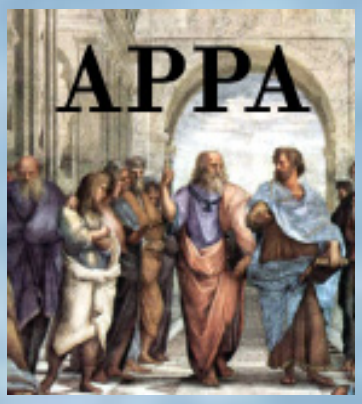

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Nemo Veritatem Regit
Nobody Governs Truth

What's Philosophical About Moral Distress?

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Abstract

Moral distress is a well-documented phenomenon in the nursing profession, and increasingly thought to be implicated in a nation-wide nursing shortage in the US. First identified by the philosopher Andrew Jameton in 1984, moral distress has also proven resistant to various attempts to prevent its occurrence or at least mitigate its effects. While this would seem to be bad news for nurses and their patients, it is potentially good news for philosophical counselors, for whom there is both socially important and philosophically interesting work to be done. In an effort to encourage such work, this paper explicates the philosophical (as opposed to more purely psychological or institutional) contours of the problem. A subsequent paper, titled *A Philosophical Counseling Approach to Moral Distress*, will highlight ways in which such a response would differ from the strategies so far deployed within the nursing profession.

Keywords: *moral distress, moral agency, nursing, health-care ethics, client counseling, worldviews, emotions*

Introduction

Several years ago, a nursing colleague asked me to look over some qualitative interview data she had collected for a dissertation on how student nurses navigate issues of cultural diversity when they began their clinical rounds. I'm not sure what that colleague thought she would find in the students' experiences, but she told me she was surprised to hear them describe what she called "moral challenges." She believed the ethics training they received as part of the nursing curriculum should have better prepared them to navigate those challenges, but it apparently had not.

As we talked, it became clear that my colleague did not just mean students were having difficulty resolving concrete moral problems that arose on the hospital ward (that is, difficulty doing what academic philosophers would likely describe as applied ethics). What concerned her was the fact that so many aspiring nurses seemed to feel they would have to put their own values aside, or to distance themselves emotionally from the values that were most dear to them, in order to succeed in their jobs. In the most severe cases, the students seemed to be wondering whether they even wanted to be nurses anymore.

My immediate thought was that these students fit Lou Marinoff's description of suitable candidates for philosophical counseling (2002: 252). They were "rational and functional," yet "confronted by issues of private morality or professional ethics" (I wasn't sure which); and many of them seemed to be grappling with "questions of meaning, value and purpose" as well. Since I regularly teach applied ethics courses to the same student demographic, I knew it was overwhelmingly likely that most of them had "underdetermined or inconsistent belief systems." And for those who claimed to have

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always dreamt of becoming nurses, the realization that a nursing career might not be the best fit almost certainly raised questions about how they might find "personal or professional fulfillment." All of this suggested that early career nurses might benefit from a more "philosophical interpretation of changing life circumstances" (*ibid.*), so I proposed that we do a study to see if philosophical counseling might help. It was while doing background research for our IRB proposal that we came across the nursing literature surrounding moral distress, and I began to read that literature pretty carefully as a way to think through the sorts of issues that might come up during counseling sessions my colleague and I planned to conduct.

Our proposal was promptly approved by our university IRB, and we even managed to convince our campus funding committee to compensate participants for traveling to counseling sessions. But when it came to recruitment we hit multiple obstacles. The primary one was that local hospitals refused to let us recruit unless we submitted a protocol to their hospital IRBs, each of which required us to have a method for tracking which nurses participated. We ultimately declined to do this out of concerns about confidentiality and privacy (plus the fact that it would have violated the protocol approved by our campus IRB), opting to pursue more informal approaches instead. But this was dependent on my colleague's network of former students, and as we were gearing up to think about new outreach strategies, she moved away. So as it turns out I have yet to counsel a nursing client. However, I remain convinced that philosophical counseling could be of significant benefit to both new and established nurses suffering from moral distress.

Consider the following examples, all of which are drawn from the large and growing literature within nursing:

> An infant in the neonatal intensive care unit was born at 28 weeks gestation with a serious infection … [and] is most likely to be severely retarded, bedridden, and in chronic pain. In some infants such as this one, parents and physicians on the unit decided to remove the infant from the respirator and to allow the infant to die. However, in this instance the parents do not seem to understand the situation, and the physicians are pursuing therapy aggressively. The nurse must perform some procedures that are painful to the infant to provide care. If the nurse were allowed to make the decision, the procedures would not be performed, but the nurse is not permitted to change the orders, and the physician does not seem receptive to a conflicting viewpoint (Jameton 1993: 542-3).

> I guess the first time it really hit me was when I had a patient to take care of who was a drug dealer and had been cooking meth and got burned. Blew his house up and got burned very badly. And there was a second patient next door that I was supposed to be taking care of as well and he was unable to eat [and] needed help … all sorts of things. And my time was very split between the two. And it was hard because there was a really big part of me that was like this other patient who is so deserving of my time and really just needs somebody there and he deserves it you know and I'm angry because there's this other patient who made a terrible choice and, as far as my personal opinion, and the lifestyle he led and—I'm a mom and thinking about my kid getting that stuff. Like it's—it really was a difficult situation for me and I cried thinking about what was right versus what I was feeling. (Stanley & Matchett, 2014: 136).

> I'm really tired of that whole system … it hurts too much to have to spend a lot of time with those patients because you know you're helpless to change the situation for them … I think what it's done is make me decide to get out of nursing because I don't like being in a situation where I feel helpless or continually have to deal with situations where I have to do things I think are wrong. (Wilkinson 1987:25).

The literature from which these examples are drawn includes empirical studies documenting the subjective experience of moral distress in nurses and other health care providers, as well as the effects of moral distress on the delivery of health care in the United States and abroad. It also documents attempts by the nursing profession to prevent the occurrence of moral distress, or at least alleviate its most harmful symptoms. Despite these efforts, moral distress continues to have an adverse effect: 30-50% of new nurses change roles or leave the profession completely within their first 3 years, and there has been a persistent, 8% shortage of nurses in the United States (MacKusick & Minick, 2010). In addition to contributing to this shortage, moral distress has been linked to decreased quality of care (Borhani *et al.*, 2014; Epstein & Delgado 2010).

While this would seem to be bad news for nurses and their patients, it is potentially good—or at least, important—news for philosophical counselors, for whom I believe there is both socially useful and philosophically interesting work to be done. In an effort to encourage such work, this paper seeks to explicate the philosophical, as opposed to more purely psychological or institutional, contours of the phenomenon. A subsequent paper, titled *A Philosophical Counseling Approach to Moral Distress*, will highlight ways in which such a response would differ from the strategies so far deployed within the nursing profession. Since the success of that kind of response hinges on the ability of philosophical counselors and nursing professionals to craft real world solutions together, both papers draw heavily on nursing research.

Jameton's narrow definition

So what exactly does that research have to say about moral distress? Despite widespread agreement that it is a "a serious issue in the workplace and deserves urgent and extended attention" (Elpern *et al.*, 2005), there is quite a bit of disagreement about how exactly to characterize the phenomenon. The most obvious entry point is Andrew Jameton's 1984 definition, which was first on the scene and continues to serve as a referent for nearly everyone working in this area. It is also the narrowest definition of moral distress that has so far been proposed.

According to Jameton: "*moral distress* arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action (1984: 6)." By way of contrast, he notes that "*moral uncertainty* arises when one is unsure what moral principles or values apply, or even what the moral problem is … One feels dissatisfied with the patient's treatment, but the nature and causes of the inadequacy are hard to pinpoint (*ibid.*)," whereas "*moral dilemmas* arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action. It seems terrible to give up either value, and yet the loss seems inescapable (*ibid.*)."

In the latter two cases, Jameton was following a well-worn path in academic moral philosophy, while also highlighting the fact that laypeople, including the nurses for whom he was primarily writing, rarely distinguish the feeling of moral uncertainty from the experience of confronting a

genuine dilemma. But in identifying moral distress as a discrete phenomenon, he was doing something new. Jameton classified all of three of these experiences as "moral problems in nursing." And the feature he used to distinguish moral distress from the others was the presence of institutional constraints.

Since moral uncertainty and moral dilemmas are likely to strike most people as more overtly philosophical problems, it is useful to reflect on the reasons Jameton may have had for limiting his definition in this way. I think there are three. First, he worried that the field of applied health care ethics had given too much attention to moral dilemmas. A philosopher himself, Jameton did not deny that careful study of dilemmas was helpful for clarifying moral principles, nor was he unaware that people might well be frustrated by dilemmatic situations. But he was convinced that academic philosophy's emphasis on dilemmas led people to question whether there was "any order in the chaos of human values at all" (Jameton 1984: 157). Because Jameton's more overarching project was to help nurses identify and apply ethical principles that could legitimately govern their work, moral skepticism was something he was eager to avoid.

Despite that emphasis, Jameton also did not want to downplay the fact that nursing practice takes place in a context characterized by "ambiguity and contradiction." What he did want to show was that nurses are, at least in general, just as morally competent as doctors and administrators who have the institutional authority to direct much of the day-to-day work nurses do. He points out that nurses "rarely undertake what they regard as questionable procedures on their own initiative" and "usually find themselves involved in bad practice through cooperation with others" (Jameton 1984: 283). And despite an emphasis on the search for abstract and general principles throughout his book, at least some portions can be read to suggest that the very "hands-on" nature of nursing work makes nurses especially well-suited to determine the best course of action in contexts where moral uncertainty is the norm. Hence, focusing attention on institutional constraints enabled Jameton to fix attention on issues of conflicting role responsibilities and relative powerlessness that he wanted to help nurses address. (I take this to be the second reason for defining moral distress so narrowly.)

Finally, and perhaps most importantly, Jameton wanted to emphasize that feeling "real guilt and real moral distress" was not enough, and that "nurses are in general accountable for harmful practices in which they are involved, even though they do not themselves initiate them" (1984: 284). Hence for Jameton, the "problem" of moral distress had less to do with the psychological suffering of individual nurses, or with determining whether any given nurse really does know "the right thing to do," than with the presence of institutional constraints that make it difficult for nurses not only to participate fully in moral decision-making on hospital wards, but to act on their own moral judgments. Viewed in this light, moral distress is the name of a deeper problem, or set of problems, having to do with moral agency. More specifically, it is a problem that can only arise for people who understand themselves—at least implicitly—to be moral agents. For moral agents act on reasons in some broad sense. And if a nurse did not have her own reasons for thinking that a particular course of action was, in fact, "the right thing to do," institutional factors requiring her to do otherwise would presumably be experienced as suggestions or directives, rather than as obstacles or constraints.

Note that my claim is not that nurses have an explicit understanding of themselves as moral agents, let alone that they are wedded to a specific philosophical theory about what it means. In fact, many nurses may not have a very clear concept of moral agency at all. My point is only that the specific distress Jameton identified is a feeling that can only arise for persons who evaluate their actions according to some set of moral values, and decide that those actions fall short.

Support for my claim can be found in a more recent article by Elizabeth Peter and Joan Liaschenko, who argue that "moral distress can be conceptualized as a reaction to the constraints to the moral identities, responsibilities, and relationships of nurses" (2013: 338). Their paper fleshes out many of Jameton's worries about nurses' lack of decisional authority and interpersonal power. Yet the three "constraints" they identify are rooted in a feminist conception which understands "moral agency as socially connected, implying that people's ability to identify, deliberate and act on moral phenomena occurs in a relational context" (*ibid.*). In that sense, their view differs significantly from the more 'principlist' conception of moral agency relied on by Jameton, who contends that nurses "need conventional and customary principles" in order to "make decisions efficiently and with the cooperation of others" (Jameton 1984: 78; cf. all of Part II). Still, the distress in the situations that Peter & Liaschenko highlight has less to do with the specific values embraced by nursing professionals than with nurses' understandings of themselves.

Questions about the nature of moral agency are philosophically interesting in their own right. However, since Jameton's narrow definition assumes that nurses have genuine moral knowledge, readers may still wonder what philosophical work is left to do if the goal is to reduce moral distress. Isn't the problem a purely practical, or perhaps political, one of removing institutional obstacles so that the 'right thing to do' is also the thing that actually gets done? Alternatively, readers may begin to wonder whether nurses' distress in the face of institutional obstacles is properly construed as a moral "problem" in the first place. After all, when people are prevented from doing what they ought, being upset by this fact seems to be a perfectly appropriate response (Nyholm: 2016). In this kind of situation, distress is actually something praiseworthy: a sign of the person's good moral judgment, not a symptom of some deeper philosophical problem needing to be solved.

In response, I want to say yes, resolving the problem Jameton identified will require finding ways to overcome (or at least navigate around) institutional obstacles; and yes, moral distress can indeed be a sign of nurses' moral good sense. But I still think there are philosophical problems lurking in the background. As Peter Raabe has usefully suggested, "philosophy can be very simply defined as a *practice* that involves examining the reasons we have for the values we hold as good and the beliefs we hold as true" (2013: 5, *emphasis mine*). In light of this definition, notice that even on the assumption that a nurse's moral judgments are perfectly accurate, her decision to do what the institution (wrongly) expects also depends on her (non-evaluative) beliefs regarding what is in fact possible or desirable. Given her moral judgments, there is at least some reason to doubt whether those wider beliefs are in fact supported by good reasons too. Moreover, the fact that nurses are characterized as feeling the self-regarding emotion of distress—rather than more other-regarding emotions like anger, frustration or outrage—suggests that they are making the additional judgments that they themselves are culpable or guilty of wrongdoing. And these stand in some tension with the judgment that they "must" or "should" act as the institution requires. Perhaps there are good reasons for the agent to hold both judgments at once. But at least on the face of things, it makes sense to ask whether both can really be true in the context. In other words, situations like these raise philosophical problems about justification and consistency.

As I understand Jameton's project, these are precisely the kinds of problems he was hoping to help nurses and other health-care decision-makers address. And in many way that project was a success (though this may have been due as much to the wider backlash against medical paternalism that characterized the time period as with Jameton's specific contribution). There have been countless articles documenting the contexts in which moral distress is most likely to occur, as well as the need to involve nurses more directly in complex decisions about appropriate care. Nurses today have much more power than they did in 1984, and many of the institutional constraints they previously faced have been eliminated. Yet moral distress persists, and is now recognized as an international phenomenon that plagues all health care professionals, including doctors (Kälvemark e*t al*., 2004; Campbell *et al*., 2016). So what accounts for this persistence in the face of nurses' greater institutional power?

Some broader definitions

Attempts by the nursing profession to answer that question fall into roughly two camps. On the one hand, there have been calls to broaden Jameton's definition to include situations involving conflicts as well as constraints. On the other, there have been efforts to clarify the precise nature or phenomenological character of moral distress, in order to more fully differentiate it from other forms of psychological suffering. Reviewing the evidence gathered by both camps suggests that moral distress is a phenomenon that arises—and indeed can only arise—in the presence of what I shall call a moral outlook. And I take it that a moral outlook is a philosophical structure if anything is. As I shall be using the term, it is the moral outlook of the nurse in the first of my opening examples that ultimately explains why painful procedures would not be performed on the infant if the nurse was allowed to make the decision. And it is also moral outlooks that ultimately explain why nurses in the second and third examples are emotionally upset. For a moral outlook is part and parcel of agents' wider "philosophical understanding of themselves and their world" (Lahav 1996).

As such, it is not an abstract theory (or set of theories) about the nature of moral agency, whether morality is in fact dilemmatic, or what to do in the face of conflicting role responsibilities. But it is also "not a psychological structure that resides in the person's mind." Rather, it is the specific concepts and patterns of reasoning that inform each person's "lived understanding," including "the person's emotions, behavior, thoughts, hopes, desires, and entire way of being" (*ibid.*: 265). And now the important point is to see that even if the nurse's moral outlook turns out, according to whatever philosophical account of morality is found to be most convincing, to be deeply flawed, the fact that it is part of her wider philosophical worldview, and represents morality-as-it-appears-to-that-nurse, suggests that any distress accompanying the outlook is a philosophical phenomenon too. As Lahav puts it, the distress is an expression of the "meaning, implications, or 'logic' of the person's attitudes toward life" (*ibid.*).

Understanding moral distress as a problem that arises within a moral worldview paves the way for a more detailed explanation of why the problem can arise independently of first order moral dilemmas. For a moral worldview does not just contain beliefs about what kinds of actions are right and wrong to do. At a minimum, it also contains beliefs about moral responsibility, and what it means to be a good—or at least morally decent—human being. Hence, the problem of moral distress has as much to do with how that particular nurse understands concepts of praise and blame and choice and identity as with the specific values and principles that inform that nurse's moral decision-making.

Interestingly, however, understanding moral distress as a problem that arises within a moral worldview also explains why it might stem from value conflicts and more general uncertainties as well as institutional constraints. This possibility was raised by Jameton himself in a later discussion of what he somewhat reluctantly described as dilemmas of moral distress, though he never fully revised his initial definition. In an intriguing passage, he recalls his own experience of asking "why is the nurse telling me this story—clearly a story of moral distress—as a dilemma, when it is clear that the nurse has made a definite moral judgment that [a specific therapy or treatment] was morally wrong?" (Jameton 1993: 543-4). His answer was twofold: first, the nurse was attempting to "soften and redirect potential conflict with other staff members," and second, "the nurse in moral distress actually did face dilemmas" (*ibid.*), though not first order dilemmas stemming from irreconcilable conflicts of moral principles. Instead, they are second order dilemmas about individual or collective moral responsibility, and when (or whether) one is obligated to 'blow the whistle,' undermine a hospital policy or physician order, or conscientiously object to what some external authority is telling the nurse to do.

More recently, Carina Fourie has pointed out that even when "researchers in the nursing ethics literature seem to assume the narrow definition tacitly … they are not consistent in sticking to [Jameton's] definition when they discuss the relationship between distress and dilemma, or when they measure moral distress" (2015: 93). Hence she contends that moral distress is more aptly defined as "a psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both" (Fourie 2015: 97). By 'moral constraint,' she means anything that prevents a nurse from acting, and Fourie's insight is that this may include a nurse's "internal" uncertainty about what to do as well as any "external" obstacles that prevent a nurse from acting on whatever conclusions she may definitively reach. This notion overlaps somewhat with 'moral conflict,' since this term refers both to conflicts with other people (doctors or other co-workers), and conflicts within what I have been calling the nurse's moral worldview. But whichever way moral conflicts are understood, Fourie sensibly points out that they need not be full blown dilemmas in order to give rise to emotions that seem quite naturally described as instances of distress.

For example, Mark Repenshek contends that the term 'moral distress' has in fact been used to refer to nurses' "discomfort with moral subjectivity" (2009). His claim is based on data drawn solely from the context of end-of-life care, and suggests that what nurses find especially troubling is the fact that questions about quality vs. quantity of life "cannot be worked out in fairly objective terms" (*ibid.*: 739). And while it is unclear whether he meant to be criticizing Jameton's definition or simply noting that other researchers have failed to apply it accurately, Repenshek's data aligns with Jameton's point that nurses prefer to avoid interpersonal conflicts. Repenshek further suggests that nurses' discomfort in this context might be alleviated by introducing them to a Catholic moral framework, which he describes as containing some "objective elements, such as whether or not a treatment is available or will be physiologically useful," but which "ultimately turns on the prudential judgment of patients with the help of their family and physician" (*ibid.*: 740). While I have been unable to find any follow up studies designed to test whether this specific intervention succeeds, to the extent that it did work, it would be an example of moral distress (or discomfort) being alleviated by bringing about a change in the nurse's moral worldview.

Alternatively, consider the nurse in my second introductory example, who "cried thinking about what was right versus what [she] was feeling." There seems to be some sense in which this nurse

"knew" she ought to provide equal care to all of her patients, and providing such care was also what the institution expected her to do. Yet this nurse also "felt" that the drug dealer was less deserving of her time. So whether we understand this conflict to be purely "internal" (a conflict among values that structure her own moral outlook) or "external" (a conflict between her subjective "feeling" that the elderly patient was more deserving, and some more objective ground for thinking she ought to care equally for the drug dealer—including, quite possibly, the fact that giving such care is what doctors, supervisors or hospital policies expect her to do) her overall distress in response to the situation—in contrast to her different "feelings" about the two patients—does seem to arise from that conflict. More importantly, whether the nurse herself understands the conflict as internal or external is relatively unimportant to understanding why that conflict gives rise to her distressing feelings. The central problem seems to be that this nurse is literally of 'two minds' about what to do.

Some philosophers may interpret this case as a problem of *akrasia* (the nurse knows the right thing to do but does not want to do it), while others may be more inclined to raise questions about the nurse's understanding of 'desert.' And others may be convinced that the nurse's distress in this case reveals improper reasoning, a lack of empathy, or limitations in some other capacity that underlies moral judgment. While adjudicating among those various interpretations is beyond the scope of this paper, all of these possibilities suggest that the nurse's feelings of moral distress can be understood as an expression of her current philosophical worldview.

The feeling of moral distress

But are the nurse's feelings best understood in this way? Since the relationship between reason and emotion, as well as the line between philosophy and psychology more generally, are also matters of considerable debate, this is yet another substantive question raised by moral distress that is philosophically interesting in its own right. But I take it that it will not be fully answered from the philosopher's armchair or the psychologist's couch. It is precisely the question my nursing colleague and I hoped to explore through our ill-fated study, one which I still hope to explore in a counseling context and hope this paper will motivate other philosophical counselors to engage with, too. For the most convincing way to answer it would be to develop a body of evidence regarding whether philosophical counseling does in fact help nurses feel better and to flourish in their chosen careers, and then to compare that with evidence about the effectiveness of other strategies designed to alleviate moral distress.

In lieu of such studies, it is noteworthy that both Fourie's definition, and the nursing literature in general, treats moral distress as "a psychological response to an ethical phenomenon" which is conceived as separate from "the ethical phenomenon which prompts the response" (2015: 93, *my emphasis*). Relying on that terminology, we can say that Repenshek views 'moral subjectivity' as an ethical phenomenon which prompts psychological 'discomfort,' that Peter & Liaschenko view 'constraints on nurse's identity' as an ethical phenomenon which prompts psychological 'reactions,' and that Fourie's definition entails that any (and every) moral challenge will prompt 'a psychological response.' Following this general pattern, the nursing literature has documented a wide variety of emotional responses as well as several different ethical phenomena that might cause them.

One of the first people to consider the possibility that moral distress can give rise to different emotions was (again) Jameton himself. In the paper on second order "dilemmas" of moral distress referred to above, he says:

> We should distinguish between two forms of distress: initial and reactive distress. Initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values. Reactive distress is the distress that people feel when they do not act upon their initial distress (1993: 544).

Though he does not identify specific feelings involved in "reactive" distress, he does suggest that any 'reactive' emotion will differ from the feelings of frustration, anger and anxiety that characterize "initial" distress (perhaps he thinks 'distress' is the right term for the feeling involved in the reactive case only). Yet Jameton's instinct was to treat both "forms" as arising from the same ethical phenomenon—namely, the presence of some institutional constraint, suggesting that the arousal of different emotions is the only way to fully distinguish between them. The term "moral residue" has since been adopted to refer to what Jameton called "reactive distress" (Webster & Baylis, 2000), and Elizabeth Epstein and Ann Hamric have documented a further "crescendo affect" on nurses' emotions when institutional constraints persist. This includes, "a numbing of moral sensitivity and withdrawal from ethically challenging patient situations; conscientious objection (citing objections in patient's chart, challenging the ordering physician, calling another physician to over-ride the original physician's order), and finally burning out, leaving the position or the field altogether" (2009: 10). Mary Corley's review of the literature provides an even longer list of emotional responses, finding that moral distress has been "manifested as anger, frustration, guilt, loss of self-worth, depression and nightmares, as well as by physical symptoms that nurses carry into their personal life" (2002: 642).

By contrast, Fourie's instinct is that forms of moral distress are more properly explained by the differing ethical phenomena which give rise to them. In other words, moral constraint distress will be characterized by one (set of) emotional response(s), while moral conflict distress will presumably be characterized by a different one (2015: 97). This is in keeping with an earlier suggestion by Judith Wilkinson, who noted that moral outrage arises when nurses believe other people are performing wrong actions, whereas moral distress only occurs when nurses understand themselves to be directly involved in some form of wrongdoing (1988: 24). Her approach treats each judgment as a distinct ethical phenomenon. And this line of thought been echoed by Epstein & Hamric, who argue that distress can only be moral when it involves "violation of [the nurse's own] core values and duties" (2009: 2). In a similar vein, Tessy Thomas and Laurence McCullough (2015) have developed a taxonomy of moral distress as arising from one of six possible ethical phenomena: (i) challenges, (ii) threats or (iii) violations to a person's professional integrity, and (iv) challenges (v) threats or (vi) violations to individual integrity.

I have presented these two explanations as significantly more independent of one another than the nursing literature itself suggests them to be. The actual empirical data suggests both that multiple emotions may be associated with a single ethical phenomenon, and that more than one ethical phenomenon may correlate with a single emotional response. In simplifying my presentation, I do not mean to discount the empirical complexity, and I do not think this complexity makes the underlying philosophical problem any less interesting. In fact, I think it reveals a third possibility

that has yet to be fully explored—namely, that moral distress is in fact a compound phenomenon that is equally philosophically complex. While there will inevitably be some overlap among cases, this suggests that moral distress will manifest differently in every individual.

To illustrate, recall the nurse in my third example who did not like being in a situation where she both felt helpless and had to do things she thought were wrong. Though it is unclear whether she understands her feeling as a response to the overall situation or as one that is 'caused' by her thought, this nurse's decision to get out of nursing does seem to be based on the hunch that being "helpless to do anything for the patient" is the actual causes of her distress. But what exactly does being helpless mean in this context? To ask this question is not just to engage in abstract philosophical speculation. After all, leaving the profession won't change the reality that the patient she is working with right now is—like many others—experiencing painful symptoms for which there may be no good treatments. And neither will it change her judgment that the health care system often treats patients in this circumstance in ways that are morally wrong. Perhaps removing the situational trigger is all she needs to find some relief (though if this turns out to be true, it implies that moral distress will continue to have a negative effect on nurses' persistence through long careers). Nonetheless, it seems highly unlikely that this kind of avoidance will really make her "feel better" unless it is accompanied by some sort of change in her worldview. For without such changes, she will still have all the same reasons to be distressed about the limitations of patient care in general, not to mention her own relative powerlessness in the face of suffering and death. And she might also be dismayed to discover that she is not the compassionate or caregiving person she had previously understood herself to be. It is only by asking the question about 'helplessness' that we can really begin to appreciate these further implications.

In raising these possibilities, my point here is not to suggest that she definitely ought to think or feel one way or another (though helping the nurse adjust her worldview in ways that are both philosophically sound and enable her to "live with" herself is the general goal a philosophical counselor would pursue). Nor do I mean to suggest that the nurse has deliberately chosen to think and feel in the way that she does; many of the beliefs and values underlying the nurse's understanding of both herself and the health care world may well be implicit, or unexamined, rather than consciously endorsed. What I am suggesting is that her distress need not be conceptualized as the result of some unconscious psychological mechanism separate from the nurse's self-understanding. It seems at least equally possible to make sense of moral distress as a feeling that contains (or simply is) a judgment, rather than one that is caused by a specific kind of thought.

To conceptualize moral distress in this way is to treat the emotions that constitute its various forms as normative judgments in their own right. This is an approach with a long philosophical history (cf. Solomon 1977; Nussbaum 1994; Raabe 2000). It is in keeping with Jameton's earliest definition, suggesting he was correct to present distress as a "moral problem" that parallels uncertainty and dilemmas. It also helps to explain findings of a "moral residue" that lingers even after the specific situation has ended. And it is compatible with the empirical data suggesting that moral distress can manifest in many different "forms," though on my understanding, identifying common "forms" is likely to be less useful than understanding the unique particulars of any distressed individual's moral worldview.

In a 2016 paper, Stephen Campbell and colleagues have argued for an expanded definition of moral distress as involving "one or more negative, self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable" (Campbell *et al.*, 2016a: 6). In response to researchers who focus more exclusively on the emotional character of the distress, they note that a person "must perceive her involvement in a morally desirable situation to be itself morally undesirable for her" in order for the distress to be distinctively 'moral.' And in response to researchers who emphasize the 'ethical phenomena' believed to cause that response, they point out that "emotions or attitudes are essential to capturing the 'distress' part of moral distress" (Campbell *et al.*, 2016b: W2). To be sure, Campbell *et al.* still use the language of emotional 'response.' But their emphasis on agents' perceptions points to the possibility that the myriad forms of moral distress documented within the nursing literature will all turn out to be direct expressions of "the different ways people conceive of themselves and the situations they face" (Raabe 2000: 63). This suggests that moral distress is indeed a philosophical problem, and one that philosophical counselors can help nursing professionals treat.

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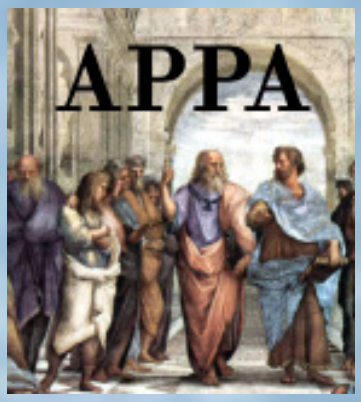

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