

Moral Distress in Healthcare

The sense that one's work life may be compromising, or even corrupting, is common. Among nurses, the experience is especially severe. "I leave work every day feeling that my heart has been torn out," reports one. She, like most nurses, works in a unit that is severely understaffed. She often feels that she is shortchanging her patients, or even endangering them.

This nurse, like many others, believes that administrators (including directors of nursing) care more about advertising, marble floors, or chic uniforms than about staffing ratios (Seabrook 2002). But moral distress, the belief that one is colluding in some sense with what one judges to be wrong, is an almost universal occupational hazard.

Even administrators who often seem so oblivious suffer this anguish. Doctors certainly experience it, when, for example, their time with patients is limited to seven minutes and their prescribing practices restricted by formularies. Many others suffer similarly: a professor who feels forced to "dumb down" his medical school course; a child psychiatric worker prohibited from ordering "time-

outs"; a professor asked to chair a "search" committee whose results have been foreordained; a manager who cannot fire a unionized nurse. Anyone who works in an organization is vulnerable to moral distress.

The paradox is that most of us accomplish far more within an organization than we could alone, and yet any organization can make decisions that are, or seem to be, morally faulty. That which makes our work effective, and even possible, can also blight it. Many factors are at play: limited resources, the need to make decisions collectively or hierarchically, the tendency of institutions to serve themselves rather than the public.

Attending to Distress

There are many kinds of moral distress. The most basic is a sense of complicity, of sharing responsibility for something that is wrong. Sometimes the responsibility is remote, as when one's employer or coworkers act badly. As the distance narrows, one's distress deepens: seeing the action or its results first hand is uncomfortable. But when one is actively involved, the real suffering begins. The nurse who has to tear her hand from a dying patient's grip; the doctor who discharges a patient not really ready to go home — these people feel personally compromised.

The suffering becomes most severe if one believes that he or she is the instrument of harm: a nurse who administered chemotherapy that she believes the patient will reject refers to herself as the "enforcement tool" of a university teaching hospital (Liaschenko 1995). A young doctor remembers his OB/GYN clerkship: "We [medical students] were practicing pelvic exams on a patient; all of us lined up, our gloved fingers held up in readiness. It felt like gang rape. I happened to look at the patient; tears were streaming down her face."

As difficult as it is to recount these stories, there is something to be learned from them. The first is that each story has more than one victim. The patients being harmed are important, but the anguish of those who feel coerced into doing harm also matters. We need to pay more attention to

their anguish and listen more acutely to those with less power — students, subordinates, employees. We must also be less swift to judge those who seem to have great power. They, too, are often caught in binds. We need to withhold our too-ready censure in justice to them, and for the sake of those we jointly serve.

We also need to pay more attention to our own moral distress. It is unfortunate that English has no term to contrast with "self-pity," an unattractive label for an unappealing attitude. We need a way to talk about the moral usefulness of recognizing our own suffering (of whatever kind), the usefulness of being able to say to ourselves with compassion, "Yes; that is hard."

Leaning toward Choice

We must honor and attend to moral distress, but we must also remain clear-eyed about it. Moral distress can be mistaken, the result of a badly formed conscience. A survey of nurses a few years ago found that many believed they had "hastened a patient's death" (Asch 1996). It is possible that these professionals did not distinguish between withdrawing treatment and hastening death.

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Doctors who believe that "money should play no role" in patient care are ignoring the fact that all treatment costs money, and that a doctor's decision spends other people's money: never the doctor's, and rarely the patient's. Money comes from somewhere, and it is finite. Our response, therefore, to moral distress should include a dispassionate assessment as well as an open heart.

Further, moral distress by its very nature includes an element of guilt. We feel moral outrage at what others do, but moral distress at our

own participation. Guilt implies agency. Rarely do we face a choice in which there is no way out. We are not characters in a William Styron novel who must choose which of two children will be killed, or lose them both (1992). We have choices: we can refuse to cooperate; we can speak up or organize resistance, or quit. It often feels as if risking opposition is pointless because it will accomplish nothing, but one never knows. Some commentators believe "managed care," for example, is as good as dead, because of public resistance. Still, there will be times, perhaps many, when the risk to ourselves outweighs the remote chance of doing good.

Listening to others and ourselves, admitting that we are making choices, recognizing the moral legitimacy of compromise — these actions will make moral distress a less subterranean and more useful phenomenon. But nothing will make it go away. We must be as honest and as compassionate as possible, with ourselves, toward those with less power, and toward those with more. None of these actions are easy, but all of them are essential to moral maturity.

References

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