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Review article

Moral distress: Terminology, theories and models

Jiří Mareš *

Charles University, Faculty of Medicine in Hradec Králové, Department of Social Medicine, Czech Republic

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ABSTRACT

Empirical researchers traditionally pay attention to ethical problems and decision-making situations related to the provision of medical and nursing care to patients. They are also interested in the fields of medicine and workplaces where such problems are solved most frequently. In recent years, however, growing interest has been paid to what the medical staff experiences in cases where the proposed care is not ethically correct, and may endanger the patient. Our surveillance study focuses on the concept of moral distress of nurses. We distinguish it from other types of distress (somatic, psychological and spiritual) owing to its ethical dimension. The study shows that it is a complex phenomenon which is not easy to define. Among other things, the value system of nurses, their moral sensitivity and moral courage play an important role. The moral distress of nurses changes over the course of time: we distinguish the initial moral distress, and then, after a period of time, the reactive moral distress. The study presents four theoretical models of moral distress. Attention is paid mainly to two of them: Model with cumulating negative impacts over time (accumulation of moral residues) and a model of progress and potential consequences of moral distress. The last part of the study describes two basic determinants of moral distress: internal (sociological and psycho-ethical characteristics of nurses) and external (specificity of the decision situation, the influence of members of the health care team, rules of functioning of the medical facility and its ethical climate, and the socio-cultural specificity of the country).

Introduction

Our external research maps various ethical problems related to providing nursing care to patients. In particular, decision-making situations that are ethically demanding draw attention, as well as health institutions and medical fields where such situations are very often found [1].

We have little knowledge about what nursing staffs go through when they are deciding about further procedures in ethically complicated cases. When they are dealing with professional and ethical problems where neither alternative is risk-free for the patient, each of them brings unfavourable consequences. The situation is complicated thanks to the fact that health care contains a professional and authorization hierarchy – which means different levels in the freedom of

* *Correspondence to*: Charles University, Faculty of Medicine in Hradec Králové, Department of Social Medicine, Šimkova 870, 500 38 Hradec Králové, Czech Republic.
E-mail address: mares@lfhk.cuni.cz

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decision-making about a patient and different levels of legal responsibility for making a wrong decision. The situation is also complicated because nursing is team work.

In the last few years, professional decision-making has included economical views, and what is optimal for a patient does not have to be optimal from the economical point of view.

So far, we have been using the term of nursing staff. In this study we will narrow it down to *nurses*, because this group has been researched the most. Often and mainly unsolved ethical dilemmas and conflicts can cause moral distress among nurses. Many aspects of moral distress that we will deal with later occur in other medical professions. Moral distress is studied in doctors [2], pharmacists, health and social workers [3], and managers of medical facilities [4]. It is studied also in people preparing for their profession, for example in students of medicine [5,6].

The first scientific theories on moral distress and also the first empirical studies appeared in nurses in the 1980s. It is understandable because it is a specific profession which includes being in contact with people: contact between a doctor and a patient, another medical staff and a patient, between family members and a patient [7]. They are the ones who most often get into ethically complicated situations which can cause a condition called moral distress, according to Andrew Jameton [8] in 1984. His research on moral distress was inspired by a book by Kramer [9], 1974, which had the provocative title: Shocking reality – or why are nurses leaving. 30 years after Jameton's publication the research has advanced, but Czech academic literature has not paid much attention to it.

Our study is an overview and has the following goals. Using the available literature: (1) to define the key concept of moral distress; (2) to determine terminological complications and relate the concept to the relative ones; (3) to present main theoretical models; (4) to summarize the existing conclusions on moral distress. This study leans on literary references that are chosen according to the following criteria: (1) the research worked on the key concepts of ''moral distress'' AND (nurse OR nursing); (2) the period between 1984 and 2016; (3) the references are in English and Czech; (4) they are overview studies or original empirical studies.

In this study, we dispense with other important issues which help to diagnose moral distress and possible interventions in people experiencing moral distress. They will be the object of an independent study.

Defining the problem

The phenomenon for which the most convenient title is being searched for has existed for centuries. It regards cases when a person cannot do what they consider right and the circumstances force them to do nothing, even if they think they should do something (that is, stop a wrong thing from happening) or they are forced to do something they inwardly do not agree with. If it were only up to them, they would act differently. They go through inner conflict, they are troubled by not having protested, and having following orders from their superiors, or by the way they were broken under the social pressure of a particular group. They realize that their actions were not right and that they were morally and ethically wrong.

Moral distress differs from other types of distress (somatic, psychological and spiritual) in its *ethical* range. In the case of moral distress, what an individual considers most convenient cannot even be considered for institutional, management or economic reasons. That is why an individual experiences specific distress.

What is the definition of moral distress? In academic literature, there are five most frequently used definitions.

Jameton [8, p. 6] says that: ''Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.'' Other studies have shown that obstacles do not have to be only *institutional* in nature, although they are dominant. They can be organizational, medical, social, familiar or individual, which prevent nurses from doing their job and performing nursing they consider best in the situation [10].

He broadened his view later and, in 1993, modified his definition: ''A nurse experiences moral distress when the nurse makes a moral judgment about a case in which he or she is involved and the institution or co-workers make it difficult or impossible for the nurse to act on the judgment''.

The author created two forms of moral distress: *initial moral distress* and *reactive moral distress*. *Initial* moral distress comprises emotions (anger, anxiety) experienced at a moment when a nurse faces institutional obstacles and conflicts with co-workers – it is a conflict of values. The nurse decides between doing nothing and acting – then decides about the alternative. The later, *reactive* moral distress comes when a nurse does not act under initial moral distress but thinks about the situation afterwards. Usually – but that is our assumption – they are not troubled by what they did, but by what they did not do and should have done [11].

There are other specifications. Corley [10] considers moral distress an unpleasant condition of a painful psychological imbalance, which causes suffering. A nurse experiences it when he/she accepts a moral decision but a convenient action does not follow because there are real or just perceived institutional obstacles.

Kälvemark et al. [12, pp. 1082–3] state that: ''Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the health care provider feels she/he is not able to preserve all interests and values at stake.''

According to Austin, we can characterize moral distress in medics as feelings of frustration and failure which appear when obstacles do not allow a medic to fulfil their moral obligations to patients, their family members and the public [13].

The most detailed definition of moral distress (in our opinion) is of Judith Wilkinson [14], who enriched the concept by *dealing with pressure*. The author mainly claims that an actual or long-term experience of morally distressed nurses is very individual. A nurse must be able to recognize a situation as a moral (or more generally, ethical) problem and come to be convinced that the consequences of such a situation are their co-/responsibility. Realizing a moral problem is the key moment that leads to moral distress. Moral distress does not occur automatically because it depends on the ability of a nurse to think about their feelings. Those are related to a