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Title	Moral distress: Feeling compelled to do the wrong thing
Author(s)	McCarthy, Joan
Publication date	2020-03-20
Original citation	McCarthy, J. (2020) 'Moral distress: Feeling compelled to do the wrong thing'. Journal of Japanese Nursing Ethics, 12 (1), pp. 4-10. doi: 10.32275/jjne.12.1_4
Type of publication	Article (peer-reviewed)
Link to publisher's version	https://www.jstage.jst.go.jp/article/jjne/12/1/12_4/_article/-char/en http://dx.doi.org/10.32275/jjne.12.1_4 Access to the full text of the published version may require a subscription.
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■ 特別寄稿

Moral distress: Feeling compelled to do the wrong thing

道徳的苦悩：間違ったことをせざるを得ない気持ち

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Key words:　moral distress, nursing, health professional, moral agency, emotion

キーワード：道徳的苦悩、看護、医療専門職、道徳的主体性、感情

Moral distress is a conceptual tool that brings the emotional landscape of the moral realm to the fore and draws attention to the socio-political and contextual features of moral agency. This essay gives a brief history of the development of the normative and empirical research on moral distress. It pays special attention to the standard definition of moral distress originally delineated by Andrew Jameton in 1984 and the early empirical research that operationalized this definition. Finally, it summarizes some of the lenses through which moral distress is currently perceived, articulated, and critiqued.

道徳的苦悩は、道徳の分野の感情的な側面を浮かび上がらせ、道徳的主体性の社会政治的で文脈的な特徴に注意を向けるよう促す概念的ツールである。本稿は、道徳的苦悩に関する規範研究や実証研究の発展の歴史を手短に紹介する。もともと1984年にアンドリュー・ジェイムトンAndrew Jametonが描いた道徳的苦悩の標準的な定義と、この定義を採用した初期の実証研究にとくに注目する。最後に、現在道徳的苦悩がどのように考えられ、示され、また批評されているか、いくつかの視点をまとめる。

1．Background

Moral distress is a complex and contested concept that draws attention to the socio-political and contextual features of moral agency and foregrounds the emotional dimension of moral decision making. It has its roots in the 1970s work of nurse theorists such as Marlene Kramer,[1] Anne Davis and Mila Aroskar,[2] as well as other scholars dating back to the late 19th century,[3] who were concerned with the way in which institutions and other external forces undermined the nurse's professional role and moral agency. However, in 1984, the philosopher, Andrew Jameton, was the first to delineate 'moral distress' as the negative emotions such as anger and frustration that arise 'when one knows the right thing to do, but institutional constraints make it nearly im-

1．はじめに

道徳的苦悩は、道徳的主体性の社会政治的で文脈的な特徴に注意を喚起し、道徳的意思決定の感情的側面をはっきりさせる、複雑で論争のある概念である。そのルーツは、1970年代のマレーネ・クライマーMarlene Kramer[1]、アン・デイビスAnne Davisとミラ・アロスカーMila Aroskar[2]などの看護理論家、および19世紀後半にさかのぼる他の研究者の業績にあり[3]、彼らは組織や他の外圧が看護師の専門職としての役割と道徳的主体性を弱体化させているあり方に、懸念を抱いていた。しかしながら、1984年に哲学者のアンドリュー・ジェイムトンAndrew Jametonは、「道徳的苦悩」を否定的な感情として初めて描き出した。彼の述べる否定的な感情とは、「行うべき正しいことを知っているが、制度上の制約によって正しい行動をとることはほとんど不可能な時」[4, 5]に生じる怒り

possible to pursue the right course of action.'[4, 5] Jameton's account of moral distress focussed on the way in which institutional policies and practices as well as co-workers may prevent nurses from acting in ways that they believe to be morally right—particularly in circumstances relating to the provision of end-of-life care.

Reporting, in 2017, on the reasons why he had originally associated moral distress with nursing practice, Jameton had this to say:

> 'I was responding to students' stories related during classroom discussions of bioethical dilemmas, such as appropriate care for dying patients, limits to life support, and communication and decision making with patients and families. Some of the students were senior nursing clinicians. A few recalled with regret hospital incidents in which they were required to perform uncomfortable or painful procedures on patients when, in their experience, curative efforts were futile. A common flash point was the suctioning of patients on respirators who had been in intensive care units for weeks and who were not going to live to discharge. Similarly, providing intensive care to premature infants with expectably poor outcomes disturbed some neonatal nurses.'[6]

Following on Jameton's philosophical account of moral distress, Judith Wilkinson, carried out the first published empirical study of moral distress among critical care nurses in 1987/88 which explicitly aimed to identify situations that gave rise to moral distress as well its effects on nurses and patients.[7] In turn, Mary Corley, one of the early empirical researchers to operationalize Jameton's account of moral distress saw her research as paying attention to the contextual nature of moral decision-making.[8-10] She wanted to challenge the traditional emphasis of medical ethics on models of ethical decision making that abstracted from the context within which the decisions were made. Instead, Corley held 'institutional constraints as a major focus [of her research] in order to amend the limited approach used by medical ethics: a focus on the context for justifying ethical decision making, to the exclusion of the context within which such decision making takes place.'[11]

や欲求不満などである。ジェイムトンJametonの道徳的苦悩の説明は、看護師たちが道徳的に正しいと信じる方法で行動することを妨げるような、組織の方針や慣行および同僚のやり方に焦点を当てている。とりわけ終末期ケアの提供に関連する状況を説明している。

ジェイムトンJametonは、道徳的苦悩を看護実践と関連させたそもそもの理由を、2017年の報告で次のように述べている。

> 「私は、死にゆく患者への適切なケア、生命維持の限界、そして患者・家族とのコミュニケーションや意思決定といった生命倫理のジレンマの授業のディスカッションの中で、学生たちの話に答えていた。学生の何人かは中堅以上の臨床看護師だった。学生の数名は、経験上治療的努力は無益であるとわかっているときに、患者につらく痛みを伴う治療法を実行するよう要求されるという病院での出来事を、後悔とともに思い出した。共通して議論を招いた点は、集中治療室に数週間にわたって入院し、退院の見込みのない人工呼吸器装着患者への喀痰吸引だった。同様に、予後不良の未熟児に集中治療を提供することは、新生児に関わる看護師を非常に困惑させていた。」[6]

ジェイムトンJametonの道徳的苦悩についての哲学的説明に続いて、最初に出版された実証研究は、ジュディス・ウィルキンソンJudith Wilkinsonが1987年から88年にかけて実施したクリティカルケア看護領域の看護師を対象にした研究である。この研究の目的は、道徳的苦悩を引き起こした場面、および道徳的苦悩が看護師と患者へ与える影響を特定することであった[7]。

次に、ジェイムトンJametonの道徳的苦悩の定義を採用した初期の実証研究者の一人であるメアリー・コーリーMary Corleyは、彼女の研究が道徳的意思決定の文脈的な性質に注目していると考えていた[8-10]。彼女は、意思決定が行われた文脈から抽象化された倫理的意思決定のモデルに対する医学倫理の伝統的な強調姿勢に疑問を投げかけたかったのである。その代わりに、コーリーCorleyは、「組織の束縛を［彼女の研究の］主要な焦点とした。その目的は医学倫理によって用いられる限定的なアプローチを修正するためであった。この限定的なアプローチは、倫理的意思決定の正当化の文脈に焦点を当てるが、意思決定が行われる文脈を排除しようとする。」[11]と述べている。

Early research on moral distress, which focussed on the experiences and practices of nurses in critical care settings largely in the US, has expanded over the last three decades to include a wide range of health professionals and allied workers e.g. doctors, pharmacists, social workers, and students working in a variety of healthcare settings and countries around the world.[12-14] This research has found that moral distress features strongly in the lives and work of very many health professionals and that it contributes to staff demoralization, desensitization and burnout and, ultimately, to lower standards of patient care.[15-19] Reflecting this broadening of interest in moral distress, journals directed at medical as well as nursing professionals have begun to include theoretical and empirical papers on moral distress such as AJOB, Bioethics, Bioethical Inquiry, Hastings Center Report, JME and HEC Forum. Moral distress is also gaining interest in the general media. For example, a 2019 article in the New York Times about the moral distress experience of a neurosurgeon garnered over 200 comments in the first ten days of its publication.[20]

おもに米国のクリティカルケア領域の看護師の経験と実践に焦点を当てた道徳的苦悩に関する初期の研究は、過去30年間にわたって拡大した。それらは幅広い範囲の医療専門職や関連する人々を対象としており、たとえば、さまざまな医療環境や世界中の国で働いている医師、薬剤師、ソーシャルワーカー、学生を含んでいる[12-14]。この研究では、道徳的苦悩が非常に多くの医療専門職の生活や仕事に強く影響し、スタッフの意欲低下、感受性の低下、バーンアウト、そして最終的には標準的な患者ケアの質の低下に関係することが明らかになった[15-19]。この道徳的苦悩への関心の広がりを反映して、American Journal of Bioethics（AJOB）、Bioethics、Bioethical Inquiry、Hastings Center Report、Journal of Medical Ethics（JME）、HEC Forumなどの医療専門職や看護職向けジャーナルは、道徳的苦悩に関する論説や実証研究の論文を掲載し始めた。また、道徳的苦悩は一般のメディアでも関心を集めている。たとえば、2019年のNew York Times紙に掲載された脳神経外科医の道徳的苦悩の経験に関する記事には、発行から最初の10日間で200件以上のコメントが寄せられた[20]。

2. Research on moral distress

For over three decades, Jameton's delineation of moral distress has, for the most part, been the standard definition deployed in the qualitative,[21] quantitative,[18, 22] and argument-based literature on this topic.[23] In quantitative studies, for example, the most widely used instrument to determine the prevalence and the impact of moral distress on professionals and patients operationalizes the standard account of moral distress. This is the moral distress scale (MDS) introduced in 2001[24] and revised and broadened as the Moral Distress Scale-Revised (MDS-R) in 2010.[25] In 2019, drawing on the international evidence gained from the deployment of the MDS-R, Epstein et al radically revised and renamed the MDS-R as the Measure of Moral Distress for Healthcare Professionals (MMD-HP).[26] Interestingly, the testing of this new scale identified, as Jameton did, that aggressive end-of-life treatment continues to be ranked very highly as a source of moral distress by all health professionals but especially by those who work at the patient's bedside:

> 'Our findings indicate that patient-level root causes, especially those related to overly ag-

2．道徳的苦悩に関する研究

30年以上にわたり、道徳的苦悩に関する質的[21]、量的[18, 22]、および論説の研究論文の大部分は、ジェイムトンJametonの道徳的苦悩の定義を採用している[23]。たとえば、量的な研究では、専門職者や患者に対する道徳的苦悩の蔓延や影響を決定する測定道具として、道徳的苦悩の標準的説明が幅広く用いられている。これは2001年に登場した道徳的苦悩尺度（moral distress scale: MDS）[24]であり、2010年に改訂され、改訂版道徳的苦悩尺度（MDS-R）として広まっている[25]。2019年、MDS-Rの展開から得られた国際的なエビデンスに基づいて、エプスタインEpsteinらはMDS-Rを根本的に改訂し、医療専門職の道徳的苦悩尺度（the Measure of Moral Distress for Healthcare Professionals: MMD-HP）と改名した[26]。興味深いことに、この新しい尺度のテストでは、ジェイムトンJametonが定義したように、人生の最終段階における積極的治療が、すべての医療専門職とくに患者のベッドサイドで働く人々の道徳的苦悩の原因として、引き続き高いランクにあることが確認された。

> 「我々の研究結果は患者レベルの根本的原因を示している。とくに、終末期の行き過ぎた積極的

gressive treatment at the end of life, continue to be among the most morally distressing for all HCPs, especially nurses and other direct providers.'[27]

Alongside the growing international and transdisciplinary empirical interest in the phenomenon of moral distress, there has also been a great deal of philosophical engagement with the conceptualization of moral distress. For some, the standard account of moral distress (as per Jameton), while imperfect, draws attention to the process and context of ethical decision-making and brings questions about moral responsibility and professional accountability to the fore.[27-29] Others dispute the usefulness of a concept that they claim does not clearly pick out a discrete phenomenon or set of phenomena, that can be counted as a genuine experience of moral distress.[30, 31] Consistent with this view are those who suggest that the standard account of moral distress is too narrow and that it should be broadened to include other morally stressful experiences and situations including, for example, uncertainty, moral conflict and moral bad luck.[32, 33] Others still, approach moral distress using a wider socio-political lens such as that of feminism,[34, 35] or, consider it in relation to other concepts such as moral sensitivity,[36] moral resilience,[37] or, powerlessness.[38]

治療に関連する諸原因が医療専門職、なかでも看護師などの患者に直接関わるケア提供者にとって最も道徳的に苦悩を伴うものであることを示している。」[27]

道徳的苦悩の現象への国際的・学際的に高まる実証的関心に加えて、道徳的苦悩の概念化を含む哲学的関与も数多くある。一部の人にとって、（ジェイムトンJametonによるような）道徳的苦悩の標準的定義は、不完全であるものの倫理的意思決定のプロセスや文脈に注意が向けられ、道徳的責任や専門職のアカウンタビリティについての疑問点を鮮明にする[27-29]。一方では、道徳的苦悩の真の経験として説明できる個別の現象、もしくは一連の現象を明確に抽出しないとして、概念の有用性に異議を唱える研究者もいる[30, 31]。この見解のもつ一貫性としては、道徳的苦悩の標準的説明はあまりにも狭義であるという主張である。たとえば、不確かさ、道徳的葛藤や道徳的不運などの他の道徳的にストレスの多い経験や状況を包むよう広められるべきであると示唆されている[32, 33]。他には、フェミニズムのような広い社会政治的な視座を用いて道徳的苦悩にアプローチするか[34, 35]、さもなければ道徳的感受性[36]やモラルレジリエンス[37]、無力感[38]などの、他の概念との関連で道徳的苦悩について考察している研究がある。

3．Conclusion

Whether broad or narrow, it is clear from the research to date that the concept of moral distress resonates with a wide range of health and allied professionals in clinical practice and there is growing international recognition that interventions are needed to address it in order to avoid its negative impact on the quality of patient care through staff burnout, staff retention, and morale.[14, 39-42]

It might be concluded that the very untidyness and the blurry parameters of the concept of moral distress provide opportunities to bring the various dimensions of the work of nurses and other health professionals to the fore in ways that might, otherwise, be overlooked. In short, moral distress might be understood as a multi-dimensional concept that articulates social and normative practices involving the construction of moral authority, the assignment of responsibility and the emotional dimensions of ethical decision-making. The words of feminist philosopher, Margaret Urban Walker, are helpful here.

3．結論

広義かまたは狭義かにかかわらず、道徳的苦悩の概念が臨床の場における幅広い医療専門職やコメディカルに適することは、これまでの研究から明らかである。患者ケアの質からスタッフのバーンアウト、スタッフの定着、やる気までへの悪影響を避けるために、その対処のための介入が必要であるという国際的な認識が高まっている[14, 39-42]。

道徳的苦悩の概念のまとまりのなさや明瞭でない変数項目は、看護師や他の医療専門職の仕事のさまざまな側面を、他では見落としていたかもしれない方法で浮かび上がらせる機会を提供すると結論づけられるかもしれない。要するに、道徳的苦悩は多次元的な概念として理解されるのかもしれない。すなわち、道徳的権限の構築、責任の割り当てから倫理的意思決定の感情的側面までを含む社会規範的な実践を明確にする概念である。

フェミニスト哲学者であるマーガレット・アーバン・ウォーカーMargaret Urban Walkerの言葉がここで役立つと思われる。彼女は次のように指摘している。

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.'[43] Urban Walker's words find an echo in the questions that Jameton originally posed when he interrogated the meaning of moral distress:

> 'What is possible for me to do?' 'What is the extent of my responsibility?' 'What personal risks are health professionals obligated to take for patients?' '[T] o what extent should I share the blame? [for shared decisions that lead to harm?]'[44]

In a world where the cost of acting ethically is becoming increasingly difficult to bear while the implications of acting unethically are increasingly grave, it is imperative that nurses and other health professionals stay with these questions in order to exert ethical authority, shape their own professional boundaries, and scrutinize organisational systems and structures that do not serve them or their patients well. '

「道徳的秩序が異なる立場の複雑なネットワークであることが多いのが現実とすれば、私たちはこれらの秩序の中で、自分が誰であり、どこにいるのかを理解する必要がある。それにより自分たちが何に責任を負っていて、誰に対する責任があるのかを知る。」[43]

このアーバン・ウォーカーUrban Walkerの言葉は、ジェイムトンJametonが道徳的苦悩の意味を問うた時に最初に提起した質問に呼応している。

> 「私にできることは何か？」「自分の責任の範囲は？」「医療専門職は患者に対してどのような個人的リスクを負うように義務づけられているのか？」「共有された意思決定が害となる場合に、私はその咎をどの程度共有すべきなのか？」[44]

今世界は、非倫理的な行動の結果がますます由々しき状況となっているなか、倫理的な行動をとる負担は負い切れないほど増大している。このような状況において、私たち看護師や他の医療専門職がこれら疑問を持ち続けることは義務である。それは、倫理的権限を行使し、自らの職業を形作り、自分や患者に役立たない組織のシステムや構造を厳しく精査するためなのである。

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