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What is This?
Constructing a theoretical model of moral distress

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Abstract
Moral distress has been characterised as one of the main ethical problems affecting nurses in all health systems, and has been depicted as a threat to nurses’ integrity and to the quality of patient care. In recent years, several studies tried to investigate moral distress, its causes and consequences for health professionals, clients and organisations. However, such studies are considered controversial and vulnerable, mainly because they lack a solid philosophical and empirical basis. The present article aimed at elaborating a theoretical model for moral distress, considering the process of moral deliberation, spaces of power and resistance and patient advocacy, and sought to carry out a reflection that culminated with the creation of a broader concept of moral distress.

Keywords
Ethics, nursing, nursing models

Introduction
Nursing literature has characterised moral distress as one of the main ethical problems affecting nurses in all health systems and has been depicted as a threat to nurses’ integrity and to the quality of patient care.¹ This way, nurses may experience moral distress when they perceive a conflict between different values, but cannot make a choice that preserves both.² The feeling of powerlessness, resulting from the inability to perform an action perceived as ethically adequate, is a key element triggering moral distress.²

In the professional context of nursing, moral distress was first described in the 1980s as distress resulting from the incoherence between one’s actions and his or her personal convictions.²,³ In this case, the nurse believes that a certain action would be the most appropriate one, but sees it as impossible to be performed; this situation can be influenced by errors of judgement, moral weaknesses or even circumstances beyond personal control.⁴

Moral distress could also be defined as a painful feeling or psychological imbalance resulting from recognising an ethically correct action that cannot be performed because of hindrances such as lack of time, reluctant supervisors or a power structure that may inhibit a moral, political, institutional or juridical action.³,⁵,⁶ When facing conflicts, many of them moral, nurses find bureaucratic obstacles and
disagreements with their colleagues, and such situations may demand countless ways to negotiate. Moral distress can therefore result from the ineffective confrontation of several situations, and it is difficult to predict the outcome of this decision-making, as each decision may involve the need for cooperation of other professionals, moral deliberation, which might mobilise different perceptions, feelings, as well as bring on different ethical implications.

Every day, it is apparent how the actions of nursing can be influenced by exhausting routines, stress, precariousness of care, lack of communication, banalisation of death and bureaucracy, among other characteristics of this job. It results in feelings of powerlessness and evident negligence towards patients, which may cause discomfort and distress, not necessarily identified as moral distress.

Over the years, several studies investigated the experiences of nursing professionals. Despite the generalised concerns of researchers of health and nursing and their researches on the work in care environments over the past decades, many nurses still face critical challenges in their practice. Also, the issue of moral distress has been associated to the abandonment of the working environment by nurses, dropout of nursing professionals and burnout.

Although results of empirical studies have recognised the causes of moral distress, not every nurse under the same circumstances will necessarily suffer moral distress. Every member of the health team perceives everyday situations and moral obligations in a unique way. Moral distress is, therefore, something the individual may experience, not a situation necessarily defined for those who go through certain events.

The concept of moral distress can be considered as controversial and vulnerable, mainly because it lacks a solid philosophical and empirical basis. When it concerns the empirical basis, it is noticeable that although the research in nursing about moral distress is extensive, it is often methodologically weak and does not have very well defined objectives, which justifies the need for a theoretical reflection on the issue.

By seeking to broaden reflection about moral distress, this study aims at elaborating a theoretical model for moral distress. The intended path to reach the objective goes through four moments – Moral Distress: State of Affairs, a chapter dedicated to the current state of knowledge production about moral distress; ‘Moral Distress and Exercise of Power: Defining a Theoretical Model’, an introduction to the theoretical model elaborated under the perspective of power; ‘Conceptual Ruptures and Continuities’, a chapter dedicated to the approach of the model to the concepts of moral distress and ‘Moral Deliberation, Resistance and Advocacy: Perspectives upon Moral Distress’, stage dedicated to final considerations based on the future perspectives on moral distress.

**Moral distress: state of affairs**

The manifestations of moral distress are not always easy to apprehend in daily practice, as they involve not only more directly identifiable expressions such as feelings of anger and frustration but also self-depreciation and self-devaluation. During their everyday practice, nurses are invariably faced with situations in which they may be forced to make ethical decisions that come into conflict with their personal values, which hinders the process of moral deliberation. The ethical conflict experienced in such situations may occur due to what has been described in the literature as a lack of congruence of ethical values or ethical priorities shared between employees and health organisations.

It is important to highlight that moral deliberation is regarded as the ethical dialogical approach based on a hermeneutic perspective which aims at resolving real cases through discussion and critical reflection. It is one’s capacity to present and discuss one’s own perspective about the phenomena, taking into consideration the perspectives of others, discussing rationally their points of view and progressively modifying the vision of the process. Deliberation is a way of action that results in a final solution that not always coincides with the opinions initially held.
Moral distress has been related to the nurses’ role in managing care, when they are faced with problems concerning priorities definition, resource limitation, organisational policies or lack of voice against unfair institutional practices. Moreover, studies have shown that the situations that normally trigger moral distress are connected to aggressive treatments of terminal patients, unnecessary tests, disappointment, inadequate treatment by colleagues, imbalance in power relations among health professionals and lack of institutional support to professionals – situations that refer to the necessity of nurse’s autonomy and advocacy as integral parts of the work.

Moral distress has already been found to be associated to the organisation of the working environment, lack of material and human resources and work overload; human resources lacking knowledge to work, as well as lack or surplus of medicines not given to patients; interpersonal relationships at work with lack of communication with leaderships and other health professionals and the lack of institutional support for exerting nurse’s autonomy; disrespect to client’s rights, especially when not clarifying the health-illness process and the practice of autonomy; death as a source of distress, especially when connected to professional negligence and, consequently, to its communication to the family; and futile care provided, the different places of action of the nurses and the kinds of care provided.

The construction of the concept of moral distress is based on the assumption that there is an irregularity between what nurses think is the right thing to do and some (inner or outer) restriction that prevent them from taking the appropriate measures according to their perceptions. Some examples of inner restrictions include the lack of moral sensitivity, knowledge, attitude and general abilities to judge and take appropriate measures. The outer restrictions, on the other hand, are identified as the impact of new technologies, leadership’s pressure over healthcare, demand for cost containment, lack of personnel, increased number of patients, lack of communication, organisational atmosphere and the patients’ increasing demands for quality in the care provided.

The relationship between sensitivity, knowledge and abilities is another aspect that needs to be clarified and described in the professional field. The philosophical concept of moral sensitivity is historically attributed to the idea of a moral sense of right or wrong, which connects the moral sense of care to a feeling of benevolence. It is different from moral deliberation, as the latter derives mostly from an intellectual rationalism based on personal values. This way, one might regard moral sensitivity as an acute sense or a critical and self-critical look used to recognise moral problems, as a keener or subtler permeability or reactivity.

With regard to knowledge and abilities, education is more commonly referred as a process that not only promotes the acquisition of new knowledge but also qualifies people for well justified actions, in a process that does not end with the formal educational processes.

In professions such as nursing, practice and experience in actual work scenarios are valued as a condition for the development of these competencies. The clinical practice, for instance, is developed through the ability to see, evaluate and compare, in which the eyes are trained to see what is imperceptible to the untrained eyes, or to add common meanings to what is seen. Just like vision, all the other senses employed in a clinical test are acquired, taught, trained and honed up to expertise. By contrast, the way sensitivity permeates the set of competencies required of a nurse is not very well investigated. There is little or no research on ways or strategies to develop moral sensitivity, or on what it would represent to the referred moral competencies, neither are there studies on how or whether this sensitivity would be affected by specialised and technical knowledge or other individual and cultural factors.

**Moral distress and exercise of power: defining a theoretical model**

The proposed model of moral distress comes from the environment formed by the multiple micro-spaces of power in which professional practice is developed. These micro-spaces are inseparably connected to the development of the ethical–moral competencies throughout existence and, therefore, strictly related to moral uncertainty and inherent to the human condition and the (ontological) social life. Within these...
micro-spaces, the confrontation with challenges requiring ethical–moral positions is highlighted, and the uncertainty is a triggering element of these confrontations.

In these dynamics, individuals develop **moral sensitivity**, or conditions to perceive the moral content of everyday actions, facts and thoughts. This perception may be more or less followed by feelings of **strangeness**, **inquietude** or **moral discomfort**. Such feelings are not necessarily connected to negative or unpleasant effects over the subject, but they are seen through his or her productivity as conditions for reflection and moral deliberation and, in particular, providing visibility of moral problems that could otherwise keep hidden or unknown to personal experience.

At least two possible paths derive from the identification of moral problems: the stagnation in uncertainty, called **obstruction** in the theoretical model, when the process of moral deliberation is not developed, and there is no ethical–moral positioning or problem confrontation; the **process of moral deliberation** in its entirety, which includes moments and actions of gathering significant information, offering alternatives, reviewing criteria and taking a decision, taking a position and acting and assessing the decision taken. Such moments are increased when the nurse has the conception of advocacy, which favours confrontations and the process of moral deliberation.

Where there is an obstruction of the process of moral deliberation, it triggers a process called **chain of moral distress**, which is a triad of cyclical, continuous or intermittent situations characterised by **feelings of reduced resistance** and **mortification of interests** and of the individuals themselves while being subjects of moral action. The first consequences of this chain are characterised by the ethical, political and advocational inexpressivity (Figure 1).

This conception determines the possibility of occurrence of three paths starting from the chain of moral distress: a path identifying moral distress and going back to a scenario of moral strangeness and discomfort, which may result in a secondary process of moral deliberation; a path related to the unnoticed stagnation in moral distress, when the professional is stagnated in the chain of moral distress, which may lead to abandonment of the profession’s ideals for a feeling of constant powerlessness; and a path of identification moral distress, when despite an obstruction, the subject manages to perceive the moral dimension of the situation and falls in a process of moral distress that can be reverted to a scenario of moral strangeness, despite physical, psychical and behavioural manifestations.

In practice, the chain of moral distress represents oft-silent situations of moral problems which are not perceived by the professionals, but confused with natural and unchangeable issues of routine. Such perception may lead to feelings of normality towards the barriers imposed to the ethical exercise of nurses, making them more and more passive and less reactive.

The different concepts associated in this matrix have a profound implication for the construction of moral competencies, which develops continuously throughout life and work, when it comes to consider those competencies that are necessary for a good professional practice. In this model, moral distress is highlighted as something positive, since the possibility to visualise everyday problems in their ethical dimension requires of the individuals ethical–moral competencies that are able to mobilise resistances against the phenomenon of moral distress.

In the micro-spaces, the power relationships are the key elements of the whole model of moral distress. It is important to note that the power relationships play an entirely producing role, not presenting characteristics of superstructures or simple prohibitions. They are presented as consequences of constant confrontations intensely sustained by the interconnection of local actions and confrontations, which are connected to one another, spread through time and space and intentionally seek to reach certain objectives.⁴¹

In its constant transformations, power designates not only mechanisms but also relationships; this way, whenever one criticises ‘power’ or ‘powerlessness’, quite a common situation among nurses facing obstructions in their process of moral deliberation, there is the designation of actions performed or not performed by specific persons, who influence or are influenced by their peers. This shows that there is no such a thing as **the power or of the power** that cannot be modified or reversed.⁴² Moral action cannot be separated from
the forms of activities over itself and is a resulting part of the personal constitution of the subject, of his or her transformation, and particular ways of subjectification.43

Starting from the theoretical model proposed, this study suggests an expansion of the concept of moral distress as the feeling of powerlessness experienced during power games in the micro-spaces of action, which lead the subject to a chain of events that impels him or her to accept imposed individualities, have his or her resistances reduced and few possibilities of moral action; this obstructs the process of moral deliberation, compromises advocacy and moral sensivity, which results in ethical, political and advocational inexpressivity and a series of physical, psychical and behavioural manifestations.

Conceptual ruptures and continuities

Facing the frequent stagnation verified before a chain of moral distress, or the alternative – adopted by few – to resist and fight its effects, choice in nursing may often end up in inaction or lack of resistance.44 The characteristics of nursing, especially the uninterrupted responsibility for care and the closer relationship with patients, are related to the complexity of the moral questions to which nurses are exposed,4 as well as to a more favourable position to perceive patients’ potentialities and beliefs and intervene in their favor.45

Concerning ethical practice, it was found that organisation and the environment of nursing work seem to have a bigger influence over this practice than the ethical values and concerns.7,8,20 Despite the fact that nurses recognise the necessity of questioning moral problems, they might feel afraid to do so, possibly because of the power imbalance experienced in the working environments,9 in the nursing team itself, and in the institution as a whole, despite its implications to the users, which may be strongly associated with moral distress.
Every day, nurses deny their exercise of power, or, at least, underestimate the power they exert. This way, they avoid responsibility in the process by which they could perform the moral deliberation.\textsuperscript{9,25–27} By taking on the moral commitment of making decisions, facing and exerting patient advocacy, nurses can show that they are in a unique position in health relations, where they can help users understand the objectives of their treatments and assist the related decision-making process in health.\textsuperscript{46}

The main role of nursing, related to care and patient advocacy in their singularities, shows in its essence a direct relationship with morals, and the fundamental activity of nursing can be seen in patient advocacy. On the other hand, advocacy may lead to moral distress when the nursing professionals cannot perform this role in a way that satisfies their ideals.\textsuperscript{47}

Patient advocacy is an important aspect of nursing care; it is considered as a fundamental value. Although advocacy is not an attribute exclusive of nurses, since other health professionals also perform it, it is clearly a noteworthy role.\textsuperscript{45} However, it is important to note that whenever nurses perform advocacy for their patients, they face certain risks and obstacles related to the organisation and power relations of the working environment, and the attempt to be a patient’s advocate may fail and several obstructions and forms of resistance may arise when they approach their patients’ rights, choices or welfare.\textsuperscript{7,48}

The demands for an ethical positioning by nurses refer to their potential to exert advocacy so that the fundamental needs and rights of the patients can be assured,\textsuperscript{42} as well as the process of moral deliberation.\textsuperscript{25–27} The process of moral distress may be related to the lack of advocacy and consequent obstruction in the process of moral deliberation by nurses, which leads to a poorer contact with patients and increases the nurse’s distress and the client’s discomfort.\textsuperscript{8–10,18}

**Moral deliberation, resistance and advocacy: perspectives against moral distress**

Possibilities of changes in the power relations are concrete realities to those nurses who seek to create forms of resistance and moral deliberation that go beyond simple acceptance of the context as it is. In order to do so, there is a need for a level of perception that allows understanding the fine lines that power weaves in the micro-spaces of action of every professional, in his or her multiple relationships with others, which grant him or her active ethical professional and personal posture, according to the professional practice exerted.

Situations triggering moral distress, perceived or not by the nurses, reinforce the need for resistance of nursing professionals so that they can act as advocates of their patients and deliberate morally, especially due to the continuing character of nursing care. Instead of questioning the reason nurses experience moral distress according to certain situations and contexts, it is more important to question the reasons why nursing professionals allow themselves to accept certain contexts as unchangeable or natural, renouncing the possibility to ethically resist situations that bring about moral distress.

The adoption of a theoretical model of moral distress allows the visualisation of everyday situations, often perceived as ordinary, but frequently hiding traps, devices and strategies of subjectivation that obstruct the process of moral deliberation and make possible the maintenance of power relations that lead to moral distress in the micro-spaces of action. Therefore, nursing professionals need a constant exercise of strangeness towards their routine, always seeking a different way to look at what is presented as normal or natural, questioning incisively their institutions, interpersonal relationships and themselves, identifying the reasons why situations become apparently insurmountable obstructions and even the reasons that lead them or not to moral distress or moral deliberation.

**Conflict of interest**

The authors declare that there is no conflict of interest.
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References


