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# Moral Distress or Moral Comfort

by Mary C. Corley and Ptlene Minick

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*Moral distress in healthcare results from a professional's inability to provide compassionate care to patients because of individual, organizational, or societal barriers. Research suggests that moral distress is a growing concern among nurses, and may be a major reason why nurses leave one job for another or abandon the profession of nursing. Some professionals, however, have identified strategies that help them work through their moral distress toward an experience of moral comfort. These strategies may be individual, organizational, or societal. The focus of this paper is to identify examples of strategies professionals have used to alleviate distressful feelings and enhance moral comfort.*

Since 1984, research has demonstrated that moral distress is a problem experienced by nurses (Rodney 1988, Corley 1995, Sundin-Huard and Fahy 1999); yet moral distress is also likely to occur among other professionals in healthcare and in other professions (Liedtka 1991, Ford and Richardson 1994).

This article focuses on strategies that help deal with moral distress to achieve moral comfort, and describes how an ethical organization can mitigate moral distress and thereby enhance moral comfort. The role of society in reducing if not preventing moral distress will also be described. Focusing on moral distress is important because of the growing complexity of healthcare and the variations in values of patients, families, and individual professionals.

## Defining Moral Distress and Moral Comfort

Jameton (1993) distinguished between initial and reactive moral distress. In initial moral distress the person feels "frustration, anger, and anxiety when faced with institutional obstacles or conflict with others about values. Reactive distress is the distress that people feel when they do not act upon their initial distress" (p. 544). Obstacles can

be lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations. All these obstacles are at the organizational or societal level and justify the need to consider strategies at these levels. In addition, power differentials and values seem to lie at the basis of moral distress (Worthley 1997). Some level of moral comfort is achieved when the individual acts on the initial distress and reaches some resolution of the problem causing the distress.

Moral distress is characterized by two aspects: the seriousness of the situation causing the moral distress; and the frequency at which the problem occurs (Corley 1995). A very serious problem may cause moral distress, even if it occurs only once. Such problems can affect the individual long after the incident occurs. Nurses report that they have left positions because of moral distress; the percent reporting resignations has increased from 15 percent in the early 1990s (Corley et al. 2001) to 26 percent in the late 1990s (Corley et al. 2000).

In contrast, less serious, yet frequently occurring situations may also cause moral distress. Situations that are part of everyday practice, or what Worthley (1997) refers to as "ethics of the ordinary," occur frequently and cause a chronic

feeling of moral distress. When health professionals feel moral distress, they may also feel burnout and reach a point at which they say "nobody else cares, so why should I?" However, they are more likely to develop chronic moral distress, in which they remain committed to the patient to the extent possible, but always feel that they have not done enough and bear a burden of guilt.

Moral comfort is an individual's feeling of ease about a decision related to ethical problems. It occurs when the professional is able to make decisions in the best interest of patients, has his or her ideas about patient care considered in the care plan, or is able to relieve or reduce the patient's pain and suffering.

### **Strategies to Enhance Moral Comfort**

This article proposes three perspectives to consider in promoting moral comfort: the individual or psychological; the organizational; and societal views.

#### ***Psychological Approaches***

Strategies from the individual or psychological approach refer to what the individual can do to prevent and manage moral distress. Although patients and their families have complained about the quality and availability of nursing services in hospitals in recent years, nurses also experience distress related to these conditions.

From a synthesis of research studies and reports, Fagin (2001) concluded that the burden of care for nurses has increased demonstrably since 1990. The burden includes providing for the safety of the patients, despite deteriorating working conditions that include more overtime and fewer registered nurses. These factors provide rich ground for the development of moral distress.

***Going above and beyond policy.*** Advocating for patients may require nurses to take risks that are not covered by policy or standards. The personal, professional, and legal ramifications may be severe (Foley, Minick, and Kee 2000). By risking something for her patient, a nurse will eventually achieve moral comfort. The following case describes this strategy.

Ms. Baird was working on the evening shift when the resident physician informed her that he was going to perform a procedure on a patient. She did not think the procedure was appropriate for the patient and asked the resident to wait and discuss his plans with the attending physician. The resident insisted on performing the procedure immediately.

Ms. Baird was afraid of consequences the patient might suffer, but she was also afraid of being reprimanded by colleagues and administrators if she intervened to postpone the medical procedure. She felt, however, that she needed to resolve the prob-

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lem before the resident acted, so she phoned the chief of surgery and told him about the resident's plan. The chief asked to speak to the resident and advised him not to do the procedure.

The next day the surgeon told Ms. Baird that he was "glad" that she had called him. "Don't ever hesitate to call me for something like this," he said. "After that," said Ms. Baird, "I was never afraid again to take action if I thought it was necessary for a patient."

In this situation, the nurse risked calling the chief of surgery. The chief could have responded angrily, or even ask that she be fired. Ms. Baird learned that she could act on her judgment, protect the patient, and seek assistance from a higher

authority. The chief of surgery agreed that the procedure was inappropriate.

Many nurses describe being humiliated when they question physicians' decisions. According to Buresh and Gordon (2000), "Sometimes doctors act very aggressively to silence nurses and put them in their place. At other times, nurses silence themselves even when doctors might not complain or might be supportive" (p. 73). The fear of being wrong or ridiculed may prevent nurses from accepting the challenge of going beyond policy to protect the patients' best interests.

Some nurses report that fear of losing their jobs is the reason they often remain silent even though speaking out would be in the best interest of the patient. Depending on each one's situation, such fears may be realistic. Job opportunities may be limited because of widespread corporate ownership or because a limited number of healthcare organizations are active in the community.

In Ms. Baird's case, the nurse learned that her judgments would be considered by a particular physician, but other physicians may not extend the same support. A reorganization within nursing could ameliorate this situation. For example, a policy indicating support of staff nurses' judgments, especially when nurses are attempting to advocate for patients, may give Ms. Baird and other nurses more confidence that they will have support from other physicians in the future. Rather than hope for a supportive physician, staff nurses could rely on supportive nursing departmental and organizational policies.

**Nursing Expertise.** The healthcare professional who develops professional expertise and takes time to understand the wishes of the patient and family may be able to reduce his or her moral distress. Several authors have described the importance of "knowing the patient," in providing expert nursing care (Benner, Tanner, and Chesla 1996, Minick 1995).

In a well-publicized case, a nurse permitted the parents of a child critically injured in an accident to be present during life-saving interventions,

including resuscitation (Gerber 1995). This nurse had spent time with the family; she knew their wishes and their ability to be present for the child's care without interfering with it. Because allowing parents to be present during resuscitation was against hospital policy, the nurse was subsequently suspended while the situation was reviewed. She was reinstated after she successfully argued that the parents wanted to be with their child, that she had prepared them for what they might see during the interventions, and that she correctly believed

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that they would be comforted by the effort to save their child.

Indeed, the parents were extremely grateful for the opportunity to be with their child during this important life transition. This nurse's bravery was effective not only in a particular hospital, which subsequently changed its policy to permit families to be present during resuscitation, but in other hospitals as well. Many hospitals now permit family members to be present during these procedures. This nurse's expertise and advocacy lessened the moral distress she experienced from violating hospital policy, and helped her deal with the stress caused by the suspension. She also felt morally comforted by having made the decision.

This situation exemplifies three components of expert nursing care that have been documented through research: (a) knowing the patient, (b) pushing the boundaries of practice, and (c) being confident in one's nursing judgments. Several levels of "knowing the patient" helped the nurse achieve moral comfort. First, the nurse had thoroughly assessed the family and knew that they would be comforted rather than distressed by the situation. Her knowledge was an important aspect in providing compassionate care.

The second aspect of expertise exemplified in this situation was the nurse's willingness to push the boundaries of practice; some might call it bending the rules or responsible subversion, while others would call it breaking the rules (Hutchinson 1990, Minick in press). This nurse felt that risking her job to obtain what the family needed was more important than upholding the rules of the institution. Her commitment was to the family rather than to the institution.

The third aspect of expertise exemplified in this situation was the nurse's confidence in her nursing judgment. Clearly, a novice or less experienced nurse would not have been able to insist so firmly on his or her judgment when other professionals and supervisory personnel began questioning the decision. Gaining expertise is another strategy for mitigating moral distress and gaining moral comfort.

**Role Clarity.** Another strategy to decrease moral distress and achieve moral comfort is to develop expertise and clarity about what one person can reasonably accomplish in a work setting. Consider the following scenario: Mr. Jones, a nurse with two years' experience, related that he felt so much moral distress working in the intensive care unit of a large medical center that he finally resigned and took a position in a physician's

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office. Mr. Jones felt that the cause of his distress was related to working with inexperienced nurses who could not provide the competent care that he thought was necessary.

After two years away from the intensive care unit, Mr. Jones realized that he wanted to work in an intensive care unit and that he had to set boundaries on the responsibilities that he would or would not accept in that work environment. He returned to his former position in the intensive care unit and informed the nurse manager about his plans to set realistic limits on what he could accomplish. He turned the responsibility for monitoring the performance of other nurses over to the nurse manager. Mr. Jones and the nurse manager were comfortable with that decision, and Mr. Jones did not experience the ongoing moral distress that had characterized his previous experience in the unit.

**Cultural competence.** As another aspect of nursing expertise, cultural competence is also a helpful strategy for reducing moral distress. Knowing the patient and family can help one provide culturally specific care and appreciate culturally different requests (Cornelison 2001). For example, if the parents of a child who belongs to the Jehovah Witness faith request that no transfusions be given to the child, the nurse who takes time to understand the role this belief plays in the family's religion may not experience moral distress even if the impact on the child is a longer recovery or even death.

### **Organizational Perspectives**

The organizational perspective is focused on the environment in which professionals work. Only a few researchers have explored the organization's role in the ethical aspects of its services. The following discussion addresses the potential that the organization's ethical environment, shared power, and decision-making processes have for mitigating moral distress.

#### ***An Ethical Environment***

An organization has several crucial strategies that it can use to influence the ethical behavior and beliefs of professionals (Olson 1995, Deshpande 1996) and reduce or prevent moral distress. The general work climate should help organizational participants identify key behaviors and attitudes, and influence their perceptions of ethical issues

and criteria that can be used to resolve them. "Thus ethical climates identify the normative systems that guide organizational decision making and the systemic responses to ethical dilemmas" (Victor and Cullen 1990, p. 123).

A major strategy in developing an ethical environment is to address societal changes. Although rapidly developing healthcare technology has been a source of ethical questions since its growth began about 1960, two additional forces now increase the complexity of providing an ethical work environment. The first is a change in healthcare policy as reflected in healthcare delivery systems, particularly managed care for public and private health insurers; the second is the growing cultural complexity of healthcare providers and patients. Organizations need to anticipate the impact of new technology, particularly, changes in delivery systems and the effects of cultural complexity on their employees; and develop strategies to enhance ethical behavior.

Many variables can affect employee perceptions of the ethical climate (Victor and Cullen 1990).

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These include the employees' positions, level of management, length of time with the organization, degree of sensitivity to ethical components, leadership behavior and style, and type of ethical issue. In addition, the size of the organization can have a negative impact on the ethical life of its professional employees. Nystrom (1990) found that smaller companies supported moral values more than larger ones. Not only the organization, but also the work group can constrain an employee's behavior and cause moral distress (Johnson and Webb 1995).

The ethical environment is reflected in the organization's mission statement (Reiser 1994). The statement includes what one can do and what one ought to do (Victor and Cullen 1988) based on values in the milieu that guide ethical behavior and priorities (McDaniel 1998). Employees should scrutinize these official documents prior to employment to assure that they can live within their parameters. Once employed, professionals should be involved in developing these organizational documents to encourage their acceptance by all parties.

Another strategy to foster moral comfort is to encourage participation in deliberations in the organization including participation in the ethics committee. Professionals will perceive that the environment is not ethical if there is no congruence between professional codes and practice. This strategy is particularly important for young professionals, or relatively new graduates.

***Power and Participation in Decision Making***

To be effective, professionals need power commensurate with their responsibilities. Kanter (1993) identified four structural factors necessary to provide employees with the power that leads to work effectiveness and moral comfort. These factors, access to information, support, resources, and opportunity, are necessary conditions for health professionals to advocate for patients.

The importance of these conditions is supported in research on job satisfaction in five countries (Aiken et al. 2001). Nurses who believe they have adequate support services, enough nurses to provide high quality care, adequate time to discuss patient problems with other nurses, participation in policymaking, and whose contributions are appreciated, are less burned out and less emotionally drained and frustrated by their work.

***Administrative Support and Resources.*** Administrative support was an important component of the ethical environment described in McDaniel's (1997) research. When the organization's hierarchy of rules and practice protocols conflict with

what the nurses are doing to protect the rights of patients, they experience moral distress (Raines 1997). If the organization also places obstacles such as inadequate staffing and administrative demands in the way of nurses trying to "know the patient," the result will be poor quality of care and increased moral distress. Thus, organizations have a major role in providing resources and support enabling their employees to perform their responsibilities and enhance their moral comfort.

**Opportunity.** An ethical work environment is characterized by good communication and collaboration among all personnel, providing opportunities to discuss the most frequent and most difficult ethical problems that arise. Through consensus based on active commitment to group cooperation, integration, and agreement, power and decision making can be decentralized (Molzahn 1997). The organization must encourage empowerment that includes growth in personal strength, power, and confidence to act in a way that respects others.

The organization has a responsibility to make sure that ethics committees are formed, available, and functioning effectively to help reduce the moral distress of professionals in the organization. Often they focus on the most controversial problems, so that ongoing problems which may be a constant source of moral distress, are never addressed (see Worthley's [1997] "ethics of the ordinary").

**Information.** Making information available is another strategy that enhances moral comfort. Professionals must be guaranteed that their concerns will be heard and that they will not be required to violate their own beliefs. If their beliefs are based on inadequate knowledge, the organization is responsible for addressing this knowledge deficit (e.g., sending employees to an education session can help those who may be withholding pain medication because they fear addiction).

Healthcare organizations can help professionals clarify their values. Health professionals must be clear about their own values and alert to the conflict in values with others. Determining whose values are in the best interest of the patient is cru-

cial to taking the patient's values into consideration when conflict among health professionals occurs. Administrators can develop forums at which professionals discuss value conflicts, experience ongoing reflection, and see the changes that result from their input.

Reiser (1994), focusing on the ethical life of healthcare organizations, points out that organizations declare what really counts by their treatment of staff, the institutional goals they set, and how they handle controversy and conflicts. He recommends that ethical analysis be part of the administrative, policymaking, and interpersonal

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aspects of organizational life to bridge the gap between professional values taught during the formal socialization process and application of those values in complex clinical settings. Thus the organization assumes some responsibility for helping those new to the organization and for reducing moral distress.

The environment must support open dialogue during distressing patient care experiences. The communication should involve all concerned parties and involve everyone in the decision-making process. When inadequate information contributes to moral distress, professionals should know where to get additional information. As Hamric (2000) points out, unjustified moral distress may occur when the professional lacks sufficient information to assess the patient's problem accurately.

## Societal Interventions

At the societal level, a number of strategies can be used to reduce or prevent moral distress. One strategy is to encourage dialogue about values and identify sources of value conflict at a community, state, and national level. This approach has been used by the state of Oregon to identify health priorities (Brown 1991) and to understand end-of-life issues (Robert Wood Foundation 2001). Society is also responsible for accommodating these differences. One major source of value differences is cultural complexity.

Laws and policies that make it difficult to provide good patient care may need to be revised and professionals may have to alert authorities to this need (e.g., patient autonomy versus a family lawsuit opposed to carrying out the patient's wishes). Providing care for a patient whose prognosis is without hope, but who is not allowed to die because someone is afraid of a lawsuit is morally distressing.

Budgets for public organizations are determined by legislators. In the course of the budgeting process, legislators must seek professional advice to guide their deliberations. Professionals may have to lobby for funds when they realize that necessary healthcare cannot be provided without increased spending, and legislators must listen to their arguments. Having to deny a patient a transplant or other care because Medicaid has run out of funds is a morally distressing experience for all caring professionals.

The interface between the organization and society may be a source of moral distress. Molzahn (1997) points out that other organizations often prescribe how healthcare personnel function. For example, accrediting organizations demand accountability, and other networks may demand information that is not relevant to practice. Health professionals must help shape the structures and processes that govern them, rather than simply acquiesce in these prescriptions and thus achieve moral comfort.

## Conclusion

In sum, as Hamric (2000) suggests, health professionals should be taught to diagnose moral distress and its sources while they are students. Even more important, we need to move from anecdotal to research-based approaches to help us identify strategies for addressing moral distress, and we must include organizational and societal approaches in our evaluation of these strategies.

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