generalizability of Findings

To explore the generalizability of these findings, Dodek et al. (2021) surveyed all critical care physicians in Canada using the MMD-HP. Overall, they found a moderate level of moral distress, and levels of moral distress were lower in those who had partners compared to those who did not have a partner. The highest-ranked item scores on the moral distress instrument were those related to overly aggressive and potentially non-beneficial treatment, lack of resources, and lack of administrative action and support. In addition, there were significant associations between moral distress and burnout and moral distress and compassion fatigue, but notably, there was no association between moral distress and a validated measure of personal resilience. Qualitative analysis of free-text comments on the surveys revealed that a combination of contextual and relational factors led to moral distress and other kinds of workplace distress, which in turn led to individual and collective negative consequences such as burnout and attrition (Piquette, 2019). These consequences were mitigated in part by individual coping strategies and the rewards of providing critical care. Interviews of some of the survey respondents revealed various approaches to moral conflicts, including self-preservation strategies, patient-oriented strategies, and relationship-oriented strategies (Piquette, 2019). In addition, modulators of moral distress included clinical circumstances, team interactions, legal context, and societal expectations. These modulators are amenable to educational and/or organizational intervention.

Considering these observations in practicing critical care professionals, Sajjadi et al. (2017) decided to look "upstream" by surveying post-graduate physicians and medical students. In a cross-sectional survey of internal medicine residents, Sajjadi and colleagues found a relatively low level of moral distress, but more than a quarter of respondents had considered quitting their residency due to moral distress, and moral distress was associated with burnout. Furthermore, the rotations associated with the highest levels of moral distress were in intensive care units and clinical teaching units (in-patient medicine). These observations informed next steps regarding investigating causes of moral distress

in these residents. In a cross-sectional survey of medical students, researchers also found a "mild" level of moral distress (Dodek et al., 2019a), and no relationship between coping strategies and moral distress (Dodek et al., 2019b).

Moving to Informed Action

Although further work is necessary to explore modifiable determinants of moral distress, its consequences (including attrition) require interventions. Given the individual nature of moral distress, one place to start is to help individuals characterize and work through their moral conflicts using a participatory approach. Chevalier, Dodek, and colleagues developed an explicit moral conflict assessment model (2022) that tested this approach in both individual and group sessions with 23 participants from three ICUs. This approach was feasible and well-received by the participants, but further experience and evaluation is needed. In the meantime, HCPs and their leaders can begin to ameliorate moral distress, first by recognizing it as a psychological phenomenon that is distinct from other causes of workplace distress, and then addressing the components of the moral conflict that usually underpin this distress. For example, conflicts related to end-of-life care can be addressed by promoting advance care planning, and by routinely considering a palliative approach for eligible patients (Venis & Dodek, 2020). Conflicts related to communication and consistency of care can be addressed by teamwork training (Clancy & Tornberg, 2019). Conflicts related to resource allocation can be addressed by involving front-line professionals in these decisions. Each of these examples requires leaders who are actively engaged with their personnel, and allot time for front-line professionals to participate in improvement work. Quantitative and qualitative inquiry would be helpful to measure the impact of these interventions, attitudes, and skills.

Future Avenues of Inquiry

Dodek and his colleagues have presented an example of a program of research on moral distress by a Canadian team of health care researchers using a combination of quantitative and qualitative

methods. The researchers have identified several modifiable causes of moral distress that are amenable to improvement (Henrich et al., 2016). Yet, many questions remain unanswered: Who gets moral distress? Are there modifiable characteristics that predict this phenomenon in health care professionals? What are the causes and consequences of moral distress in health care leaders and decision makers? Where does moral distress occur—is there a relationship to organizational culture? And if so, what are the modifiable characteristics of the workplace that can ameliorate moral distress? Do patients and their family members get moral distress? If so, what are the modifiable determinants of their distress, and is there a relationship between their distress and moral distress in their HCPs? Can teams benefit by forming communities of practice related to preventing and ameliorating moral distress, or by studying success factors in sites that have less moral distress? Further theoretical and empirical work is needed in order to answer these questions. However, theoretical and empirical work alone is insufficient to effect change in health care environments. Moral leadership within health care organizations is also necessary to support interventions that address and ameliorate moral distress.

Recommendations to Influence Change Through Moral Leadership

In this chapter, we have endeavored to track the evolution of the concept of moral distress, which nurses and other HCPs may experience as a result of the ethically complex situations they encounter in practice. We began by defining moral distress and differentiating it from other, overlapping concepts. Then we delineated the reciprocity between the moral context of nursing practice and moral agency. Next, we shifted our focus to some of the key debates surrounding moral distress, which allowed us to highlight gaps in our current knowledge base. At the same time, these gaps serve as signposts to guide further research and the development of interventions that support the moral agency of nurses and other HCPs in addressing moral distress. Below, we provide recommendations for addressing moral distress. We recognize that addressing moral dis-

tress requires simultaneous, multi-pronged approaches at micro, meso, and macro levels of the health care system.

To begin, further theoretical and empirical work is necessary to answer questions that remain unsettled in the definitional debates around moral distress, including how to move toward strategic action. Fourie's (2015) interrogation of the compound nature of Jameton's 1984 definition of moral distress is one example of theoretical work supporting a more robust understanding of moral distress. Furthermore, McCarthy and Monteverde (2018) have pointed to the need for investigations of the link between moral emotions, moral judgment, and moral action in the experience of moral distress. Understanding the role of moral emotions may explain why some HCPs who experience moral distress become more attentive to their individual patients (micro level response) (Musto et al., 2021; Wilkinson, 1987), while others direct their actions towards instigating systemic (meso or macro level) change (Musto et al., 2021).

Theorizing about moral emotions will also assist in distinguishing moral distress from other closely related concepts such as burnout, compassion fatigue, and vicarious trauma—while at the same time potentially clarifying the distinction, or transition, between moral distress and moral injury in health care. Theorizing about how to address power dynamics between health care disciplines and hierarchical positions within health care organizations is a particularly worthwhile area for exploration and speculation about interventions to prevent and/or ameliorate moral distress.

Qualitative and quantitative empirical research on moral distress, (for example, Dodek et al.'s program of research presented earlier in the chapter), is ongoing across disciplines, settings, and specialty populations. One of the particular strengths of empirical research is the opportunity for researchers to assess the effectiveness of specific interventions. Researchers using quantitative measures can identify potential decreases in moral distress experienced by nurses and other HCPs following interventions, whereas researchers using qualitative methods may be able to identify *why* the interventions were effective. This can allow researchers and HCPs the opportunity to explore—and ultimately address—the complexity of the lived experiences of HCPs within complex health

care contexts. Such contextually based inquiry makes it possible for researchers, advanced practice nurses, and other health care leaders to work with HCPs to develop effective interventions at micro, meso, and macro levels of health care delivery. In what follows, we outline interventions that we believe have promise at all levels of health care delivery. These interventions have been informed by related scholarship and research, and would also benefit from ongoing qualitative and quantitative evaluative research.

At the micro level, nurses can use strategies to improve moral resiliency to decrease moral distress (Rushton, 2016). Individualized self-care strategies, including spiritual, emotional, physiological (diet and exercise of some form), and psychological practices that support the wholeness of HCPs can be useful. In addition, strategies for developing critical reflection on practice, with supportive mentoring from colleagues and supervisors, can be significant in helping to ameliorate moral distress. These self-care strategies need to be meaningful to the individual, not simply prescribed by health care organizations or regulatory bodies.

Addressing the concept of *critical resilience* can be beneficial in promoting and supporting strategies at all levels. In a book addressing "survival" and "change" for nurses in the United Kingdom, Traynor (2017) emphasized that "[t]he combination of becoming informed about the political and policy forces acting on day-to-day working experience and frank, mutually supportive discussion can develop critical resilience" (p. 30). Traynor also stressed that discussion and information must be used in a complementary manner, explaining that neither "on its own is enough" (p. 30). We take Traynor's recommendations to be foundational to effective interventions at all levels in all practice arenas. Interventions that we believe would benefit from empirical research include

- Implementation of communication tools to support effective team communication;
- Team-based education and strategies for addressing moral conflict; for example, moral conflict assessment (Dodek et al., 2022), and implementation or adaptation of Pediatric Ethics and Communication Excellence (PEACE) rounds (Wocial, 2017);

- Support for the involvement of nurses and other HCPs in multidisciplinary meetings (Morley et al., 2021); and
- Ensuring that the input of front-line nurses and other HCPs is consistently considered and addressed in health care environments.

Challenges during the COVID-19 pandemic have often meant that interventions to address moral distress, or other workplace problems, have been difficult to implement. For example, Havaei et al. (2021), working from the University of British Columbia School of Nursing, examined the impact of COVID-19 workplace conditions on nurses' mental health outcomes. They found disturbingly high rates for post-traumatic stress disorder (47%); anxiety (38%); depression (41%); and high emotional exhaustion (60%). In addition, these researchers discovered that nurses who reported adverse mental health outcomes also gave negative ratings about workplace relations, organizational support, organizational preparedness, workplace safety, and access to supplies and resources.

Havaei et al. (2021) concluded that because of the negative mental health self-reports by nurses during the COVID-19 pandemic, better workplace policies and practices were urgently needed to prevent and mitigate nurses' suboptimal work conditions. Havaei et al. emphasized that their findings support two decades of research showing that the ability of nurses to give their patients effective care is influenced by the workplace conditions of nurses. These research findings have significant implications for promoting the psychological and moral well-being of nurses, and, thus, for improving the overall moral climate for nursing practice and patient care.

Developing interventions for strengthening supportive leadership can be effective in reducing moral distress at the meso and macro levels, and includes strategies such as (a) ethics education; (b) teaching leaders how to apply ethical frameworks; and (c) supporting nurse leaders to be effective mentors (Musto et al., 2021). As mentioned above in work by Dodek et al. (2016), researchers in moral distress have noted the impact on practitioners across disciplines and have indicated that nurses experience higher levels of moral distress than HCPs in other disciplines (Dodek et al., 2016;

Epstein et al., 2019). However, across disciplines the experience of moral distress has been linked to compassion fatigue and burnout, and a willingness to leave the profession (Epstein et al., 2020). Given the impact of moral distress on practitioners, it is imperative to begin preparing nursing and other health care students for the ethical challenges they will inevitably encounter in the work setting.

Guzys's (2021) model of factors influencing the development of moral distress across the micro, meso, and macro levels of health care is a helpful starting point for developing strategies and interventions to address moral distress. Guzys's model also reflects the shared responsibility for fostering a resilient health care work force. Professional identity of a practitioner is central to the model, and Guzys presents a curricular guide to mitigating the influences of moral distress. Theorizing about how to address power dynamics between health care disciplines and/or hierarchical positions within health care organizations is a particularly worthwhile area for exploration about interventions to prevent or ameliorate moral distress. For student nurses, it is important to foster self-awareness so they come to understand their own values, knowledge, assumptions, and attitudes. It is essential to introduce students to the concept of critical reflective practice that requires practitioners to "ask critical questions of themselves and their practice through a consideration of the moral, ethical, and sociohistorical contexts of their practice" (Guzys, 2021, p. 662). For example, teaching students effective communication skills for practice, and teaching them how to recognize and communicate respectfully and helpfully in situations that involve values conflicts, will help mitigate moral distress in their future practice. Nurses must have more than a simple awareness of the existence of a professional code of ethics. Teaching nursing ethics and professional ethics is required, so that students are able to deal effectively with moral distress (Guzys, 2021). As part of their professional identity, students need to understand the moral nature of the nurse-patient relationship in a way that provides support for quality care and serves as a foundation for moral courage. Further, assisting students to develop leadership skills, and teaching them about ways to influence change, is essential as they develop their professional identities. Student education

should also include the involvement of relevant provincial, territorial, and national professional associations.

Researchers studying interventions to address moral distress regularly call for the creation of moral communities within organizations to mitigate some of the factors that contribute to moral distress. Epstein et al. (2020) defined moral communities as "groups of people bound together for a common moral purpose that transcends personal interests and promotes the well-being of others" (p. 147). Similarly, the Canadian Nurses Association (CNA, 2017) stated that a moral community is "a workplace where values are made clear and are shared, where these values direct ethical action and where individuals feel safe to be heard (adapted from Rodney et al., 2013a)" (p. 24).

Theorizing about how to address power dynamics among HCPs within health care organizations is a worthwhile area for exploration about interventions to prevent and/or ameliorate moral distress. This requires supporting the involvement of nurses and other HCPs, in unit organization-wide committees, as well as health care agency groups and committees. Advanced practice nurse leaders are key to developing processes to ensure the involvement of nurses and other HCPs in fostering safe moral communities where all their voices are heard.

As described above, research conducted about moral distress has significant implications for leadership action at micro, meso, and macro levels for physicians, nurses, and other HCPs. For example, at the individual level, it is clear that all HCPs ought to have consistent access to expert and supportive mentors with whom they can debrief and seek ethical and emotional support. Such support can help to build resilience of individuals and teams. As mentioned earlier, Traynor (2017) developed a focus on *critical resilience* for nurses. He explains:

> For me the key difference between resilience and "critical resilience" is that critical resilience is about understanding ourselves and our experiences in relation to our society—to take a phrase from feminist consciousness-raising groups (Chicago Women's Liberation Union, 1970). The combination of becoming informed about the political and

> policy forces acting on day-to-day working experience and frank, mutually supportive discussion can develop critical resilience. (pp. 29–30)

Conclusion

Moral distress often results when HCPs believe that they have contributed to wrongful harm, or violated their professional obligations, leading to the suffering of other people. In this chapter, we have argued that addressing moral distress is a responsibility that is shared among health care organizations, those in positions of leadership, and individual practitioners across all health care disciplines. Central to our argument is the recognition that an individual's enactment of moral agency is dynamic and is shaped by the context in which HCPs work. We provided theoretical perspectives and definitions related to moral distress and moral agency. In addition, we made recommendations for changes that are needed in order for nurses and other HCPs to work in environments where moral distress is no longer a prevalent feature of their practice. We discussed why a multi-pronged approach is required for meaningful interventions at the micro, meso, and macro levels of the health care system to prevent or minimize moral distress. In the absence of such interventions, there is a risk of further erosion of health care delivery due to unacceptable levels of moral distress faced by nurses and other HCPs.

QUESTIONS FOR REFLECTION

1. *What are the implications of moral distress for nurses and other **HCP**s in your area of practice?*

2. *How ought we to educate nurses and other **HCP**s about moral distress and its implications?*

3. *What actions might advanced practice nurse leaders take to ameliorate moral distress in their areas of practice?*

4. *What research studies could advanced practice nurse leaders design to evaluate the effectiveness of interventions meant to address moral distress?*

5. *How might advanced practice nurse leaders advocate for interventions to address moral distress at micro, meso, and macro levels across Canada?*

Endnotes

1 See, for example, Sherwin (1992), Rodney & Varcoe (2012), and Baylis et al. (2008).

2 For more information about the research conducted by the editors of this book, please see Rodney et al., 2002; Storch et al., 2009; and Varcoe et al., 2003.

3 These are instruments in which respondents assess the frequency and level of distress that is associated with specific situations. Using a semi-quantitative scale for each of these components, the product of the scores for frequency and level is the score for each item, and the sum of these products for all items is the overall score. Advantages of this quantitative approach include understanding the strongest determinants of overall moral distress (ranking of items by score), making comparisons within and among groups of respondents, and analyzing associations between moral distress and other measures such as demographics and other measures of wellness. Limitations of this approach include inability to explore causes of moral distress that are not included in the items in these instruments, inability to explore local nuances of items, and inability to explore consequences of moral distress (other than attrition) and potential solutions. These limitations can be addressed by complementary qualitative assessments and participatory action research. Using both contemporary quantitative and qualitative methods, we have explored moral distress and related measures of wellness in critical care professionals, post-graduate medical trainees, and medical students.

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