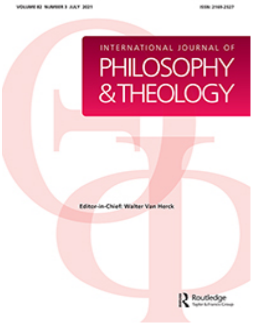

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Experiences of powerlessness and the limits of control in healthcare

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ABSTRACT
To what extent are experiences of powerlessness explained as involving a loss of control, and to what extent are attempts to increase patients' control suitable as means of addressing these experiences? In this paper, I present some findings from a recent project in the phenomenology of powerlessness to argue that in response to experiences of powerlessness, the ideal of control has limited use in either a diagnostic or therapeutic function.

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Recent years have seen an increased sensitivity to issues of empowerment within contexts of healthcare[1]. In the wake of the scandal surrounding the Mid-Staffordshire NHS trust, successive UK Governments have required the NHS to emphasise the empowerment of patients. Consider, for example, the following ambition from a recent NHS Mandate, the primary mode of ministerial instruction to NHS England:

> NHS England's objective is to ensure the NHS becomes dramatically better at [. . .] empowering [patients and their carers] to manage and make decisions about their own care and treatment [. . .] Achieving this objective would mean that by 2015 [. . .] far more people will have developed the knowledge, skills and confidence to manage their own health, so they can live their lives to the full; everyone with long-term conditions, including people with mental health problems, will be offered a personalised care plan that reflects their preferences and agreed decisions; patients who could benefit will have the option to hold their own personal health budget as a way to have even more control over their care[2].

In this Mandate we find a clear example of what has come to be the dominant way of conceiving of disempowerment and initiatives designed to address it[3]. In the view spelled out by the Department of Health, patients were disempowered insofar as they lacked sufficient *control* over their own healthcare. Consequently, patients are to be empowered by being given more control over the ways in which they are treated. Thus, the NHS is encouraged to explore a number of initiatives with the aim of promoting this goal: the offer of 'personalised care plans' and the opportunity to manage your own 'personal health budget' are explicitly presented as ways of transferring power from institutions to patients and their carers, precisely by means of increasing their control.

This pattern of diagnosis and response is also manifest in recent discussions surrounding the phenomenon of 'moral distress'. The term 'moral distress' was first introduced by

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Andrew Jameton in the 1980s to refer to a distinct sort of experience familiar to nurses and other healthcare workers[4]. We can introduce the idea quickly with an example.

> An elderly woman is in the advanced stages of cancer and is entering the last hours of her life. She and her family have expressed the wish that the medical staff should not attempt to resuscitate the patient. However, the patient codes (enters cardiopulmonary arrest) before the attending staff have completed the formal 'Do Not Resuscitate Order'. Consequently, the interns and residents that arrive on the scene quickly begin to attempt to resuscitate the patient. An attending nurse, aware of the situation, attempts to intervene and stop the resuscitation but is overruled by the attending physicians and is physically removed from the bedside[5].

Unlike experiences of moral dilemma, in which you are torn between two competing courses of action, in situations of moral distress you think you know what you should do, but you feel that you are unable to do it. Experiences of moral distress reportedly involve feeling powerlessness, increase in severity over time, and may be a major contributor to burnout[6].

HT I want to focus on the dominant responses to moral distress, as exemplified by the guidance of the American Association of Clinical Care Nurses (AACN). According to the AACN, if you believe that you may be experiencing moral distress, you should follow four steps, the so-called '4As': you should **ask** whether your 'symptoms' are consistent with the diagnostic criteria that are supposed to describe the 'condition' of moral distress; you should **affirm** your professional obligation to act to address the situation; you should **assess** your situation, first identifying ways in which you can make a difference and then making an 'action plan' to bring this about; and you should **act**, putting into practice 'strategies to initiate the changes you desire'[7]. The 4As framework, then, also exemplifies the paradigm according to which experiences of powerlessness are equated with experiences of loss of control and resources are invested into ways in which the individual can strive to regain control over her situation, such as commitments to action, strategies for change, action plans and the like[8].

Although the two documents we have just introduced are not unambiguously committed to any particular theory of agency, we can nonetheless tease out an ideal that is consistent with their focus and which shares much in common with some prominent philosophical accounts[9]. The ideal I have in mind places a high premium on *individual control*. By 'individual control', I mean **the activity of bringing about changes in the world according to your pre-existing intentions**. We can see this ideal reflected in our examples in two ways. Firstly, by describing what it is to be empowered, the ideal entails a conception of what it is to be disempowered, namely, to have lost control. In this way, the ideal can serve a diagnostic function in helping to identify the problem that is to be addressed. Secondly, by offering an ideal of empowerment, the ideal offers a goal that responses to disempowerment should aim at, namely, the maximisation of the individual's control. In this way, the ideal can serve as a standard by which the success of initiatives aiming at responding to disempowerment might be measured.

Now, there may be much to be said in favour of positing control as an ideal of agency within certain contexts. It is hard to deny the value of being in control, for example, when you are performing a delicate surgical procedure. Moreover, it seems almost a truism to suppose that the presence of some form of individual control is essential for agency. In this paper, however, I shall raise some doubts over whether individual control is an appropriate ideal in each and every context, either as a diagnostic criterion or as an aim of care, by appeal to a form of agency that is not reducible to the exercise of individual control. More specifically, by drawing out some central features of the lived experience of powerlessness, I shall argue that these experiences need not involve a sense of having lost control. So the ideal of control is not always useful in helping us to understand what individuals are going through. Further, I shall argue that these experiences are not always best addressed by the attempt to increase an individual's control. So the ideal is not always appropriate as an aim of treatment either. In this way, I hope to demonstrate some of the limits of the ideal of control in contexts of healthcare. That is not, of course, to deny that the ideal of control has considerable value in many different contexts, just to push back against the dominant paradigm that tends to promote individual control without consideration of other aspects of agency.

II

I shall, then, be focusing on experiences of powerlessness. But what does it mean to experience yourself to be powerless? Testimony of those who experience themselves to be powerless can appear to support the intuition that these experiences involve feeling that you are unable to bring about a change in the world according to your intentions. Consider, for example, the following:

> I am terrified that something could happen. I might consider leaving my home for the day. But more than that is impossible for me . . . it's like jumping in the dark . . . I do not control things and do not know what to expect[10].

Testimony of this sort thus seems to suggest that the ideal of control is indeed appropriate in the face of experiences of powerlessness, both as a diagnostic criterion and as an aim of care. For in these contexts, individuals seem to experience themselves to be powerless insofar as they feel that they have lost control. And why would it not be appropriate to respond to such experiences precisely by seeking to restore what has been lost?

If we take another look at the phenomena, however, then things begin to look more complicated. Consider, for example, the following:

> One participant [of the study] explained that she had not been able to be fully a grandmother because of her fear that she might drop her grandchildren while trying to hold them in her arms when they were babies. [. . .] One male participant felt particularly distressed, as he felt he could be neither a proper spouse nor a proper father, and maybe not even a proper man[11].

To be sure, the grandmother experienced a loss of the power to *do* something specific, namely, to lift her grandchildren. But this is not all there is to say. Her sense of having lost the ability to *do* something specific manifested an experience of the loss of the power to *be* a grandmother. Similarly, the second participant experienced himself to be powerless owing to his perceived inability to *be* a real spouse, father, and man. A broader view of experiences of powerlessness presented in other studies reveals a similar pattern. Consider the following testimony of a nurse in a burns unit who experienced herself to be powerless upon being unable to avoid inflicting pain when dressing patients' wounds:

> It's just this horrible inadequacy that I can't do my job properly, that this patient is showing this emotion and this level of pain [. . .] Um, it kind of goes against everything in nursing: you're supposed to help these people and fix these people but you can't[12].

The nurse felt that she could not *be* a real nurse – she felt inadequate to her role – because she felt that she could not *do* what she took to be central to being a nurse, namely, the alleviation of pain and the provision of remedial care. These considerations, I submit, urge a modification of our initial analysis. For experiences of powerlessness do not simply involve the sense of being unable to *do* something specific; they also seem to involve the sense of having lost the ability to *be* someone. But what is the power to *be* a nurse, a grandmother, or a father? And is the loss of this power reducible to a loss of control, such that it would be best addressed by attempts to increase control?

We do not have space to conduct a full analysis here, but we can make a number of initial observations[13]. Being able to be a grandmother plainly involves a number of capabilities, such as the ability to lift children, being able to take the children to the zoo, being able to read bedtime stories, and so on. But being able to a grandmother is not reducible to the possession of these or any other capabilities of this sort. You might have all the foregoing capacities. But that would not be sufficient to make you able to be a grandmother, since the way you draw on these capabilities might have nothing at all to do with a relationship to a grandchild. To able to be a grandmother, then, your capabilities must have a particular place in your life, namely, they must be bound up with your relationship to your grandchild. To develop this thought a little further, suppose that you were to discover that you are, as a matter of hereditary fact, someone's grandmother. If the discovery that you are a grandmother is to give rise to the *ability* to be a grandmother, then the fact that you are a grandmother will have to matter to you. If it did not, then the fact would remain blankly third-personal, extrinsic to your life. More specifically, the fact of that you have a grandchild will have to matter to you in such a way that you find yourself faced with the task of learning how to be a grandmother, otherwise you would never acquire the skills through the performance of which that ability is exercised. Moreover, you cannot learn how to be a grandmother either quickly or once and for all; the demands of being a grandmother are constantly changing, with developments in your family and the maturation of your grandchild. So being able to be grandmother is a constant learning process. For these reasons, being able to be a grandmother has to involve caring about making sense of what it would mean for you to live *as* a grandmother, so that your life takes shape in terms of that possibility. This will be a matter of figuring out how you can draw on your capabilities, and cultivate others, around that concern. So you might think about the things that you are good at and the things that you enjoy and which you would like to share with your grandchild. In addition, you will likely think about the new skills you will have to learn so as to best support your grandchild.

From these brief considerations, I want to take the following general lesson: if the ability to be someone or other is appropriately characterised along these lines, then it is not merely the possession of a particular set of abilities, but the on-going articulation of your abilities around the orienting concern of figuring out how to live *as* that sort of person. I shall refer to any particular concern for making sense of what it means for you to be someone or other as a 'power-to-be'.

Is the loss of a power-to-be a loss of control, such that it would be appropriate to aim to increase control for the sake of empowerment? It might seem, again, that the answer is obvious. Plausibly, to exercise a power-to-be is to actively bring about changes in the world according to your pre-existing intentions. So a grandmother will go about figuring out what it means for her to be a grandmother precisely by finding practical things to do that will make a difference for the good of her grandchild. But if control is the activity of bringing about changes in the world in accordance with your pre-existing intentions, and if powers-to-be are ways of actively realising your intentions by making changes in the world, then powers-to-be are ways of being in control. If this is right, however, then when someone is disempowered owing to a compromised power-to-be, the ideal of control will be helpful in both diagnosing the problem and in guiding attempts to cultivate the powers that have been compromised.

There are, however, ways of resisting this argument. In the rest of this section, I shall argue focus on three. Each argument gives evidence for the hypothesis that powers-to-be are not reducible to ways of actively making changes in the world according to your pre-existing intentions. The first suggests that powers-to-be are, at least in some cases, dependent on the co-operation of others in a way that goes beyond the agent's own intentional action. The second suggests that powers-to-be involve, at least in some cases, allowing your intentions to take shape around commitments that are binding prior to your intentional action. In each case, the exercise of a power to be goes beyond the control of the agent. For that reason, the ideal of individual control will be of limited use in either diagnosing what is lost, in experiences of powerlessness, and in identifying ways to address the problem.

Consider the following testimony from a chronically ill woman who had been cared for by her daughter:

> Let's put it that way: whereas we used to have a normal parent-to-child relationship before, the disease changed it all . . . it was as if she had become the parent and me the child. And that, I couldn't accept . . . She always wanted to decide things for me and I kept telling myself, what is going on here? We had many disputes, we broke off many times[14].

Although we have not heard the daughter's side of the story, the sketch of the relationship by the mother gives us enough to go on to fill in a fuller picture that is plausible as a configuration of a possible relationship, even if it departs from the reality of the specific relationship the mother is describing.

I might hear that an old friend is in dire straits and be motivated to find a way to support and care for him. But it might also be that our relationship has deteriorated dramatically over the last few years to the extent that I am severely impeded in being able to make good on my intentions. It might be, for example, that I am in no position to imagine what would be genuinely helpful to my old friend. That could be the case for a variety of reasons, such as a loss of familiarity owing to the time that has passed since we were last close, or an inability to separate out, in my imagination, ways of helping him from ways of getting back at him. Furthermore, it might be that the mere act of remembering myself to him at this time would be unhelpful to him, since my presence is unwelcome. In the face of such difficulties, we might want to say that the only way of being a good friend is to withhold from stepping in, and thus refraining from acting on your desire to help. But we might also want to say that, when the difficulties are severe enough, your desire to help, and the unavailability of avenues by which to realise your good intentions, reveal to you that you have lost the ability to be a friend to this person, such that anything you do will be more an expressive of a fantasy of the possibilities that you wished were open to you, rather than the realisation of a possibility that is really there. From these brief reflections I wish to draw the following point: whether I am able to be a friend depends not only on my intentional action, but the availability of avenues by which my intentional action can be expressive of an on-going relationship. But whether such avenues are available to me, and whether my intentional actions are following these routes, is not solely within the scope of my intentional action, since the context is held upon by the relationship with others, who may withdraw participation and collapse the context. Consequently, it might be that, despite my best intentions, the context in which my actions could amount to exercises of my ability to be a friend is withdrawn[15].

To press the argument that exercising a power-to-be is not reducible to the activity of *bringing about* changes in the world, let me now turn to another example. Consider a teacher who cares about the education of her students. In pursuing her commitment to teaching, she may be active in all sorts of ways. She might, for example, plan lessons carefully, deliver them with verve, and answer questions sympathetically. In these ways and others, the teacher may be active and in control of the methods she pursues. But although she may be in control of her means, these are not the means of control, since she cannot simply *bring about* the changes in the world she aims for in her practice, no matter how actively she is involved, and yet the realisation of these aims is central to whether she is being a teacher. The teacher is aiming to help the students to go on by themselves without her support; she would fail to teach her students long division, for example, if she had to prod them along at every step of the way. In this respect, teaching aims at its own redundancy. But the teacher cannot make it the case that the students are able to carry on by themselves, no more than she can go to the dentist for them. The students have to do this for themselves if it is to be done at all. If that is right, however, then she might even inhibit the exercise of her power to be a teacher if she were to try to *cause* her students' education – to 'transfer knowledge', in our grey idiom – even if she must be in control of the means by which their learning might be cultivated.

As in the first case, this example shows us that the exercise of the power-to-be someone is not reducible to being in control. In the example of the mother and daughter, this was because exercising a power-to-be not reducible to being active. In the example of the teacher, in contrast, exercising the power-to-be does not always involve *bringing about* the aims of the practice, since a central aim of that practice – namely, the education of the students – cannot be caused by her efforts, no matter how actively she cultivates that possibility.

Let me turn now to a final example to argue that exercising a power-to-be is not reducible to the activity of bringing about changes in the world *according to your pre-existing intentions*. We can first note that the ideal of control imposes a requirement on the direction of fit between the agent's intentions and her world, such that the agents' intentions serve as the measure with which the world is to be brought into conformity. But exercising the power-to-be someone or other does not always involve bringing the world into line with your intentions; it can require you to allow your intentions to take shape around the world. Consider one last time the example of discovering that you are a grandmother. Suppose that this has come as a total surprise. In responding to this discovery, you may simply brush it aside as a curious turn of events that is of no concern to you. But that would be precisely to refuse to learn how to be a grandmother. If you are to learn to be a grandmother, in contrast, and therefore to come to exercise the power-to-be a grandmother, you will have to let yourself be subject to the task of figuring out what it means for you to be a grandmother. Since this discovery has come as a shock, the task will strike you as disruption. Your best laid plans are now under review, in light of new demands. In that case, however, your power to be a grandmother has served to reorient you in the world, turning you away from some concerns and towards others. That is precisely to reverse the direction of fit required by the ideal of control. No longer is the world to be brought into accordance with your intentions; your intentions are to be brought into accordance with the world[16].

As with the previous two examples, this case shows that the exercise of the power-to-be someone is not reducible to being in control. We have already seen that exercising such a power is not always to be *active* and not always to *bring about* changes you would like to happen. We have now seen that exercising the power-to-be someone is not always to bring events into line with your preferences, but, least on some occasions, requires precisely the reverse.

Let me briefly sum up the argument I have been pursuing and draw out an implication. I began by introducing some concrete examples of experiences of powerlessness and arguing that central to these experiences is the sense of having lost the power to *be* someone or other. I argued that to have the power-to-be someone or other is to be concerned to make sense of what it means for you to be, for example, a grandmother. I introduced an argument according to which the exercise of this power is the exercise of a capacity for control. I then turned to three examples to show that exercising the power-to-be a certain sort of person is not reducible to being in control. Exercising that power is not reducible to your own activity; it need not always aim at bringing about changes; and sometimes it requires you to let your intentions take shape around the world, rather than the other way around. If that is right, however, then we can help ourselves to the following implication. The ideal of control has limited use as either a means of articulating experiences of powerlessness or in stipulating a response to them. For if exercising the power-to-be someone is not reducible to being in control, then that power might be undermined even if you remain in control. This point is made dramatically clear by the case of the overbearing daughter. She was in error to the extent that she related to her ability to be a daughter as exhaustible by her own activity, rather than constitutively dependent on her history and relationship with her mother. Consequently, the ideal of control does not identify a paradigm with respect to which the daughter has fallen short, but a mode of agency pronounced to a disempowering degree. We would, therefore, misdiagnose the problem by insisting that she is disempowered in virtue of lacking control; she is disempowered in part because she seeks control. So the ideal of control is of limited use in its diagnostic function. And we would risk to exacerbate her disempowerment by seeking to find yet more ways of increasing her control. So the ideal of control is also of limited use in its remedial function. Consequently, individual control is not always and everywhere appropriate as an ideal of agency in either of its characteristic functions. And that gives us reason to push back against the dominant paradigm, in which primary focus is given to means of increasing control. In conclusion, let me return to one of the examples with which I opened our discussion to see how this push-back may play out concretely.

III

The following testimony is taken from a first-person account of leaving the practice of nursing following an experience of moral distress:

> I was a staff nurse in a critical care unit and for that evening I had been caring for a 96-year-old African American woman [. . .] She was clearly dying. I talked to her family earlier in the day and they were ready to make her a DNR, Do Not Resuscitate. But the doctor had not gotten around to writing the order for the DNR yet. She coded in the ICU and the interns and residents come rushing in, and because she didn't have a DNR order, they started to resuscitate her, and I said, "Wait a minute; the family is in an agreement. The only thing that's not done is the order. This woman should not be being resuscitated." One of the doctors grabbed my arm and threw me up against the wall to get me out of the way so that they could resuscitate this woman. She died and of course it was awful. They broke every rib in that poor woman's body and she was left like this, and then they walked out. I went to my manager and to the Director of Nursing and I got no support for what I'd done, to try and intervene in this hopeless situation [. . .] That was my final night in a hospital. I never went back to a hospital after that. I went on and got a master's degree in Psychiatry and headed my own private practice and consulting firm since then. And most nurses who leave have this defining moment. That was a defining moment. If they were not going to protect that woman, I could not have anything to do with that hospital[17].

We need not offer any judgment as to whether she was right to leave her job in order to note that the 4As framework – the dominant guidance for responses to moral distress – leaves no space for the *possibility* that this was the best available solution. To recall, the second step requires you to **affirm** your professional obligation to act to address the situation. It therefore requires the individual to, so to speak, renew her vows to the profession. But this is precisely what the subject of the above testimony did not do. She renounced the commitment and moved on with her life. So the 4As framework rules out of bounds the possibility to which this testimony attests, namely, that it may be best to give up on the professional commitment to nursing[18]. Our discussion, however, gives us reason to suppose that by excluding this possibility from consideration, the 4As framework may further compound some experiences of disempowerment that can follow from moral distress, as I shall now explain.

I have suggested that the power-to-be a particular sort of person is practiced concern for making sense of what it means for you to be that sort of person. Through our discussion, we discussed a number of ways in which that you might experience that power to be compromised through the sense of having lost the ability to be involved with certain practices. So you might find your ability to make sense of yourself as a grandmother hampered owing to your inability to spend time playing with your grandchildren. In such cases, there remains a persisting concern for making sense of yourself in particular ways, but you experience a block to the concrete pursuit of that concern through the practices that you take to be central to that way of life. I want now to draw attention to another way in which a particular power-to-be might be compromised, namely, through the loss of *concern* for making sense of yourself in some particular way. This is, I take it, a relatively common experience: you might find your enthusiasm for your career waning, as the aspects that drew you in are increasingly eclipsed by mounting, tedious demands. In such cases, you might experience yourself to have lost the power-to-be a particular sort of person despite the fact that you do not experience yourself to have not lost the power to pursue any specific practices. Rather, you have lost the *concern* for making sense of yourself in the way that gave a point to undertaking the practices of which you remain capable.

With this in mind, we can return to the testimony I introduced at the start of this section. I suggest that the nurse in question did not simply experience a loss of the power to undertake the actions expressive of her commitment to nursing; her concern for the commitment collapsed, so she quit. To be clear, I am not suggesting that she became indifferent to the needs of patients or, more generally, gave up on the concern for caring for others. The fact that she went on to retrain in a different context of care speaks against that interpretation. Rather, I am suggesting that the specific concern for making sense of herself *as a nurse* collapsed; she fell out of love with that way of life. If this is an apt description of the situation the nurse found herself in, will the 4As framework be of any help to her? I suggest not. If you are facing up to the experience of having lost concern for making sense of yourself in some particular way there are two ways of responding: you may seek to revive your concern for the commitment; or you may seek to accept the collapse of concern of her commitment. The 4As framework does not address either of these possibilities for the simple reason that it requires the affirmation of your commitment to professional practice. That is a bit like advising someone who has fallen out of love that he should make a marriage proposal; in neither case does the advice take seriously the possibility that the recipient might be unable to affirm the commitment without crossed fingers. And yet this is the problem – the sense of not being able to honestly affirm a commitment – that is at issue in the cases we have been describing. It does not show up in the terms of the 4As framework.

None of this gainsays the possibility or value of recommitting to the practice in the face of moral distress. The point is just that the dominant paradigm can serve to occlude other ways in which we might be disempowered that are not best met by attempts to increase control and which demand a different response. By pushing back against the dominant paradigm in the way that I have urged here, I have hoped to have drawn attention to forms of disempowerment that fall outside its scope and which thus raise the question of what it would mean to live well in light of the *limits* of control. How to answer that question is, of course, no small matter. But it is, I submit, of first importance that we should ask it.

Notes

1. Between 2015 and 2018, I worked in collaboration with Béatrice Han-Pile and Daniel Watts on *The Ethics of Powerlessness: The Theological Virtues Today*, a research project funded by a major grant from the UK's Arts and Humanities Research Council. Our aim was to use the tools of phenomenological analysis to examine experiences of powerlessness. In addition, we wanted to see whether the Christian theological tradition contained any resources to help us understand these phenomena. In developing my argument below, I draw upon findings, themes, and ideas that were cultivated throughout the course of this project in close collaboration with my colleagues and the many co-conspirators we drew in along the way. For more information on the project, including links to research outputs, see http://powerlessness.essex.ac.uk (accessed 08/01/19 18:00).

2. Department of Health, 'The Mandate: A mandate from the Government to NHS England 2014–15', 11.
3. 'We want people to be empowered to shape and manage their own health and care and make meaningful choices' Department of Health, 'The Mandate: A mandate from the Government to NHS England 2018–19', 8.
4. See Batho & Pitton 'What is Moral Distress? Experiences and Responses', 3.
5. Ibid. 10.
6. See Wagner 'Moral Distress as a Contributor to Nurse Burnout'.
7. AACN 'The 4A's to Rise Above Moral Distress'.
8. In this and other contexts, the focus on the *individual's* responsibility to regain control may also be problematic, since it may serve to divert attention away from the institutional issues that contribute to these experiences. For a discussion of this problem in related contexts, see Harper and Speed 'Uncovering recovery: The resistible rise of recovery and resilience.' For further discussion of the ideal of control in contexts of healthcare, see Batho 'Experiences of Powerlessness in End-of-life-care', 2–7.
9. I have in mind any theory according to which agency meets its ideal in the form of *rational self-determination*. Major figures in this tradition are Kant, Fichte, and Hegel (for a useful overview, see Patton 'Freedom as Radical Self-Determination'). These philosophical accounts depart from the ideal as I have described in several important ways, not least that they emphasise the importance of the *rationality* of the agent's preferences.
10. Aujoulat et. al. 'The Perspective of Patients on Their Experience of Powerlessness', 778.
11. Ibid. 781.
12. Kornhaber, R, Wilson, A, 'Enduring feelings of powerlessness as a burns nurse: A descriptive phenomenological inquiry', 174.
13. See Batho 'The Phenomenology of Powerlessness', Blattner 'ability-to-be'.
14. See note above 10, 858.
15. These reflections do not necessarily translate without loss to the consideration of the example with which we began; we might think that relationship between a mother and a child is *sui generis* in such a way that the mother's ability to be a mother is not dependent upon her child's grace in the way in which friendship is essential mutual. We can imagine, for example, a mother finding herself able to be a mother through sustaining an offer of love while fully expecting her offer to be spurned. The mother-child relationship is not dependent on mutual acknowledgement in the way in which friendship is.
16. One might object to this line of argument as follows: since it is the preference of the grandmother to bring her preferences into line with the demands of being a grandmother, the realignment of her preferences is still a matter of bringing about a change according to her preferences and, therefore, amounts to a way of being in control. Although we cannot fully respond to this objection here, we can note that it is committed to the view that we are able to *cause ourselves* to have new preferences: if the process of developing new preferences is one that meets the ideal of agential control, then it will be one by which the agent actively *brings about* those new preferences. We may wish to be sceptical of the claim that we have this sort of voluntaristic control over what you care about, not least because we do not appear to have it.
17. Lachman 'UK Moral Distress Education Project'.
18. One might respond that it is hardly a surprise that the 4As framework does not acknowledge the possibility that, in some cases, it might be best for some members of staff to leave the profession behind them. In the UK especially, in the context of a mounting crisis in dropout rates, to draw staff to consider whether it might be best for them to quit might seem downright reckless. But that is not to speak against the criticism I have articulated above; it is to concede that the framework does not have the needs of staff at its heart, except when they are in line with those of the institution, which retains overarching priority. If we assume that frameworks of the sort developed by the AACN are aimed at the good of the staff, then the criticism stands: the 4As framework excludes a possibility that may, in some cases, be the best way to respond to experiences of moral distress.

Disclosure statement

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