Moral distress is an umbrella concept that describes the psychological, emotional and physiological suffering that may be experienced when we act in ways that are inconsistent with deeply held ethical values, principles or moral commitments. The philosopher, Andrew Jameton [1, 2], first coined the term, moral distress, in his book on nursing ethics, published in 1984 in order to articulate what he saw to be the case among the nursing students that he was teaching; that the nursing role is morally constrained in a significant way. Jameton’s original account of moral distress focussed on the way in which institutional policies and practices can lead nurses to do things that they believe to be morally wrong. Since then, various accounts of moral distress have been developed along with a range of empirical tools to identify the sources of moral distress and to measure and assess its impact on nurses as well as other health professionals.

Nursing Ethics has had an important role to play in the dissemination of research on moral distress. From January 1995 to December 2012, thirty-two articles published in the journal address the topic of moral distress in a significant way. Of these, three articles take a philosophical and methodological step back to analyse the concept of moral distress and critique the empirical research in the area.[3-5] One additional article interrogates the concept of ‘moral distress’ in relation to the concept of ‘moral stress’ and draws tentative comparisons between the former and the latter.[6] Twenty-four articles concern qualitative [7-18] and quantitative research [19-30] on moral distress and four literature reviews directly, or indirectly, overview the research on moral distress.[31-34] For this Special Issue of Nursing Ethics, I have included a range of these articles that, I think, represent the broad canvas of thinking and research on moral distress.

The three theoretical articles on moral distress as well as the account of the related concept of moral stress have been republished in this Issue precisely because there is a dearth of theoretical work that unpacks the concept of moral distress and critically considers empirical research that delineates and measures it. It is worth taking the time to read and reflect on each of these pieces of writing.

Firstly, Corley’s ground-breaking research on moral distress, based on Jameton’s original definition, is well known but scholars in this area should also be familiar with her 2002 article[3] which proposes both a theory of moral distress as well as suggesting an agenda for further research in the area. A highlight of Corley’s article is the Model of Moral Distress visually represented on page 644 where she draws the parameters of her account of nurses’ moral distress and its impact on nurses and organizations.[3]
While Corley’s article focusses on theory development, both McCarthy and Deady[4] and Repenshek [5] take a critical view of existing accounts of moral distress. In particular, the former trace the evolution of the concept of moral distress back to philosophers Aristotle and Williams and raise concerns about the lack of clarity in the way in which the concept of moral distress is deployed in nursing research.[4] Similarly, Repenshek takes issue with Jameton’s definition of moral distress. He argues that it is important to distinguish between genuine instances of moral distress where nurses may feel compelled to act in ways that undermine their professional integrity and instances of moral discomfort where nurses’ own subjective beliefs about what ought to happen, does not come to pass.[5] Finally, Lützen et al [6] also interrogate Jameton’s conceptualization of moral distress and propose that greater attention should be given to the ethical dimensions of the experience of moral distress. They suggest the deployment of the concept of moral ‘stress’ instead of ‘distress’ as one means of achieving this.[6]

The empirical research published in Nursing Ethics considers moral distress in diverse healthcare settings including critical, general, neonatal, pediatric and psychiatric hospitals, pharmacies and military war zones and in many different countries and cultural contexts including Canada, China, Iran, Italy, Japan, Malawi, UK, US and Sweden.

The authors of four of the twelve qualitative studies published in Nursing Ethics since 1995 pay particular attention to the implications of their findings for advancing our theoretical understanding of moral distress and it is for this reason that I include these articles in this issue. Liaschenko’s 1995[13] article was the first to engage with the concept of moral distress in the journal and it continues to be relevant to researchers today. Her account links moral distress with the notion of the nurse as ‘an artificial person’ because ‘[t]he work of nursing is embedded in complex institutions and networks of power, in which nurses must act on decisions made by others. [13]p.187 Secondly, Fry’s 2002[9] account of moral distress highlights the moral labour of nurses working in the military services and, also, offers a Model of Moral Distress that can, arguably, be applied to other healthcare and occupational settings. Thirdly, Begley and Piggott’s 2012[7] study also makes an original contribution to research on moral distress. It draws on Aristotle’s notion of akrasia, or, weakness of will, in order to clarify the distinction between moral distress and moral stress. It also extends research on moral distress to consider the experiences of patients and relatives who must make hard ethical choices and who can suffer moral distress and stress as a result.

Finally, Varcoe et al’s 2012[18] account of the responses of 292 registered nurses to three open-ended questions in a survey that they carried out identified a number of systemic factors that lead to moral distress including; workload/overload, lack of competency of self and others, witnessing unnecessary suffering and moral compromise. What is of particular interest is that this study pays close attention to the responses of nurses to the experience of moral distress and their description of the impact of moral distress on patient care. In the majority of cases, the authors note that nurses responded positively and actively to morally distressing situations and they suggest that moral distress should not be viewed as an ‘inability to act’; rather, it should be seen as a ‘relational concept that takes into account the contexts of practice and power dynamics’ [18] p.497 within which nurses must make decisions. (See also Pauly et al 2009[25] article for the rest of the results of the survey.)
The quantitative research on moral distress published in Nursing Ethics is as varied as the qualitative studies. I include four of the possible twelve articles in this volume to indicate the breadth of the research to date. Corley features again in this category as the Corley et al 2005[19] article identifies a relationship between medico-surgical nurses’ experiences of moral distress and the nature of the ethical environment within which they work. This article also charts the reasons for the modification of Corley’s original Moral Distress Scale (MDS) from a 32-item to a 38-item scale.

Ohnishi et al[24] and Lazzarin et al [22] adapt and translate Corley et al’s MDS in order to measure the experiences of nurses working in psychiatry and pediatrics. Ohnishi et al[24] developed the MDS-P to examine the moral distress of Japanese psychiatric nurses (n=289). Their findings suggest that Japanese nurses confront moral distress more frequently but with less intensity than their US counterparts working in critical care. However, the item with the highest intensity score in both Corley et al’s [19] and Ohnishi et al’s [24] studies pertains to unsafe staffing levels suggesting that staff shortages are a universal trigger of moral distress. Lazzarin et al [22] developed the MDS-PV to examine the moral distress of Italian nurses working in paediatric oncology and haematology wards (n=182). One finding of interest in this study is that 13.7% of the sample indicated that they had left their previous employment for moral distress reasons. This is consistent with Corley’s earlier work on MD[35] though Corley et al’s later study published in this volume puts the figure at 25.5%[19].

Sporrong et al’s[27] article is included in this volume, in particular, because their mixed-method study aimed to construct and validate an instrument that could measure moral distress among a wide range of healthcare workers. The questionnaire that they developed, on the basis of three focus groups with relevant stakeholders, included two factors: level of moral distress and tolerance/openness towards moral dilemmas. It was completed by 200 staff in clinical departments (e.g. nurses, physicians, auxiliary nurses) and 59 staff in pharmacies (e.g. pharmacists, pharmacy assistants). What the authors of the study share with other authors published in this volume is the insight that levels of moral distress are related to the ethical climate of healthcare organisations (e.g. Corley et al[19]; Liaschenko[13], Varcoe et al[18]). (See also Sporrong et al[28] for a related study involving an educational intervention to reduce moral distress.)

Finally, two literature reviews are also included in this Special Issue. Schluter et al’s [33] 2008 review (1980-February 2007) is of particular interest because it critically considers the link between unresolved moral distress, ethical climate and nurse retention. The review indicates that the causes of moral distress are poor-quality care and futile care; unsuccessful advocacy and the provision of unrealistic hope to patients and families. It suggests that moral distress affects the physical and mental health of nursing staff, the quality of nursing care, job satisfaction and nurse turnover. Burston and Tuckett [32] 2012 review (1982-2011), while differently structured, suggests similar sources of moral distress and confirms Schluter et al’s conclusion that moral distress impacts on nurses’ health, quality of care and staff retention. Burston and Tuckett [36] also provide a useful summary of suggested interventions to alleviate nurses’ moral distress. These include interprofessional ethics education and discussion forums, critical self-reflection, mentoring schemes, peer support and improved communication with patients and families.

All of the articles published in this Special Issue of Nursing Ethics indicate that moral distress is an issue of concern for nurses and other health professionals around the world. While the theoretical articles included indicate that the way in which moral distress is defined and operationalized in
empirical studies is problematic, nevertheless, the empirical research and literature reviews that are also published in this issue indicate some consensus in relation to the factors that contribute to moral distress and its impact on nurses and nursing care.

One important insight that emerges from the research to date is that there is a relationship between the experience of moral distress and the nature of the work environment. Readers interested in this train of thought would also do well to consider a special issue of HEC Forum that includes publications emerging from a recent symposium on moral distress in British Columbia, Canada.[36-40] Their core message, a message that I think ought also be taken from the articles published in this Special Issue, is that moral distress should not be seen as, solely, an individual problem nor, solely, an institutional problem – it is not about blaming the individual or blaming the system. Rather, what research on moral distress highlights is the significance of the relationship between individuals and organisations. The work of feminist philosopher, Margaret Urban Walker, is helpful here. She points out that ‘[i]f moral orders are often, in fact, complex networks of different positions, people need to understand who they are, and where they are, in these orders, to see what in particular they are responsible for, and to whom.’[41] p.100 In short, moral distress prompts questions about the construction of moral authority, the assignment of responsibility and the processes of accountability.

In this regard, I am reminded of Arthur Frank’s Thirteen Steps of the Recovering Care-giver which he has kindly agreed can be included in this editorial.[42] Frank himself describes them as ‘provisional resolutions, offered for dialogue and revision by professionals who feel a need to reflect on what care means in their lives and their conditions of work’[42]. I see them as tools of reflection that can be used as part of an educational intervention to reduce moral distress:

1. Any expertise or skill I offer is based, first and last, on offering my presence as a fellow human being.

2. My words and gestures, and the attitudes I project through my actions, affect the healing of my patients, the morale of my co-workers, and the moral self I become.

3. I am responsible for how I offer care, but I do not work in conditions of my own choosing.

4. I forgive myself for doing what my working conditions require, but forgiveness requires working to change whatever is detrimental to care.

5. If I ever feel my work is out of my control, then I have ceased to be an effective professional and need either a day off, or to lead a protest, or both.

6. I refuse to blame patients when their troubles reveal inadequacies of either professional institutional capacity to care or professional ability to treat.

7. I will recognize who — patient, co-worker, or myself — pays what price in which currency — money, time, physical risk, dignity — to keep the institution running.
8. I will ask myself: By telling or not telling a truth at this moment, whom is that serving?

9. I refuse the self-defense of blindness to the gap between my patients' needs and what care I can offer.

10. When I reach the limit of my ability to provide care, I will recognize what remains uncared for and offer appropriate expressions of regret.

11. Faced with patients or co-workers whom I find difficult, I will first ask myself what difficulties they confront, and how they are struggling to hold their own. If recognizing their struggle fails to bring resolution, I will protect myself.

12. I will never forget that any person's suffering is every other human's vulnerability, including my own.

13. I will seek, in each person, what is most admirable, enjoyable, and soulful. I choose to respond to these qualities with what is best in me.[42]

To conclude, the story of moral distress, as it unfolds in *Nursing Ethics*, reveals moral distress as a complex and contested concept which draws attention to the moral labour of nurses and other health professionals, highlights the way in which responsibility and authority is divvied out in healthcare settings and acknowledges the role that emotions play in having a moral life and being a moral agent. I invite you to read the articles included in this Special Issue and to continue the story through your own reflections and research.

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January 2013