

PROFESSIONAL THEORETICAL ARTICLE

Moral distress in physical therapy practice

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ABSTRACT

The purpose of this article is to discuss the theoretical concept of moral distress in the context of current physical therapy practice and ethics knowledge and differentiate it from emotional distress and burnout. Moral distress, largely discussed in nursing, is a theoretical concept that has the potential to elucidate the experiences of physical therapists delivering direct care to patients in complex health care situations and to contribute to physical therapy ethics knowledge and education. It focuses attention on the role of moral agent and the ethical dimensions of practice, offers a basis for dialogue among health professionals, and promotes analysis of the impact of the organizational environment on practice. The article concludes by suggesting how an understanding of the concept of moral distress might inform existing physical therapy ethical decision-making models and future research directions by which the experience of moral distress in physical therapy might be explored.

INTRODUCTION

In recent years physical therapists have responded to the challenges presented by an increasingly complex health care environment. However, this has also required them to respond to a bewildering array of funding decisions, policies, and guidelines resulting from major and ongoing changes in health care system delivery and health institution reorganization. Such strategic imperatives rarely involve frontline practitioners in decision making and yet have direct impact on patient care, professional interaction, and availability of services and programs (Blau et al, 2002). The influence of the health environment on professional integrity, standards of practice, and interdisciplinary collaboration is not consistently understood and can be antithetical to the philosophy of patient-focused or client-centred practice espoused by rehabilitation therapists (Townsend, 1998). During the same period of change, physical therapists have gained considerable professional autonomy with the concomitant expectations of accountability, fiscal responsibility, and life-long learning requiring proactive education programs

both entry-to-practice and continuing professional development.

In this article I discuss the theoretical concept of moral distress in the context of current physical therapy practice and ethics knowledge, the potential relationship between moral distress and burnout, how the concept of moral distress might contribute to physical therapy and interdisciplinary practice and education, and future research directions.

“Morals” refer to the personal and professional beliefs, principles, and values held by individuals about what is right and wrong, which contribute to the judgments and decisions made by individuals in particular situations (Scott, 1998). A moral agent is someone who is capable of deliberating, thinking, deciding, and acting in accordance with personal and professional moral standards and principles. Implicit in the idea of agency is the autonomous ability to reflect on, and assume responsibility for, the outcome of an action (Gabard and Martin, 2003).

The concept of moral distress was originally identified in the nursing literature (Jameton, 1984); subsequently, research exploring the experience of moral distress has been conducted primarily in nursing (Kalvemmark et al, 2004). More recently, other health professions (e.g., medicine [Hamric and Blackhall, 2007; Webster and Baylis, 2000]; pharmacy [Sporrong et al, 2005]; and psychology [Austin et al, 2005]) have begun to discuss the concept of moral distress in relation to clinical practice. In physical therapy there

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has been a growing interest in the ethical dimensions of practice and the role of physical therapists as moral agents (Swisher, 2002) but to date, moral distress has not been explicitly discussed. As a result I draw on the health care literature, primarily nursing, in exploring the concept of moral distress and discuss it in relation to current physical therapy ethics knowledge.

THE CONCEPT OF MORAL DISTRESS

The changing definitions of moral distress illustrate the ongoing and dynamic nature of the current debate. Jameton (1984) originally described moral distress as “arising when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action.” Wilkinson (1988) conceptualized moral distress more from an individual perspective 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 in that decision.” More recently, Webster and Baylis (2000) suggested that these definitions, although appropriately oriented, are too narrow to reflect the current complexity of health care practice. In their view, “moral distress may also arise when one fails to pursue what one believes to be the right course of action (or fails to do so to one’s satisfaction) for one or more of the following reasons: an error of judgment, some personal failing or other circumstances truly beyond one’s control.” The experience of moral distress is associated with unresolved feelings of incompetence, compromised integrity, frustration, anger, powerlessness, outrage, and sadness (Schluter, Winch, Holzhauser, and Henderson, 2008; Webster and Baylis, 2000).

Different types of moral or ethical distress have been identified. Jameton (1993) described “initial” distress as involving “the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values.” He considered this type of moral distress to generally cause nurses to put into action strategies by which the situation may be resolved. “Reactive” distress occurs if these strategies are unsuccessful and is associated with an inability to act upon the initial distress, resulting in disturbed sleep, depression, nightmares, headaches, and feelings of worthlessness. Purtilo (2005a), an ethicist and physical therapist, differentiated type A and type B ethical distress. Type A, characterized by certainty, occurs when health professionals know “what the morally appropriate course of action is but cannot achieve it because of external barriers,” such as institutional or traditional role barriers. Type B, which occurs “when there is a high level of uncertainty regarding the

information needed to arrive at an outcome consistent with a caring response,” is associated with uncertainty. Discussions of types of moral distress remain at the theoretical stage and as yet little empirical evidence is available to support them.

Underpinning these definitions of moral (or ethical) distress is the assumption that practitioners are guided by moral values, such as respect, dignity, honesty, and integrity, and consequently, they may experience moral distress when these values are threatened (Storch, Rodney, and Starzomski, 2004). Webster and Baylis (2000) suggest that “the setting aside or violation of deeply held (and publicly professed) beliefs, values and principles” results in unresolved moral distress, and they contend that practitioners can continue to experience moral distress even when the situation is no longer occurring. The cumulative effects of unresolved moral distress have been labelled “moral residue” (Webster and Baylis, 2000) and described as the recollection of practice situations that clinicians carry with them, powerfully concentrated in their thoughts, when they know that they should have acted as a moral agent but were unwilling and/or unable to do so at the time (Webster and Baylis, 2000). Most physical therapists can relate to the experience of carrying the memories of “difficult” practice situations with them, particularly when they were unable to satisfactorily resolve them (Carpenter, 2004). A description of such a situation is provided in Table 1. As Webster and Baylis (2000) suggest, “the passage of time may blunt the acute distress ... [but] people who have lived through serious moral compromise carry the remnants of the experience for many years, if not a lifetime.” Takahashi (2004) capitalized on this “distress” in her exploration of how physical therapists learn ethical conduct by asking study participants to recall and analyze ethical dilemmas they had experienced during their professional careers.

The concept of moral distress appears to offer new ways of understanding the moral realm of health professionals. However, there is a lack of a consensus about how to define it. Some authors (McCarthy and Deady, 2008; Webster and Baylis, 2000) express concern about this lack of “conceptual clarity” (McCarthy and Deady, 2008) in research and the broad uncritical adoption and application of the concept in nursing practice. In addition, authors from different disciplines, discussing moral distress in the context of their professional practice, appear to be uncritically adopting the definitions developed by nursing.

In summary, moral distress is associated with individual practitioners’ experiences of loss of personal and professional integrity when their desire to maintain professional standards achieve the best outcomes for clients and act as advocates for clients within complex health care environments cannot be realised.

TABLE 1 Example of situation causing moral distress in physical therapy practice.

Dawn (pseudonym) was a member of a team of therapists (physical therapy, occupational therapy and speech language pathology) who provided rehabilitation care for clients admitted with a diagnosis of stroke throughout a large acute hospital. A client had been transported from the ward that morning to the rehabilitation treatment area. She had a history of circulatory problems. When Dawn saw her in the treatment area she was “sweating, breathless, distressed and her leg was blue and mottled” and she told Dawn that during the night she had told staff that she was having leg and chest pain. From experience Dawn knew that, given the client’s history, these signs were very serious and probably indicative of deep vein thrombosis and/or pulmonary embolus. She went on to explain:

There was no recognition of these problems on the part of the nursing staff or they would never have sent her down to OT. We immediately put her on a stretcher, gave her oxygen, and took her back to the ward. I talked with the ward nurse who frankly did not understand the implications – that it was an emergency. She said she’d ‘deal with it’ but she clearly wasn’t going to call the physician. I know I’m not a diagnostician but I think I knew what was happening and it was an emergency. I explained my concerns to her but in the end I phoned the family doctor which was really something that should have been done earlier in the morning. Anyway the long and short of it was that the patient had a mass of tests all day. She was terrified because the nurses had turned off the call bell, they weren’t listening to her, awful punitive stuff going on, awful stuff! The tests all came back and the nurse’s comment was that they couldn’t get hold of the family doctor. So I suggested that as the vascular surgeon had been involved with this client that we should call him. She didn’t want to go behind the family doctor’s back etc. etc. I mean that’s just not the way to handle this. The patient died that night. I knew that was going to be the end result. I’d spoken with her family physician and the vascular surgeon. I’ve been around, I knew it was likely to happen; she was a sitting duck with her history. It wasn’t her death so much that distressed me but I am desperately distressed with the way this patient’s last 12 hours was managed and how terrified she was. I felt so awful for her. I keep thinking if I could have done anything else. I can’t get her out of my mind.

The situation lasted approximately 24 hours but was vividly recounted by Dawn many months later.

Carpenter (2002)

CURRENT PHYSICAL THERAPY ETHICAL KNOWLEDGE

Swisher (2002) conducted a retrospective analysis of ethics knowledge in physical therapy between 1970 and 2000 and found a significant increase in the number of publications addressing ethical practice in physical therapy during the decade 1990–2000. A detailed review of recent physical therapy publications (Carpenter and Richardson, 2009) identified the following areas of interest: 1) informed consent and disclosure (Elkin, 2001; Purtilo, 2005b; Scott, 2001) and confidentiality (Cross and Sim, 2000) related to the communication between practitioners and patients; 2) the ethical responsibilities involved in conducting research (Clemence, 2001; Henley and Frank, 2006; Williams, 2000); 3) physical therapy students’ development of moral reasoning and integration of ethical decision making into practice (Dieruf, 2004; Geddes, Wessel and Williams, 2004; Jensen and Paschal, 2000; Sisola, 2000; Solomon and Geddes, 2000); and 4) exploring how physical therapists’ identify and address ethical issues in practice (Carpenter, 2004; Finch, Geddes, and Larin, 2005). In addition, a number of models (Geddes, Finch, and Graham, 2005; Swisher, Arslanian and Davis, 2005) and frameworks (Edwards, Braunack-Mayer, and Jones, 2005; Schenkman, Deutsch, and Gill-Body, 2006) have been developed with the aim of facilitating ethical decision making in practice, and some authors (Barnitt and Roberts, 2000; Triezenberg, 1997; Triezenberg and Davis, 2000) have focused on proposing

strategies by which the ethical education of physical therapists could be facilitated.

Qualitative or mixed methods (qualitative and survey) research approaches were predominantly used in the studies investigating ethical and moral issues in physical therapy with two notable exceptions (Dieruf, 2004; Sisola, 2000) where a standardized instrument—the Defining Issues Test (DIT)—was used to investigate the correlation of moral reasoning ability with competence in clinical practice and the impact of an education program on the moral reasoning of physical therapy students. The DIT is a structured test that generates quantitative data about three schema of moral reasoning: 1) personal interests; 2) maintaining norms; and 3) postconventional reasoning (Rest, Narvaez, Bebeau, and Thoma, 1999). The test’s original purpose was to assess the transition of moral development from adolescence to adulthood, and it is based on Kohlberg’s theory of moral development, which has been criticized as gender and culturally specific. It is composed of six hypothetical stories, not specifically related to health care or physical therapy practice, each presenting a moral dilemma. The aim of quantifying or measuring moral behavior and establishing correlations with other characteristics such as clinical competency and burn-out is in a rudimentary stage. Quantitative research approaches are unlikely to capture the multiple factors that constitute the ethical situations that characteristically cause moral distress and used alone may be of limited value in developing physical therapy ethics

knowledge. There is clearly a continuing interest in the ethical dimensions of physical therapy practice but a more coherent and integrated approach to the generation of ethics knowledge, using mixed methods research, might more explicitly respond to the needs of individual practitioners and the profession.

RESEARCHING MORAL DISTRESS

Research, primarily in nursing, focuses on practitioner's experiences of moral distress in specific settings: nursing primary care (Laabs, 2005); mental health (Austin, Bergum, and Goldberg, 2003); intensive care units (Elpern, Covert, and Kleinpell, 2005); pharmacies (Sporrang et al, 2005); or psychologists working in psychiatric and mental health care settings (Austin et al, 2005). Schluter et al (2008) conducted a systematic review of nine nursing studies investigating the effects of unresolved moral distress and poor ethical climate but found the studies lacked rigor and the data limited.

An interest in measuring moral behavior is evidenced in the development, and use in research, of a Moral Distress Scale (MDS) (Corley, Minick, Elswick, and Jacobs, 2005; Elpern, Covert, and Kleinpell, 2005; Meltzer and Huckabay, 2004). The MDS aims to measure the degree to which moral distress is an element of nurses' professional experience (Corley, Elswick, Gorman, and Clor, 2001). The scale consists of 32 items that reflect moral problems encountered by nurses in hospital adult services. Respondents indicate the degree of moral distress associated with each item using a Likert scale. The MDS generates statistical data on the frequency of moral distress and type of "problem" situation most likely to cause it. The clinical "problems" reflect nursing practice only in a hospital context, do not reflect the breadth and complexity of nursing practice, and have little relevance for other disciplines. Some of the criticisms levelled at the use of the DIT may apply to the MDS because no information is generated about the degree, significance, nature, or pervasiveness of the experiences. In addition, no account can be made from the results of the studies, in which the MDS is used, for the diversity of factors that may contribute to the experience of moral distress.

MORAL DISTRESS AND BURNOUT

Some authors in nursing (Corley and Minick, 2002; Corley, Minick, Elswick, and Jacobs, 2005; Meltzer and Huckabay, 2004; Pendry, 2007; Schluter, Winch, Holzhauser, and Henderson, 2008; Sundin-Huard

and Fahy, 1999) have suggested that the experience of moral distress contributes to burnout and is associated with professional attrition and staff turnover; however, the research evidence to support these claims is very limited (Schluter, Winch, Holzhauser, and Henderson, 2008). Burnout is considered to occur when the intensity and complexity of the workplace exceeds the personal and professional resources of an individual. Donohoe et al (1993) defined burnout in the physical therapy context as "a syndrome of physical and emotional exhaustion involving the development of both a negative self-concept and a poor or negative attitude towards one's job." Burnout or occupational stress in physical therapists has been investigated. The Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1993), an established measure of a person's overextension or exhaustion at work, relationships with clients, and self-competency, was used to determine the prevalence of burnout in physical and occupational therapists in hospital and clinics in New York (Balogun et al, 2002); head injury rehabilitation (Schlenz, Guthrie, and Dudgeon, 1995); orthopedic physical therapists (Wandling and Smith, 1997); and recently qualified physiotherapists in South Africa (Scutter and Goold, 1995). Balogun et al (2002) also focused on sociodemographic factors associated with burnout, such as number of children and religious affiliation. Others (Broom and Williams, 1996; Donohoe et al, 1993) identified work-related factors, such as excessive workload, lack of supervisor support, time constraints, inadequate staffing, coping with administrative and policy changes, and expectations of patients.

None of these studies considered the ethical dimensions of physical practice or suggested that the complex ethical dilemmas encountered in practice might contribute to burnout. Burnout in the physical therapy literature is generally viewed as an extreme response on the part of an individual to specific work-related stressors, an individual "adaptive" strategy in response to the "particularities" of clinical practice and the demands of the work environment, and as a largely negative experience that results in long-term exhaustion and diminished interest that requires individual remediation (Waldrop, 2003). Proposed strategies to manage burnout generally focus on the individual and neglect the contribution the administration or management can make to preventing burnout by creating a positive and supportive work environment. In contrast, moral distress, although it may involve similar emotional and psychological responses, draws attention to the ethical dimensions inherent in specific complex multidisciplinary clinical situations and the organizational context in which these occur and to the sense of moral and professional compromise experienced by individual practitioners.

CONTRIBUTION OF MORAL DISTRESS TO PRACTICE

Hanna (2004) reviewed the current moral distress debate in nursing and warned against conflating it with psychological distress. In her opinion, doing so implies that practitioners are powerless to act or effectively manage situations that give rise to moral distress and undermines the contribution that an analysis of the experience of moral distress can make to understanding the often “morally untenable” work environment (Rodney, Brown, and Liaschenko, 2004) and the shared interdisciplinary experiences of clinical situations.

Ethical work environment

Webster and Baylis (2000) define an ethical environment as one “in which there is coherence between what a health care organization publicly professes to be and what the employees, patients and others both witness and participate in.” Organizational values are evident in the priority given to patient rights, and how staff are treated, institutional goals are established, conflict is managed, and multidisciplinary relationships are facilitated (Corley, Minick, Elswick, and Jacobs, 2005; Schluter, Winch, Holzhauser, and Henderson, 2008).

Few physical therapy studies have investigated the impact of health care environments on practice. Mellion (2001) addressed the impact on ethical decision making of managed health organizations (MHOs) in the United States and concluded that the establishment of MHOs has “dramatically altered the delivery of health care, raising numerous ethical challenges.” Blau et al’s (2002) qualitative study explored the experience of providing physical therapy services during a time of systemic change within a large urban academic medical center. It is of interest that while participants’ descriptions of their experiences—loss of control, stress, discontent, and disheartenment—reflect the factors associated with burnout, an overarching theme showed that, despite these negative feelings, they were able “to find a silver lining” in their daily work lives. The positive contributing factors included pride and “enjoyment in being a physical therapist, having strong relationships with peer, and the belief that they were delivering high quality care to patients.”

The organizational culture clearly affects the quality of practitioners’ decisions, but little research is available to support that claim in physical therapy. Health professionals frequently fail to explicitly recognize the extent to which this context can shape professional practice and interdisciplinary relationships, dampen initiative, sustain

hierarchies, and consume time and resources (Mattingley and Fleming, 1994; Townsend, 1998).

Shared experiences in interdisciplinary practice

The practitioners’ role of moral agent is embedded in the social relationships developed within a work environment. Understanding the concept of moral distress can shift attention “to a network of individuals acting in relation to one another, sometimes in ways that worsen moral distress and sometimes in ways that resolve it” (Rodney, Brown, and Liaschenko, 2004). The goal of “shared” decision making between the client and interdisciplinary team members and the importance of peer support in resolving practice situations have been consistent themes in physical therapy research exploring ethical and clinical decision making (Barnitt and Partridge, 1997; Carpenter, 2004; Finch, Geddes, and Larin, 2005; Jensen, Gwyer, Shepard, and Hack, 2000). Interdisciplinary collaboration and communication, concerns about other disciplines’ practice, and perceived pressure from others in decision making have also been identified as sources of ethical dilemmas in physical therapy (Carpenter, 2004; Cross and Sim, 2000; Finch, Geddes, and Larin, 2005).

While each discipline providing services for clients has a different and unique professional “ethos” (Stiller, 2000), it is likely that practitioners in similar practice settings will identify similar ethical dilemmas or issues and share experiences of moral distress. However, research exploring moral distress has primarily focused on the individual health provider and, in particular, nurses. Only one study (Kalvemark et al, 2004) has investigated the experience of moral distress in a multidisciplinary context. Three focus groups were conducted, which consisted of physicians, nurses, auxiliary nurses, medical secretaries working together in a cardiology and haematology department, and pharmacists, dispensers, and pharmacy assistants working in a pharmacy. The results show that all disciplines experienced moral distress, moral decisions were made singly and with others, and moral distress did not occur solely as a consequence of institutional constraints but as a result of other factors such as legal regulations. It has been suggested that the position of nursing in the “hierarchy of decision-making may expose them to greater moral grief” and explain why “the discourse of moral distress has particular resonance for nurses” (McCarthy and Deady, 2008). Despite this argument, Paley (2004) is critical of nursing research because 1) it focuses solely on the experience of moral distress suggesting that it is, in effect, an invitation to “whine” and

indulge in “professional gossip” and 2) it uncritically draws on “the meta-narratives of powerlessness and oppression by medicine” that permeate nursing discourse. He suggests that focusing on nurses’ accounts of moral distress implies that no other health disciplines are morally sensitive or experience moral distress. A focus on understanding different health professionals’ experiences of making difficult moral judgments in a multidisciplinary context may facilitate a discourse of shared concerns and issues that transcends those of specific disciplines.

Ray, Goodstein, and Garland (1999) suggest that “clinicians caught in [a] maelstrom of competing values have sought refuge in the individually focused bioethical foundations of clinical practice to provide the patient care they consider appropriate.” A normative, biomedical principles approach to ethical decision making (Beauchamp and Childress, 2005) has traditionally conceptualized health care practice as an individual (respect for autonomy of the patient and professional autonomy) rather than a collective experience. It is, however, unreasonable to expect that individual practitioners can resolve the complex situations characteristic of moral distress, by working individually. Sherwin (1995) proposed the concept of relational autonomy as an alternative to the principle of respect for autonomy. She argued that people, when making decisions, most often consult and take into consideration their relationships, whether these are with parents, family members, partners, children, or other professionals. The concept of relational autonomy “uses a more accurate understanding of humans as deeply interconnected and interdependent as a base, one that requires that appropriate supportive social conditions be put in place” (Hardingham, 2004) and could form the theoretical framework for future interdisciplinary interactions and research exploring the shared experience of moral distress in practice.

MANAGING MORAL DISTRESS

A number of individual and collective strategies have been identified that may assist practitioners to manage situations that cause moral distress, such as problem solving with peers, collaborating with other team members, accessing ethic committees, and seeking information from managers or professional associations (Corley and Minick, 2002; Meltzer and Huckabay, 2004; Zuzelo, 2007). Researchers in physical therapy (Carpenter, 2004; Jensen, Gwyer, Shepard, and Hack 2000) found that expert practitioners used their practice knowledge and experience in a diversity of creative and resourceful, but largely taken-for-granted ways to advocate for their clients and to “get round the system.”

Wong (1992) argues that such individual resourcefulness is “necessary for the ability to act on one’s own moral position while minimizing damage to one’s relationship with those in opposition, for the ability to find concessions acceptable to oneself and others, and for the ability to incorporate elements from ethical systems conflicting with one’s own.” The outcome of effectively managing the experience of moral distress can be seen as “energizing” and result “in a feeling of accomplishment of professional goals” (McCarthy and Deady, 2008), and promote critical self-reflection and awareness of an individual’s personal and professional values and beliefs. There is a danger, however, that these types of activities, enacted by individuals without a broader critical analysis of the situation, could have negative as well as positive consequences. They could, for example, result in inconsistencies or inequities of client care, disempowerment of the client, neglect of the client’s wishes and desires, and a lack of respect for the roles and responsibilities of other health care professionals and administrators (Carpenter, 2004).

Researchers (Barnitt and Partridge, 1997; Carpenter, 2004; Finch, Geddes, and Larin, 2005) have noted that while physical therapists recognize ethical situations in practice, they do not have the ethical or moral language by which to identify and assess the situation, rarely use the health care ethics literature as a resource, and when they do access these resources, they predominantly use a limited biomedical normative “principles” (Beauchamp and Childress, 2005) ethical decision-making approach. Romanello and Knight-Abowitz (2000) and Greenfield (2006) argued that an “ethics of care” (Carse and Nelson, 1996) approach provides an alternative way of conceptualizing physical therapy practice. A more in-depth and nuanced understanding of ethical theories, including concepts from moral philosophy and biomedical and health care ethics may aid in identifying common issues and experiences, including those that contribute to moral distress, as well as facilitating the development of body of ethical knowledge specific to physical therapy (Barnitt and Roberts, 2000). Swisher (2002) recommended that the profession develop a coherent ethics research agenda that reflects the realities of practice. Such research could inform the ethical content of physical therapy curricula and the strategies by which clinical decision making is taught in academic programs (Barnitt and Roberts, 2000; Triezenberg and Davis, 2000).

It is generally acknowledged by health care administrators and educators (Gardiner, Chamberlin, Heestand, and Stowe, 2002) and students (Hawk et al, 2002) that interdisciplinary education is a desirable and necessary precondition for (effectively) working together in complex health care environments to comprehensively address the needs of individual clients. Health care

ethics seems particularly appropriate as a focus for interdisciplinary education initiatives because it provides a common language with which to discuss complex issues that transcend the discrete identities of individual professions (Carpenter, Ericksen, Hill, and Purves, 2004). The concept of moral distress, if more thoroughly understood and investigated across disciplines and included in interdisciplinary education, might facilitate a more comprehensive approach to understanding and managing the complex realities of practice and the effects on individual practitioners.

MODELS OF PHYSICAL THERAPY ETHICAL DECISION MAKING AND MORAL DISTRESS

The physical therapy decision-making models, introduced earlier, represent a desire to integrate clinical and ethical components of decision making in complex situations. Edwards, Braunack-Mayer, and Jones (2005) sought to address “both the particular circumstances and contexts of patients and the more generalizable or universal characteristics of their clinical problems” by incorporating ethical reasoning into a wider clinical reasoning framework. In developing their model they drew on and compared the epistemological (the nature of knowledge) assumptions, such as the hypothetical-deductive and narrative approaches to clinical reasoning and the ontological (the nature of reality) basis of casuistry or “case-based” (Jonsen, Siegler, and Winslade, 1992), “principles” (Beauchamp and Childress, 2001), and virtue ethics (Pellegrino, 1995) approaches to ethical decision making. As a result the model effectively demonstrates how theory can inform practice.

Geddes, Finch, and Graham (2005) proposed a Moral and Legal Template for Health Care Practice that integrates morality (a person’s sense of right and wrong) and law (rules, regulations, and laws)” and “also incorporates the individual, professional, and societal perspectives of the decision-maker.” This template offers a simple and useful way of analyzing or diagnosing the choices faced in practice and of weighing the consequences of actions, but without the user having a sound understanding of ethics, it is likely ethical decisions may be subsumed by the more concrete legal concepts incorporated into the template.

Swisher, Arslanian, and Davis (2005) proposed the Realm-Individual Process-Situation (RIPS) Model of ethical decision making based on three realms within which ethical situations occur: an individual realm concerning “the good of the patient/client focuses on rights, duties, relationships, and behaviours between

individuals;” an institutional or organizational realm concerns “the good of the organization and focuses on the structures and systems that facilitate organizational goals”; and a societal realm concerns “the common good.” Four tools are proposed by which the ethical dimensions can be evaluated (moral sensitivity, moral judgment, moral motivation, and moral courage) and situations are broadly characterized by issues/problems, dilemmas, distress, temptation, and silence. This model clearly addresses the essential components of the role of moral agent and the organizational and societal context within which decision making occurs. As such, it provides sufficiently nuanced guidance to assist practitioners to explore experiences of moral distress in practice and to form a framework for ethics curriculum planning and research.

Fry, Harvey, Hurley, and Foley (2002) in nursing proposed an explanatory theory and associated model that traces the progress of moral distress and identifies other moral concepts, such as moral integrity, moral courage, advocacy, and autonomy, that can contribute to preventing and managing moral distress. The purpose of this theoretical work is to develop an understanding of moral distress in nursing, how to prevent it, and when it cannot be prevented how to manage it (Corley, 2002). The model incorporates the concepts of initial and reactive distress (Jameton, 1993) and outlines the process (analysis of situation and barriers) by which action can be taken in the face of moral distress. It is described in general terms and takes into account ethical theory and concepts and as such could be applied to different professional practice settings. Issues such as practitioner “suffering,” “burnout,” and career attrition form components of the model; however, as described earlier, there is little or no association made between these issues and the ethical components of practice and no evidence to substantiate the assumption of a relationship between burnout and moral distress. Despite these limitations this theory and model could be adapted to effectively reflect the potential experiences of other health professionals and guide further discipline-specific and interdisciplinary explorations of the phenomenon of moral distress.

The ability to effectively integrate ethical and clinical decision making is predicated on a profession’s knowledge of ethics and an ability to identify ethical issues in practice. These models of ethical decision making represent an important development in physical therapy and may “create a space for moral dialogue” (Swisher, Arslanian, and Davis, 2005) between disciplines, provide the structure for understanding the moral experiences of others, such as moral distress, and facilitate a systematic approach to analysis and problem solving of complex ethical situations in practice.

CONCLUSION

The concept of moral distress highlights issues related to the ethical nature of the work environment and interdisciplinary practice and the role of the moral agent in managing ethical situations in practice. Research is, therefore, needed that systematically investigates the impact of organizational environments (institutional obstacles and facilitators) on patient care and professional (discipline-specific and interdisciplinary) practice and to generate evidence that supports the development of ethical health care environments. The argument has been made that the experience of moral distress is shared by different disciplines, but to date there is little research evidence to substantiate that claim. Multi-disciplinary research using mixed methods approaches is needed to explore the experiences of specific professional groups such as physical therapists and professionals working in teams who have to make difficult moral judgments and decisions in complex situations. Finally, research that identifies the types of situations and factors that cause physical therapists to experience moral or ethical distress in practice could inform models of clinical decision making and enhance the teaching of ethics in physical therapy programs.

Moral distress, largely discussed in nursing, is a theoretical concept that has the potential to focus attention on the deeply troubling aspects of physical therapy practice in complex health situations and to contribute to ethics knowledge and education in physical therapy. It is theorized differently from emotional distress and burnout in that it focuses attention on the role of moral agent and the ethical dimensions of practice. Moral distress offers a basis for dialogue among health professionals and promotes analysis of the impact of the organizational environment on their collective practice.

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