

Moral Distress and Moral Disorientation in the Context of Social Accountability

LYNETTE REID, PhD

Medical educators^{1–5} are turning their attention to a concept from nursing ethics: *moral distress*, defined as distress that results when health care providers are unable, because of institutional constraints, to do what they believe to be the right thing.¹ The original definition, and much of the research tradition, pertains to analyses of nurses as disempowered.² The concept also assumes a patient-centered lens: Patients do not cause moral distress; rather, insufficient resources, inflexible institutions, or family wishes that are discordant with patients' needs cause distress for nurses who want to deliver patient-centered care. According to Berger,¹ a hidden curriculum and poor role modeling constitute structural constraints on moral action. Medical learners, who are subordinate in the hierarchy, may also experience moral distress.

Recently, some researchers have assumed a broader definition of *moral distress*, to include internal constraints, such as personal limitations of skill or courage. Others argue we should go beyond a definition solely based on constraints to include situations of moral conflict, where the right course of action is not clear.³ In a more critical vein, some have questioned the implicit assumption that nurses' best interest judgments are reliable guides for action.⁴ Others question whether positioning nurses as disempowered is still accurate in the current environment.⁵

In this issue, Aultman and Wurzel⁶ explore moral distress through focus groups with residents in 3 obstetrics and gynecology programs in Ohio. Those programs provide care to underserved populations. As such, the context for their research reflects academic medicine's social accountability mandate.⁷

According to the researchers' interview guide, residents were invited to identify patients considered difficult, reflect on those patients' characteristics, explore their own emotional and rational responses, and discuss whether and how caring for such patients caused them moral distress. Exploring the connection between stigmatizing patients as "difficult" and experiencing moral distress was the research goal, rather than something that arose spontaneously from

an open-ended invitation to residents to describe practice challenges.

A critical question is, what is the "right thing" that residents want to do? What are the constraints that stand in their way? The focus on patient characteristics leaves these important questions implicit. Are residents distressed at the behavior of their patients—behavior that they morally judge? Do those patient behaviors require morally compromised action by the residents or is the distress "second-hand"—arising because residents are not accustomed to dealing with people who make choices that the residents deem to be wrong? Are the residents distressed by the social arrangements that condition the experience of poverty and disadvantage in America today? Is the residents' distress a result of cognitive dissonance between what they believe to be their professional responsibility—compassionate care to an underserved population, or, more modestly, nonjudgmental care—and the judgments they find themselves forming? Is the relevant "institutional constraint" that the institution serves a patient population with a mix of poverty, addictions, and psychiatric comorbidities that the residents are not well-prepared to manage?

Residents' comments, as reported by the researchers, suggest a mismatch between the competencies residents have developed and the social accountability mission of their programs. This mismatch is not superficial: It encompasses professional identity formation. Specifically, some residents report a mismatch between their ideas of the physician's role as providing diagnosis and treatment and what the practice in this setting requires of them: delivering cost-conscious and comprehensive psychosocial care to patients whose lives are very different from the residents' own. Perhaps, the practice of medicine requires such care of physicians in any context.

The broad sweep of the authors' analysis indicates that the authors understand "patient-blaming" to be a suboptimal response to a challenging practice environment. The authors state that this response should be addressed through narrative and reflective ethics education in residency. If the mismatch is one of professional identity, reinforced by the limited set of technical skills mastered in their medical education programs as physicians, in comparison to the clinical and social needs of the patient population cared for in their residency program, then enhanced ethics education would only be 1 part of the solution. Residents need knowledge and skills that em-

Lynette Reid, PhD, is Associate Professor, Department of Bioethics, and Faculty of Medicine, Dalhousie University, Halifax, Nova Scotia, Canada.

Corresponding author: Lynette Reid, PhD, Department of Bioethics, Dalhousie University, PO Box 15000, Halifax, NS B3H 4R2, Canada, 902.494.3801, lynette.reid@dal.ca

DOI: <http://dx.doi.org/10.4300/JGME-D-14-00345.1>

power them to meet the social accountability mandate of their programs. Future research should explore whether and how that education might also address attitudes.⁸ One of the authors, Aultman, has written of the challenges of addressing inequality and oppression through narrative.⁹ A neuroscience-based program in empathy has shown results in patients' perception of empathy in residents' care.¹⁰

A relevant challenge is the political context of care: Residents may be shaped by polarized public debate long before they enter medical training. To promote compassionate care, we reframe "difficult patients" as *challenging physician-patient encounters*, and "demanding" patients or patients "refusing" care as *patients whose views of appropriate care differ from their providers*. Meanwhile, the culture has moved in the other direction: Residents may see patients not only as "demanding" and "difficult," but as being that way because they are "entitled" and as taking resources from those who "deserve" those resources, whether the "deserving poor" or the taxpayer.

The authors do not always use distancing devices when reporting statements that could be interpreted as patient-blaming. They rarely use scare quotes or qualifications. They cite literature on how patient characteristics influence difficult physician-patient relationships, rather than literature that attends to the influence of provider and systems characteristics.¹¹ This light use of distancing devices and selective reporting of the literature may generate discomfort or confusion in some readers.

Programs delivering care to underserved populations hope and expect that their residents will care compassionately for patients of diverse socioeconomic circumstances. Such work is never easy: The idealism that leads people to service meets the reality of conflicting worldviews, contrary winds in the political climate, and frayed patient-provider trust. If the moral disorientation¹² that results is distressful—and it surely is—then the concept of moral distress may usefully be extended in new directions.

References

- 1 Jameton A. *Nursing Practice: The Ethical Issues*. Englewood Cliffs, NJ: Prentice-Hall; 1984.
- 2 Austin W. Moral distress and the contemporary plight of health professionals. *HEC Forum*. 2012;24(1):27–38.
- 3 Fourie C. Moral distress and moral conflict in clinical ethics [published online ahead of print November 8, 2013]. *Bioethics*. doi:10.1111/bioe.12064.
- 4 Repenshek M. Moral distress: inability to act or discomfort with moral subjectivity? *Nurs Ethics*. 2009;16(6):734–742.
- 5 McCarthy J, Deady R. Moral distress reconsidered. *Nurs Ethics*. 2008;15(2):254–262.
- 6 Aultman J, Wurzel R. Recognizing and alleviating moral distress among obstetrics and gynecology residents. *J Grad Med Educ*. 2014;6(3):457–462.
- 7 Woollard B, Boelen C. Seeking impact of medical schools on health: meeting the challenges of social accountability. *Med Educ*. 2012;46(1):21–27.
- 8 Antiel RM, Kinghorn WA, Reed DA, Hafferty FW. Professionalism: etiquette or habitus? *Mayo Clin Proc*. 2013;88(7):651–652.
- 9 Wear D, Aultman JM. The limits of narrative: medical student resistance to confronting inequality and oppression in literature and beyond. *Med Educ*. 2005;39(10):1056–1065.
- 10 Riess H, Kelley JM, Bailey RW, Dunn EJ, Phillips M. Empathy training for resident physicians: a randomized controlled trial of a neuroscience-informed curriculum. *J Gen Intern Med*. 2012;27(10):1280–1286.
- 11 Breuner CC, Moreno MA. Approaches to the difficult patient/parent encounter. *Pediatrics*. 2011;127(1):163–169.
- 12 Harbin A. Bodily disorientation and moral change. *Hypatia*. 2012;27(2):261–280.