The Chaplain's Response to Moral Distress

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Moral distress is rampant among nurses and other health care professionals, but few know what it is and even fewer know how to manage it. Since the mid-eighties, studies on moral distress have increased in frequency and in acuity. The role of chaplains in today's health care setting requires a working knowledge of moral distress that includes how it affects staff and how we can help to ameliorate those effects.

What is moral distress?

Since Jameton's work in the mid-eighties, moral distress increasingly has been seen as a key factor negatively affecting health care providers. Though the primary research focus has been on nursing, all who work in health care are affected by moral distress. Moral distress is experienced by those who, like nurses, feel caught in the middle between the needs of the patient and the demands of the institution. It also is more common among those who are situated midway in a highly stratified institution, such as a hospital. A person in such a position often has a tremendous amount of responsibility in caring for the patient, but very little authority to determine how this care should be provided. As Jameton noted, it is a situation with "strong tensions between power and powerlessness." Nurses are not the only health care professionals who experience moral distress, but given their more intimate involvement in patient care situations, especially as the ones who must often administer painful treatments, they are more prone to experiencing it.

Moral distress—as distinguished from moral uncertainty and moral dilemma—occurs when an individual is prevented from acting on an ethical decision because of some constraint or barrier. Since moral distress often is the product of an unethical work environment, educating and empowering individuals are not sufficient responses. As chaplains, it is essential to identify and name moral distress, for only then may steps be taken to effect changes toward a more ethical work environment in the institution. This essay defines and analyzes moral distress and suggests ways for chaplains to address it.

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Nursing literature contains various definitions for moral distress. Jameton understands moral distress as arising when a nurse “makes a moral judgment about a case in which he or she is involved and the institution or coworkers make it difficult or impossible for the nurse to act on that judgment.” Wilkinson defines moral distress as “the psychological dis-equilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision.” According to Redman and Hill, moral distress is “the experience of knowing the right thing to do but being faced by institutional constraints, lack of authority, or lack of access to decision-making channels through which conflict is defined and resolved and therefore unable to pursue the right course of action.” Finally, Corley sees moral distress as “the painful psychological dis-equilibrium 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 consideration.”

Moral distress is a unique phenomenon that differs from what ethicists call moral uncertainty and moral dilemma. Moral situations that involve ethical decision making are rarely pure moral distress or pure moral dilemma. Nevertheless, it can be helpful to differentiate between the two. In his 1984 study, Jameton made the following distinctions.

Moral uncertainty occurs “when one is unsure what principles or values apply, or even what the moral problem is.” That is, the nurse may be uncomfortable executing a procedure or providing care in a particular situation but does not know why.

Moral dilemmas, on the other hand, occur “when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action.” The result is that the nurse does not know which option to choose. For example, a nurse may not know whether to enforce exercise after surgery, i.e., beneficence, or to allow the patient to determine if and when he or she wants to exercise, i.e., patient autonomy. A moral dilemma may occur within a given individual or between two or more people and, though normally involving a conflict, an adversarial relationship is not necessary. A moral dilemma is simply not knowing which to choose when presented with two equally attractive, or unattractive, choices.

Moral distress is different. “Moral uncertainty and moral dilemma produce negative feelings because of the nurses’ inability to decide what is right. Moral distress, on the other hand, produces negative feelings because nurses are prevented from doing what they have decided is right.” In a moral distress case, the nurse sees one clear moral principle on which to act, but is unable to do so because something or someone prevents her.

The effects of moral distress

The effects of moral distress are far reaching, exacting a toll on the patient, on the care provider, and on the hospital. Concerning the toll on patient care, Kramer, quoted and expanded by Wilkinson, notes the following:

Most assuredly the care [given by a nurse who is in the throes of moral outrage, rejection, disillusionment, hostility, and despair] will be different and less effective if it is agreed that the climate and milieu that surrounds the patient (the nurse being part of the climate) is instrumental to his health maintenance and recovery process. ... A nurse who is severely at conflict and unhappy will experience difficulty in affecting the climate and relationship with her client that is most conducive to his well-being.

In other words, a nurse who is conflicted, for whatever reason, about the care to be provided tends to compromise such care either by avoiding the patient or by over compensating.

The effects of moral distress on the care provider can be both immediate and long term. As Wilkinson notes, the immediate effects may include a “psychological dis-equilibrium and negative feeling state,” which may in turn find expression in anger, biting cynicism, silent withdrawal, and depression. These effects may have a tremendously negative impact. Wilkinson noted that among the nurses she interviewed “nearly all the subjects believed that ongoing moral distress had been detrimental to their personal or professional wholeness.”

Corley, citing Rushton, contends that if the distress continues unresolved, “the nurse’s self-worth is jeopardized, personal and professional relationships may be affected, and psychological
changes, behavioral manifestations, and physical symptoms may occur." It is even suggested that "chronic distress contributes to burnout and the decision to leave nursing." From these examples, it becomes clear how moral distress affects a hospital:

1. When the care of a patient is compromised in any fashion, the quality of care is decreased, which affects patient satisfaction and loyalty.

2. If the nurse experiences burnout as the result of moral distress and decides to leave nursing, the hospital loses trained staff.

3. If moral distress is rampant among the nursing staff and the hospital does not effectively address it, nurses may collectivize their actions in the form of a union in order to create the changes necessary to provide them with moral relief.

Health care chaplains have the task of helping to provide quality care to patients, families, and staff. Thus, they need to find effective ways to address moral distress. Although this is an undertaking that involves more than the spiritual care team, today's health care chaplains are in a favorable position to contribute significantly to the amelioration of moral distress among health care professionals. To this end, an analysis of moral distress is appropriate here.

The phenomenology of moral distress

There are six key elements that comprise the phenomenon of moral distress:

1. A relationship.
2. A particular situation.
3. A person's beliefs.
4. A moral judgment.
5. A constraint or obstacle restricting moral act.
6. An emotional response.

These elements are present in every moral distress case, though they may vary in significance. Consider the following example.

Jennifer was born at twenty-eight weeks gestation with a serious infection and is now in the Neonatal Intensive Care Unit (NICU). Kelly is her primary nurse. After extensive interventions, Jennifer experienced severe neurological insults and has poor prospects for a normal life; indeed, Jennifer most likely will be severely retarded, bedridden, and in chronic pain. In cases such as this, parents and physicians sometimes decide to remove the infant from the respirator and thus to allow death to occur. However, in this case, Jennifer's parents, Robert and Linda, do not seem to understand the situation, and Dr. Smith, the neonatologist, is pursuing therapy aggressively. In order to follow the plan of care, Jennifer's primary nurse, Kelly, must perform some procedures that are painful to Jennifer. If Kelly were allowed to make the decision, such procedures would not be performed; however, Kelly is not permitted to change the orders, and Dr. Smith does not seem receptive to a conflicting viewpoint.

A relationship is the foundation for moral distress. In this example, Kelly, as Jennifer's primary nurse, has a relationship with Jennifer. Nurses form relationships with patients and their families; this is a byproduct of their caring. The Florence Nightingale Pledge defines this relationship for nurses as follows: "With loyalty ... I will devote myself to the welfare of those committed to my care." One way to avoid moral distress is to resist the formation of a "devoted" or caring relationship. Some nurses may be able to do this, but most cannot or do not.

Moral distress requires not only a particular situation, but also a certain set of beliefs on the part of the nurse. As Wilkinson noted "moral distress does not automatically occur just because a certain type of case occurs. It requires the nurse's belief system plus the case." In the example above, a nurse other than Kelly might not experience conflict in continuing aggressive interventions. There must be something in the situation that runs counter to that which the particular nurse considers to be ethically or morally in the best interest of the patient.

Often there is something in the situation that creates some level of unnecessary suffering for the patient and the family as perceived by the nurse. This suffering may be physical, psychological, social, and/or spiritual. The situation itself may be a single traumatic event or it may be series of repeated and similar events that by their very frequency create moral distress.

Based on interviews with nurses, the following are typical situations in which they experience moral distress:

1. Participating in care with which they do not agree.
2. Providing aggressive care for the hopelessly ill.
3. Not addressing impending death honestly.

4. Feeling caught within forces they do not endorse and are powerless to change.

5. Carrying out physicians' orders for unnecessary tests and treatments.

6. Ignoring situations in which they suspect that patients have not been informed adequately before giving their consent.

The nurse encounters a situation, e.g., Kelly being told to perform a painful procedure. Based on his or her beliefs, the nurse makes a moral judgment or evaluation as to the rightness or wrongness of a given course of action. In Kelly's situation, not wanting to perform the procedure is her moral judgment. Once the nurse makes a moral judgment, the question arises as to how to implement it. Does Kelly confront the patient's physician, does she inform nursing administration, or does she say nothing and do nothing?

Generally the obstacle or barrier that restricts action on the part of the nurse is related to the institution, e.g., "lack of time, supervisory reluctance, an inhibiting medical power structure, institutional policy, or legal consideration." These obstacles or barriers may be said to be within the institution and often are outside the nurse's control. For example, Kelly's obstacle appears to be the intransigence of Dr. Smith for entertaining conflicting views. In turn, he may be bound by the desires of the infant's parents. This institutional obstacle may be represented by a person, e.g., physician, administrator, whose power over the nurse is not necessarily due to moral character, but rather to that person's position within the institutional hierarchy.

At other times, the obstacle or barrier is due to some internal constraint, such as the "nurses being socialized to follow orders, futility of past actions, fear of losing their jobs, self-doubt, and lack of courage." These constraints may be said to be within the nurse and are more often subject to the control of the nurse. If it is simply a matter of overcoming one's fear and/or self-doubt, then the moral situation can be addressed by empowering the nurse as a moral agent. However, this socialization, fear, self-doubt and/or sense of futility is often a product of an unethical and oppressive work environment. If one only empowers the particular moral agent who is the victim and leaves in place the disempowering structure, then moral distress will continue to occur among others in the institution.

Though the example does not describe Kelly's emotions, in situations of moral distress, others have expressed "feelings of frustration, anger, and guilt." Jameton further differentiated two levels of emotional response in moral distress: "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 distress is the distress that people feel when they do not act upon their initial distress." Some nurses have found that by speaking up when they first encounter situations of moral distress, regardless of whether they are heard or if it makes a difference, helps to reduce reactive distress.

Designing interventions for moral distress

The first step in any intervention is defining the situation. Is it moral uncertainty, moral dilemma, or moral distress? As it is rare to find a "pure" case, the goal is to identify the dominant moral situation, which, if resolved, will provide the greatest moral comfort.

Once it is determined that it is a moral distress case, two additional factors should be noted. The chaplain first needs to identify the situation that is creating the moral distress, and subsequently, the barrier or obstacle that hinders implementation, which will take one of three basic forms:

1. The obstacle is due to something within the nurse, e.g., fear of confrontation or a sense of futility.

2. The obstacle is due to something within the institution, e.g., an unethical or demeaning work environment, or a lack of administrative support.

3. The obstacle is due to something between the nurse(s) and the institution, e.g., a history of "them" never listening to "us," or "that doctor" always does this.

The primary goal of the intervention is to address the crisis effectively as presented within the staff person and/or as presented within the institution with the secondary goal being that of avoiding a crisis between the staff person and the institution.
Interventions designed for distress within the staff person

Often an internal constraint prevents or hinders nurses from acting on their moral judgment. For example, some people think it is not polite to confront those with whom they disagree or to create situations where discord may occur. In other instances, these internal constraints may include the “nurses being socialized to follow orders, futility of past actions, fear of losing their jobs, self-doubt, and lack of courage.”

In such cases, intervention includes identifying what is hindering the nurse from acting and then finding a way to empower the nurse to overcome the constraint(s). Empowering the nurse may include various forms of education and encouragement, including education about moral distress and its effects. As moral distress is often accompanied by “a sense of being silenced,” the very act of naming the situation as one of moral distress may help the process of liberation. One nurse said, “[I]n my unknown fear allowed me to begin to work through my conflicts and my emotions.”

Chaplains may reassure nurses that moral distress indicates that they have values and that they care for their patients. This may enable them to articulate more clearly what they do believe. Chaplains may also facilitate consideration of the dynamics of moral courage in terms of when to take a stand and when it may be more advantageous to compromise with integrity, possibly encouraging the nurses to look to their profession as a resource, e.g., respected nursing colleagues, a particularly trusted administrator or ethics committee member. In this vein, Hirsch suggests that “if we are to stem the growth of moral distress (and its negative consequences), we must reconnect with what brought us to medicine in the first place.”

Chaplains should remember that they are there to support, to encourage, and to coach with a goal of empowering the nurse to be a responsible and responsive moral agent, who is able to act even in light of obstacles and barriers. “Advocating for patients may require nurses to take risks that are not covered by policy or standards. ... By risking something for her patient, a nurse will eventually achieve moral comfort.”

Interventions designed for use within the institution

Even nurses who overcome their own internal constraints or obstacles may still be prevented from acting on their moral judgment due to some sort of obstacle in the institution. If interventions are designed only to help individuals deal with their own internal constraints, they run the risk of merely helping staff to endure situations when the situations themselves need to be transformed. Here one enters the realm of organizational ethics, a complete study of which is beyond the scope of this paper. However, there are several basic issues that must be addressed if an intervention is to have an effect within the institution.

Foremost is the creation of an ethical work environment. According to Corley and Minick, “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.” Redman and Hill concur, suggesting that an ethical work environment involves identifying what the conflicts are and then developing a process that involves joint ethical problem solving. They note that “significant numbers of nurses felt ethics committees did not address their concerns. The survey of Maryland nurses found that most discussed issues with nursing peers; only 11 percent reported consulting with an ethics committee.” These results indicate the organization has the responsibility to make sure the ethics committee functions effectively, that it is available to all, and that the staff, patients, and families are educated as to how to use it and what its functions are.

The recognition that every employee is a moral agent should form an integral part of institutional policy making. According to Andre and Kellan, “along with the financial, legal, and practical questions, the following considerations will also be on the table: Will our employees feel morally empowered by what we are doing? Is there a chance that they will feel morally compromised by it?”

Ultimately, in order to develop an ethical work environment, administrative support is necessary. Staff need to have an effective and safe way to address their concerns and also need to be well informed as to how to access it. Corley and Minick even suggest that the administration should go beyond sympathetic support and actually develop “a policy indicating support of staff nurses’ judgments, especially when nurses are attempting to advocate for patients.”
this end, administration could provide the services of an ethicist, a chaplain and/or a mental health nurse whose time "should be given, and even required, for support groups to discuss moral issues."[4]

Another ingredient for developing an ethical work environment is education. This article, for example, is designed to educate chaplains about moral distress and its effects so that they in turn may educate staff regarding moral distress and ethical thinking. Concerning the staff, Corley and Minick note, "if their beliefs are based on inadequate knowledge, the organization is responsible for addressing this knowledge deficit."[51]

Athens (Georgia) Regional Medical Center has developed a unit-based approach to ethical thinking and problem solving. Departmental surveys are conducted to identify the most important ethical issues encountered. Study groups comprised of staff from a given unit or department and members of the hospital's ethics committee develop a focused presentation that deals with these issues and includes the aspect of moral distress, which is offered as an inservice across the shifts in the unit. This has resulted in increased staff awareness and ownership of the ethical environment.

Interventions designed for use between staff and institution

Moral distress crises between staff and institution occur when neither is willing to accept any responsibility for a role in the situation. Such situations may begin with an "us" versus "them" attitude, and if an intervention persuades the parties to accept responsibility for their respective parts, the situation will deescalate to one in which the moral distress lies within the staff person(s) and/or the institution rather than between them. Situations which are allowed to continue sometimes result in staff resignations or union organization with the potential of strike, neither of which is conducive to quality patient care.

Both parties need to remain in dialogue, with each party owning its part. If chaplains elect to actively intervene in such situations, they should be wary of triangulation. If the chaplain moves from external mediator to a participant in the conflict—the one in the middle—it will become a no-win situation.

Conclusion

Chaplains recognize that nurses are a primary source for spiritual care referrals. Through conversations with them, emotional and spiritual problems may surface and opportunities to minister to their needs arise. Moral distress is one such problem. It takes time, energy, and intentionality to develop ethical work environments. Professional health care chaplains, with their theological education, their clinical experience, and their ethical sensitivity are in an excellent position to begin this process. As chaplains make their rounds, they have the opportunity to initiate the ethical conversations. Within the committees on which they serve, they can engender further discussion. In so doing, they also may begin to effect positive change throughout their institutions.

References

3. Ibid., 542.
9. Ibid., 23.
10. Ibid., 22.


35 Ibid., 256.


38 Ibid., 5.

