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Living with conflicts-ethical dilemmas and moral distress in the health care system

Sofia Källemark^{a,*}, Anna T. Höglund^a, Mats G. Hansson^a,
Peter Westerholm^b, Bengt Arnetz^a

^aDepartment of Public Health and Caring Sciences, Uppsala University, Uppsala Science Park, Uppsala S-751 85, Sweden

^bThe National Institute for Working Life, Arbetslivsinstitutet, S-112 79 Stockholm, Sweden

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Abstract

During the last decade, the Swedish health care system has undergone fundamental changes. The changes have made health care more complex and ethics has increasingly become a required component of clinical practice. Considering this, it is not surprising that many health care professionals suffer from stress-related disorders. Stress due to ethical dilemmas is usually referred to as “moral distress”. The present article derives from Andrew Jameton’s development of the concept of moral distress and presents the results of a study that, using focus group method, identifies situations of ethical dilemmas and moral distress among health care providers of different categories. The study includes both hospital clinics and pharmacies.

The results show that all categories of staff interviewed express experiences of moral distress; prior research has mostly focused on moral distress experienced by nurses. Second, it was made clear that moral distress does not occur only as a consequence of institutional constraints preventing the health care giver from acting on his/her moral considerations, which is the traditional definition of moral distress. There are situations when the staff members do follow their moral decisions, but in doing so they clash with, e.g. legal regulations. In these cases too, moral distress occurs. Hitherto research on moral distress has focused on the individual health care provider and her subjective moral convictions. Our results show that the study of moral distress must focus more on the context of the ethical dilemmas.

Finally, the conclusion of the study is that the work organization must provide better support resources and structures to decrease moral distress. The results point to the need for further education in ethics and a forum for discussing ethically troubling situations experienced in the daily care practice for both hospital and pharmacy staff.

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Introduction

During the last decade, the Swedish health care system has undergone fundamental changes. New

evidence based medicine and health care quality certification programs have been implemented alongside the development of advanced biomedical techniques. Organizational reforms have been carried out in order to make health care more efficient, often including elements of competitive inducements between health care providers. A more educated population and changes in values have increased the consumer demand on health care services (Forsberg, 2001).

*Corresponding author. Tel.: +46-706-335536; fax: +46-185-06404.

E-mail address: sofia.kallemark@apoteket.se (S. Källemark).

The changes have made health care more complex and ethics¹ has increasingly become a required component of clinical practice. Demands on first-line professionals, i.e. doctors, nurses and auxiliary nurses, to make decisions concerning priority-setting in their everyday work have resulted. Not only do they have to consider what is best for the present patient, but also consider the future patient's needs and questions of social economics.

Despite the increasing demands for qualified ethical judgements the health care organization often lacks standardized policies for guidelines as well as systematic education in ethics and structures of ethical support for their staff members who are to carry out the decisions. Considering this, it is not surprising that many health care professionals suffer from stress-related disorders. Several studies have shown how fundamental changes in the health care organization have added new stressors to the medical profession. Arnetz (2001) has identified several stressors facing physicians as part of their medical practice. Most stressors identified are psychosocial in their origin, such as workload, unsatisfying tasks, lack of skill development and lack of clear work directives from the immediate supervisor. According to recent studies ethical dilemmas can also cause stress-related disorders among health care professionals (van der Arend & Remmers-van den Hurk, 1999; Raines, 2000; Corley, Elswick, Gorman, & Clor, 2001). Stress related to ethical dilemmas is usually referred to as "moral distress". A well-established definition of moral distress is that it "occurs when one knows the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action" (Raines, 2000, p. 30).

In this article, the results of an investigation concerning the views of health care professionals themselves on what kinds of situations involve ethical dilemmas are presented. Building on Andrew Jameton's definition of moral distress (Jameton, 1984, 1992, 1993), an analysis of whether these ethical dilemmas could also be considered as creating moral distress among health care professionals of different categories is undertaken. Unlike previous studies on moral distress, which have often focused upon the work situation of the nurse, this study covers health care in a broad perspective and includes both hospital clinics and pharmacies.

¹According to the conventional definition, morality refers to personal opinions of good and bad, right and wrong, and ethics to the theoretical reasoning over morality. In this article we mainly follow this distinction, but since the concepts often overlap both terms could sometimes be used.

Background

Stress related to ethical dilemmas, or moral distress, has been discussed particularly in relation to nurses. According to Raines (2000) the impact of ethical issues in nursing practice in the United States has increased tremendously during the last decade. Nurses in almost every practice setting spend increasing amounts of their time resolving ethical dilemmas, as well as experience more stress in dealing with ethical conflicts. The trend has continued despite efforts by health care institutions and professional organizations to standardize policies relating to ethical issues in health care.

Job satisfaction instruments for doctors and nurses have often included items of moral value. For example, Berger, Seversen, and Chvatal (1991) measured the frequency of encountered ethical dilemmas among nurses and the degree to which they were disturbed by them. According to Corley (1995) no instrument had until then been developed specifically to measure levels of moral distress. To fill that gap, Corley et al. (2001) developed the moral distress scale (MDS) to measure moral distress as an element of job stress in nursing. When applying this, Corley and co-workers found that 69% of the nurses in their study sometimes had to compromise their values, due to hospital policy or standards, a physician's request or nursing administration requirements. They were also sometimes forced to act against principles, as ethical guidelines (and in some cases even legal requirements) were impossible to carry out because of organizational constraints, such as lack of resources or lack of power (Corley et al., 2001).

Raines (2000) developed a model for stress related to ethical dilemmas: the ethics stress model. The model is an adoption of Wilkinson's (1987/88, 1989) studies of moral distress and describes the relation between moral reasoning, coping style and the amount of stress experienced in ethical decision-making situations in nursing. Raines' study shows that the most frequently experienced sources of moral distress for oncology nurses were pain management and cost containment issues (Raines, 2000). Wilkinson (1987/88) had earlier identified three major types of ethical issues causing moral distress among nurses, namely situations involving prolonging life, performing unnecessary tests, and the desire to tell the truth. Rodney (1988) found that critical care nurses experienced resentment, frustration, and sorrow when they were unable to act on their moral choices.

Theoretical framework

The present research derives from Jameton's (1984, 1992, 1993) concept of moral distress in nursing. A basic assumption is that health care professionals hold values

in their work and strive to deal with ethical dilemmas when they arise in their work environment. The principle starting point is that moral distress could not be studied adequately without taking philosophical concerns, concerning the concept of moral distress, seriously. Moral distress is therefore studied from two angles: the moral/ethical perspective and the stress perspective.

Jameton has studied moral distress primarily among nurses. He identifies moral distress as painful feelings that occur when because of institutional constraints the nurse cannot do what he/she perceives as morally correct and necessary. The distress is based on a perception of moral responsibility and relates to a perception of being individually responsible but restricted by circumstances. In nursing practice, Jameton (1984, p. 6) distinguishes between:

- *Moral uncertainty*, arising when one is unsure whether there is an ethical dilemma or not, or, if one assumes there is, one is unsure what principles or values apply in the ethical conflict.
- *Moral dilemmas*, arising when two or more principles or values conflict. More than one principle applies and there are good reasons to support mutually inconsistent courses of action. Although it seems terrible to give up either value, a loss is inescapable.
- *Moral distress*, finally, occurring when one believes one knows an ethical dilemma is at stake and also the morally right thing to do, but institutional constraints make it impossible to pursue the desired course of action.

Jameton thus separates the nurse's experience of moral distress from her experience of moral dilemmas, although the distress is built upon the identifying of a dilemma; it does not occur in cases of uncertainty. Wilkinson (1987/88, p. 16), building on Jameton, defines moral distress as "the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision". The failure to follow through the decision is due to institutional constraints. In accord with Jameton, Wilkinson assumes that moral distress could not occur in a state of uncertainty; on the contrary, the distress is a consequence of a severe moral dilemma, when the rightness or not of different courses of actions has been evaluated.

In an article from 1993 Jameton brings in yet another distinction, namely between *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 (Jameton 1993, p. 544).

Initial distress is caused by bureaucratic obstacles and/or disagreeable colleagues. According to studies performed by Jameton and Wilkinson, nurses express a variety of strategies for coping with these situations, such as trying to influence the physician, call in the head nurse, submit an incident report or discuss the problem with the medical head of the unit (Jameton, 1993; Wilkinson, 1987/88). If these strategies are not successful the *reactive distress* results. Depression, nightmares, headaches and feelings of worthlessness characterize this form of distress. Some studies have indicated that chronic reactive distress contributes to burnout and the decision to leave nursing (Jameton, 1993; Fowler, 1989).

Following Jameton and Wilkinson the accepted definition of moral distress could be as follows:

Traditional negative stress symptoms, such as feelings of frustration, anger and anxiety, which might lead to depressions, nightmares, headaches and feelings of worthlessness, that occur due to a conviction of what is ethically correct but institutional and structural constraints prevent the desired course of action.

Given Jameton's and Wilkinson's definitions it is not surprising that studies of moral distress have usually been conducted on nurses. They are the ones assumed to be unable to act on their beliefs as they are not the highest in rank in the hospital organization and do not take the final decisions concerning patient care. This research measures moral distress among health care professionals in a broader perspective, including nurses, doctors, auxiliary nurses and pharmacy staff. The central questions are: What kind of situations do health care providers themselves consider involve ethical dilemmas? Do they experience stress in connection with these dilemmas? Is moral distress limited, as it has hitherto been defined, to situations where the health care giver knows what is ethically correct but is prevented from acting in that direction?

Method

To identify situations of ethical dilemmas and moral distress focus group interviews were carried out. The idea that group processes can help people explore and clarify their views in new ways seems to lay behind every definition of the method. All definitions centre on the use of interaction among participants as a way of accessing data that would not emerge if other methods were used (Webb & Kevern, 2000).

There are also difficulties associated with the focus group method. It involves group dynamics that might be

difficult to manage and communication and interaction within the group might imply that everybody's personal view is not expressed due to, e.g. power imbalances and tensions within the group. The investigation was conducted in a way that sought to avoid these methodological dilemmas.

The present study included focus groups in a clinical department of cardiology, a clinical department of haematology and a pharmacy, all located in the region Uppsala/Stockholm. In each group 5–7 persons participated, in the clinics consisting of physicians, nurses, auxiliary nurses and medical secretaries, at the pharmacy consisting of pharmacists, dispensers and pharmacy assistants. The participants were chosen by a contact person on the clinic/pharmacy who was asked to form a group of people with different occupations, background, age, gender and work experience.

Two researchers were present during the interviews, one as moderator/facilitator and one responsible for documentation. The sessions lasted from one and a half to 2 h. The interviews were recorded and transcribed. One of the researchers also made notes during the sessions. A question guide was designed to cover different aspects of ethical dilemmas in general and moral distress in particular. All questions were followed up by discussions in the group and/or additional questions from the moderator.

Results

Below the results of the focus group interviews are presented and categorized. The statements were analysed and categorized from the point of view of the interviewees. The categories were deduced from statements dealing with ethical questions and particularly those that are associated with stress. Many of the situations that are described could be assigned to more than one category.

- Resources:
 - Lack of time/staff: The present patient versus the future patient.
 - Lack of time/staff: The patients versus administrative work.
 - Lack of beds—choosing between patients.
 - Economic concerns.
- Rules versus praxis:
 - Difficult (impossible) to act according to guidelines.
 - Voluntarily breaking the rules.
 - Forced to act according to regulations.
 - Justifying breaking the rules.
- Conflicts of interest:
 - Patient's integrity, professional secrecy.

- Professions relations—conflicts in values and hierarchy.
- Patients versus colleagues.
- Lack of supporting structures.

Resources

Many of the situations involving ethical dilemmas that were reported in the focus groups seem to occur due to the lack of resources. Resources can, of course, be basically understood as financial resources, a question of how much money is allocated to the clinic/pharmacy and how it is spent. Below, the question of resources is split into four categories, based upon how the staff interviewed chose to describe them.

Lack of time/staff: The present patient versus the future patient

Many dilemmas seem to occur due to the lack of time or personnel being forced to prioritize their time between tasks that seem equally important. If there is a patient to attend to immediately, the time and effort spent on that patient will have consequences for other patients. Many encounters between health care personnel and patients are supposed to last a certain amount of time, and spending “too much” time with one patient means that others will have to wait. The patient may be waiting in a queue for an operation, or something should be prepared for a patient who will come in later. It is easy to prioritize the patient who is present, as that person's needs are evident. The informants are well aware of this:

We prioritise the customer who's at the counter right now, but not the customer we know will come in within two hours time (Pharmacy staff).

You feel you don't have time to show them around, as you would like to do. It's just “hello” and then you go to the next one. And maybe they have waited for a very long time; I might have taken some samples and informed them on what I'm going to do. That takes maybe five minutes or a quarter of an hour; and then they have to wait another couple of hours until a doctor has time to talk to them. And then maybe another couple of hours until they can go to some preparatory examination... (Nurse)

...some patients are summoned and then they are cut out from different programs and they don't get the information or the treatment at the time they were promised... (Doctor).

Lack of time/staff: the patients versus administrative work

Health care personnel have many tasks to fulfil and meeting patients is just one of them. The administrative workload is heavy, as experienced by participants in the focus groups. Nevertheless, all informants seem to share

the opinion that the patients ought to be the focus of the job and expressed in many ways the frustration they felt when they could not live up to their own standards.

You realize you ought to call and have contact with your patients more than is possible. That, I think, is a constantly bad conscience. ... You would feel better if you had the time to call them once in a while, to see if everything is all right (Doctor).

Sometimes it feels as if we don't have time to have any patients, actually. And then I wonder: What are we doing here? That's the reason why we are here: to take care of the patients. And then we never really have the time! (Nurse)

In my opinion the administrative work requires more and more space. ... In my experience it takes more time today than it used to... (Nurse)

I don't experience that the problem occurs when I actually have my patients... [The problem] is when I don't have the time for them. Everything else takes so much time. That is the problem (Doctor).

There are a lot of things we have to do, in order to make our organization work, which are not directly related to the patients. We have...research...education and administrative work that we must do for different reasons, you can't be in this business otherwise. ...But sometimes I feel that this is not what I prefer to do. Much of the documentation we do is very time-consuming (Doctor).

Being aware of the lack of staff has consequences:

To report sick is hard. I know the consequences if I don't turn up. Consultations must be cancelled so you'll have to call a lot of patients to tell them we can't make it. Maybe they have left home already, travelled far and then they have to go back again. Another colleague may have to do surgery, and thereby will work double, without lunch or other breaks, and stay after work, just because I'm at home. That doesn't feel good (Doctor).

Lack of beds—choosing between patients

The informants report situations where they are not able to offer the care they think the patient is entitled to. A very explicit example is when there are more patients in need of a bed than there are beds available. To be forced to choose between individuals who are all in need could be perceived as unethical.

That is something that you can feel stressed about and you feel...feel terrible towards the patient because of it; that is, when you can't offer someone a hospital bed. ...They can be ever so ill and you can't offer them what you really think they need (Doctor).

What puts us under stress down here is that we don't have enough beds, as we see it. When a patient

arrives here the clinic is often full...and then you suddenly have to prioritise what patient is most fit...to lie somewhere else. Sometimes it will be in the corridor, sometimes in an examination room. But it's often fast decisions that can be stressful (Nurse).

One way of coping with this dilemma is described by a doctor:

When we treat a patient, we do it well. I think it's better to do it well with that patient and let someone else wait for a while. And we always prioritise those who are acutely ill, I think. ...Even if it isn't good for the one who is less acutely ill to have to wait the patients understand, if they are properly informed, that others are worse off (Doctor).

Economic concerns

As mentioned above, almost all lack of resources can be interpreted as a lack of money. However, in the focus groups the participants talked more often about lack of other resources than money as such. When discussions came to money, it was primarily about how authorities at higher administrative levels make their decisions and about salaries for health care staff.

You have a hard time trying to grasp this, when it comes to money. That staff cost so much, when you look at everything else... Rebuilding...computers ...moving about clinics...What money that costs! (Nurse)

But that is not the same account (Doctor).

No, but it's money anyway! (Nurse)

If you should plan the content of health care; what we do, whether we treat the right patients, in the same precise way as you do when it comes to keeping within the budget and what we use money for, then we surely would have some other content in what we do. But that is not prioritised. ... We don't take the time to do that (Doctor).

But on some occasions, economy is mentioned as the reason why making a certain decision in a situation creates a moral dilemma.

Some patients do not receive optimal care because of economic reasons. We don't give patients the more expensive medicines they ought to have according to national and international guidelines, because we find them too expensive. This is both right and wrong. It's wrong in relation to that particular patient, not getting the medicine we believe in. But at the same time we are forced to make some sort of economic prioritisation, too. We know that if we give too much of this medicine we will have to cut down on something else (Doctor).

Another issue that came up in all the focus groups, i.e. in both pharmacies and hospital clinics, was the patients' lack of money. Most care requires the patient to pay a fee even if it is much lower than the actual cost. But some patients (e.g. illegal immigrants and tourists) are not incorporated in the social security system, which could place staff in a situation where they have to deny patients care for economic reasons.

...those who can't pay. When you actually know, to be honest... They don't have any money to pay for the visit (Doctor).

This aspect will be further developed under the breaking-the-rules-category below.

Rules versus praxis

Some of the quotations in the former categories are also relevant to those presented in the following. The fact that documentation takes time depends on the regulations for documentation; that is, if personnel actually do what they are told to do. To say that patients cannot afford treatment is also only true if they are actually charged as they are supposed to be.

In this category examples are given of situations when, in the focus groups, staff are specifically referring to regulations. The problems in this area are mainly three:

- it is difficult or impossible to act according to regulations/guidelines, or
- breaking a rule because of moral conviction is not legally admitted,
- an action is perceived as morally right, but is difficult or impossible because of, for example, administrative routines.

Difficult (impossible) to act according to regulations and guidelines

In the first example the nurse has to choose between the doctor's order and a regulation implying that patients are not supposed to lie in the corridor. She has no choice but to go against one of these regulations and so it is impossible for her to act "legally". She has to break a rule.

And then we treat patients illegally when we put them in corridors or lavatories. You do that, don't you? (Doctor)

In that case we break the rules every day (Nurse).

When I call and say that now I have another patient, and you say that you don't have a bed, are you then to go against my instruction or violate the law which says you mustn't...? (Doctor)

Well, then I violate the law, of course, because there's someone who is sick (Nurse).

In times of scarce resources prioritization is necessary. According to the national guidelines in Sweden doctors are not allowed to prioritize on the basis of age.

And then The National Board of Health and Welfare doesn't allow us to have an age limit. We can't say someone is too old to have a certain treatment, whether it is heart transplants or something else. You can't use it as an argument for not giving them every treatment. But of course we do. We don't say that the patients are too old, but you try to justify it through...in that age it's too risky or complicated. ...It can't be reasonable to put so much resources, both personnel and financial, and discomfort for the patient, after a certain age. Even if it may be technically possible (Doctor).

Voluntarily breaking the rules

Many examples were given of situations when rules and regulations were broken. In almost every case there was a conflict between the regulation and what the personnel saw as best for the patient.

We do break the rules sometimes. One person came in and had an attack of asthma but no prescription. And then you feel "oh, my God!" ...I gave her the medicine.

And I had someone who needed nitro-glycerine acutely. But in that case, it was not worth hesitating. You just have to [deliver it] (Pharmacy staff).

We have patients that are not supposed to attend here. ...Both those who cannot attend because they don't belong to [this county]...or patients who come from another country and aren't really entitled to get this, reimbursed and so on. We have treated them anyway (Doctor).

And then we have those who come and ask for medicines. They can't afford to get them and we know that if we don't give them an injection they will not have any. On those occasions we are kind [to them] (Nurse).

It's hard to find examples where we go against regulations, but at the same time you can construe them differently. We do give medicines and treatments that are not always approved by The National Board of Health and Welfare or recommended or so. ...If I believe that this is good...for just this patient, then I will give it (Doctor).

Forced to act according to regulations

As we have seen the health care personnel admit sometimes breaking rules—by their own free will or because it was inevitable. But there are also examples of personnel wanting to break a rule but prevented from

doing so because of organizational concerns (in the case below meticulous book-keeping at the hospital).

There are other occasions, when it may be impossible to cheat on the system and follow your conscience. ...If it is hospital care with treatments that the patients can't afford, if they come from another country, then you can't act against the regulations. We've had things like that. And then you have tried...to get [the patient] out from the hospital as soon as possible. ...And then we tried to help via the phone, to relatives, and prescribe to the home, and check out how they were. It cost too much for them to get care at the hospital (Doctor).

Justifying breaking the rules

The previous examples show that rules are not always followed. But how do health professional justify their behaviour? When asked, they usually refer to the patient in front of them and to the needs of that patient.

You do it for the patient (Nurse).

You do it because it is more ethical in a humanitarian way (Doctor 1).

It would rather be worse for my conscience to do otherwise (Doctor 2).

We can't say we have a bad conscience about breaking the rules. We don't (Doctor 1).

What we do is to, on a small scale, help them who need help; even if they don't have the economical resources or social security or whatever it is... (Doctor 2).

If you only follow the regulations it becomes very simple. And very square, I think (Doctor).

Conflicts of interest

Several themes in the interviews concerned different forms of conflicts of interest. Below these conflicts are separated into three sub-categories, namely conflicts referring to the patient's integrity, conflicts due to hierarchies, professional relations and moral values, and finally conflicts concerning the relations between patients and colleagues.

Patient's integrity, professional secrecy

One of the biggest issues in health care provision is of course how to relate to the patient and his/her integrity. This is exemplified below through quotations about professional secrecy as well as decisions actually concerning the patient's life. In some cases routines as well as facilities affected how the informants felt they could relate to the patients.

We are like on a stage. And later on in the afternoon it is quite noisy in here and we talk louder and louder during the day, and in the end... Maybe we shout to someone: "Can you get me some Benzodiazepine?" And that's not nice, really. We disregard our professional secrecy. ...And I can feel a bit bad because I may reveal more than the customer would like the others to know (Pharmacist).

The fact that you can't give out information when there is a person who is an addict and goes to different doctors. ...And that, I think, makes me be feel bad (Pharmacist).

And with the diagnosis we have...and then you have half an hour or twenty minutes when all this is to be taken care of. ...You can't inform about everything in a very short time. What if they get to know that they have a cancer that is to be treated with cytotoxin and you just move on? (Doctor)

Professional relations—conflicts in values and hierarchy

The hierarchy between different professionals effects how a professional can act out her own moral position. Sometimes a person who is below in the hierarchy has to carry out orders from a superior against their own conviction. This could take place between different staff categories within the same organization, but it could also, as in the example pharmacist–doctor below, happen between categories that do not share the same employer.

Pharmacist–doctor

Another thing...is when we feel that the prescription isn't right. You check with the doctor maybe two times whether the dosage should be like this. He says yes, and we... In our experience it isn't a good dosage. We have tried to make him aware. It's the same thing when there are prescriptions from different doctors and you see that it's not good. The total situation for the customer isn't good. But what are you to do? (Pharmacist)

Doctor–nurse

We have heard nurses I think, quite often express that they think it happens too often that resuscitation is provided too long and that we don't decide early enough that this is not a thing we should do. ...I think we are keener on trying some more. We see the patients more as medical objects. ...They have seen more of them and in another way and they see that this is an old person who is ready to die (Doctor).

You give intensive care to patients that are very old, they can be almost 100. And then you do everything, they can't be allowed to die, so to speak, a natural death but you keep them alive as long as possible. And why? (Nurse)

Patients versus colleagues

Health care personnel are not only to be there for the patients, they are also involved in complex cooperation with other professionals at their clinic/pharmacy. There can be a problem with loyalties—would you risk a conflict with the colleague you see every day because of a patient who visits you for a short time?

We have developed a culture in which we should always be available, at every cost. ... We have ourselves said that it is high quality with a high availability. The result is that we have pagers now so we can be disturbed all the time, really. ... People can be upset when they know you have a pager and haven't answered. And you may have been sitting with a patient, telling him that he has a lethal disease or something like that. You can't run away from that, even though you have a tendency to do that, I'm sorry to say, too often (Doctor).

Lack of support structures

One theme discussed in the interviews concerned whether the workplace provided any organized support on ethical issues. There did not appear to be any form of organized way of discussing ethical dilemmas in any of the clinics/pharmacies studied. Typically, these issues were discussed during coffee breaks and in a very informal way. Only when serious incidents happened did the personnel at these clinics meet for more official discussions.

Well, not in an organized way, so to speak, but we may mention it ... but not that we sit down and reason about how it felt and how we could have done things differently or better. We've never done that (Nurse).

The pharmacy staff gave an example of a customer suddenly collapsing inside the pharmacy. Later they found out that he actually died:

A lot is discussed in the staff room.

Yes, it must come out, what you feel.

And sometimes we go behind and just sigh: "What a customer I had" (Pharmacy staff).

Discussion

The results show several situations where ethical dilemmas caused frustration and distress among all staff categories studied. The dilemma generally arises through the staff's experience of conflicting goals, primarily the interests of the organization versus the interests of a particular patient. The dilemma is often due to the shortage of resources and the relation between the care provider's own conscience and a complex health care reality.

Concerning the conflict between the time and work spent on patients in relation to time for administrative tasks, several of the informants express a form of what Jameton called reactive distress. They talk about "a constantly bad conscience" and hold that they "would feel better" if they had more time with the patients. They do not see the patients as the root cause of the problem. On the contrary, they hold that according to their conscience their prime task is to be there for the patients. Rather, it is the lack of resources, in this case, the lack of time that causes the dilemma. Even though the clinical staff mentions this problem more often, the problem also exists for the pharmacy personnel, who express frustration over the lack of time for the customers and a wish to spend more time with them.

Another situation where reactive distress is expressed concerns situations where there are more patients than beds at a clinic. In such a case the caregiver knows the morally right thing to do (take care of the needing and suffering patient) but organizational constraints could prevent him/her from carrying out this decision. The restrictions consist of either the lacking of resources (beds) or of an order not to break the regulations from a superior. It is important to note that even though health care providers experience this as lack of resources, it could also be that resources are not being utilized in an optimal manner.

Following Jameton's definition, these are all clear examples of moral distress. However, our study also shows that there are several occasions when moral distress occurs independently of the definition "the caregiver knows the right thing to do but is prevented from carrying it through because of institutional constraints".

The informants give several examples of how they strive to avoid moral distress through breaking the rules in their practice. In one of the clinics the doctors and nurses admit that they break the rules every day, as they place patients in corridors and lavatories. But by doing this they follow their conscience: "I violate the law, of course, because there is someone who is sick", as one nurse puts it.

The informants seem to be in a genuine dilemma: follow the regulations and act against your conscience, or follow your conscience and break the law, which in turn may lead to negative stress. This conflict is illustrated in Fig. 1.

According to Jameton, a nurse facing a moral dilemma and acting according to what she/he presumes is morally right would not create moral distress. In our study, however, the reality is shown to be more complex. This leads us to a revised definition of moral distress:

Traditional negative stress symptoms that occur due to situations that involve ethical dimensions and

| | <i>Legally right</i> | <i>Legally wrong</i> |
|----------------------|----------------------|----------------------|
| <i>Morally right</i> | Just do it | Moral distress |
| <i>Morally wrong</i> | Moral distress | Don't do it |

Fig. 1. Dilemma of moral distress.

where the health care provider feels she/he is not able to preserve all interests and values at stake.

This definition differs from the one given by Jameton in that it does not require the separation of moral dilemmas from moral uncertainty for moral distress to take place, and it is not dependent on the position held in the workplace hierarchy.

However, the results show how the fact that nurses have an obligation to carry out the physician's orders sometimes cause problems. On occasions, doctors and nurses seem to disagree because of their differing values, for instance continued treatment or ceased treatment for older patients. On other occasions pharmacy staff and doctors conflict in values and opinions. In the latter form it is often a disagreement about prescriptions.

Nurses, doctors and other staff members do not always agree on what constitutes a moral issue. This means that besides the conflict between the caregiver's commitment to the patient and his/her commitment to the organization can be a conflict in values between different staff categories. However, this could be due not only to different moral opinions but also to differences in knowledge and access to differing facts about the situation. Both these ethical conflicts could cause moral distress.

The health care staff gave examples of individual coping strategies in order to reduce the moral distress. The most frequent answer to the question of how to justify the breaking of rules is that it is done in favour of the patient, that it is humanitarian and that it would create even more bad conscience to do otherwise.

Given the fact that all the categories of health care professional studied report situations where there was moral distress, the question arises: does the hospital/pharmacy provide support to the professionals troubled by ethical dilemmas? Are there any support structures and resources to increase moral competence at the workplace? Corley (1995) raises questions about the impact of hospital policies and guidelines. Similarly in our investigation, guidelines and policy documents are not referred to very frequently in the interviews. Ethical dilemmas are, according to the informants, mostly discussed in coffee breaks and in other informal situations. What is most reported as lacking is education and a forum for discussing ethical dilemmas and sharing experiences. None of the studied workplaces reported any form of institutionalized ethics discussions. Neither education, nor ethical rounds (Hansson, 2002) was mentioned as being organized on a regular basis.

To reduce moral distress individual coping strategies are obviously not enough. We conclude that the focus must be upon work organization and management. Ethical judgements rarely refer to an individual person knowing certainly what is right or wrong. The process of ethical decision-making is much more complex. The reducing of moral distress is closely connected to work organization and its provision of support structures for ethical discussions. These can help health care providers to live with the conflicts and ethical dilemmas that will always occur in their day-to-day practice.

Conclusion

The conclusions are threefold: first, all categories of staff interviewed express experiences of moral distress. Therefore, the definition of Jameton and followers was revised, to make it clear at the conceptual level that this phenomenon is not related to one specific category of health care professionals.

Second, moral distress does not only occur as a consequence of institutional constraints preventing the health care giver from acting on his/her moral considerations. There are situations when the staff members follow their moral decisions, but in doing this they clash with e.g. legal regulations. Jameton and followers focused on the individual health care provider and her/his subjective moral convictions. Further, they assumed that she/he is aware of what is ethically correct and necessary in different situations. Our results show that the study of moral distress must focus more on the context of ethical dilemmas. Ethical judgements are seldom apprehended as clearly right or wrong by the individual.

Third, the health care organization must provide better support resources and structures to decrease moral distress. Primarily, a need for further education in ethics and a forum for discussing ethically troubling situations experienced in the daily practice of care has been shown. Realizing that there are different ways of reasoning in ethical dilemmas could help professionals to understand better their own process of ethical decision-making and create a greater readiness for related situations. Ethics rounds, with interdisciplinary participation, could be one strategy. Hopefully, such intervention strategies could help to identify ethical dilemmas earlier and increase the tolerance and respect for the moral perspectives of others, and thereby reduce the level of stress experienced.

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