Editorial

Moral Distress, Moral Courage

By Richard H. Savel, MD, and Cindy L. Munro, RN, PhD, ANP

Working with colleagues on a multidisciplinary intensive care unit (ICU) team is a noble endeavor. Similarly, providing high-quality, coordinated care to patients who are deathly ill, snatching them from the jaws of death and reuniting them with their loved ones and with a functional life, is both personally and professionally rewarding—that is, when things go well.

Unfortunately, sometimes things do not go so well. Sometimes we know what we want to do, but we're unable to execute our desired action plan. Perhaps it's because we're providing care we deem inappropriate. Or maybe we believe families are being given false hope. These pangs we feel needn't be patient related, however: anytime our moral compass is being spun against our will, we feel wounded. We go home feeling a terrible combination of anger, fear, confusion, and powerlessness.

That noxious emotional concoction has a name: *moral distress.* To battle moral distress, one must understand that it exists, understand what it is, and understand that there are structured approaches to help recognize and manage the problem.

In this editorial we discuss the concept of moral distress and consider ways to alleviate it. For readers who are new to the topic, we hope you find the information valuable for improving the quality of your professional life. If you're already familiar with this topic, we hope our editorial inspires you to share what you know with colleagues, paying it forward.

In what follows we'll discuss moral courage as a partner concept to moral distress. Also, we will provide some cognitive strategies to help improve one's ability to recognize moral distress and to develop skills that strengthen moral courage.

Moral Distress

Initially described by Andrew Jameton in 1984,[1] moral distress is defined as *knowing what to do in an ethical situation, but not being allowed to do it.* Numerous examples of moral distress emerge in everyday clinical practice[2] including continued life support, even when it may not be in the best interests of the patient; inadequate communication about end-of-life care among providers, patients, and families; inappropriate use of health care resources; inadequate staffing; and false hope given to patients and families. A key component in recognizing moral distress is a sense of powerlessness.

These constraints can be internal, such as anxiety or self-doubt about creating conflict, or external, related to power imbalances in the workplace.[3] One can distinguish between a moral dilemma, in which there are multiple choices to make and the correct path may not be clear, and moral distress, in which the path is clear, but the ability to implement a solution is somehow blocked.[4]

doi: http://dx.doi.org/10.4037/ajcc2015738

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In 2004, the American Association of Critical-Care Nurses published *The 4A's to Rise Above Moral Distress* to help clinicians recognize and address moral distress.[5] In this document, the 4A's are presented to help combat the frustrations in these complex situations: ask, affirm, assess, and act. We will go into some detail below.

Stage 1

Ask. Here, the question is, "Am I, or any members of my team, feeling symptoms or showing signs of suffering? Have coworkers, friends or family members notices these signs and behaviors in me?" This paradigm divides the types of responses into 4 major groups: physical (eg, fatigue, exhaustion, lethargy, impaired sleep), emotional (eg, anger, fear, guilt, confusion, anxiety), behavioral (eg, addictive behavior, controlling behaviors, apathy, indifference, depersonalization), and spiritual (eg, loss of meaning, crisis of faith, loss of control and self-worth, disconnection with people or work community). The goal here is to become aware that moral distress is present.

Stage 2

Affirm. Here the focus is on one's commitment to care for self. The emphasis is on the professional responsibility for the creation of a healthy work environment. It is important to validate feelings and perceptions with others. This recommended approach goes all the way up to the ANA Code of Ethics: "The nurse owes the same duties to self as to others, including preservation of personal integrity and wholeness of character."[5] The goal of this stage is to make a commitment to address moral distress.

Stage 3

Assess. This stage involves identifying the source or sources of moral distress. Is it related to a particular patient situation? A unit policy? A lack of collaboration? One also should determine the severity of the distress on a scale of 0 to 5. The 4A's document has some structured exercises to help determine the risk/benefit score for a particular situation.[6] The goal at this stage is to be ready to make an action plan.

Stage 4

Act. This stage involves creating and implementing an action plan. The goal is to preserve your integrity and authenticity. Although the action plans will vary depending on the problem to be solved, some "big picture" strategies include remaining true to yourself and remembering that caring for yourself mentally, physically, and spiritually is of the utmost importance; being an advocate for your patients at all times; identifying and working with a leader in your unit; anticipating and managing setbacks; and continuously reevaluating.

Moral Residue

Once an event that causes moral distress is over, the health care professional does not go back to his or her moral baseline afterwards. This is called *moral residue*[7] and refers to the fact that each time a morally distressing situation occurs and resolves, the level of residual moral distress continues to rise.[8]

Another way of looking at this concept is that moral distress can linger and, unfortunately, even grow with time (ie, moral residue crescendo), with devastating long-term consequences. Two of the most serious problems are (1) becoming morally numb to ethically challenging situations and (2) developing clinician burnout and potentially leaving the profession.[9] Such serious risks remind us that moral distress is not benign; it behooves organizations to do what they can to prevent and snuff out moral distress as part of their strategic retention plan for employees.

Moral Courage

Although courage can be defined in many ways, an outstanding description as it relates to the ICU is the old adage that "moral courage entails feeling fear and acting anyway." It's not always easy to summon up the moral courage to act on one's beliefs.[10] We would like to focus on some cognitive strategies to help improve and strengthen one's abilities to use moral courage to solve morally distressing problems.

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Examples include cognitive reframing, whereby a person learns to stop negative thoughts and substitute more positive self-talk; self-soothing, whereby one takes steps to quiet oneself while facing a complicated situation;[11] recognition of professional obligation; and developing risk tolerance. Having good mentorship and role models can help strengthen self-confidence and make people less risk averse. It's a good idea to talk to colleagues who have less emotional attachment to a given situation; doing so can enhance confidence and decrease risk aversion. Another skill involves being an excellent communicator, specifically with regard to the techniques of assertiveness and negotiation. One of our favorite quotations is, "Moral courage is a means to triumph over fear with practical action."[12]

Conclusion

As we've emphasized in previous editorials, our profession is a noble one. Nevertheless, at some point in our daily practice most of us will encounter circumstances that bring about moral distress. We've tried to show that moral distress happens, that none of us are alone, and that there are numerous structured interventions that can help minimize the negative impact of these situations. Simply being able to recognize that our vague symptoms of anxiety, anger, and confusion may be related to moral distress can help to alleviate and even improve our personal outlook. When the members of the ICU team work together in a unified way toward developing our collective "moral courage muscle,"[13] we all become better advocates for our profession and for our patients.

ACKNOWLEDGEMENTS

RS would like to thank Thomas Smith, RN, DNP, NEA-BC, Chief Nursing Officer and Senior Vice President, Maimonides Medical Center, for his support and inspiration in writing this article.

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