Moral Fatigue — A Nursing Perspective

by Susan Taylor

It is perhaps inevitable that a phenomenon called moral fatigue would be labeled, described, and applied to nurses, whose working environment has more than its share of moral conflicts. When professionals' duties to patients and their families — duties that are caught up in uncertainty and fast-paced institutional and cultural change — are made to seem irrelevant to the patients' real needs, the resulting discomfort of professionals is generally called moral distress. This article explores the dimensions of moral distress among nurses and presents moral fatigue as a holistic experience with both personal and institutional consequences.

The literature in nursing ethics first identified the phenomenon of "moral distress" in the 1980s (Jameton 1984). Corley (1995) uses Jameton's definition of moral distress as the basis for her work. She defines moral distress as "the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal considerations."

"Moral distress was a consequence of the effort to preserve moral integrity. It is the result of believing that one is not living up to one's moral convictions" (Kelly 1998, p. 1145). Viney (1996) studied the experiences of doctors and nurses in decisions to withdraw treatment and found differences related to roles; doctors were primarily decision makers, whereas nurses were information brokers. As a result, doctors often suffer moral dissonance, a conflict among principles; while nurses are more likely to suffer moral distress, a threat to their integrity.

Moral distress occurs when one knows the right thing to do but is constrained by the institution or one's coworkers from doing it. Moral distress involves recognizing that an ethical decision is difficult to act upon. It has three components — an element of emotional distress, a choice, and the required action (Tiedje 2000). Moral distress does not imply that the nurse makes unethical choices but that he or she knows that the strategy or action selected will cause distress. If nurses take the action they believe to be the right one, they can expect to experience distress from others' responses. If the action they choose is not "right," they will suffer from their own responses and perceive their choice as a threat to their integrity.

The conflicts nurses face are grouped into two broad categories: (a) those that arise through institutional policies and physician orders, and (b) those that arise from the usurpation of the legitimate authority of the nurse regarding nursing care (Curtin 1980). Misunderstandings and even conflicts with doctors, resulting from the nurses' inability to influence decisions and decision-making processes, were sources of moral

distress for every nurse interviewed in a qualitative study of fourteen nurses and seven doctors working on adult medical-surgical units in one large acute care Canadian hospital (Oberle and Hughes 2001). The possibility for such conflicts occurs routinely and increases with each occurrence. "It is not unusual that moral uncertainty is first experienced and escalates to moral distress as patients' rights are not respected or as institutional constraints are applied and nurses feel unable to act on their moral choices and judgments" (Hamric 2000, p. 199).

Employed by a hospital to care for patients whose medical treatment is determined by physicians, nurses find themselves having to serve several masters (patient, physician, institution), not all of whom have the same values and objectives. The profession admonishes the nurse to be the advocate of the patient. While this advocacy role is clearly the morally correct position for the nurse, it only increases tension and distress. The nurse is contractually beholden to the organiza-

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tion. Hamric (2000) notes that in many instances advocating for the patient puts the nurse in an apparent conflict with institutional policies and procedures. At other times, the nurse may be in conflict with the physician over patients' goals and expressed wishes. Nurses are often constrained in what information they can give to patients and families.

The massive changes that are occurring within healthcare institutions also add to nurses' moral distress. With the current (and worsening) nursing shortage, the likelihood of moral distress will only increase. Short hospital stays make it difficult for nurses to prepare patients and families to manage the patient's care after discharge. The system focuses on the technical, mechanical aspects of care — giving medications, doing treatments — thereby diminishing the ability of the nurse to interact with the family and patient to provide essential psychological support and teaching. A Canadian nurse describes the problem:

> I'm a registered nurse who has just completed a 12-hour shift on a busy surgical floor. This is the fourth shift I've worked in a row. My manager has just told me they can't find anyone for nights and that I have to stay and work the shift. I said I was too tired to work another 12 hours, but my manager told me I will be charged with abandonment and reported to RNABC if I don't stay. Do I have to stay and work another 12 hours? (Ellis 2001, p. 32)

Krishnasamy (1999) asserts that increasingly, nurses find themselves in an exposed position between the doctor and the patient, a situation potentially heightened when an ethos of cure comes face to face with an ethos of care. Nurses' lack of autonomy and authority leads them to feel as though they must betray their personal values in caring for their patients. Thus, they feel personally devalued within the healthcare team, are insecure, and have low self-esteem — all of which influence their ability to act in the best interests of their patients (Krishnasamy 1999).

Erlen (2000) notes that the close relationship of the nurse to the family can also lead to ethical dilemmas. Nurses can be caught in the middle and morally distressed by constraints within the healthcare system. How many times can a nurse tell the patient and family, without paying a high personal price, "I don't have time for you?" Many nurses feel that their current behavior says to patients: "I don't have time to meet and know you as a person. My view is necessarily limited to the site of your surgery, the fact of your disease, the medications that are prescribed for you, and the machines to which you are connected."

The distress increases as nurses become edu-

cated and develop a professional focus that is more than simply following physician orders — a view still held by many administrators and physicians. Nurses know how to improve quality of life during an illness, for the immediate and long term. They are confronted daily with opportunities to do nursing that they do not have time for — tasks that are considered outside the purview of the care situation. The inability to do the best one knows is distressing, and not only morally distressing. When the nurse knows that something should be done but can't be, he or she faces an ethical dilemma that leads to moral distress. One student puts it this way:

> We are supposed to be patient advocates. Where I work if you do that you can lose your job. . . . Whatever happened to caring for your patients? . . . In school we are taught one thing but when we get out there working, it is something entirely different. . . . We are unable to do the jobs that we were trained to do. It appears to me that money is being put before human caring and well-being (Lisa 2002, p. 14).

Redman and Fry (2000) describe ethical conflicts for nurses. Their themes include differences in the definition of adequate care among professionals, the institution, and society; differences in the philosophical orientation of nurses, physicians, and other health professionals involved in patient care; a lack of respect for the knowledge and expertise of nurses in specialty practice; and difficulty in carrying out the nurse's advocacy role for patients.

The pervasiveness of moral distress is not known. My experience suggests that it is widespread. A review of the literature on moral distress shows that the theme resonates with nurses across a wide sprectrum. For example, studies have identified or described the moral distress of nurses working with dying children (Davies et al. 1996), technology-dependent children (Cohen 1999), patients in cancer clinical trials (Krishnasamy 1999), and families (Erlen 2000). Moral distress is also present in settings such as NICU and perinatal care (Hefferman and Heilig 1990,

Tiedje 2000), acute medical units in community hospitals (Rodney 1997), acute care (Corley et al. 2001, Oberle and Hughes 2001, Tuck et al. 2001), critical care (Bamford 1995), and oncology (Raines 2000). Moral distress also affects nurse educators (Lyndaker 1995), nursing staff development educators (Cummings 1995), and new graduate nurses in hospital nursing (Kelly 1998).

Moral Fatigue

The consequence of continuing distress is fatigue. The logical consequence of continuing *moral* distress is *moral* fatigue. The healthcare literature does not reference moral fatigue. A computer search (using Google.com) revealed only one reference to moral fatigue in health-related literature. Edwards (2001) identified moral fatigue as a major issue for oncology nurses. The issue, Edwards says, concerns nurses who are committed to the best possible care for their patients, but who work in systems necessarily concerned with the financial bottom line.

Ethical concerns that segue into moral fatigue continue to drive many excellent oncology nurses from the field and cause stress to those that remain. The description of general fatigue provides an image that can guide our thinking about moral fatigue.

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Nurses have attempted to define moral fatigue by integrating its psychological and physiological aspects. According to the North American Nursing Diagnosis Association, fatigue is "the self-recognized state in which an individual experiences an overwhelming sustained sense of exhaustion and decreased capacity for physical and mental work that is not relieved by rest" (Carpenito 1995, p.

379). Ream and Richardson (1997) define fatigue as "A subjective, unpleasant symptom which incorporates total body feelings ranging from tiredness to exhaustion creating an unrelenting overall condition which interferes with individuals' ability to function to their normal capacity" (p. 45).

Fatigue is further conceptualized as "the awareness of a decreased capacity for physical and/or mental activity due to an imbalance in the availability, utilization, and/or restoration of resources needed to perform activity" (Aaronson et al. 1999, p. 5). Moral fatigue has a profound effect on the person suffering from it and those around that person.

Knowledge from Experience

The effects of fatigue are indeed profound. In 1993, I was diagnosed with breast cancer. I was treated with surgery followed by concurrent radiation and chemotherapy. My fatigue was over-whelming. It was both physically and emotionally debilitating. Though I knew that I should be taking care of daily activities, I didn't have the capacity to focus what energy I had on the tasks at hand. And when I could finally decide what I should do, I didn't have the physical stamina to accomplish the tasks. The best I could do was conserve my energy and wait for a day when I might feel strong enough to do something. There were times when the fatigue was immobilizing and times when I could do a few things.

As I neared the end of a cycle of chemo, I would feel an almost normal level of energy, though I knew that the fatigue would recur with the next event of chemo, some other onslaught of treatment, or the stress of daily living. Such profound fatigue affected my family — I was unable to meet their needs or communicate my needs to them. It was years before I learned the significance of this event on family members. It affected my work — it was hard to think and perform creatively. I didn't deal well with stress. It affected my view of myself — I had to clarify my values, question what I was doing, and accept that I had an uncertain future. To this day, I have a diminished capacity for activity.

Moral Fatigue As a Consequence

The cause of moral fatigue, however, is not physical illness. The cause of moral fatigue can be found in environments that require confronting moral situations on a regular basis. This confrontation requires the expenditure of energy. When these

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situations become overwhelming in frequency or intensity, fatigue results. As Goble (2000) describes it: persons experiencing moral fatigue are unlikely to maintain either their anger or their focus. Instead they turn to other issues. As their interests change, they are likely to say and do less about the morally distressing situations that led to the fatigue. Congar (1917) describes moral fatigue as "a lack of strength and energy that saps the mind and immobilizes thoughts." H.G. Wells (1917) describes moral fatigue:

> Never have I been so desirous to work well in my life. And never have I been so slack and weak-willed and inaccurate. . . . Sloppy. . . . Indolent. . . . VICIOUS! . . . What's got hold of me? . . . I used to work well enough. It's as if my will had come untwisted and was ravelling out into separate strands. I've lost my unity. I'm not a man but a mob. I've got to recover my vigor. At any cost. . . . And what I think of it . . . is this: it's fatigue. It's mental and moral fatigue. Too much effort. On too high a level. And too austere. . . . One strains and flags and then the lower stuff in one, the subconscious stuff, takes control.

The consequences of moral distress are well documented in the nursing literature (Corley et al. 2001, Millette 1994, Erlen and Frost 1991). Moral distress is a significant factor in nurses' decisions about remaining in practice. Corley's 1995 study of 111 critical care nurses found that 12 percent

had left a nursing position primarily because of moral distress.

Moral distress also takes a toll on the moral agent. Kelly (1998) in a study of recently graduated nurses found that the most pervasive attributes of moral distress were self-criticism and self-blame, an acute form of psychological disorientation in which informants question their professional knowledge, and the kind of nurses they are or are becoming. Others describe powerlessness and discouragement as outcomes of moral distress. Buehler (1990) concluded that the moral distress that arises when nurses are unable to fulfill their responsibilities poses a very serious ethical challenge and significant economical challenge as nurses quit their positions or provide less-than-optimum care.

Fenton (1988) noted that feelings of emotional distress result from participation in a patient-care situation that involves an ethical issue. The ineffective resolution of such issues can significantly affect one's personal and professional sense of wholeness. Moral distress affects the nurse's ability to care for the patient and may require a significant period of resolution. Krishnasamy (1999) suggests that nurses "need to be proactive in promoting an exploration of the role that emotions play in moral decision making and in examining the contribution of emotions to what they care

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about and why, if they are to function effectively. Otherwise they may fail to see the ethical dimensions in clinical situations. This loss of sensitivity produces the weariness of the whole person that is moral fatigue.

The outcome of moral fatigue differs from the outcome of distress. Distress can move one to action. It can lead to an activism that manifests itself in the person taking on the system — through organizing and participating in system activities to create change (fight response). Moral fatigue is more likely to lead to withdrawal — to nurses leaving the bedside to use their education and talents in other ways, such as working for insurers or selling real estate (flight response). Or it can lead to apathy such that the nurse no longer cares and quits trying to evaluate situations.

Fatigued nurses do only what is required and do it in any manner — without conveying a caring attitude to the patient and family. This apathy is probably the most dangerous response because a nurse who doesn't care is more likely to make mistakes, discharge patients who are ill-prepared to care for themselves, or make the illness experience so unpleasant that patients delay care in the future to avoid such situations. Since the concept of moral fatigue was only recently identified, it is possible that outcomes previously associated with moral distress may, in some instances, be from fatigue. Research is needed to clarify the distinction.

Value Conflicts and Education
There is yet another important aspect to the issue of moral distress and fatigue. Only the moral person can experience moral distress. However, persons with poorly formed understandings of ethics and morality often perceive situations as stressful that need not be seen in that way. Many healthcare workers have only a limited education in ethics, which can lead to erroneous perceptions and increased distress. Improved education in healthcare ethics and its application to clinical situations could help reduce this distress.

A commitment to understanding and valuing divergent ethical reasoning in and across professional cultures of care can help us avoid or overcome moral distress or fatigue (Krishnasamy 1999). However, better education from the perspective of care and relationships can also be an additional source of distress. When the nurse is well schooled in nursing ethics from the perspective of caring and relationships, value conflicts are bound to arise if these perspectives are not the dominant view in contemporary healthcare.

Value conflicts are identified as a significant source of moral distress by many researchers (Corley et al. 2001, Oberle and Hughes 2001, Bamford 1995, Tuck et al. 1996, and Tiedje 2000). Better education provides the nurse with resources to help select management strategies, and ameliorate distress. Continuing distress, with no resources to address its causes, leads to moral fatigue, the most threatening barrier to the integrity of nurses.

Moral Fatigue and Burnout

Sundin-Huard and Fahy (1999) have demonstrated relationships between moral distress, aggression, and burnout that show clear links between repeated unsuccessful attempts at advocacy, the experience of moral distress, and the loss of experienced nurses. Sundin-Huard (2000) notes that doctors and nurses do not usually take a collaborative approach to the ethical challenges of the critical care environment. Their failure to work together leads to the stress that produces moral anguish and burnout.

The literature on burnout also provides clues to the outcome of moral fatigue. For example, Demerouti et al. (2000) found that (1) job demands, such as demanding contacts with patients and time pressures, are the most predictive measures of exhaustion; (2) job resources, such as (poor) rewards and (lack of) participation in decision making, are the most predictive measures of disengagement from work; and (3) job demands and job resources have an indirect impact on nurses' life satisfaction, through the experience of burnout (i.e., exhaustion and disengagement).

Can we change the institutions and situations that cause fatigue? It does not seem that wide-sweeping changes in today's fundamentally flawed healthcare system are possible. Can incremental changes work? Perhaps. Nurses must become more involved in the organization — by participating on ethics and policy committees. They must work with professional organizations to gain acceptance and recognition of nursing's essential contributions to the health and well-being of patients and society. Individual practitioners of nursing must distinguish what is essential from what is nice to expand their energy and impact.

Arthur (1995, p. 5) describes a model of professional collaboration and growth that incorporates moral distress meetings in the care planning process. The focus is on sharing individual experience and concerns. "Our goals are to learn how we can move beyond coping with challenges in practice, to higher levels of communication and decision-making at the bedside and, ultimately, to raise awareness of our individual and collective power to change healthcare for the better."

There are other solutions. But the paradox of moral distress is that its solutions require energy. And the nurse who is experiencing moral fatigue doesn't have enough energy to change the situation. Therefore, the commitment of social institutions is needed to help change the environment that causes moral fatigue. Once institutions recognize the need to change, will they have the energy, the resources, and the will to do so? Or is moral fatigue an inevitable problem for nurses?

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