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Laura Kolbe & Inmaculada de Melo-Martin

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TARGET ARTICLE



## Moral Distress: What Are We Measuring?

Laura Kolbe  and Inmaculada de Melo-Martin 

Weill Cornell Medical College

### ABSTRACT

While various definitions of moral distress have been proposed, some agreement exists that it results from illegitimate constraints in clinical practice affecting healthcare professionals' moral agency. If we are to reduce moral distress, instruments measuring it should provide relevant information about such illegitimate constraints. Unfortunately, existing instruments fail to do so. We discuss here several shortcomings of major instruments in use: their inability to determine whether reports of moral distress involve an accurate assessment of the requisite clinical and logistical facts in play, whether the distress in question is aptly characterized as moral, and whether the moral distress reported is an appropriate target of elimination. Such failures seriously limit the ability of empirical work on moral distress to foster appropriate change.

### KEYWORDS

Moral distress; moral agency; empirical bioethics; clinical practice

## INTRODUCTION

Moral distress is a matter of great concern in the healthcare professions. The exponential growth of its study since the term was first coined in 1984 (Lamiani, Borghi, and Argentero 2017) and the fact that the topic of moral distress is now among the competencies expected of doctors and nurses in training (American Nurses Association 2018; ACGME 2019) betray its importance.

Interest, both scholarly and practical, in moral distress seems reasonable. First, it affects healthcare professionals' wellbeing in various ways. According to various studies, moral distress correlates with worsened physical and mental health (AACCN 2020; Fard et al. 2020; Christodoulou-Fella 2017). Symptoms often associated with it can be emotional such as frustration, anger, and guilt; physical, such as muscle aches, headaches, heart palpitations, neck pain, diarrhea, or vomiting; and mental problems such as depression, PTSD, risk of suicide emotional detachment, and the inability to build healthy relationships and empathy. Empirical studies have also shown that those who score higher in reports of moral distress are more likely to score highly on validated instruments to detect and diagnose psychiatric morbidity (Christodoulou-Fella et al. 2017). Second, moral distress has consequences for workplace functioning and thus ultimately for the wellbeing of patients. Several studies have shown the relationship

between moral distress and burnout (Neumann et al. 2018; Beck et al 2020), job performance (McClendon and Buckner 2007), patient care (Elpern, Covert, and Kleinpell 2005), and workplace attrition (Corley 2002; Elpern, Covert, and Kleinpell 2005). Moral distress results in frustration and burn-out, which can lead to individuals leaving the profession. As some have pointed out, these constitutes a vicious circle, as shortages of personnel then contribute to situations that create moral distress (Corley 2002; Cacchione 2020; Gebreheat and Teame 2021; Firouzkouhi et al. 2021; Silverman et al. 2021).

The substantial amount of scholarship on moral distress notwithstanding, including efforts to build a consensus definition (McCarthy and Gastmans 2015; Morley et al. 2019), disagreements remain regarding what actually constitutes moral distress. They involve disputes about what the particular features of moral distress are, when and by whom can moral distress be experienced, and how it is best measured (Campbell, Ulrich, and Grady 2016; Crane, Bayl-Smith, and Cartmill 2013).

Despite the marked conceptual heterogeneity on a variety of aspects, some agreement exists that moral distress is, at least in part, the result of constraints on healthcare professionals' moral agency. Indeed, empirical work on moral distress is often grounded on an effort to identify aspects of healthcare institutions or practice that impose these constraints so that they can

be altered (Corley et al. 2001; Källemark Sporrang 2006; Hamric et al. 2012; Whitehead et al. 2015; Epstein et al. 2019). Arguably, at least some constraints that could be morally distressing are necessary for the care of patients (e.g., respecting patients' wishes), or are legitimate for some other reason (e.g., appropriate decisions about scarce resources, or isolation precautions for a patient with an infectious disease). Hence, insofar as a goal of identifying aspects of institutional environments that produce moral distress is to eliminate or reform them, the relevant constraints must be those that are illegitimate or inappropriate (e.g., disregard for patients' wellbeing; pressures to order unnecessary medical interventions; inattention to safety procedures for clinicians and patients). Identification of these factors would allow us to determine whether they are modifiable and whether changes in practices and policies can accomplish needed reforms. It would also provide relevant evidence to inform strategies aimed at transforming problematic factors and potentially identifying areas for system modifications.

The purpose of this paper is to argue that current moral distress measurement tools cannot provide us with relevant information to address it. This is so because by relying on self-reported assessments, measuring instruments are unable to accurately capture the phenomenon of relevance. Current measuring instruments fail to reliably ascertain whether reports of moral distress involve an accurate assessment of the requisite clinical and logistical facts in play, whether the distress in question is correctly characterized as *moral*, and whether the moral distress reported is actually called for, that is, whether it constitutes a justified response of a morally engaged agent, and thus is not an appropriate target of elimination. To the extent that current measuring tools are unable to make these necessary distinctions, their results fail to provide evidence about the factors that need to be changed in order to reduce moral distress. The upshot of this paper is that if institutions are to develop clear strategies for handling moral distress successfully, then better measurement tools need to be developed.

In what follows, we first briefly discuss some of the various concerns that trying to understand moral distress raise. We then describe some of the most common instruments to measure this phenomenon and show why they fail. We end by suggesting new directions for conducting empirical work on moral distress, so that it better captures factors that illegitimately constrain the moral agency of healthcare professionals.

### ***Moral Distress: A Phenomenon Difficult to Capture***

Despite the recognition that moral distress is of significant concern, important disagreements remain regarding what such a phenomenon involves. Various definitions of moral distress have been proposed (Morley et al. 2019). The earliest, in Andrew Jameton's 1984 study of ethics in nursing practice, defines moral distress as a phenomenon which "arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984). Others have defined it as "psychological disequilibrium 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" (Wilkinson 1987), as "traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the healthcare provider feels she/he is not able to preserve all interests and values at stake" (Källemark Sporrang et al. 2004), and as "the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards" (Varcoe et al. 2012).

These, as well as other definitions that have been offered (Morley 2019), differ in substantive respects. For example, scholars disagree about whether a correct moral judgment—or indeed a moral judgment at all—is a necessary feature of moral distress (Jameton 1984; Campbell, Ulrich, and Grady 2016; Fourie 2017; Morley et al. 2021). Disagreements also extend to the nature of moral distress, with some understanding it as an event (Varcoe et al. 2012), while others take it to be an emotion (Källemark Sporrang et al. 2004; Wilkinson 1987), a particular kind of moral judgment (Jameton 2013; Musto et al. 2015) or a combination of the experience of a moral event and of psychological distress when these are causally related (Morley 2021). Likewise, differences exist regarding whether the distressing action or event need be one that has been performed by the person morally distressed (Mitton et al. 2011; Nathaniel 2006), can be anticipatory (Campbell, Ulrich, and Grady 2016), involves simply witnessing the action (Campbell, Ulrich, and Grady 2016; Oshana 2006), or implicates no specific action or event, only a context or environment (Barlem and Ramos 2015). Similarly, competing claims about who can experience moral distress are at stake. Originally, the phenomenon of moral distress was thought to be nursing-specific because of their role at the interface of physicians and patients. Recently, however, there have been calls to broaden the category of subjects capable of experiencing moral

**Table 1.** Definitions of moral distress focusing on illegitimate constraints and moral agency (italics ours).

Jameton (1984)	Moral distress arises when one knows the right thing to do, but <i>institutional constraints make it nearly impossible to pursue the right course of action.</i>
Jameton (1993)	Initial moral distress involves the feelings of frustration, anger and anxiety people experience when faced with <i>institutional obstacles and conflict</i> with others about values.
Austin et al. (2003)	The state experienced when moral choices and actions are <i>thwarted by constraints.</i>
Nathaniel (2006)	Moral distress is pain affecting the mind, the body, or relationships that results from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action, yet, as a result of <i>real or perceived constraints</i> , participates, either by act or omission, in a manner he or she perceives to be morally wrong.
Mitton et al. (2011)	Moral distress is the suffering experienced as a result of situations in which individuals feel morally responsible and have determined the ethically right action to take, yet <i>due to constraints (real or perceived)</i> cannot carry out this action, thus committing a moral offense.
Rodney et al. (2013)	What nurses (or any moral agents) experience when they are <i>constrained from moving from moral choice to moral action</i> —an experience associated with feelings of anger, frustration, guilt, and powerlessness.
Barlem and Ramos (2015)	The feeling of <i>powerlessness</i> 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 <i>few possibilities of moral action; this obstructs the process of moral deliberation</i> , compromises advocacy and moral sensitivity, which results in ethical, political, and advocational inexpressivity and a series of physical, psychological, and behavioral manifestations.

distress to physicians (McCarthy and Deady 2008), social workers (Fronek et al. 2017), pharmacists (Astbury and Gallagher 2020), respiratory therapists (Caplan et al. 1995), health systems managers (Mitton et al. 2011), medical students (Camp and Sadler 2019; Perni et al. 2020) and non-clinician patient aides and companions (Brassolotto et al. 2017).

To complicate things further, discussions about moral distress in the literature sometimes overlap with concerns about “moral injury,” “moral stress,” “burnout,” and the like, as well as with positively-valenced terms such as “moral courage” (Hebert 2020; Numminen 2021; Giwa et al. 2021; Čartolovni et al. 2021; Sheather and Fidler 2021; Ducharlet et al. 2021; Akram 2021; Hossain and Clatty 2021). Clinicians in everyday speech also often use many of these terms interchangeably (Griffin et al. 2019; British Medical Association 2021).

Additionally, various measuring tools are used to purportedly capture its presence and effects. They differ greatly in structure and goals. Some attempt to quantify the intensity of moral distress (Falcó-Pegueroles, Lluch-Canut, and Guàrdia-Olmos 2013), while others aim to quantify the health-related effects on those who experience it (Raines 2000). Others focus on qualities of the workplace that might have mitigating or amplifying effects on moral distress, (Kälvemark Sporrang, Höglund, Arnetz 2006), and still others attempt to capture the perceived prevalence of specific behaviors and events presumed to be morally distressing such as deception (Corley et al. 2001) or the existence of inadequate staffing (Ohnishi et al. 2010). New instruments have also been proposed to measure these factors in the context of the COVID-19 pandemic (Lake et al. 2022).

This brief overview shows the complexity of the phenomenon of moral distress. Indeed, the conceptual

confusion and methodological problems have been so salient that some have called for abandoning the notion of moral distress altogether (Johnstone and Hutchinson 2015). However, in spite of these various differences, substantive agreement exists that illegitimate institutional constraints affecting the moral agency of healthcare professionals are a significant source of moral distress (Table 1).<sup>1</sup> If we are to reduce moral distress then, instruments measuring it should be able to provide relevant information about such illegitimate constraints. The information would then allow institutions to develop appropriate strategies for addressing those constraints. Unfortunately, as we show below, current measuring tools are not up to the task and are thus unable to provide us with valuable information that can be used to reduce at least some causes of moral distress and its negative effects.

### Some Caveats

As we have indicated, moral distress is a complex phenomenon. Given such complexity, it should be unsurprising that good reasons exist for investigating moral distress that have nothing to do with identifying its sources.<sup>2</sup> After all, experiencing moral distress can have significant negative effects on healthcare professionals as well as an adverse impact on patient care (Elpern, Covert, and Kleinpell 2005;

<sup>1</sup>A clarification is in order here and we thank an anonymous reviewer for pressing us on this point. The definitions included refer to constraints or obstacles, not to *illegitimate* ones. Also, there is some disagreement about whether the constraint must be real or simply perceived. Whether the constraint is real or perceived, legitimate, or illegitimate, makes a significant difference for how to address the constraint in question. Insofar as an important goal of these measuring tools is to provide information regarding the institutional factors that need reform so as to minimize moral distress, arguably such constraints must be real and also illegitimate.

<sup>2</sup>We thank an anonymous reviewer for inciting us to clarify this point.

Christodoulou-Fella et al. 2017; Lake et al. 2022; Firouzkouhi et al. 2021). Concern about the subjective psychosocial ramifications that moral distress has on those who experience it, regardless of what the sources of that distress are, is thus important in itself (Prentice et al. 2020; Carse and Rushton 2017). Also relevant is interest in developing interventions to ameliorate the toll that moral distress wreaks on individuals (Morley et al. 2021; Imbulana, Davis, and Prentice 2021). Indeed, interventions such as structured educational, debriefing, or counseling sessions have shown promise on these subjective aspects of the experience of moral distress (Abbasi et al. 2019; Allen and Butler 2016; Vaclavik et al. 2018). For these interventions to be successful, i.e., for them to ease the often-profound suffering of individuals who feel themselves to be morally distressed, it is of lesser importance what the cause of the moral distress may be—that is, the self-perception of moral distress may be sufficient to adversely affect clinician wellbeing, whatever objective features of the case may be present.

Likewise, even if concern with the causes of moral distress is the subject of investigation, various sources—other than constraints on moral agency—can be of relevance. For instance, several scholars have postulated moral uncertainty, moral dilemmas, or simply a moral event as sources of moral distress that should also be examined (Kälvemark Sporrang et al. 2004; Fourie 2015; Campbell et al. 2016; Morley et al. 2019; Morley et al. 2021). Developing tools to determine these other sources of moral distress can both contribute to understanding of the phenomenon as well as provide evidence to advance mitigation strategies.

Our focus on instruments that attempt to identify sources of moral distress—and in particular, the presence of illegitimate institutional constraints—is thus not meant as a dismissal of the importance of other work aimed at either detecting the presence of moral distress or investigating other causes of it. As mentioned, these investigations can be very valuable in addressing moral distress, its sources, and its negative effects. They may also be valuable in illuminating conditions under which morally challenging situations promote moral resilience instead of, or in addition to, distress.<sup>3</sup> But we believe that our focus here is justified on several grounds. First, while minimizing or eliminating the negative effects that the experience of moral distress can have on people is important, attempting to ascertain what produces the distress in the first place is at least as important. After

all, identifying the sources of moral distress can provide us with relevant evidence to remove or transform such sources, when doing so is possible, and consequently the moral distress they produce. Second, whatever the success of interventions aimed at mitigating the consequences of moral distress (Morley et al. 2021), if the sources of the distress are not removed, or minimized, healthcare professionals will continue to experience moral distress. Third, a preponderance of empirical research on moral distress actually focuses on determining institutional factors that produce moral distress with the goal of providing grounds for reforms to the healthcare environment (Corley et al. 2001; Hamric et al. 2012; Whitehead et al. 2015; Epstein et al. 2019; Ness et al. 2021).

### **Measuring Moral Distress**

Perhaps the best-known quantitative instrument to measure moral distress is Corley and colleague's 2001 Moral Distress Scale (MDS) (Corley et al. 2001), along with a 2005 revision (Corley et al. 2005) and the 2012 revision by Hamric and colleagues (Hamric et al. 2012). The concern of the 2001 MDS is investigating and addressing the moral problems that result from institutional constraints in hospital settings, as identified by nurse respondents. The scale's items describe particular scenarios in the work of nurses and ask respondents to rate, on a Likert scale, how much moral distress they have experienced when encountering the scenario in question (Table 2). Some of the scenarios include "Work in a situation where the number of staff is so low that care is inadequate," or "Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients." Items on the scale are designed to relate to at least one of three factors: individual responsibility, not in patient's best interest, and deception, that can impose constraints on people's moral agency. These factors are meant to help guide strategies when applied to a particular workplace. For instance, a hospital where nurses report high distress on the "deception" items but little distress on the "individual responsibility" items is likely to have different workplace concerns and need different solutions than a hospital where the opposite results are the case.

The 2012 revision of the MDS by Hamric's group, the Moral Distress Scale-Revised (MDS-R), changes many of the items' scenarios: eliminating some of them, and introducing alternative ones more applicable to, for example, pediatric healthcare work, and to roles other than nursing. This is a change in the

<sup>3</sup>We thank an anonymous reviewer for reminding us of the importance of this concern.

**Table 2.** Sample items from instruments measuring moral distress.

Moral Distress Scale (MDS) (Corley et al. 2001)	<ul style="list-style-type: none"> <li>• Work in a situation where the number of staff is so low that care is inadequate</li> <li>• Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients</li> <li>• Work with "unsafe" levels of nurse staffing</li> </ul>
Moral Distress Scale-Revised (MDS-R) (Hamric et al. 2012)	<ul style="list-style-type: none"> <li>• Let medical students perform painful procedures on patients solely to increase their skill</li> <li>• Follow the family's request not to discuss death with a dying patient who asks about dying</li> <li>• Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support</li> <li>• Provide less than optimal care due to pressures from administrators or insurers to reduce costs</li> <li>• Witness healthcare providers giving "false hope" to a patient or family</li> <li>• Watch patient care suffer because of a lack of provider continuity</li> </ul>
Measure of Moral Distress—Healthcare Professionals (MMD-HP) (Epstein et al. 2019)	<ul style="list-style-type: none"> <li>• Witness healthcare providers giving "false hope" to a patient or family</li> <li>• Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient</li> <li>• Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments</li> </ul>
Instrument of Moral Distress (Kälvemark Sporrang et al. 2006)	<ul style="list-style-type: none"> <li>• Witness low quality of patient care due to poor team communication</li> <li>• The patient/customer who "cries out loud" gets more or faster help than others</li> <li>• The integrity of the patient/customer relative to other patients/customers is disregarded</li> <li>• It is difficult to adjust information to the needs of the patient/customer</li> </ul>

scale's particular contents rather than its overall methods and assumptions. Scenarios include (Table 2) "Follow the family's request not to discuss death with a dying patient who asks about dying," "Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support," "Provide less than optimal care due to pressures from administrators or insurers to reduce costs," "Witness healthcare providers giving 'false hope' to a patient or family," and "Watch patient care suffer because of a lack of provider continuity."

The larger theoretical change of the MDS-R is in asking respondents to rate, as before, not only the level of disturbance or intensity of each item, but also its frequency on a separate Likert scale. Total scoring is performed by multiplying the intensity times frequency of each item, such that high-frequency/high-intensity items garner the highest composite score, while high-frequency/low-intensity and low-frequency/high-intensity items, for example, might earn similar scores. For the authors, this constitutes a more accurate reflection of moral distress, as they posit a "crescendo effect" because of the relationships that exists between repeated experiences of moral distress and its intensity (Hamric et al. 2012, 8).

Other instruments comparable to the MDS-R include Epstein and colleagues' 27-item "Measure of Moral Distress—Healthcare Professionals" (MMD-HP) (Epstein et al. 2019), which like the MDS-R scores both the frequency and the level of distress associated with each questionnaire item. The MMD-HP contains items that, according to the authors, describe root causes of moral distress that the MDS-R fails to capture. Sample items include (Table 2) "Witness healthcare providers giving 'false hope'

to a patient or family," "Follow the family's insistence to continue aggressive treatment even though I believe it is not in the best interest of the patient," and "Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments."

Epstein and colleagues' instrument is similar to others in that its questionnaire items are derived from clinical situations and scenarios, but has the additional feature of batching particular questionnaire items according to levels at which the morally distressing event is purportedly rooted, e.g., at the level of patient/family (i.e., at the bedside), at the level of unit/team, or at the level of system/organization. This would allow its results to more easily point out aspects of a healthcare institution most in need of scrutiny. For example, the item "witness low quality of patient care due to poor team communication" is one the authors associate with "unit/team" root causes of moral distress. The authors maintain that institutions could therefore deploy this scale in order to better locate at what level of operations moral distressing events are predominantly occurring, and thus to develop and implement strategies better able to address the reasons for moral distress, looking at the MMD-HP results for guidance about which aspects of the organization have most need of reform.

Kälvemark Sporrang and colleagues' "Instrument of Moral Distress" (2006) retains other scales' interest in understanding the subjective degree of distress perceived by respondents, with the additional feature of items measuring aspect of workplace climate. The aim is also to better target institutional features that increase the risk of moral distress and may need restructuring. This tool is aimed not only at clinicians but also pharmacists. Like the MDS-R and MMD-HP,

their survey tool rates the frequency of particular, pre-specified scenarios in the healthcare setting. Examples include (Table 2), “The patient/customer who ‘cries out loud’ gets more or faster help than others,” “The integrity of the patient/customer relative to other patients/customers is disregarded,” “It is difficult to adjust information to the needs of the patient/customer.” It then asks respondents to rate how stressful they find a given item. Additionally, it contains additional items aimed at measuring respondents’ workplaces’ “tolerance/openness towards moral dilemmas” (e.g., “At my place of work different opinion and values are tolerated”). The purpose of these types of questions is to identify workplaces with higher prevalence of moral distress by looking at two different factors that might contribute to such prevalence: either a higher presence of ethical dilemmas, or organizational factors in the work environment that intensify the way that individual experience such dilemmas.<sup>4</sup>

### How the Instruments Fail

As this brief overview shows, some of the most commonly used tools to measure moral distress attempt to identify various aspects of clinical practice or institutional environments that impose illegitimate constraints on healthcare professionals’ moral agency. If successful, such information would allow us to determine necessary changes that would help reduce moral distress, and with it, the negative effects it produces. Unfortunately, these measuring instruments cannot provide such relevant information. This is so for several reasons: 1. they cannot determine whether the self-reported moral distress results from a correct assessment of the facts; 2. they fail to identify whether the distress is aptly characterized as moral; and 3. they are unable to ascertain whether the experienced moral distress is an essential response of a morally engaged agent or not, and thus whether it is an appropriate target of elimination. Below we discuss these failings.

### Is the Assessment of the Facts Correct?

Whether a particular practice, activity, or context that produces moral distress illegitimately constrains moral

agency requires a correct assessment of the facts at play. For instance, if nurses are enjoined to provide care that they consider medically inappropriate, one must determine whether such care is indeed so.<sup>5</sup> Unfortunately, current measuring tools cannot establish whether respondents’ assessment of the facts of a given situation is indeed appropriate.

Take, for instance, scenarios in the MDS that contemplate whether respondents “Work in a situation where the number of staff is so low that care is inadequate,” or “Carry out the physician’s orders for unnecessary tests and treatments for terminally ill patients.” Because the responses are grounded on self-report, these instruments offer no way to ascertain whether the respondent’s assessment of these scenarios is factually correct; that is, they cannot tell us whether the physician’s orders for tests or treatments were indeed unnecessary or whether the number of staff was in fact inappropriately low.

Other instruments present similar problems. For example, the MDS-R contains items such as “Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support” and “Witness healthcare providers giving ‘false hope’ to a patient or family.” In the contemporary hospital setting, characterized by shiftwork and multidisciplinary teams, team members may have intermittent knowledge gaps, whether due to scope of practice or to slow dissemination of information across large and complex teams. A respiratory therapist, for example, may believe that a ventilated patient is “hopelessly ill” because she has not yet learned from the attending physician that the patient’s underlying disease is likely reversible. Similarly, she may believe that no one will make a decision to withdraw support because she has not yet learned that the family have decided to do so after a brief spiritual ceremony planned for the next day. Likewise, a hospitalist may deem that the oncologist is providing “false hope” to a patient, when in fact the patient has told the oncologist frankly that while she knows she is dying, she no longer wants to hear about it during their daily rounds. Note that we are not arguing that respondents are *necessarily* making inaccurate assessments of the facts or that they actually lack relevant knowledge. What we are arguing is that given that humans are subject to

<sup>4</sup>We do not mean for this overview to be comprehensive. We focus only on the instruments with most widespread use. Several others, less common or that have substantial overlap with the ones we include (e.g., Baele and Fontaine 2021; Wocial and Weaver 2013; Schaefer et al 2016; Eizenberg, Desivilya, and Hirschfeld 2009), are not discussed here. We do not include either instruments for potentially-overlapping terms such as moral injury (Currier et al. 2015; Nash et al. 2013) or some very new instruments developed in response to the COVID-19 pandemic (Lake et al. 2022).

<sup>5</sup>As indicated earlier, although factual correctness may not be important for interventions simply aimed at improving providers’ *sense* of moral distress and its psychological sequelae, whether the constraints are real or what they are, is clearly relevant if we want to reduce illegitimate constraints on moral agency. This requires an adequate assessment of the facts at stake.

misinterpretation, it is conceivable that they *might* make such inaccurate evaluations. The measuring instruments cannot make this distinction. Thus, the data obtained will not be reliable in determining what the sources of the moral distress are.

The MMD-HP include scenarios that pose a similar problem. Consider, for example, a question whether the respondent has “experienced lack of administrative action or support for a problem that is compromising patient care.” It is quite possible for respondents to be unaware of what the reasons might have been for the lack of administrative action. For instance, such action was considered and rejected because of legal constraints; or an inquiry actually took place, but it was determined that patient care was not compromised (e.g., a respondent believes that a particular surgeon denied a patient an appendectomy because of racial bias, but upon investigation it becomes clear that the surgeon was using evidence-based algorithms that predict which patients will recover with antibiotics alone).

Or take, for instance, an item that asks whether the respondent has “participated in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.” It can be difficult for some healthcare professionals to correctly ascertain what the clinical facts of a case might be so as to deem that a patient’s suffering is unnecessary. Moreover, whether such suffering is “unnecessary” is a judgment that requires knowledge of the patient’s wishes with regard to balancing pain control alongside other risks and benefits.

Similar problems can also be found in the Instrument of Moral Distress. In it one can find items such as “the patient/customer who ‘cries out loud’ gets more or faster help than others” and “the care of patients/customers is deficient owing to pressure of time.” Correct factual assessment of these cases can be challenging without appropriate information about whether unfair preferential methods of distributing patient care are actually present, or whether quality of care is substandard. Again, our contention is not that respondents are necessarily incorrect in their assessment of the facts. Our claim is simply that the instrument questions do not allow us to make such determination. But if we cannot accurately determine whether respondents have a correct understanding of the facts involved in the scenarios about which they are asked, then it is not possible to establish whether the moral distress they report is the result of *illegitimate* constraints.

### *Is the Distress Moral?*

As we have seen above, the term “moral distress” presents at best significant conceptual heterogeneity, and at worst confusion. It is also frequently associated in healthcare education and training with related—but presumably distinct—topics that might not always involve moral aspects such as burnout (Neumann et al. 2018; Beck et al. 2020; Perni et al. 2020). Hence, it would be unsurprising if someone were to characterize an event as *morally* distressing when in fact it posed, for example, a logistical dilemma, or if they had difficulties determining whether it provoked a negative emotion unrelated to a constraint on a person’s moral agency.

Some of the scenarios found in Corley and colleagues’ MDS are affected by this concern. For instance, respondents are asked whether they have “assisted physicians who are practicing procedures on a patient after CPR has been unsuccessful.” Although this activity could produce *moral* distress, particularly if someone feels that they cannot refuse, it could also result in a variety of feelings or emotions that do not involve moral agency. For instance, nurses might find such activities uncomfortable or distasteful, even when the patient in question had previously consented to such activities. Similarly, a scenario such as whether someone has been enjoined to “carry out a work assignment in which I do not feel professionally competent” may negatively affect one’s moral agency if, for instance, one is asked to do so despite there being other staff who could do the task more competently. However, carrying such a work assignment might make people feel uncomfortable and distressed, but might well not involve people’s moral sense if the situation is urgent, all other staff are either less competent or unavailable for justifiable reasons, and doing nothing would harm patients even more severely than carrying out the assignment in a less than completely competent way.

Other scales raise similar problems involving the possible miscategorization of a nonmoral emotion as a moral one. For example, items in the MMD-HP by Epstein and colleagues such as “watch patient suffer because of a lack of provider continuity” may be frustrating and stressful. Nonetheless, it might not constitute a moral wrong, if, for example, the reason for the lack of continuity is justified, such as when one provider goes on medical leave and another steps in to deliver care—care that can involve some delays despite the efforts of everyone involved to do their best.

Similarly, Kälve mark Sporrang and colleagues’ scale (2006) also includes some quotidian scenarios, such as



“it is difficult to adjust information to the needs of the patient/customer,” which may reflect either moral or nonmoral concerns. For instance, one may be morally distressed by institutional constraints that unjustly impede one’s ability to communicate information to a patient, e.g., a lack of appropriate interpreter services despite the institution being well-resourced and theoretically committed to providing such services, or by having failed in one’s duty to communicate appropriately and compassionately with a patient. One may also have a non-moral reaction of stress or frustration because of the challenging nature of certain patient interactions when emotional, psychological, or cognitive barriers make such encounters arduous. Insofar as many scale items in common instruments measuring moral distress are too broad or open to various reasonable interpretations, they cannot offer us information about whether the emotion at stake is *moral* distress, or whether it is stress, frustration, or annoyance in the face of challenging situations that are part and parcel of healthcare encounters.<sup>6</sup> They thus fail to provide helpful data about whether changes in practices are needed to deal with problems that constrain healthcare professionals’ moral agency.

***Is the Moral Distress an Appropriate Target for Elimination?*** Although the literature on moral distress often characterizes it as something to be prevented, arguably moral distress can also be not only an apt response to a morally distressing situation, but a desirable one. Moral distress can reflect people’s moral engagement. It can involve the recognition of people’s moral integrity and their commitments to moral principles and practices that by their own judgment they have failed to uphold (Carse and Rushton 2017). The presence of this fitting moral distress is valuable in its capacity to prompt reflection and action when faced with wrongdoing, even when that wrongdoing might have been unavoidable (Tessman 2020). Hence, we should not seek to reduce or eliminate the presence of at least some moral distress, given that such distress can be a fitting response to situations where important values one holds dear are threatened. This kind of moral distress may crucially reveal what really matters to one and be an important indicator of moral conscientiousness (Prentice, Gillam, Davis, and Janvier 2018b; Tessman 2020). Indeed, the nature of medicine and healthcare practice is fraught with situations that call for moral emotions

associated with moral distress, such as regret and remorse. For instance, the untimely death of a patient who could not be saved is likely to produce regret in healthcare professionals. And of course, moral distress is certainly an apt response to engaging in wrongdoing that is easily avoidable.

Just as common measuring instruments have difficulties determining the accuracy of factual assessments of respondents and identifying whether the distress experienced is a moral one, they are also unable to ascertain whether the moral distress engendered by some of the items is or is not an apt response to the circumstances. Indeed, many of the scenarios present situations that reflect the unavoidable value-ladenness of many medical encounters and the presence of moral conflicts difficult to eliminate. Consider, for example, scenarios such as “follow the family’s wishes for the patient care when I do not agree with them” found in Corley and colleagues’ MDS and various similar iterations in other scales. These items can reflect illegitimate constraints on healthcare professionals’ moral agency if, for instance, institutions are unwilling to support the healthcare team even in the face of controversial requests from family members, e.g., continuing aggressive care on a brain-dead patient, or insistence on not sharing a room with, or receiving care from, individuals of a particular race or gender expression. However, these scenarios can also, and not uncommonly, involve situations where the surrogates’ assessment of the patient’s best interest differ from that of clinicians. These differences might result from a better knowledge of what the patient might have wanted, or from reasonable differences in values, beliefs, and judgments. Even when the family’s decision can be judged justified, healthcare professionals often feel distressed by having to choose between what they take to be best for the patient and upholding the patient’s autonomy in deferring to the patient’s chosen decision-maker. Moral distress that results from hard-to-solve moral conflicts is both appropriate and unlikely to disappear through institutional or workplace changes. Similarly, while items such as “provide less than optimal care due to pressure from administrators or insurers to reduce costs” in Hamric and colleagues’ MMD-HP may reflect illegitimate institutional constraints, e.g., an unwillingness to devote money or resources that are actually available, they may simply reflect morally legitimate constraints and value differences regarding how to distribute limited resources. To some degree or another, this, too, is endemic to the healthcare professions, and clinicians’ distress about such limitations

<sup>6</sup>Which, as we have indicated earlier, does not mean that such emotions should be disregarded given that they might still have negative effects on the wellbeing of healthcare professionals and that of their patients.

on their ability to act in patients' best interest is arguably a desirable moral reaction that reflects their moral engagement.

Furthermore, moral distress that arises from witnessing, abetting, or perpetrating moral wrongs that come about not from illegitimate constraints but from personal choice is hardly the type of moral distress that we should aim to eliminate. Yet again, tools measuring moral distress are unable to make these needed distinctions. For example, several items in the MDS scale describe witnessing another person in an action of potential moral wrongdoing. For instance, respondents are asked whether they have "Observed without intervening when health care personnel do not respect the patient's dignity," "Ignored situations of suspected patient abuse by care givers," or "Ignored situations in which I suspect that patients have not been given adequate information to insure informed consent." These activities can certainly involve illegitimate institutional constraints such as an unjust and dysfunctional hierarchical workplace, or one where the threat of severe negative institutional sanctions prevents people from speaking up when facing clear wrongdoing. But it is also possible that in a functional workplace where people are encouraged to speak up, moral wrongs will still at times occur, observed by morally negligent witnesses who inappropriately fail to react. In such cases, it seems that moral distress at the recognition that one has acted wrongly is the appropriate reaction and not something we would wish to reduce or eliminate. These difficulties in identifying whether the moral distress is an expression of moral engagement involving situations where conflicting values are at stake can be found in some MDS-R items such as "Witness healthcare providers giving 'false hope' to a patient or family" or "Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing." Insofar as the institutional environment does not make being frank excessively costly, and one could confront these challenges by exercising moral courage, then the moral distress resulting from a choice not to do so is arguably an appropriate response. This sort of moral-distress response reflects the challenging and value-laden context of healthcare, rather than necessarily calling for transformation of institutional practices. The MMD-HP items such as "Work with team members who do not treat vulnerable or stigmatized patients with dignity and respect" pose similar challenges: to the extent that dysfunction or unjust workplace practices abet the poor treatment of patients, those institutions are

creating undue moral distress that we should aim to eliminate by transforming institutional environments. But if and when workplaces create mechanisms for protection of the vulnerable and ways of reporting mistreatment, and yet healthcare professionals choose to ignore their duties because of convenience, excessive fears, or lack of moral courage, then experiencing moral distress remains an appropriate response that should not be eliminated. Common measuring instruments, however, do not allow us to determine whether the moral distress is a fitting expression of moral engagement or the result of institutional practices in need of reform.

## CONCLUSION

The growing concern about moral distress in the healthcare professions attests to the prevalence and intensity of moral challenges within the workplace. It also manifests a justifiable worry about the toll such distress can have on individual providers' health and wellbeing, institutional functioning, and patients' care. Attempts at reducing the causes of moral distress seem thus appropriate.

While the precise definition of moral distress remains a subject of some debate, there is some agreement that moral distress derives from workplaces' illegitimate constraints on individuals' moral agency. Tools to measure the presence of moral distress could constitute diagnostic instruments that pinpoint the sources of illegitimate constraints. They could thus be of immense utility in improving organizational functioning and with it, healthcare professionals' wellbeing, workplace operations, and patient care. In this diagnostic spirit, several different instruments have been developed to measure the sources of moral distress of individual respondents. Unfortunately, none of them is capable of reliably providing the relevant information to guide action and produce change where needed.

We have here assessed in detail four commonly used scales—the Moral Distress Scale by Corley and colleagues (2001, 2005), the Moral Distress Scale-Revised by Hamric and colleagues (2012), the Measure of Moral Distress-Healthcare Professionals by Epstein and colleagues (2019), and the Instrument of Moral Distress by Kälvmärk Sporrang and colleagues (2006) and have argued that all of them present crucial problems. They cannot reliably discern whether or not the respondent has a correct understanding of the facts surrounding a distressing incident, whether the distress in question is moral distress or implicates

distressing feelings that do not involve moral agency, and whether the moral distress experienced is a fitting response that reflects moral engagement and therefore should not be eliminated. These problems are fatal: common tools are liable to overstate the presence of moral distress<sup>7</sup> and, worse still, to misdiagnose its sources. They thus provide unreliable information about what transformation is needed to avoid undesirable moral distress.

If we are correct, empirical work on detecting the phenomenon of moral distress must correct the problems we have pointed out in order to provide useful evidence that could ground sound institutional changes. As we have discussed, experience level, personal knowledge gaps, and situational role can lead individuals to believe that an unethical act is occurring, when that might not be the case. Current instruments fail to account for these possibilities and thus run the risk of pointing to institutional failures that do not exist. Similarly, instruments' inability to differentiate moral distress from other non-moral feelings and emotions that might be common in healthcare settings, such as stress or frustration, can also overstate the presence of moral distress and misdiagnose its sources. Finally, insofar as common measuring instruments for moral distress fail to distinguish moral distress that is an appropriate target for elimination and that which is not, they similarly run the risk of leading institutions to useless or inappropriate changes.<sup>8</sup>

For all its conceptual heterogeneity, moral distress is a concerning phenomenon that warrants careful empirical study. We hope that pointing out some of the problems affecting current moral distress instruments will contribute to improving such tools and produce evidence that could guide the development of strategies aimed at the elimination of illegitimate workplace constraints on moral agency when and where they exist.



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<sup>7</sup>Or at least the presence of moral distress that results from real constraints as opposed to perceived ones.

<sup>8</sup>We note again that though these instruments may fail to provide us with reliable information regarding needed institutional changes, they might still offer information about healthcare professionals' experience of moral distress, and this information can be valuable to develop strategies to help clinicians deal with the psychological effects (Morley et al. 2021).

## ORCID

Laura Kolbe  <http://orcid.org/0000-0002-8780-8533>  
Inmaculada de Melo-Martin  <http://orcid.org/0000-0001-8656-8497>

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