Recognizing Moral Disengagement and Its Impact on Patient Safety

Josh Hyatt, DHSc, MHL, CPHRM, FASHRM

Moral disengagement refers to a process that involves justifying one's unethical actions by altering one's moral perception of those actions. The moral disengagement that occurs in the health care industry poses serious threats to patient safety, the culture of the institution, and even the mental health of care providers. This article describes the factors that create moral distress and impact moral disengagement among health care professionals, as well as ways to identify moral disengagement.

Keywords: Moral disengagement, moral distress

Objectives

- Differentiate moral disengagement and moral distress.
- Identify causes of moral distress.
- Discuss mechanisms of moral disengagement.

An 87-year-old woman, known to the emergency room as a "frequent flyer," arrives there late one evening with her caretaker complaining of abdominal pain. While in the lobby, she begins vomiting in a garbage pail. The caretaker notifies the triage nurse of the vomiting who states, "She always has stomach problems, I'm sure it is nothing serious. She probably hasn't taken her meds." As the evening passes, the patient continues vomiting and sweating, and the caretaker continues to ask about her being seen by the physician. One of the front desk staff tells the caretaker, "We will see her as soon as a bed opens up. It's not that bad, she will be fine." After 4 hours of not being seen, the patient faints and a rapid response team is called. She is later diagnosed with a perforated stomach ulcer. When asked by the investigator why it took the patient fainting to be seen, the triage nurse said, "I was just following the policy. Blame the hospital."

Institutional culture and systems influence the actions and behaviors of staff and physicians. Behaviors that are not permissible at one institution may be culturally accepted or tolerated at another, sometimes within the same corporate enterprise. When staff or physicians begin to justify adverse behaviors that impact a culture of safety or resort to sullying patients or families to redirect attention from those behaviors, the institutional culture and individual practitioner are negatively impacted. These cultural and system foundations are found to impact many aspects of regulatory and compliance expectations, as well as patient safety and employee satisfaction. This fundamental concept is foundational to the social psychology phenomenon known as moral disengagement, which is a defense mechanism and displacement of responsibility related to a sense of moral distress.

Displacement of responsibility is often linked to the "just following orders" mindset, which has significant impact to culture and safety. Such claims dominated the Nuremberg Trials at the end of World War II. In day-to-day examples, it is not uncommon to see health care professionals undermedicating patients for pain because of a fear of addiction, ignoring inpatient call-bells because they consider the patient to be "problematic," or undermining the fear of patients by saying "it could be worse" or "it isn't that bad." This article describes the factors that create moral distress and impact moral disengagement among health care professionals, as well as ways to identify moral disengagement.

Moral Disengagement and Moral Distress

Moral disengagement refers to a process that involves justifying one's unethical actions by altering one's moral perception of those actions (Bandura, 1999). Predictably, moral disengagement is associated with several negative outcomes for those experiencing it and those affected by it. Thus, efforts have been made to understand how moral disengagement can be avoided or minimized. Simply, it "is a process that enables people to engage in negative behaviors, from small misdeeds to great atrocities, without believing that they are causing harm or doing wrong" (Sucher & Moore, 2011). The moral disengagement that occurs in the health care industry poses serious threats to patient safety, the culture of the institution (Just Culture and Culture of Safety), and even the mental health of care providers.

A significant precursor of moral disengagement in health care is the moral distress that results from working in an institution in which the systems and processes are dysfunctional and/or cultural issues exist related to power differentials or disruptive behaviors. *Moral distress* can be a condition in which one identifies the correct ethical action and wants to execute it but is prevented from doing so by barriers, such as bureaucratic rules and time constraints (Barlem & Ramos, 2015; Musto & Rodney, 2015).

Moral distress can also be related to health care providers who are not self-aware of personal discomfort and who project it onto others. For example, a nurse is ordered to provide a 24-year-old Marine an injection. However, the patient fears needles and flinches when the needle is brought near the skin. The nurses says, "You're a Marine. Buck up and act like a man." In such a situation, the nurse is generally acting out of his or her own discomfort by embarrassing the patient rather than by addressing the personal discomfort and the patient's fear in a constructive manner.

Moral distress is related to but distinguishable from other moral concepts that can also lead to moral disengagement, including *moral courage*, which refers to the tendency to do what is right regardless of other pressures; *obedience*, which refers to the tendency to do what one is told regardless of what is right; and *ethical dilemmas*, which occur when one needs to choose between two options that are not ethically discriminable (Ganz, Wagner, & Toren, 2015).

The phenomenon of moral distress was first studied in 1987 by Judith Wilkinson, who was interested in the role of moral distress in nurses and patients. Based on work with nursing students, Andrew Jameton coined the term 3 years earlier (1984). In 2015, McCarthy and Gastmans published a systematic review of the literature on moral distress and identified three key contributory features:

- Health care providers who undergo moral distress endure suffering that is psychological, emotional, and physiologic.
- These providers participate in unethical behavior or wrongdoing.
- Their acts result from environmental or cultural constraints.

The tension involved in the combination of these features of moral distress represents a type of cognitive dissonance or tension between principles. The dissonance is between what one knows is right and what one feels he or she must do. Cognitive dissonance is a well-studied phenomenon, known to be averse. When a person experiences cognitive dissonance, he or she attempts to reduce the perceived friction. With moral distress, the cognitive dissonance leads to moral numbness and moral disengagement (Epstein & Delgado, 2010). Moral disengagement reduces cognitive dissonance by reframing the situation so the person performing the unethical act no longer perceives it as unethical (Bandura, 1999; Bustamante & Chaux, 2014; Hinrichs, Wang, Hinrichs, & Romero, 2012).

Although moral distress was first studied in nurses, it affects all health care professionals, including physicians, psychologists, therapists, pharmacists, social workers, patient care technicians, and administrators (Varcoe, Pauly, Webster, & Storch, 2012). For the sake of patient outcomes and the well being of health care professionals, moral distress and its ability to lead to moral disengagement must be minimized. Understanding the factors that create moral distress and impact moral disengagement is therefore a critical area of study.

Identifying Moral Distress

Identifying the initial behaviors linked to moral distress and addressing them constructively can aide in reducing the impact long term. Affective, cognitive, somatic, and behavioral indicators can assist in identifying moral distress. The affective symptoms of moral distress include frustration, guilt, depression, anger, resentment, shame, powerlessness, and helplessness (Corley, 2002); cognitive symptoms may include a loss of self-worth and a loss of a sense of self (Payne, 2011).

Although the affective and cognitive symptoms are intuitive, the physiologic and behavioral symptoms may not be. The somatic symptoms are fatigue, aches, pain, sleeplessness, heart palpitations, and nightmares (McCarthy & Gastmans, 2015; Payne, 2011). These symptoms reflect the significant stress health care providers facing morally distressing situations undergo. Behavioral symptoms of moral distress include gossiping, being late or absent, distancing from patients, avoiding work-related tasks, and engaging in horizontal violence (Payne, 2011). *Horizontal violence*, also called lateral violence, refers to nonphysical bullying caused by feelings of oppression that lead to anger and resentment. Like the physiologic symptoms, these symptoms signify how deeply moral distress affects people.

Of course, the symptoms of moral distress can result from other causes. For example, *compassion fatigue*—a diminished desire to help—can produce the physical symptoms of moral distress as well as anger, frustration, hopelessness, and depression. However, compassion fatigue results from consistent exposure to stressful situations. Moral distress, on the other hand, involves compromising moral integrity and experiencing a conflict between moral conscience and behavior. Therefore, it needs to be addressed before it progresses to moral disengagement.

Causes of Moral Distress

Moral distress can occur for reasons related to a person's experiences with his or her organization, work, and those with whom he or she works. The biomedical model, especially in the intensive care, surgical, and emergency room milieus, is based on a vitalistic perspective of "maintaining life at all costs." This perspective may undervalue the question, "What is the acceptable quality of life for the patient?" According to the biomedical model, because health care systems tend to emphasize cure over compassion, body over mind, and treatment over prevention, those involved in the system are particularly susceptible to moral distress (Crowley-Matoka, Saha, Dobscha, & Burgess, 2009). Because the ethical act often involves being compassionate, catering to the mind, and helping prevent or avoid illness, the relative devaluation of these concepts in health care can be distressing to those who must act in ways that are inconsistent with what they believe is the ethical approach.

An example of this the moral distress is experienced by nurses and other health care providers when providing nonbeneficial care to a dying patient. In many cases, the nurse understands that the care is nonbeneficial and can prolong suffering. Providing nonbeneficial care to the patient can be perceived by the provider as engaging in a maleficent act. Without the proper tools or support to express their concerns, and without appropriate ways to channel these concerns,