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MORAL DISTRESS AND THE HEALTH CARE ORGANIZATION

A DISSERTATION SUBMITTED TO

THE FACULTY OF THE GRADUATE SCHOOL

IN CANDIDACY FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

PROGRAM IN PHILOSOPHY

BY

ANDY KONDRAT

CHICAGO, ILLINOIS

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And, of course, my parents, Bill and Cheryl Kondrat. It is not an exaggeration to say this would not have been possible in any way, shape, or form without their ceaseless love, encouragement, and support. I am so very fortunate to have parents who actually thought getting a PhD in philosophy was a good idea (I'm still on the fence about the matter), and they never doubted for a second that I would succeed. I hope that, in part, this dissertation proves them right.

For my parents, who knew before I did that I should pursue philosophy,
and then let me find out for myself

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CHAPTER ONE

INTRODUCTION AND DESCRIPTION OF MORAL DISTRESS

Introduction

Over the past three-plus decades, a literature has emerged identifying, defining, and addressing the experience of moral distress in health care professionals. Since the introduction of the concept in 1984, many writers have discussed moral distress as a nursing ethics issue, or more broadly as a clinical ethics issue, but there has been almost no literature addressing moral distress in health care professionals as an organizational ethics issue. This dissertation is an attempt to fill that gap.

The format of the dissertation is as follows: Chapter One surveys the literature on moral distress, and provides a working definition of what it means to experience it. In doing so, moral distress is differentiated from moral dilemmas and conscientious objection in health care. This chapter also discusses the causes of moral distress, its scope, and its effects on health care professionals, health care organizations, and the patients they care for. Finally, it delineates the particular contexts in which moral distress occurs that are the specific focus of this project.

Chapter Two makes the argument that moral distress ought to be seen as an organizational ethics issue, and that an institution that does not respond to moral distress in its health care professionals is failing in its moral obligations. This argument rests on the premise that groups generally, and health care organizations specifically, are capable

of moral agency. The main arguments in support of this claim are summarized in this chapter. Following that, examples of what is currently being done by health care organizations to address moral distress are examined, and the argument is made that the most prevalent responses are hierarchically structured; that is, situations of moral distress are typically handled through an appeal to institutionally established patterns of hierarchical authority. The first major normative thesis of the dissertation is introduced at this point; namely, that such a hierarchical response is an ethically incorrect response to moral distress in health care professionals, and that a morally superior response can be identified by examining the defects of contemporary responses.

Chapter Three provides a detailed argument for why efforts to address moral distress hierarchically should not be implemented as an organization's primary ethical response to moral distress, and ought to be replaced by a response that respects the moral equality of health care professionals. To this end, an argument for including the morally distressed individual in the resolution process is defended, followed by an argument for the inclusion of other health care professionals in the discussion and resolution of moral distress, *even if they are not among the morally distressed individuals*. This will then lead to the introduction and explanation of what this dissertation calls the "content-thin common moral framework" that is shared by most health care professionals in American society (and other similar societies). In order to explain this framework, Michael Walzer's "thick/thin" distinction of moral concepts is introduced, as is the concept of a common professional morality, and the existence of such a common morality among most health care professionals in American society will then be defended.

By sharing this common professional morality, health care professionals share, at least broadly and blandly, key concepts about their professional obligation to uphold the goals and values of professional health care. Because of this, the content-thin common moral framework is available to provide the means to create the peer-to-peer, equality based, inclusive, non-hierarchical forum that is needed for health professionals to discuss and resolve situations of moral distress.

Building on the content-thin common moral framework, Chapter Four studies the contrasts between "moral friends," "moral strangers," and "moral acquaintances" developed and discussed most directly by H. Tristam Engelhardt and Kevin Wm. Wildes in order to develop the philosophical basis for the model of moral distress resolution proposed in this dissertation. This chapter argues that because their common professional morality creates a content-thin common moral framework in which to discuss moral matters, health care professionals can be considered moral acquaintances, who sufficiently understand each other's moral worlds that they can share their various perspectives within it. If this is the case, then Engelhardt's moral strangers' purely procedural, content-free moral context is not the only available response to moral distress. However, because health care professionals are moral acquaintances and not moral friends, a thoroughgoing, content-full response is not available and would also be inappropriate. What will be needed, therefore, is the middle ground of a content-thin response to moral distress, and so a procedure for achieving this kind of discussion should be developed.

Chapter Five appeals to Jürgen Habermas' theory of communicative action and rules of discourse ethics to provide such a procedure in the form of rules and premises that health care professionals, as moral acquaintances, can use to create the forum for a content-thin procedural response to moral distress. The chapter will show that, in "everyday" communication, health care professionals interact with each other much in the way described by Habermas' theory of communicative action. However, when moral distress is experienced, and a resolution of the moral distress situation is needed, Habermas' theory of discourse ethics can provide procedural rules appropriate for moral acquaintances, using their content-thin common moral framework as a basis for their discussions, to address moral distress in the proper way.

In Chapter Six, an example of an insufficient moral distress resolution process will be analyzed, and by highlighting how a health care organization can fail its obligation to respond to moral distress, the chapter will then be able to offer suggestions for practical positive institutional responses. In the chapter's concluding remarks, some unresolved questions raised in this dissertation will be acknowledged, and areas for further investigation will be identified.

Moral Distress Defined

Though there is basic and generic agreement in the literature on what moral distress is and when it occurs, there is not, in fact, a specific or technical definition for moral distress. The term "moral distress," in relation to how it is understood today, first

appeared in 1984 in Andrew Jameton's *Nursing Practice: The Ethical Issues*.[1] Jameton

contrasts moral distress with two other types of ethical problems found in hospitals:

moral uncertainty and moral dilemmas.[2] Moral uncertainty occurs when one does not

know which moral principles apply, or cannot even articulate what the moral problem is,

in a given situation. Moral dilemmas arise when two or more moral principles or other

moral standards apply to a morally problematic situation, but these are at odds with one

another regarding which course of action each would support. Moral distress, finally,

occurs "when one knows the right thing to do, but institutional constraints make it nearly

impossible to pursue the right course of action."[3]

Jameton provides an example—a case in which a hospital's procedures state that

all patients admitted to the hospital must receive unnecessary blood tests, which incurs

both cost and risk—and states that moral distress could occur if a nurse believed adhering

to these procedures is unethical but "staff nurses employed by the hospital have neither

the personal authority nor access to decision-making channels needed to change the

practice. Moreover, it is personally risky for staff to criticize a practice that helps the

hospital make ends meet."[4] Jameton does not elaborate on the concept of moral distress

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[1] As Jameton refers to moral distress as an "ethical issue," it is important to note that he does not draw a distinction between the definition of "moral" and "ethical." The literature on moral distress has continued to use the two interchangeably, and that will be the case in this dissertation as well.

[2] Jameton differentiates the three types of moral problems, but then interestingly conflates, or even ignores, the issue throughout the rest of his work.

[3] Jameton, *Nursing Practice*, 6.

[4] Jameton, *Nursing Practice*, 6.

further, but his description provided the nucleus around which all subsequent discussions have revolved: moral distress occurs when someone knows the ethical thing to do, but is unable to act on it due to constraints of some sort.

Since Jameton originally coined the term, numerous different proposals have been given for a definition of moral distress, including one more by Jameton himself. Within a decade of introducing it, Jameton had refined the concept by dividing the phenomenon into the separate categories of (1) initial distress and (2) reactive distress.[5] Epstein and Hamric, though preferring the terms "moral distress" and "moral residue" to label the two categories, state that initial moral distress is felt during the acute phase of a situation occurring, while the moral residue is the lingering discomfort felt when the situation is over, but the morally distressed person still carries the weight of having had her values compromised.[6] Most writers, however, do not separate these two stages while discussing moral distress.[7] Instead, the differences among definitions more often are in regard to either the kinds of feelings that "count" as moral distress, or the contexts in which or the sources from which they arise. But the bulk of the literature, as will be shown, agrees enough on central themes and signs of moral distress to build an adequately clear description of moral distress to work with in this dissertation.

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[5] Jameton, "Dilemmas of Moral Distress."

[6] Epstein and Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect."

[7] Though this dissertation does not explicitly address moral residue, the suggestions for how to resolve moral distress offered here would likely also have a positive effect on the reduction of moral residue.

The Literature Describing Moral Distress

Two of the five articles in a 2012 issue of *HEC Forum* dedicated to moral distress make the claim that because, as Pauly, Varcoe, and Storch state, "moral distress is defined variously in different studies,"[8] there is currently no standardized, dependable definition of moral distress. Furthermore, these authors believe that these different definitions are an impediment to dealing with moral distress: "Research and action on moral distress has been constrained by lack of conceptual clarity and theoretical confusion as to the meaning and underpinnings of moral distress."[9] Hamric agrees, stating that though the term is now three decades old, "alternative definitions and concepts abound and there is no central agreement on the key definitional features of the phenomenon."[10] However, there are many articles that work with relatively similar descriptions of moral distress, and therefore an adequately clear description of this phenomenon can be arrived at by looking at those descriptions to see what they have in common. It's interesting to note, as well, that though Pauly and colleagues and Hamric here state that the concept remains unclear, each of those authors provide definitions of moral distress in other articles. In other words, even those authors who discount the existence of a coherent definition of moral distress use the term comfortably and assume that their readers know what it means well enough.

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[8] Pauly, Varcoe, and Storch, "Framing the Issues," 2.

[9] Pauly, Varcoe, and Storch, "Framing the Issues," 1.

[10] Hamric, "Empirical Research on Moral Distress," 40.

There are four core themes comprising the experience of moral distress that emerge in almost all the literature: a morally distressed individual (1) believes she knows what the ethical course of action to take is, but (2) is prevented in some way from following that course, or must in fact do, or cooperate in doing, otherwise, due to (3) internal or external constraints. In doing so, she (4) acts in a manner contrary to her personal or professional values, which undermines her integrity and authenticity.

The first theme, and chronologically the first step in moral distress, is that the individual believes she knows what the ethical course of action to take is: she has made what some writers call a "moral decision" or a "moral choice" about what ought to be done.[11] Although the strong claim has been made that in a moral distress situation the individual *knows* the ethically correct course of action,[12] a weaker claim, namely that the individual *believes she knows* or *has a conviction regarding* what the ethically correct course of action is, seems more appropriate.[13] This distinction is not only important for descriptive purposes, but for normative purposes as well (that is to say, for how moral distress can be resolved successfully, which will be discussed later in this dissertation).

Descriptively speaking, moral distress is a reaction to what one sees occurring (or not occurring) and, as will be shown later, one that involves a "psychological

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[11] Corley, "Nurse Moral Distress," 643; Viney, "Ethical Decision-Making Experiences," 186; Zuzelo, "Exploring the Moral Distress of Registered Nurses," 344-45; Austin et al., "To Stay or to Go," 199; Rushton, "Defining and Addressing Moral Distress," 161.

[12] Elpern, Covert, and Kleinpell, "Moral Distress of Staff Nurses," 523; Rushton, "Defining and Addressing Moral Distress," 161.

[13] Austin et al., "To Stay or to Go," 198-99; Epstein and Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," 331; Kälvermark et al., "Living With Conflicts," 1077; Schwenzer and Wang, "Moral Distress in Respiratory Care Practitioners.

disequilibrium"[14] or "negative feeling state."[15] But because moral distress is an individual's (emotional and/or physical) reaction to what she regards unethical, it cannot be the case that the individual *must* be taken to *know* what the ethical course of action is in order to experience moral distress, for that would imply that her moral judgment about the matter must be correct to in order to say that she is "really" experiencing moral distress. It does not make sense to require that the individual must actually be correct in order to acknowledge that she feels the negative symptoms associated with her belief about the matter. Saying that moral distress only occurs when the distressed individual *knows* the correct course of action is therefore too high an epistemic bar to set, given the empirical reality of moral distress and the fact that it can be felt *even if the distressed individual is mistaken* for some reason or another in her conviction.

The second component of a moral distress situation is that, given that an individual believes she knows what the ethical course of action is, or believes she knows that the course about to be undertaken is unethical, she is nevertheless unable to perform that action, or must do or be complicit in doing what she thinks is unethical. Put most simply, she is "not able to 'do the right thing'" (which, in practice, may translate into participating in the wrong thing).[16]

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[14] Corley, "Nurse Moral Distress," 643.

[15] Viney, "Ethical Decision-Making Experiences," 186.

[16] Pauly et al., "Perceptions of Moral Distress," 562.

The reasons for this inability are the third core feature of moral distress, which are internal (i.e., personal) or external constraints.[17] External constraints can include, for example, "coworkers' attitudes, inadequate staffing, the hierarchy of medical power, policy constraints, and financial limitations."[18] External constraints can also include demands of patients and/or families that health care professionals deem not to be in the patient's best medical interest. Situations of this latter sort arise from the primacy placed on patient/surrogate autonomy in our health care system, even when the patient's/surrogate's preferred course of action is at odds with medical recommendations.

The division between internal and external constraints is common to many authors on moral distress and corresponds to many first-person reports of moral distress. But as will be argued below more fully, any constraint labeled "internal" is in fact a symptom of an external constraint over which the morally distressed person has no control. This is the principal reason why it will be argued that, when determining how moral distress ought to be resolved, individual responses are likely to fail and organizational action is ordinarily required. It is also why, when appropriate organizational action is undertaken (as will be explained in this dissertation), so-called "internal" causes of distress may be resolved in the same way as external causes of moral distress.

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[17] Ulrich, Hamric, and Grady, "A Growing Problem," 20. See also Austin et al., "To Stay or to Go," Epstein and Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect" and Rushton, "Defining and Addressing Moral Distress."

[18] Schwenzer and Wang, "Moral Distress in Respiratory Care Practitioners," 2967.

For example, two common types of internal constraints are "a lack of moral courage"[19] and "personal inhibition."[20] As will be shown later, organizational structures are almost always involved when a distressed individual feels that she lacks courage, or she feels unable to address an ethical failing. Attempting to fix internal constraints only at the individual level overlooks the fact that the individual is often, through no fault of her own, ill-equipped to solve her own distress when no organizational mechanism is in place to address moral distress.

In fact, organizational mechanisms can contribute to and, in fact, exacerbate the moral distress; still worse, blaming the victim of the moral distress for its existence can create a vicious circle if she experiences further moral distress from being unable to resolve it. Thus, stating oversimply that moral distress comes from within (1) ignores the fact that an external factor is almost always one cause of the moral distress situation, and (2) implies that the individual should be able to address the problem on her own, because the moral distress is her fault. This incorrectly attributes responsibility and often blame to a person reacting to a barrier most likely placed by someone or something other than herself.

A further weakness of the internal/external distinction was hinted at in the above explanation, but should be made explicit. One factor that can cause or contribute to moral distress is the circumstance in which the health care team of which a health care professional is a part decides to act in a way she believes to be ethically incorrect. This

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[19] Austin et al., "The Balancing Act," 89-90.

[20] Schwenzer and Wang, "Moral Distress in Respiratory Care Practitioners," 2967.

kind of situation does not fit neatly into the internal/external distinction, for the health care professional is a member of the team that has decided to act in a way she deems morally incorrect. Thus, while the decision comes from within the group, it comes from outside the individual. Unfortunately, this specific iteration is not often directly addressed in the moral distress literature. But as medical practice in health care institutions becomes more frequently, and necessarily, team-based care, this type of moral distress situation will happen more and more often. As the number of health care professionals that care for a single patient increases, the possibility for disagreement, conflict, and distress also increases, especially as power dynamics come into play.

Take, for example, a typical patient in the ICU of a good-sized hospital. On any given day, participating in the care of this patient will be: a number of nurses (at least one per shift), resident coverage (at least two a day), an attending physician (one of several rotating weekly or more often, with coverage and call as needed), respiratory therapist, pharmacologist, lab technicians, x-ray and radiology specialists, and depending on the level and type of illness of the patient, one or more of the following specialists: infectious disease, nephrology, catheterization lab, oncology, allied health, hematology, hospice/palliative care, and a number of other possibilities. Contemporary medical practice is necessarily team practice, and there is plenty of room for conflict among the above health care professionals before patients and families are even involved as decision makers in the course of care. Thus, it seems clear that, in addition to the other constraints to acting on an ethical decision, moral distress can arise when the health care team, or the authoritative body in charge of the team (say, the attending physician), acts in a way that

one of its members believes to be ethically inappropriate, and that person does not

have the power to effectively raise objections to, or in any case to change, that decision.

The fourth component of moral distress is that the individual acts (or the team of

which she is a part acts) "in a manner contrary to [her] personal or professional values."[21]

Because a health care professional in a moral distress situation is helpless to

"translate…moral choices into moral action," the fact that she must act "in a manner

contrary to personal and professional values undermines the individual's integrity and

authenticity."[22] Even though, as stated above, a health care professional ordinarily ought

not blame herself for experiencing moral distress, the fact that she is unable to alter what

she sees as morally wrong causes her to feel as if she has "failed to act ethically,"[23] or is

even complicit in the moral wrongdoing. Moral distress, then, is not merely disagreeing

with the decision made by another. By being unable to change the decision while playing

either an active or passive role in its implementation, in moral distress the individual feels

uprooted from her personal and professional values, or even that she has violated those

values or duties.[24]

Moral distress, then can be defined as follows: An instance of moral distress

occurs when an individual believes she knows what the ethical course of action to take is,

but is prevented from implementing that course or must do or cooperate in doing

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[21] Elpern, Covert, and Kleinpell, "Moral Distress of Staff Nurses," 523.

[22] Rushton, "Defining and Addressing Moral Distress," 161.

[23] Austin et al., "The Balancing Act," 90.

[24] Epstein and Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," 331.

otherwise, due to external or internal constraintss; and in doing so, she acts (or is

complicit in, or views herself as acting complicitly) in a manner contrary to her personal

or professional values, undermining integrity and authenticity.

What Moral Distress Isn't

Before proceeding, however, it is important for the sake of clarity to differentiate

moral distress from what it is *not*, which includes such categories as moral dilemmas,

moral stress, and conscientious objection in health care.

As was noted above, in his original work on moral distress Jameton differentiated

moral distress from moral dilemmas (as well as from moral uncertainty, but as moral

uncertainty involves not even knowing what the problem is, it is so far removed from

moral distress it need not be addressed further here). Moral distress is *not* the agony that

comes with not knowing what the ethical course of action is, or which of two or more

conflicting ethical principles or other moral standards should take precedence in a given

situation. Being unsure of what to do in a given clinical scenario, as in a moral dilemma,

is not a cause of moral distress as the concept is currently understood, even if this is a

cause of moral *stress*.

In a situation with a moral dilemma, for example, there might be a conflict

between patient autonomy and nonmaleficence (to use two "standard" principles of

bioethics), "but to act on one necessarily precludes acting on the others [sic]. While doing

something right, the person is also doing something wrong, by not doing something else

that is right."[25] Or, it could be that "the ethically correct course of action is in doubt,"[26]

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[25] Corley, "Nurse Moral Distress," 637.

but *some* action is required (in health care dilemmas, unlike in theoretical ones, not coming to a decision still creates an outcome), so there is a moral dilemma as to which course of action to choose. Moral dilemmas are about picking the most ethical action, while moral distress is the reaction to the belief that the action (or lack thereof) being picked is unethical, and being unable to do otherwise. The question raised with moral dilemmas might be, "What should we do?" The question moral distress might prompt is, "How can we be doing this?"

Conscientious objection in health care professionals also differs from moral distress in important respects. According to Mark Wicclair's detailed study, health care professionals "engage in acts of conscientious objection when they: (1) refuse to provide legal and professionally accepted goods or services that fall within the scope of their professional competence, and (2) justify their refusal by claiming that it is an act of conscience or is conscience-based."[27] Given this definition, Wicclair identifies four differences between conscientious objection and moral distress in the work of health care professionals.

The first is that "moral distress is considerably more pervasive than conscientious objection."[28] For as will be shown the causes of moral distress are both diverse and myriad, while conscientious objection is often "limited to a few specific goods and services, such as EC [emergency contraception], family planning, abortion, palliative

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[26] Elpern, Covert, and Kleinpell, "Moral Distress of Staff Nurses," 523.

[27] Wicclair, *Conscientious Objection in Health Care*, 1.

[28] Wicclair, *Conscientious Objection in Health Care*, 9.

sedation, and organ donation after cardiac death."[29] A health care professional, then, is far more likely not only to witness, but experience, moral distress, than she is to feel the need to perform an act of conscientious objection.

Secondly, Wicclair claims that moral distress most often is the result of a violation of "generally recognized ethical and professional norms," while an act of conscientious objection occurs when one's personal ethical beliefs are violated.[30] If a health care professional is experiencing moral distress, she can usually point to some agreed-upon professional or ethical standard being ignored or impinged upon (indeed, these agreed-upon standards will play an important role in the proper resolution of moral distress situations, as will be discussed in Chapter Three). Conscientious objection, however, occurs when a health care professional disagrees ethically with "procedures *that do not violate professional standards*."[31] Thus, while a conscientious objector believes a course of action is unethical *in spite of* what is professionally *appropriate*, moral distress occurs *because* a health care professional believes a course of action is professionally *wong*.

The third difference Wicclair notes is that while conscientious objection is an act of refusal to provide care in a given way, "moral distress arises from *an inability to refrain from*: (1) acting inappropriately, (2) participating in inappropriate action, and/or

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[29] Wicclair, *Conscientious Objection in Health Care*, 9.

[30] Wicclair, *Conscientious Objection in Health Care*, 10.

[31] Wicclair, *Conscientious Objection in Health Care*, 10. Emphasis added.

(3) preventing others from acting inappropriately."[32] When experiencing moral distress, it is not that an individual refuses to act unethically, but that she *can do nothing else* other than act unethically, or at least be complicit in or be unable to prevent an action she considers morally wrong. She cannot withdraw from the situation as a conscientious objector attempts to do, but instead is forced into the psychological disequilibrium of being unable to avoid being be a part of that which she believes to be morally inappropriate.

Finally, Wicclair proposes that, because the belief spurring conscientious objection is rooted so deeply in the individual performing it, to do otherwise and to act against one's conscience is far more likely to be "an act of self-betrayal" than instances of moral distress, which instead involve "actions that are perceived to be morally *inappropriate*."[33] Here, Wicclair is attempting to show that performing actions that one conscientiously objects to is experienced as being a far more egregious violation of oneself than acts (or acts of omission) that give rise to moral distress. But the literature on moral distress shows that moral distress can also undermine integrity and authenticity, so Wicclair's fourth distinction may not hold up under more careful examination. It is therefore noteworthy that Wicclair also hedges here; he uses the phrase "morally inappropriate" when most authors use stronger phrases like "morally wrong" or "ethically right" in relation to moral distress. However, Wicclair is correct in stating that moral distress need not only occur when an action or procedure is "contrary to one's core moral

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[32] Wicclair, *Conscientious Objection in Health Care*, 10. Emphasis in the original.

[33] Wicclair, *Conscientious Objection in Health Care*, 10-11. Emphasis in the original.

beliefs," as is the case in conscientious objection.[34] This lower threshold than is

characteristic of conscientious objection, however, is the reason why moral distress is as

prevalent as it is in health care professionals, and thus a matter requiring serious moral

attention.

Alternate Definitions of Moral Distress

Because there has been so much discussion in the literature about what counts as

moral distress, it is worth briefly noting and setting aside the proposals that are most at

odds with the mainstream on this point, as there are a few writers on moral distress whose

definitions of the term differ markedly from the one offered as a working definition in

this dissertation. Oberle and Hughes state that "Misunderstandings and even conflicts

with doctors, resulting from an inability to influence decisions and decision-making

processes" were causes of moral distress in nurses.[35] Austin, meanwhile, writes (as one of

the *three* different definitions she has provided among her various works) that moral

distress refers to "experiences of frustration and failure arising from struggles to fulfill

their moral obligations to patients, families, and the public."[36] In both cases, these authors

are outside the mainstream of scholarly work. Oberle and Hughes are applying the term

"moral distress" to what sound like disagreements or confusion, which, while potentially

stressful, are different from the undermining of values that stems from being unable to

pursue the ethical course of action; that is, Oberle and Hughes set the bar too low for

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[34] Wicclair, *Conscientious Objection in Health Care*, 11.

[35] Oberle and Hughes, "Perceptions of Ethical Problems," 709.

[36] Austin, "Moral Distress and the Contemporary Plight of Health Care Professionals," 28.

moral distress. Austin, meanwhile, has provided too little information to sufficiently define moral distress. It seems that her description could just as easily apply to what Jameton termed "moral dilemmas," as Austin's wording does not include a reason why there is a struggle to fulfill a moral obligation (remembering that moral dilemmas can occur when competing ethical standards exist, it could be that one moral obligation is going unfulfilled for the sake of another one). Furthermore, Austin does not say that, in this struggle, the outcome is that the health care professional must engage in or be complicit in an act she deems unethical. Again, the bar is set too low to call this an adequate definition of moral distress, given how the topic is treated in the work of most authors.

In a similar vein, Sporrong and colleagues say that a "broader definition" of moral distress is appropriate because it can "'occur due to situations…where the health care provider feels she or he is not able to preserve all interests and values at stake'. This means that the concept includes stressful responses to ethical dilemmas also when a desired action has been pursued."[37] Førde and Aasland state that moral distress can be caused "by conflicting ideals and by moral uncertainty."[38] Thus, these authors explicitly collapse the distinction between moral distress and moral dilemmas even though this distinction is found in the rest of the relevant literature.

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[37] Sporrong, Höglund, and Arnetz, "Measuring Moral Distress," 418. This excerpt quotes Kälvermark et al., "Living With Conflicts," 1082.

[38] Førde and Aasland, "Moral Distress Among Norwegian Doctors," 521.

Not Only Nurses

Much of the moral distress literature discussed up to this point has focused on nurses.[39] For, since it is a historical fact that nurses have been expected to care for patients without being able to direct the care, moral distress is most obviously a nursing issue, and it makes sense that the majority of the moral distress literature has focused and continues to focus on nurses. That being said, however, a number of studies have shown that moral distress exists across the health care professions. Moral distress has been found in doctors across the spectrum of specialties,[40] as well as newly-minted doctors in residency programs.[41] Pharmacists and pharmacy assistants, in both pharmacies and clinical settings, experience moral distress.[42] Respiratory therapists report "moral distress in many areas of their practice."[43] Austin and colleagues have studied moral distress in both psychologists[44] and psychiatrists.[45] In one study on home-based palliative care, moral distress was reported in nurses, personal support workers, occupational therapists,

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[39] As an acknowledgement of the historically gendered nature of the nursing profession, much of the literature on moral distress uses the pronoun "she."

[40] Førde and Aasland, "Moral Distress Among Norwegian Doctors."

[41] Rosenbaum et al., "Sources of Ethical Conflict in Medical Housestaff Training."

[42] Sporrong, Höglund, and Arnetz, "Measuring Moral Distress."

[43] Schwenzer and Wang, "Moral Distress in Respiratory Care Practitioners," 2967.

[44] Austin et al., "To Stay or to Go."

[45] Austin et al., "The Balancing Act."

physiotherapists, and speech language pathologists.[46] Non-medical specialists such as

social workers[47] and health care managers[48] also experience moral distress. It seems

clear, then, that moral distress is not solely a nursing issue, but can affect any health care

professional that interacts with institutions or other professionals in the course of

providing care for patients: that is to say, *all* health care professionals. Furthermore, as

physicians, like most other health care professionals, are more and more frequently

becoming employees of hospitals and of health systems (e.g., hospitalists, or belonging to

health system-owned group medical practices), it seems likely that physician providers

will experience moral distress more frequently.[49]

In addition, in the Moral Distress Scale developed by Corley and colleagues to

assess the types and rates of moral distress in nurses, many of the 32 different markers for

moral distress are scenarios that would affect all health care professionals. Consider, for

example, markers such as "perform a procedure when the patient is not adequately

informed about procedures which he/she is about to undergo" or "follow the family's

wishes to continue life support even though it is not in the best interest of the patient."[50]

Hamric has in fact created multiple versions of the Moral Distress Scale that are

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[46] Brazil et al., "Moral Distress Experienced by Health Care Professionals," 1688.

[47] Ulrich et al., "Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States."

[48] Pauly et al., "Perceptions of Moral Distress," 2.

[49] The original germ of this thought is in Hamric, "Moral Distress in Everyday Ethics," 200.

[50] Corley et al., "Development and Evaluation of a moral distress scale."

specialty-specific, including specialized caregivers like pediatric physicians, and a catchall category of "other" health care providers. Therefore this dissertation will not limit its focus to nursing, but instead address moral distress in health care professionals generally, even though much of the scholarly work that has been done on the subject has focused on nurses and their experiences of moral distress.[51]

The Impact of Moral Distress on Health Care Professionals and Institutions

Moral distress affects individual health care professionals in different ways. However, some general themes have emerged in the literature regarding its effects on the people experiencing it, and in turn the effects moral distress has on team dynamics and patient care. For moral distress has effects both internal and external to the individual.

Physical reactions to moral distress include bodily pain "such as sweating, headaches, nausea and diarrhea, and crying,"[52] as well as sleep dysfunctions including insomnia.[53] In one small study of critical care nurses, emotional responses included sadness, anger, frustration, and disgust.[54] Feelings of powerlessness are common.[55]

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[51] Though it was just shown that moral distress is not bound by profession, following in the tradition of the literature on moral distress this dissertation will use the pronoun "she" when a pronoun is required, with the awareness that such usage is a product of the historically gendered nature of the nursing profession.

[52] Austen et al., "To Stay or to Go," 200.

[53] Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress," 235.

[54] Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress."

[55] Epstein and Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," 334; Zuzelo, "Exploring the Moral Distress of Registered Nurses," 346.

Nurses experiencing moral distress stated they were reluctant to come to work or care

for patients, as well as emotional and physical withdrawal from others.[56] Left unchecked,

moral distress can lead to a loss of self-worth.[57] Ultimately, the effects of moral distress

can lead to professional burnout,[58] or cause an individual to leave her profession

entirely.[59]

All of the above symptoms also have, not surprisingly, a detrimental external

effect on professional conduct and collaboration. This is not only due to the turnover that

comes with morally distressed health care professionals leaving their profession, though

turnover does lead to lost expertise, short-staffing, and added work and stress put on

those that remain. It is also due to the fact that morally distressed health care

professionals and their peers "may experience poor communication, lack of trust…and

lack of collaboration across disciplines."[60] This will have a clear effect on team cohesion,

especially, as will be discussed later, when moral distress arises from hierarchical

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[56] Pauly et al., "Perceptions of Moral Distress," 562.

[57] Elpern, Covert, and Kleinpell, "Moral Distress of Staff Nurses," 529; Zuzelo, "Exploring the Moral Distress of Registered Nurses," 346; Rushton, "Defining and Addressing Moral Distress," 162.

[58] Corley, "Nurse Moral Distress," 639; Førde and Aasland, "Moral Distress Among Norwegian Doctors," 521.

[59] Corley et al., "Nurse Moral Distress and Ethical Work Environment," 382; Rushton, "Defining and Addressing Moral Distress," 162; Zuzelo, "Exploring the Moral Distress of Registered Nurses," 346.

[60] Rushton "Defining and Addressing Moral Distress," 162.

processes that frustrate attempts to do what one thinks is right.[61] For now, it is enough

to note that nurses who are criticized for making suggestions or left out of the decision

making process "frequently feel powerless to influence care situations and some no

longer attempt to implement moral judgment due to frustration and anger provoked from

lack of physician response to their input in previous ethical situations."[62] High quality

health care depends on, and demands, a team valuing the expertise of each member to the

full extent that her expertise can be provided and is relevant, and when one team member

does not feel that she is an equal part of the caring and decision making process, moral

distress can easily occur, negatively affecting the unity of team practice: those that feel

"left out" rarely keep a collaborative spirit about them.

The above outcomes of moral distress, in turn, have clear effects on patient care.

As mentioned above, much of the research in moral distress has focused on nursing, and

in the literature on effects of moral distress on patient care, the focus has been almost

entirely on nurses, as nurses are seen as the locus of active care for the patient. However,

as was shown above, "moral distress is not unique to any one professional discipline

within healthcare."[63] Thus, when reviewing the effects discussed in the nursing literature,

it is easy to see how the effects, like much of the moral distress research, easily be

applied to all health care professionals. Rushton states that nurses experiencing moral

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[61] Oberle and Hughes, "Perceptions of Ethical Problems," 710.

[62] Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress," 237.

[63] Houston et al., "The Intensity and Frequency of Moral Distress Among Different Healthcare Disciplines," 110.

distress "lose their capacity for caring, avoid patient contact, and fail to give good physical care; they…physically withdraw from the bedside, barely meeting the patient's needs."[64] Likewise, a small study of nurses reported physical withdrawal, decreased interactions with families and patients, and requests not to care for a specific patient.[65] In critical care situations, "the role of the nurse as collaborator of care and patient advocate is a crucial one best served by primary nurses. Nurses reluctant to act in a primary nurse role prevents the patient from being able to obtain these important benefits and may put the patient at risk for problems related to ineffective communication, fragmented care, and lack of patient and family advocacy."[66] And, indeed, one study found that patients experienced "increased pain, longer hospital stays, and inadequate and inappropriate care" when nurses were experiencing moral distress.[67]

It might be argued that these internal symptoms and external effects of moral distress would be, while unfortunate, relatively unimportant if the phenomenon happened infrequently enough. Though most quantitative studies on moral distress are small in sample size, and though there is no evidence for the strong claim that every health care

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[64] Rushton, "Defining and Addressing Moral Distress," 162.

[65] Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress," 236.

[66] Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress," 238.

[67] Corley, "Nurse Moral Distress," 641.

professional experiences moral distress on a daily, weekly, or even monthly basis, the majority of health care professionals report experiences of moral distress.[68]

Corley has done the most work in attempting to quantify the prevalence of moral distress, having in 2001 created the Moral Distress Scale (MDS) mentioned above. The MDS has also been appropriated and modified by other researchers, though the individual modifications—not to mention the differing definitions of moral distress used in the first place—make comparison across studies difficult. Further, almost every quantitative study of moral distress was specific to nursing, though Førde and Aasland's study of doctors in Norway found that 51 percent of doctors surveyed expressed moral distress.[69] Pauly and colleagues surveyed nurses in British Columbia, and found that "On a scale of 0-6, the mean moral distress intensity was 3.88…Only two items on the 38-item [modified from the original 32 in Corley's 2001 study] MDS scale had frequencies lower than the midpoint of 3."[70] The most telling statistic, however, might be that in Corley's original 2001 paper, 15 percent of nurses reported that they had actually left a job due to moral distress.[71] Thus, while Hamric might overstate the matter when she says that "moral distress is a nearly universal phenomenon in the everyday [medical] ethics arena,"[72] it

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[68] Houston et al., "The Intensity and Frequency of Moral Distress Among Different Healthcare Disciplines."

[69] Førde and Aasland, "Moral Distress Among Norwegian Doctors," 523.

[70] Pauly et al., "Perceptions of Moral Distress," 566-67.

[71] Corley et al., "Nurse Moral Distress and Ethical Work Environment," 254.

[72] Hamric, "Moral Distress in Everyday Ethics," 199.

seems that the effects of moral distress cut a wide enough swath that they necessitate attention.

The Causes of Moral Distress and the Focus of This Project

Given the above, it is clearly important to determine what actually causes health care professionals to experience moral distress. With moral distress occurring so often, it is not surprising to find that the catalysts for moral distress are myriad. Studies have found that moral distress can be caused by fairly distant external factors such as organizational decisions made far from the direct care setting like inadequate staffing or lack of institutional or professional support, but more common in the literature are instances of moral distress arising in clinical situations involving, for example, unnecessary or futile treatment, aggressive treatment that is not in the patient's best interest, a lack of truth-telling,[73] initiating life-saving actions that only prolong death, and inappropriate use of resources.[74] Nurses can also experience moral distress when witnessing untreated pain or suffering in patients, seeing patients treated as objects, confronting or butting heads with health policy parameters, when a patient's dying is prolonged without providing the patient/family with proper information regarding choices, when disagreeing with end-of-life decisions,[75] and carrying out orders for unnecessary tests or treatments.[76] A study in Sweden comprising physicians, pharmacists,

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[73] Hamric, "Empirical Research on Moral Distress," 41.

[74] Epstein and Hamric, "Moral Distress, Moral Residue, and the Crescendo Effect," 332.

[75] Corley, "Nurse Moral Distress," 639.

[76] Zuzelo, "Exploring the Moral Distress of Registered Nurses," 352.

and nurses found additional sources of moral distress from lack of resources, conflicts

between rules and praxis, conflicts of interest, and lack of support structures.[77] In a study

involving dying patients in the intensive care unit (ICU), both nurses and doctors ranked

their top three situations of moral distress in the same order: following a family's wishes

to continue life support when it is not in the patient's best interest, initiating life-saving

actions that ultimately only prolong a patient's death, and continuing to participate in care

for a patient when no one will decide to stop life support.[78]

Rather than trying to speak directly to all of these causes of moral distress, this

dissertation will focus on those that stem from conflicts between a health care

professional and either a) other health care professionals, or b) patients and families. That

these are the most salient cases of moral distress is supported by an internal study from

the former head of the NorthShore University Health System's Institutional Ethics

Committee, E. Dennis Murphy. In Murphy's analysis, a full 60 percent of ethics

consultations conducted by the Committee over a number of years involved a health care

professional experiencing moral distress because the professional saw something as

inappropriate in the course of a patient's treatment, whether due to another professional's

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[77] Kälvermark et al., "Living With Conflicts," 1078.

[78] Hamric and Blackhall, "Nurse-Physician Perspectives on the care of Dying Patients in Intensive Care Units," 425. The causes discussed in this section are also reported in: Corley et al., "Development and Evaluation of a Moral Distress Scale," Elpern, Covert, and Kleinpell, "Moral Distress of Staff Nurses," Førde and Aasland, "Moral Distress Among Norwegian Doctors," Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress," Pauly et al., "Registered Nurses' Perceptions of Moral Distress and Ethical Climate," Rosenbaum et al., Sources of Ethical Conflict in Medical Housestaff Training," and Schwenzer and Wang, "Assessing Moral Distress in Respiratory Care Practitioners."

decisions, or demands by the patient or family. 67 percent of cases were categorized as

"conflict in management" of care, whether between staff and family, or intra-

professionally. Further, "The majority of consults are done in the inpatient setting, with

medical floor units and ICU's contributing more than 90% of our requests."[79] That is to

say, more than 90 percent of the time, ethics consults were requested to address a specific

case, as opposed to more general systemic concerns. Conflicts between health care

professional and institution, so prevalent in Jameton's original definition of moral

distress, were the occasion for this Committee's intervention in only three cases out of

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Thus, while the theoretical bioethics literature often discusses the ethical

challenges of resource allocation and institutional hamstringing as causes of moral

distress, this study from one Ethics Committee and the causes listed above point to a

different pattern of moral distress that has been under-represented in the theoretical

bioethics literature. To fill that gap, the focus of this dissertation will be on moral distress

in clinical situations where the protagonists are health care professionals themselves,

along with patients and families.

As mentioned above, these include causes of moral distress such as cases of futile

or unnecessary treatment, treatment that is both aggressive and not considered in the

patient's best interest, failure to meet the standard of informed consent, and a lack of

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[79] Murphy "Contemporary Ethics Consultation in a Multi Hospital University Affiliated
Suburban System 2005-2012," 4.

truth-telling (all told, comprising the majority of cases that reach NorthShore's

Institutional Ethics Committee).[80]

Given that the above posits that patients and families can be, in effect, a cause of

moral distress, it would seem to follow that they can also experience moral distress when

disagreements arise with the professionals caring for them. However, they, too, are

outside the scope of this dissertation. The first reason is a theoretical one, for patients and

families do not necessarily participate in the shared moral obligations of health care

professionals, and these shared obligations will be the basis for the response to moral

distress offered in this dissertation. The second reason is practical, in that it would be

nearly impossible to create a properly structured forum for addressing patients' and

families' moral distress like the structured discussions by involved health care

professionals that will be proposed in this dissertation. The hope is that for most health

care institutions, those in the roles of social worker, care manager, or chaplain can assist

patients and their families in relevant ways.

Health care organizations can address, however, what one study found to be the

most common source of moral distress: "a misalignment between healthcare

professionals."[81] That is to say, even if the cause of moral distress initially stems from the

wishes of a patient or family, the decision of how to proceed given those wishes will

reside with the health care team, and it is here moral distress will therefore often arise and

cause tension among health care professionals (e.g., someone on the team has to agree to

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[80] Hamric, "Empirical Research on Moral Distress," 41.

[81] Bruce, Miller, and Zimmerman. "A Qualitative Study Exploring Moral Distress in the ICU Team," 826.

fulfill those wishes, and other health care professionals on the treating team may experience moral distress because of it). Thus, however the distress of patients and families could be best addressed, the focus of this dissertation is on this "misalignment" among health care professionals which, because of its negative effects, must be addressed by the health care organization and that means (as will be shown) it must be resolved among and by these health care professionals.

It should also be acknowledged that other health care providers (i.e., non-professional) and employees of a health care organization may experience moral distress related to their caregiving roles. Chapter Two will argue that the respect a health care organization owes all its employees, and the efforts and goals they share, means that a health care organization ought to attempt to resolve moral distress in all its staff. However, as it will be shown in Chapter Three, the moral distress resolution process detailed in this dissertation rests on a shared professional morality. Whether or not this common ethical framework exists for non-professional staff of a health care organization (or if an individual organization itself can create one for its employees) is not examined in this dissertation, though it is an area for further thought, and Chapter Six will briefly offer some notes on what direction that thinking could take.

Conclusion

This chapter introduced and defined moral distress, including its effects on health care professionals and patient care, and delineated the scope of this project. Chapter Two will turn to the health care organization, and make the claim that health care organizations have an obligation to address moral distress in its health care professionals,

which presupposes the concept of group agency, which will also be explained.

Following that, some examples of current organizational responses to moral distress will

be examined, and it will be shown that they fail due to a reliance on institutional

hierarchies, which will be seen to be an ethically insufficient way to address moral

distress.

CHAPTER TWO

THE HEALTH CARE ORGANIZATION AS MORAL AGENT

As Chapter One has explained, moral distress has detrimental effects on health care professionals, and affects their ability to practice according to their profession's expertise and engage in the best patient care. This chapter will argue that when these two effects of moral distress are present in a health care institution and are not properly addressed, this constitutes an ethical failure of that institution because of the obligations on the part of a health care organization (i.e., at the organizational level) to strive first of all for the health of its patients through the expertise of its health care professionals. But is it correct to say that a health care organization has obligations and can act in unethical ways? An affirmative answer to this question will be defended in this chapter; and therefore moral distress must be viewed as a matter of organizational ethics and it is the responsibility of each health care organization to respond to moral distress and not doing is a moral failure of that institution.

Health Care Organizations Have Obligations

In "Organizational Ethics in Health Care: Toward a Model for Ethical Decision Making by Provider Organizations," The National Working Group on Health Care Organizational Ethics convened by the Institute for Ethics at the American Medical Association examines norms from "business ethics, professional ethics, and law and social context" in an attempt to determine what priorities health care organizations ought

to honor if they are said to be upholding ethical standards.[1] Ultimately, the Working

Group identified two main priorities for health care provider organizations. The first

priority is that of health care itself. Not only from a business perspective, but more

importantly from its presenting itself to the larger society as a *health care* organization,

the care of its patients must be its highest priority. Thus a health care institution's profit

motive and other goals must be subjugated to its care-oriented mission as a health care

organization.

 The second priority the Group identifies is that patient care be provided by means

of the expertise of health care professionals in clinical matters. As the Group states,

"there is a powerful, continuing role for health professionals' expertise in determining

what counts as health for patients and therefore what sorts of interventions are beneficial

to their health."[2] If these two priorities are not met, the result is a health care organization

failing to meet its ethical obligations, and the undermining of the organization's mission.

 The descriptions of the causes and effects of moral distress in Chapter One show

that moral distress occurs when a health care professional has reason to believe that her

expertise is being ignored or overridden, and the results of such moral distress frequently

include a lowered level of care which can put patients at risk. Thus, it is clear that moral

distress, if not addressed, will effectively cause a health care organization to fall short in

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[1] Ozar et al., *Organizational Ethics in Health Care*, 4. The authors, admittedly, simply posit rather than argue the existence of group agency and institutional obligations and then move on. This chapter will explore these positions in more detail than their document does.

[2] Ozar et al., *Organizational Ethics in Health Care*, 11.

meeting *both* priorities central to its mission, and thus can create an institution whose commitment to ethical conduct, and thus its integrity, can be questioned.

Because moral distress can, in effect, threaten the core of what a health care organization ought to be focused on providing, and thus is an organizational issue, it is imperative that the problem be addressed at the level of the health care organization. Later in this chapter some proposed responses to moral distress will be examined that are either not generated at the organizational level, or are organizationally insufficient ways of dealing with the issue. Chapter Three will lay the moral groundwork for an appropriate response by a health care organization to its health professionals' moral distress, and the remaining chapters will propose a concrete organizational mechanism for achieving this.

The thesis that health care organizations have obligations in this matter, however, presupposes that groups like health care organizations are capable of acting as single entities and can have moral obligations and be held responsible for their actions. That is, it presupposes that they are capable of group agency. Since there are admittedly writers who disagree with the claim that agency can be attributed to groups, a discussion of the arguments in favor of this presupposition is appropriate at this point. The following will summarize arguments for group agency generally, and then focus on corporate (as opposed to the broader term "group") action, and finally on group agency of health care organizations specifically.

Arguments for Group Agency

One reason for thinking about groups as unitary actors (agents) is that there is an intuitive way in which assigning group agency makes logical and semantic sense:

Margaret Gilbert states that the notion "that social groups are subjects of action and

cognition clearly accords with one way in which collectives are commonly spoken and

thought about."[3] To put it another way, David Copp states that group action—and group

intentionality—is entailed in our descriptions of many events. Taking an example from

semi-recent history, Copp discusses the British invasion of the Falkland Islands.

In this example, we feel (semantically) comfortable speaking about Great Britain

intentionally invading the Falkland Islands, Argentina intentionally defending them, and

early in the conflict, England intentionally sinking the Argentine ship *General Belgrano*.[4]

We tend to take these statements as fact. Without actually thinking about it, in using this

sort of language to discuss these events, we are tacitly affirming that nations or militaries

are able to intentionally make, and successfully execute, plans. Copp calls this "the

Intuitive Argument." By taking it as a fact of history that Britain sank the *General*

Belgrano, he writes, "Intuitively, we hear this literally, as ascribing to Britain the action

of intentionally sinking something, the same kind of action we would ascribe to Margaret

Thatcher in saying she intentionally sank her dinghy."[5] What this intuition leads us to is

the idea that when we talk about a collective entity performing an action, we are

decidedly not meaning to say only that the individuals making up the collective, or

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[3] Gilbert, *On Social Facts*, 206.

[4] By "intentionally" in this context, Copp is referring to something akin to "meaning to," and states that intentionality is a necessary component of group agency. He states more generally that "Intentional states can be thought of as states that are 'directed toward' or are 'about' some 'thing,' or 'some state of affairs.'" (Copp, "On the Agency of Certain Collective Entities," 197.)

[5] Copp, "On the Agency of Certain Collective Entities," 195.

certain individuals in the group, intentionally performed that action. A collection of

individual soldiers, or the members of British Parliament, didn't invade the Falkland

Islands: *England* did, an England that is a different entity from the sum of its parts.

Borrowing language from Gilbert, this makes England a *non-summative group*.[6]

For another example of a non-summative group, consider the phrase "In 2014 the

San Francisco Giants won the World Series." It would be very difficult to disassociate

group agency from the meaning of that phrase, and instead break agency down to the

individual level. There are a few reasons for this. First, "San Francisco Giants" does not

apply to a specific set of people. Rosters change throughout the season, with different

players on the team, and yet the whole is always the San Francisco Giants. Even in a

single game, it is very rare that all nine players that start the game are still playing at the

end of it (having been replaced by substitutes), and yet we still feel very comfortable

saying the Giants, as a group, won or lost that game. That ascription of the outcome

applies to individual Giants players that didn't get on the field that day and even those

who happen to be rehabbing from injuries on the Giants' minor league teams.

This brings us to a second reason: when we assign agency in such a case, there's

not even a clear definition of the individuals we are speaking of as comprising the group

"San Francisco Giants." The players are surely included, but does it also include the

manager? The third base coach? Or the team's scouts, or even the General Manager? The

point here is that the set of individuals that make up the group "San Francisco Giants" is

both fluid and fuzzy, especially at the edges, and yet when we talk about the group itself,

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[6] See Gilbert, "Modelling Collective Belief," 190-200.

we ordinarily have a clear understanding of our meaning.[7] This is the presupposition Copp is discussing with the Intuitive Argument.

In this baseball example there is a third reason, not appealing to the Intuitive Argument, why think about the Giants as a non-summative group, and not a collection of players and their individual achievements. If we think about each individual hit, walk, catch, or play that ultimately contributed to the Giants winning the World Series, it becomes clear that the championship cannot be explained with just a description of each of these individual actions or even the additive collection of them. For there is something above and beyond a mere accounting of each player's actions in a season which makes it sensible to talk about the team winning the World Series, and not a collection of players. One way to call attention to what that something is, is to say that individual actions *only* make sense in context of "winning the World Series" if they also refer to something other than the collection of these individual actions put together. Crucially, the individuals' performance of those actions only makes sense in the actual situation because they are done on behalf of the team; that is, because they contribute to the group action by which the Giants won the World Series.

Each individual player is related to each other player by virtue of being part of the group, and there is a structure in place that informs how the group, as a unit, operates, and this structure organizes and makes sense of each individual action. In baseball, those

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[7] And to complicate things further, consider the fact that we feel comfortable with the notion that it was the "same" San Francisco Giants that also won the World Series in 2010 and 2012, even though there were plenty of changes to the rosters each of these seasons.

structures are, broadly, things like the goals and rules of the game, and more specifically things like the team's lineup and strategy. These structures allow the individual actions to *make sense*, in that they are done in the context of a larger group action.

Moving the discussion to speaking explicitly about corporations and similar organizations now, Larry May makes much the same point about the structure of a corporation as was just made about the structure of a baseball team. It is worth quoting him at some length to see the parallels:

> …[S]tatements made about the corporation are not simply statements made about the corporation's members seen as discrete human persons. Such statements also refer to an organizational structure whereby several persons, who are members of Gulf Oil Company, are designated as those who will decide where all of the members will work. The use of the fictitious phrase "Gulf Oil Company left Pittsburgh" can be justified by reference to the decision structure which related and partially transformed the actions of individual board members and employees of this corporation.[8]

As the rules of the game and the strategy of gameplay are to baseball, so too are its organizational structure and decision making processes to a corporation. May is claiming that, much as individual players can make up a team that itself is said to act, ("The Giants bunted the runner to third base"), a corporation is said to act when the members of the group act *as* the corporation ("Gulf Oil Company left Pittsburgh"). When statements such as these are made, May argues, collective action—group agency—is occurring. He calls this "vicarious agency" because it is distinguishable from the actions of the individuals who make up the group, and even distinguishable from the additive sum of all the

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[8] May, *The Morality of Groups*, 12-13.

individual actions (much like a collection of runs and outs cannot add up to winning the World Series). May states that there is a formal relationship between corporation and employee, because of which actions performed by an employee can only be fully described by referencing the causal role organizational structures have in rendering that action as a corporate one. Though it is an individual person (or, say, board of directors) who may implement a policy or vote on a plan, May says that "it is impossible to describe accurately the acts that occur in the corporate setting merely by referring to acts of the individual members of a corporation, and not mentioning in the description a causal role of the structure of the corporation."[9] In regard to the Gulf Oil example, if attempting to describe the moving from Pittsburgh as a series of events (voting to move, buying a new building, each employee leaving the town, etc.), this portrayal "would fail to capture the fact that Gulf Oil Co. acted" in some important way that is more than the sum of its parts.[10]

For May, "vicarious agency" allows for corporations to be evaluated in moral terms because, even though an individual or group might be acting on behalf of the corporation, that action would not take place without a corporate intention.[11] There is "something more" than just an individual action. A number of writers such as David Ozar, Kenneth Goodpaster, and Peter French have attempted to determine what that "something more" might be.

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[9] May, *The Morality of Groups*, 45.

[10] May, *The Morality of Groups*, 45.

[11] May, *The Morality of Groups*, 65.

"Something More": Non-summative Group Agency

In order to tease out a better understanding of this "something more," it is useful to focus for a moment on very small groups of people, and Ozar has provided a well-constructed summary of the point being made here.[12] Let's say, he proposes, that while at a conference, you see a friend, and the two of you decide to get a drink that evening, or go for a jog the next morning. Then, let's say that at the time when the two of you previously agreed to meet, you show up, while your friend does not. In this case, Ozar claims that you would be justified in judging that your friend had failed to do what she ought to have done and, if pressed to explain your displeasure at her, you would probably say something like "We agreed to meet" or "We had a plan" or something to that effect. As Ozar states, there is "something" created, above and beyond two individuals each deciding on an action, which now exists, and non-conformity to that something is grounds for a negative judgment. That something is contained in the "we" in "*We* had a plan."[13]

The point that Copp, May, and Ozar are all generally making is that it simply doesn't seem to be the case that a group decision or action can be adequately described as the sum of its individual parts. Whether we speak of this in terms of "something more" or that a group is "non-summative," the point is that once certain conditions are in place

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[12] Ozar, "Attributing Moral Agency to a Group."

[13] This same theme has been further supported by Gilbert by the introduction of the notion of "group intention" in *On Social Facts* and in articles and books since then, and by a number of other scholars developing her work over the last decades.

regarding the individuals who constitute a group, the group must be described as a single actor in its own right, with actions that are partly constituted by but not reducible to the individual actions of its members. As Ozar states, when a group makes a decision, "this 'something more' has precisely to do with [the] unitary character of the decision, that it is one decision—i.e. one decision by the parties acting together."[14] For present purposes, where the focus is on health care organizations, this unitary character can be discussed most easily in terms of Goodpaster's Moral Projection theory and French's Corporate Internal Decision Structure theory in order to better explicate what that "something more" actually is.

In "The Concept of Corporate Responsibility," Kenneth Goodpaster also argues that groups—in this case specifically corporations—make decisions and act as unitary agents and not simply as a sum of their parts. He states that not shifting the analysis of decision making in a corporation from the individual to the organization itself "fails to take seriously enough the fact that organizations are more than simple collectives or groups of persons without structure, like passengers on a train."[15] Mirroring an idea of Gilbert's, he continues: "The actions and decisions of corporations are not usually a simple function of any single manager's values. Even the chief executive officer of a corporation often must, in his or her leadership role, work indirectly in efforts to guide

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[14] Ozar, "Attributing Moral Agency to a Group," 10 [on draft copy provided by author].

[15] Goodpaster, "The Concept of Corporate Responsibility," 10.

the large organization toward its goals."[16] In effect, Goodpaster is saying that the moral

analysis of a corporation's actions cannot be reduced to a moral analysis of the

individuals within the corporation, because, again, an organization is more than simply

the sum of its parts; Goodpaster refers to the "joint force"[17] of all the individuals in a

corporation much in the same way Gilbert refers to "joint commitment"[18] or Ozar to

"something more."[19]

Once the conditions necessary for attributing group agency are fulfilled,

Goodpaster states, then his theory of moral projection becomes relevant; namely, that it is

therefore normatively appropriate "to look for and foster moral attributes in organizations

by analogy with those we look for and foster in individuals."[20] In a morally responsible

individual,[21] Goodpaster believes there are four essential elements for making a decision:

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[16] Goodpaster, "The Concept of Corporate Responsibility," 10.

[17] Goodpaster, "The Concept of Corporate Responsibility," 10.

[18] Gilbert, "Who's to Blame?" 105.

[19] There is no guarantee that a given plurality of individuals will fulfill the conditions required for their actions together to count as the unitary agency of the group as such. That is, some sets of persons that may be treated socially as units may nevertheless fall short of being unitary group agents. But determining when this is the case depends on identifying the requisite conditions, which is the task that the work of May, Ozar, and Goodpaster summarized here is focused on. The rest of this dissertation will assume that we are discussing health care organizations that do fulfill these conditions. See also comments made at the end of this section.

[20] Goodpaster, "The Concept of Corporate Responsibility," 10.

[21] Goodpaster specifies that when he uses the term "responsible" in reference to both individuals and corporations, he is referring to capacity for decision making, or how a person thinks about and responds to a given situation.

perception, reasoning, coordination, and implementation.[22] Goodpaster's task, then, is

to see if those four elements can be mapped onto how a corporation makes decisions. If

he is able to do so, it looks like we may be better equipped to see what that "something

more" is in group agency.

Goodpaster thinks it is clear that corporations can engage in *perception*. For

any given corporation is always gathering data for many different purposes (marketing,

production, personnel, finance, etc.), and these data are "processed through various parts

of the organization, purified, clarified, simplified, and ultimately either 'forgotten' or

stored for use in decision-making by line management."[23] That is, we speak of

organizations not only gathering, but processing information, which looks and is

conceptually different from individuals looking for, gathering, and then pooling data

together.

According to Goodpaster, a corporation can be said to morally *reason* in an

informal manner when it contains an "understood but unwritten set of values" that create

something of a corporate culture.[24] Formally, a corporation can introduce mechanisms

that promote ethical decision making, whether they be corporate codes and guidelines,

appointment of ethics officers, or creating incentives for morally laudable achievements.

For example, the Ford Motor Company, Goodpaster says, failed to exercise moral

reasoning when designing the Pinto as an extreme fire hazard. It would be impossible to

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[22] Goodpaster, "The Concept of Corporate Responsibility," 8.

[23] Goodpaster, "The Concept of Corporate Responsibility," 11.

[24] Goodpaster, "The Concept of Corporate Responsibility," 12.

identify some specific individual or individuals responsible for the problems with the

Pinto without also invoking the idea of group agency and therefore group responsibility.

That is, to speak accurately we must say that it is the corporation, the Ford Motor

Company, that put profit above safety.

A corporation *coordinates* when is able to balance moral and non-moral

considerations, the latter category including things like economic objectives and

regulatory compliance. Goodpaster admits this is a difficult task for an organization to do

effectively, as it "consists of integrating the formal and informal mechanisms of moral

reasoning with the wider set of organizational needs and goals,"[25] but it also seems clear

that this *is* something that can happen either explicitly or organically, and it is such

coordination that points to a non-summative description of group agency. That is, a

corporation may simply "have a way of doing things" that yields such coordination; it is

not necessary that a specific person or persons balance competing objectives, since an

organization's culture can arise that secures certain values and goals over others.

Finally, Goodpaster states that *implementation* is the process by which a

corporation is able "to motivate and facilitate effective organizational responses to plans

and policies."[26] That is to say, once the first three tasks of decision making are completed

and a response to a situation that is acceptable to the corporation as such is determined,

then a corporation, much like an individual, must actually *do* that thing. Even if the CEO

is the one to give ultimate approval to some sort of plan, Goodpaster states that she is

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[25] Goodpaster, "The Concept of Corporate Responsibility," 13.

[26] Goodpaster, "The Concept of Corporate Responsibility," 13.

doing so in the context of group agency, instantiating the corporation's decision and

the corporation's acting, even if (or especially if) she personally would choose to do

otherwise.

Thus, with Goodpaster's analysis of corporate decision making, we can see one

notion of why the "something more" of non-summative group agency is relevant in an

organizational setting and Goodpaster's moral projection thesis can apply to corporate

actions. Peter French's discussion of a Corporate Internal Decision Structure fleshes out

Goodpaster's ideas even more, and French has also helpfully written about the moral

obligations of health care organizations specifically. Indeed, when his account is applied

to corporations, including health care organizations, French provides an explicit answer

for what the "something more" is that turns the decisions of individuals into the decisions

of a corporation as plural subject.

In various writings in which French attempts to show that a corporation ought

to be treated as a moral person, he relies on what he calls a Corporate Internal Decision

Structure (CID Structure), which has two distinct parts. The first is an organizational

chart that demarcates levels of power and station, and the second is a "corporate decision

recognition rule(s)," which functions to differentiate a person's decision from a decision

of a corporation (especially when those decisions happen to overlap).[27] The CID

Structure serves to subordinate and synthesize any person's actions into the mechanism

of a corporate decision. The organizational chart of a corporation is an important part of

the synthesis process, because it gives decision making power to a position, or a web of

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[27] French, "The Corporation as a Moral Person," 212.

positions, as opposed to a specific person: "That a particular person holds a particular

position with a firm is a contingent property of that corporation."[28] What is important is

not who fills that position, but how that position is related to other positions in the

organization. The organizational chart, according to French, provides the grammar for

corporate decision making, while the CID Structure as a whole are the rules of the

decision making.[29] The CID Structure is what turns a number of actions by individual

persons into a group decision, into the "something more" of group agency. For it maps

the connections of the group members and indicates why their actions constitute a

singular decision of a plural subject—in this case, a corporation. French writes: "What I

mean by that is that the CID Structure not only organizes the various human beings in the

organization into a decision-making and acting entity, it makes it possible for us and

those within the organization to describe what is happening as an organization's actions,

plans, positions, etc. and not just as the actions of a specific manager or officer of the

organization. In absence of the structure, many of the activities of the humans and

machines would be utterly unintelligible."[30]

     For French, then, the CID Structure consists in the rules that explain how a

decision made by, for example, the three members of the Board of Executives is, in fact,

a corporate decision, in that the CID Structure can show that if a decision was made in

order to implement corporate policy in accordance with company procedure, then it was

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[28] French, *Collective and Corporate Responsibility*, 28.

[29] French, *Collective and Corporate Responsibility*, 42-43.

[30] French, "Inference Gaps in Moral Assessment," 17.

done for corporate reasons, it can be considered an intentional act of the organization itself.[31]

In regard to health care organizations in particular, French sees no significant difference between their CID Structures and those of any other sort of formal organization. Health care organizations have managerial structures, corporate models of organization, and policies that provide the rules for unitary action.[32] Because of this, French says, health care organizations (if they fulfill these conditions) can be said to act as group agents, and indeed French sees numerous examples of this. "They set admission policies and procedures, make contracts with physicians and other providers, negotiate payments with insurance carriers, HMOs, and patients, open and close clinics and various types of units, relocate hospital facilities, make deals with various government agencies, purchase equipment, upgrade facilities, report financial statements to various entities and individuals, etc."[33] Assuming the relevant conditions of group agency have been met, then all of these actions can be properly attributed to the organization itself, as its CID Structure provides the rules for its group agency.

The preceding section provided a brief account of arguments for group agency generally, and more specifically, group agency for corporations. Thus, going forward, we hopefully have clear picture of what is being discussed when we talk about a health care organization acting, and having an obligation to respond to moral distress situations. And

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[31] French, "Inference Gaps in Moral Assessment," 18.

[32] French, "Inference Gaps in Moral Assessment," 20.

[33] French, "Inference Gaps in Moral Assessment," 21.

though the argument for group agency is an important one, even if one disagrees with the position whose defense has been summarized here, it would still fall to individual decision makers within a health care organization to enact change, and the proposals in the following chapters regarding how to respond adequately to health professionals' moral distress would still apply to them as individual decision makers. This same conclusion also follows regarding decision makers in health care institutions that are not sufficiently unified in their agency to be considered unified moral agents.

Health Care Organizations as Hierarchies

Another important structural characteristic of health care organizations besides the fact that they can exhibit group agency is that health care organizations are structured hierarchically.[34] The ramifications of this fact on how organizations ought to respond to health professionals' moral distress will be explored later in this chapter and the next. But it is important to indicate the consequences of this structural characteristic of health care organizations on their typical ways of responding to perceived problems (e.g., moral distress).

Any discussion of corporate decision making or action relies on a tacit understanding of the power relationships within that organization, as was just explained in terms of French's CID Structure. The CID Structure includes "an organizational or

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[34] Kathryn King discusses the relation of organizational hierarchy to the idea of and the conditions for group agency in her doctoral dissertation (King, "Corporations as Group Agents"). She shows how "existing philosophical arguments for the group agency of corporations are crucially dependent on the existence of corporate hierarchy" (97), and argues that the fact that health care organizations are hierarchical does not automatically challenge the claim that a particular organization (e.g., a health care organization that meets the relevant conditions) is a group agent.

responsibility flow chart that delineates stations and levels within the corporate power

structure,"[35] which should be familiar to anyone that has looked at an organizational chart

delineating who reports to whom in any given organization. Indeed, hierarchy in an

organization is referenced explicitly any time someone talks about "my boss," or "the C-

suite," or even says, "You need to talk to HR about that."

For another example of the existence of corporate hierarchies, Boyle and

colleagues cite the rational systems approach to organizations as the standard approach to

understanding organizations in the business ethics literature, and as a rational system, "an

organization has (1) a visible set of hierarchical authority relations in which (2) work

activities are governed by formal rules and clearly defined criteria for evaluation,

relations that (3) are designed to pursue some set of goals."[36] All corporations necessarily

rely on hierarchical structures in order to operate, and health care organizations are no

different. At a broad level, French states "Hospitals, whether or not they are for profit,

mirror the corporate model in their managerial structures. The same can be said of clinics,

HMO's, and the insurance companies that now virtually control the delivery of health

care in the society."[37] Regardless of how the mission (or tax status) of a health care

organization might differ from more "traditional" companies, structurally, it will look

like very much those companies, complete with their complex hierarchies.

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[35] French, "The Corporation as a Moral Person," 212.

[36] Boyle et al., *Organizational Ethics in Health Care*, 31.

[37] French, "Inference Gaps in Moral Assessment," 20.

The importance of this fact about health care organizations and the challenge as

it pertains to moral distress is that, as they do anywhere, hierarchies in health care

organizations create superior-subordinate relationships, as well as more subtle power

dynamics among team members or between different sections of the institution.[38] Though

these hierarchies and relationships are both unavoidable and necessary in an organization,

Boyle and colleagues realize that they also might stifle an individual's ability to speak up

when she has issues with those above her in the CID Structure or organizational chart:

"The reality of power relationships, and many staff members' perceptions of power and

its possible use against them, mitigates against the likelihood that most employees will

take courageous positions or even raise uncomfortable questions."[39]

Boyle and colleagues also note that this power disparity has long existed in a

special way in the clinical setting between, for example, physicians and nurses,[40] and that

this may be the catalyst for moral distress when a nurse believes she can't speak out

regarding a physician's decision that she sees as ethically troubling.[41] Hamric, Epstein,

and White point out the link between corporate structure and moral distress in noting that

"moral distress is rarely if ever *only* about [a] particular case. On digging more deeply,

team, unit, and even systems problems that underlie these individual patient situations

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[38] See King "Corporations as Group Agents," 97-98.

[39] Boyle et al., *Organizational Ethics in Health Care*, 55.

[40] Boyle et al., *Organizational Ethics in Health Care*, 84.

[41] See Oberle and Hughes, "Perceptions of Ethical Problems," and Viney, "A Phenomenological Study of Ethical Decision-Making Experiences Among Senior Intensive Care Nurses and Doctors Concerning Withdrawal of Treatment."

become clear—poor communication routines between providers, lack of unit-to-unit interaction, lack of policy to guide appropriate action, inadequate staffing, inappropriate use of resources, *and hierarchical hospital structures that limit providers' abilities to be assertive*."[42]

It is clear, then, that hierarchies in health care organizations can be a cause of moral distress, or at least often inhibit adequately responding to it. In light of this, this dissertation will argue that organizational responses to moral distress that are themselves specifically hierarchical in nature are ethically insufficient. Unfortunately, as the next section will explain, the organizational mechanisms for moral distress resolution that have been offered up to this point fall short in this respect. They either attempt to solve moral distress in an explicitly hierarchical way, or are sufficiently dependent on the hierarchy of roles and offices that they will most likely be stymied in their efforts.

After explaining here how the dependence of these efforts on the respective organizations' hierarchical structure undercuts the achievement of their intended goal, this dissertation will then argue that an alternative, non-hierarchical approach is the ideal response to moral distress. But first it is important to demonstrate that there are very practical reasons why moral distress should not be addressed hierarchically.

Hierarchies and Moral Distress

The first practical reason why moral distress should not be addressed hierarchically is that it may be the case that moral distress is, in fact, being caused by

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[42] Hamric, Epstein, and White, "Moral Distress and the Healthcare Organization," 141. Emphasis added.

institutional hierarchies or structures that impact the relations of health care

professionals to one another and to patients and their families. In such instances, the

affected health care professional will typically not feel that she can appeal to, or within,

those same structures for relief. For example, if a resident's moral distress stems from

taking part in carrying out the decision of the attending physician to whom she reports

and who will evaluate her performance as a resident, the resident may well think

reporting this to anyone could put her at professional risk beyond the moral distress itself.

The analogy to a potential corporate whistleblower is clear in regard to the latter's fear of

repercussions for reporting corporate wrong-doing. In such cases, the established and

recognized hierarchy is a component of the causation for the moral distress, as the

realistic resident "cannot do anything other" than what her attending physician orders.

Thus, as was mentioned in Chapter One, the person experiencing moral distress might

actually feel doubly constrained because she *also* feels distress in that she is unable to

report her moral distress and have it be resolved appropriately (i.e., without negative

professional consequences).

The second practical reason to avoid a hierarchical response to moral distress

stems from an argument that will be discussed more fully in the next chapter: all health

care professionals are moral reasoners capable of contributing to a discussion of the

circumstances in which moral distress arises. Even if it were a case of moral distress

being felt by only one person, other health care professionals are going to be involved at

least indirectly or be on the same team, and will often be able to understand the

circumstances underlying another person's experience of moral distress and very likely

can be instrumental in its resolution. Furthermore, since differing ethical judgments among team members may be the catalyst for someone's moral distress and the fact that a morally distressed team member may negatively impact inter-professional relationships or medical care provided, the other team members involved in the case are causally or contextually related to the moral distress experience. A hierarchical organizational response (i.e., one that does not allow for peers to come together as moral equals to discuss the causes for, experiences of, and possible solutions to, a moral distress situation) may well mean that the professional relationships and medical care affected by the situation might remain damaged even if some other sort of resolution has been organizationally effective. It is therefore crucial from a simple practical point of view, so it can attend to its main obligation *as* a health care organization (i.e., the health of its patient), that an organization's response to moral distress explicitly attend to the possible negative impact of its hierarchical structure on these efforts.

Example of Ethically Insufficient Responses to Moral Distress

Though much has been written about moral distress, there are only a small number of proposals that exist on how to address it. Unfortunately, each of the following proposals either attempt to solve the problem hierarchically or would most likely be stymied by the very hierarchical approach that may have caused the moral distress in the first place.[43] For example, Rushton devised the "four A's" for addressing moral distress,[44]

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[43] There is at least one response to moral distress that has been written about that can be considered ethically sufficient and appropriate; that response and other positive suggestions will be explored in the remaining chapters of this dissertation.

which has since been adopted by the American Association of Critical-Care Nurses

(AACN),[45] and anecdotally is quite popular as a teaching tool for how to respond to

moral distress. Rushton and the AACN provide four steps as a "framework for support"

for nurses who are looking for "a catalyst for positive change" in the face of moral

distress.[46] Though both Rushton and the AACN state that health care organizations are

responsible for addressing moral distress,[47] the proposals they provide in the four A's

framework put much of the burden on the nurses themselves, which will be shown to be

ineffective in a hierarchical health care organization.

The four A's are *ask*, *affirm*, *assess*, and *act*. A nurse is supposed to first *ask*

herself if what she is feeling is, in fact, moral distress. If she believes it is, the next step is

to *affirm* the moral distress and *affirm* a commitment on her part to take care of herself,

along with her professional obligation to act to address the moral distress. Third, the

nurse is directed to make a thorough assessment of the source and severity of the moral

distress, and then *assess* her own readiness to act "to rise above the moral distress."[48]

Finally, the nurse is instructed to *act* by "[initiating] specific actions that address the

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[44] Rushton, "Defining and Addressing Moral Distress."

[45] AACN, *The 4 A's to Rise Above Moral Distress*.

[46] Rushton, "Defining and Addressing Moral Distress," 162.

[47] AACN, *The 4 A's to Rise Above Moral Distress*, 1; Rushton, "Defining and Addressing Moral Distress," 166. Rushton, in particular, does advocate for institutions to undertake root-cause analyses of moral distress cases, which will be discussed in Chapter Six.

[48] AACN, *The 4 A's to Rise Above Moral Distress*, 5.

source of distress."[49] The AACN provides some examples of what this action might look like, with the overall gist being that the nurse must be responsible for changing the practices of the unit, with others' buy-in if possible, but alone if necessary.[50]

What Rushton and the AACN fail to account for, however, is the fact that moral distress is often caused, or exacerbated, by hierarchical organizational structures or team dynamics. When this is so, then given the hierarchy of roles in the organization, the distressed individual *already cannot act in any other way* and thus cannot change the underlying situation, at least not easily or effectively, since *acting* according to the four A's presumes her the ability to *act to address the distress* by, for example, changing the practices of the unit, single-handedly if necessary. That is to say, the very same hierarchies that were a catalyst for the moral distress in the first place aren't going to allow for a nurse to enact organizational change. For example, if a nurse can't alter the course of a patient's care, it seems unlikely she'll have the standing to affect the underlying structures that stop her from being able to alter the course of patient care. As was explained in Chapter One, health care professionals often feel helpless in their experiences of moral distress precisely because of the hierarchical structure of the organization, and Rushton and the AACN are begging the question by saying, "If you feel like there's nothing you can do to solve your distress, the best thing to do is solve the cause of your distress." It's a solution that ignores the reality of the hierarchy of a health care organization, and instead places the burden of resolving moral distress and its causes

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[49] Rushton, "Defining and Addressing Moral Distress," 165.

[50] See AACN, *The 4 A's to Rise Above Moral Distress*, 9-11.

on the already-distressed individual. Though Rushton and the AACN are careful to avoid language that blames nurses for their distress, they do nevertheless place the responsibility for fixing it with them as individuals. This could easily create a feedback loop of moral distress, in which the distressed individual is unable, thanks to organizational hierarchies, to alleviate her distress, and then becomes distressed at her inability to enact change to address the original distress.

A small study by Beumer provides empirical backing for this analysis. In this study, a workshop was held for ICU nurses that was meant to define and identify moral distress, and the 4 A's model was introduced as a strategy to address moral distress when it occurred. Questionnaires were completed before and after the workshop to gauge the effects of the education and implementation of strategies. The responses from nursing staff to the questionnaires administered after the workshop showed that "staff reported no change in empowerment about speaking up if patient's care was perceived as futile,"[51] and that "there was no change in staff response to being listened to and respected when mentioning an ethical concern" to others.[52] While the study did report some positive outcomes stemming from the workshop, the markers that relate to nursing staff's ability to address moral distress within a hierarchy were underwhelming. In other words, tools like the 4 A's that focus on empowering the person experiencing moral distress only are effective if the affected individual can speak up, and when the organization's hierarchy is

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[51] Beumer, "The Effect of a Workshop on Reducing the Experience of Moral Distress in an Intensive Care Unit Setting," 265.

[52] Beumer, "The Effect of a Workshop on Reducing the Experience of Moral Distress in an Intensive Care Unit Setting," 266.

operating in the usual way, the person experiencing moral distress rarely has this ability. The same criticism befalls Corley, creator of the moral distress scale, when she states that "nurse empowerment" is a key to decreasing moral distress.[53]

Daar's article "A Clash at Bedside" also provides an ethically insufficient solution to moral distress dependent on hierarchies when discussing the role of the physician's professional conscience as a factor in medical decision making. Though Daar does not use the phrase "moral distress" specifically, her description of professional conscience makes it clear that moral distress is the phenomenon she is addressing. For example, what she describes is precisely the distress inherent in a situation in which a patient feels "empowered" to seek treatments that physicians consider "medically futile or inappropriate."[54] In addition, many of the cases she analyzes are paradigmatic moral distress cases and at one point Daar states that "The nurses were feeling trapped by an endless treatment plan that obliged them to provide treatment they did not believe was appropriate or could benefit a dying patient."[55]

In attempting to provide a solution for physicians who are directed by patients or their surrogates to provide medically futile care, Daar also employs the institutional hierarchy to resolve situations of moral distress. Daar proposes what she calls a "treatment evaluation board" (TEB) as an appropriate use of bureaucratic power to resolve moral distress. The TEB would be used as forum in which physicians could (1)

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[53] Corley et al., "Nurse Moral Distress and Ethical Work Environment," 388.

[54] Daar, "A Clash at the Bedside," 1246.

[55] Daar, "A Clash at the Bedside," 1259.

discuss their disagreements over the course of treatment requested by patients, (2)

determine how to meet the needs of the patient, and (3) decide how to transfer the patient

to another physician or hospital, as needed.[56] While these goals are potentially useful

steps for resolving moral distress, Daar's recommendation regarding what the board

should look like reveals the same kind of ethically problematic dependence of hierarchal

solutions as the authors discussed above. As Daar states, "Ideally, a TEB should be

composed of two members from the full-time medical staff, one member who represents

the hospital administration (this member should serve as the chair of the board), and one

member who is a hospital social worker…In addition, for each case presented to the

board, the chair should appoint one member of the medical staff who has expertise in the

particular disease or injury from which the patient suffers."[57]

Note, however, that *not* included on this board is the health care professional that

is experiencing the moral distress. Instead, the situation is handed over (or up) to hospital

administration to be dealt with via the TEB. This explicitly hierarchical approach takes

away the voice of, and the proper share of the decision making from, the morally

distressed person, as well as other health care professionals who might be involved. It

transfers conflict resolution power to the institution, without acknowledging that a

morally distressed health care professional, and her peers, ought to be part of the

conversation of how the distress, and the situation causing it, will be resolved. In fact, the

TEB does nothing to resolve the impact of the distress on the individual, or its effect on

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[56] Daar, "A Clash at the Bedside," 1285.

[57] Daar, "A Clash at the Bedside," 1285-86.

the health care team or the organization, though perhaps it can remove the

patient/situation causing it in this one instance. This proposal also ignores both the

individual character of the experience of moral distress and the fact that, as will be shown

in Chapter Three, team members should have a place at the table to discuss the situation.

The bureaucratically impartial adjudication model that Daar proposes may remove the

specific catalyst for a given instance of moral distress, but that is not equivalent to

resolving the individual experience of moral distress.

Writing from the perspective of a registered nurse, Gutierrez offers a host of

strategies for removing moral distress from nurses and nursing practice that unfortunately

also depend on an appeal to the organization's hierarchical structures. She does seem

more aware than Daar that those experiencing moral distress need to be able to own a part

of its resolution, and her proposals do suggest some awareness that she is asking those

hierarchies that cause distress to then produce the solution. For example, on the one hand

she suggests that the multiple parties in a morally distressing case "should be encouraged

to engage in open dialogue, whereby moral concerns are addressed in a respectful,

nonintimidating [sic] manner, thus empowering participants."[58] She also recommends

that forums be developed where nurses are able to tell their "concerns to physicians,

patients, and families" as a coping mechanism.[59] In the end, however, none of her

recommendations explicitly recognize that, if a moral distress situation is one in which a

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[58] Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress,"
238.

[59] Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress,"
239.

nurse feels she can't do the right thing, it is also quite likely she will be unable to voice

that distress within the hierarchical structure causing the distress. While Gutierrez

recommends that there ought to be a way for nurses to talk about their distress, especially

to those people or entities that cause it, she nevertheless fails to explain how the hierarchy

can be changed to be accommodating of such dialogue.

Gutierrez does suggest that those at "high administrative levels" get "feedback

from nurses regarding lack of inclusion" in order to analyze causes of distress.[60] While a

laudable goal, once again, this assumes that those experiencing moral distress should feel

comfortable enough to initiate a conversation about powerlessness with those in power,

and discuss the moral distress that the powerful or the hierarchy of roles they represent

may have helped to cause. Without some explanation of how this will be made possible,

it is difficult to see how Gutierrez' suggestions are to be implemented to any effect. What

is needed are ideas, like the one this dissertation will offer, that do not depend on

hierarchical solutions to moral distress that are so often directly caused, or significantly

contributed to, by the hierarchical structure of the organization itself.

It might be argued that institutional policies on futile treatment and unilateral do

not attempt resuscitation orders (i.e., a hospital refusing to attempt resuscitation on a

given patient) are ways in which health care organizations attempt to use hierarchy to

avoid moral distress in their professionals. For a health care professional can appeal to

the organization's policies and procedures of this sort for institutional support, at least in

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[60] Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress,"
239.

cases when the issue is to not provide that kind of treatment.[61] Nevertheless, even if a

health care professional who may experience moral distress over continuing futile

treatment is able to appeal to such a policy, this does not address or even acknowledge

her moral distress. It is easily perceived as an institutional resolution of practical problem

in which, in effect, the health care professional relinquishes ownership of the situation to

the organization in order to do the right thing. Absent responses to moral distress that do

not refer the resolution to the organization and its hierarchical decision making

mechanisms, even policies like these can be seen as overlooking, or leaving in place, the

professional's moral distress (i.e., leaving it to the person experiencing the distress to

resolve it alone). What is needed is a way to respond to moral distress that is done in

conjunction with the distressed individual, not in place of her.

Institutional policies such as these may resolve the specific case in which the

distress exists, but unless a way of properly addressing the moral distress is also in place,

they do so only by the institution taking the issue out of the hands of those distressed by

the case. This seems to be a resolution of fact, but not of feeling. The individual may be

glad that she doesn't have to treat a patient anymore, but won't feel that it was because

she was able to play an active, participatory role in the process.

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[61] While such policies are inadequate for resolving moral distress for the reasons to be offered here, organizational policies of this sort are very valuable in other ways, and there are plenty of instances in which these policies are extremely useful and in which moral distress isn't an issue.

Conclusion

Recalling that the two top priorities of a health care organization are to provide health care services to patients and to do so by means of the expertise of health care professionals in clinical matters, and that institutions can be held morally accountable for not fulfilling its ethical obligations, it has been argued that the above examples of hierarchical responses to moral distress fail to fulfill those priorities and that health care organizations that rely on them are morally accountable for this failure. As discussed in Chapter One, unresolved moral distress leads to disengagement from patient care, emotional and physical withdrawal from others, and ultimately professional burnout. These effects have clear implications on patient care, both directly (i.e., clinician-to-patient contact) and indirectly (i.e., as these effects relate to team dynamics). Furthermore, withdrawal from participation in patient care means that a morally distressed person is not fully contributing her professional expertise, if at all, and most likely feels that her expertise is being ignored by her patients, team members, and/or institution. Thus, given the inadequacies of employing hierarchies as a response to moral distress as shown above, a health care organization that does so can be held ethically responsible for its failure to uphold its main priorities as a health care organization. A better solution would be one that includes those that are distressed in resolving the situation in concert with other health care professionals, meeting in a non-hierarchical, equality-based, inclusive forum. The following chapters will explain the moral reasons for preferring such a solution and describe a practical organizational mechanism for achieving it.

CHAPTER THREE

THE CONTENT-THIN COMMON MORAL FRAMEWORK

Chapter Two made the argument that health care organizations are not responding in an ethically adequate way and can be held morally accountable when they attempt to resolve situations of moral distress in its health care professionals in what was described as a "hierarchical" manner. This argument was based on the primacy of a provider health care organization's obligations to provide appropriate care to its patients and to assure that the provision of health care is directed by the combined expertise of its health care professionals. But there are further reasons for concluding that hierarchical efforts at resolving moral distress are ethically insufficient.

This chapter's arguments regarding the inadequacies of hierarchical approaches to moral distress focus more closely on the concepts of equality and inclusion of all health care professionals in addressing and resolving moral distress. It will offer two different reasons to favor non-hierarchical, equality-based, inclusive responses to moral distress. The first, which was suggested in Chapter Two, is an argument for the inclusion of the morally distressed individual from the resolution of her moral distress. The second is an argument for inclusion of other health care professionals in the discussion and resolution of moral distress, *even if they are not among the morally distressed individuals*. Following these arguments, a framework for non-hierarchical, equality-based, inclusive

responses to moral distress will be outlined. The remaining chapters will then develop this framework in fuller detail.

Inclusion of the Morally Distressed Health Care Professional

In Chapter One, it was shown that moral distress has myriad causes and effects for all kinds of health care professionals. Another way of stating that fact is simply that moral distress occurs in, and affects, different people, and people in different health care professions, in different ways:[1] there is no one, or "right," way to experience moral distress. This makes moral distress a personal, subjective experience. Even if it can be appreciated to some extent by other persons, and at times can also be considered communal in that many health care professionals can be involved in, and be distressed by, the same situation,[2] still the *experience* will always be personal. This stems from the fact that part of what informs a person's individual moral sensibility are her life experiences and the process of how she reflects on and interprets the meaning of those experiences. Because of this, how people have reflected on past experiences and acclimated to those experiences and reflections into their lives has also helped to individualize them, with the result that people will experience, internalize, and react to moral distress in an individualized way. Though there may be experts in talking about moral distress generally, the individualized nature of the experience means that each individual person is the one best able to understand her own moral distress.

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[1] For a fuller analysis of this claim, see Houston et al., "The Intensity and Frequency of Moral Distress Among Different Healthcare Disciplines."

[2] Varcoe et al., "Moral Distress: Tensions as Springboards for Action."

In other words, each individual is uniquely qualified to explain and talk about her own moral distress, and it follows that all health care professionals who have experienced moral distress are equally qualified to talk about their own moral distress. It is the case that overlap of knowledge, vocabulary, and some experiences means that health care professionals can intellectually understand another's moral distress in order to learn from the person's description of it and identify similarities to their own experiences.[3] But even if the same situation is a catalyst for two health care professionals' moral distress, and the symptoms of the moral distress appear identical to outsiders, the simple fact that the two people think and reflect differently means that it will be *experienced* differently.

It should be made clear that the claim that all health care professionals are, so to speak, experts in their own moral distress—because moral distress is first of all a subjective experience—is not an argument for moral relativism, either descriptively or normatively. As will be shown later in this chapter, commonalities among health care professionals in regard to basic ethical norms make for the possibility of ethical discussions, including those about moral distress situations, that are shareable in mutually constructive ways. But the variability of experience means that health care professionals cannot expect to fully understand one another's moral distress, and for persons not involved in the moral distress situation and those who are not health care professionals, the extent to which a distressed person's experience can be understood and shared is still less.

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[3] This idea will be returned to in the next section, "The Inclusion of Other Health Care Professionals."

As noted above, there is no "one way" to experience moral distress; therefore

the individualized experience of moral distress is not amenable to a "one size fits all"

resolution process. Because the morally distressed person has a unique understanding of

her experience of moral distress, not only should the resolution process include her, it is

the case that the process *cannot* be addressing her moral distress without her

participation. Therefore, as was argued in Chapter Two, hierarchical responses that

exclude the morally distressed individual can thus produce only an un-individuated

response, which in fact leaves the moral distress in place—and leaves unresolved its

negative effects both on patient care and on the morally distressed person's expert

contributions to patient care.

But furthermore, Ozar and colleagues argue in *Organizational Ethics in Health

Care* that health care organizations have obligations to those professionals who provide

care to the organization's patients. While these obligations do not ethically outweigh the

organization's two prime obligations to patient care based on professional expertise,[4] they

are nevertheless obligations that, if ignored by a health care organization, could leave that

organization open to moral criticism:

> Within [health care] provider organizations there is also a special kinship between
> the organization and the health care professionals…who are the direct providers
> of health care to the organization's patients. This special kinship, while founded
> on the relationship of shared effort and common goals…is both strengthened and
> deepened by the specific shared commitment of the provider organization and the
> organization's clinical staff…to serve the health of patients as priority 1 [of the
> health care organization]. Because of this shared commitment about what is the

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[4] For a discussion of a rank order of the priorities see Ozar et al., *Organizational Ethics in Health Care*, 11.

highest priority for both of them, the sense of kinship will likely be greater in this instance than in a provider organization's relationships with other stakeholders.[5]

So a health care organization that moves the resolution of a morally distressing situation out of the hands of those experiencing it not only marginalizes them from participating in a process in which they are uniquely qualified to participate, it also inhibits the resolution of a situation that they experience as significantly negative and ethically challenging and thus disregards the ethical relationship (the "special kinship") it has an obligation to build. Handing off the issue to a superior or to a different office or department, for example, in an attempt to "solve" it sends a clear message that the person experiencing moral distress is not respected as a unique individual or as a significant contributor to the shared effort and common goals of the organization, and furthermore that their distress and its negative psychological or physical effects are of only indirect concern to the organization, to be mediated by the hierarchy. This would be yet another obligation (in this case to its health care professionals) that a health care organization could be criticized for failing to uphold.

While it is possible that an organization might sometimes successfully resolve a moral distress situation in the same manner it solves, say, technology acquisition (i.e., through chain-of-command and levels of approval), it does so not only at the peril of marginalizing the distressed health care professional's moral experience and subjugating it to someone else's—someone who cannot adequately substitute their experience for the experience of moral distress as felt by the individual experiencing it—but also at the peril

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[5] Ozar et al., *Organizational Ethics in Health Care*, 13.

of marginalizing and devaluing the person herself. That is to say, sometimes the *situation* that causes moral distress may be solved via "normal" organizational channels, but not the moral distress itself. A hierarchical response to moral distress that excludes the morally distressed professional fails to grasp the point of what the resolution of moral distress itself looks like—it targets the wrong problem because the true problem can only be properly addressed if both the person's understanding of the situation and the value of the person experiencing it are treated as essential parts of the resolution process. An organization's failure to recognize this is clearly an ethical failing on the part of the organization.

Inclusion of Other Involved Health Care Professionals

The argument for including other health care professionals in a moral distress resolution, even if they themselves are not experiencing moral distress in the situation, may be less obvious than the argument for including the morally distressed health care professional, but is equally important to this dissertation's framework. So this section will argue that any other health care professionals who are involved in the morally distressing situation should also be included in the process of resolving the moral distress of the person experiencing it. There are both practical and more general philosophical reasons for this inclusion. The practical reasons will be explained in this chapter. The more general philosophical reasons will be explained in Chapter Four, where they will also be seen to serve as grounding for how resolution of moral distress can occur.

As has been shown, hierarchical responses that exclude a person experiencing moral distress from the resolution are ethically inappropriate, both because they prevent

resolution from occurring (with the continued adverse effects of moral distress on patient care and respect for professional expertise) and because they do not respect the ethical relationship between the organization and health care professional. But it is important to note, first, that not including *other* health care professionals also prevents resolution from occurring (and thus the same continued adverse effects on patient care and respect for professional expertise). This is because moral distress only occurs when different participants in a situation have differing judgments about what ought to be done in that situation (and at least one of the participants cannot act in accord with her belief of what ought to be done). If the only participant in this situation who has a voice in the resolution is the morally distressed person, then the moral views of those who have not been given the opportunity to speak up will not be included in the resolution process, which may in fact create *more* moral distress in those ignored health care professionals. In other words, this is an argument for equality—*specifically within the process of resolving moral distress*—of the moral views of all health care professionals involved in the situation. If this argument is correct, it clearly implies the practical importance of including the other health care professionals involved in the situation, if they choose to participate.

There are a number of ways in which a person's view of what ought to be done can be in conflict with the moral views of others in a given situation, and so a concrete example that was noted in Chapter One will be helpful here. A common situation is one in which a health care team's decision regarding treatment for a patient can cause an individual member of that team to experience moral distress if she thinks the plan is

unethical and she is unable to alter her team's choice. Suppose only the person experiencing moral distress participates in the resolution process (along with whomever from outside the situation is representing the organization's effort to resolve situations of moral distress), but not the other care professionals in the situation. If the moral view of the health care team is the action supported by those outside the situation, then little has occurred to resolve the distressed person's moral distress (and the situation differs little from the hierarchical solutions criticized above). But if the moral view of the distressed person is supported by those outside the situation, there is very good reason to expect the non-participating members of the health care team to experience moral distress themselves (as they also had made a decision about what the ethical thing to do is and now are being told by the institution that they cannot act on it) and, in any case, to experience to devaluing of themselves and their efforts at moral judgment found ethically wanting in the previous section.

It was noted in Chapter One that a team member's moral distress can have repercussions on the rest of the team or staff. Recalling that moral distress can lead to withdrawal from patient care, burnout, depression, and more, these symptoms can negatively affect the ability to care for any given patient. But team members can also be affected by another health care professional's unresolved moral distress, leading perhaps to a difficult work environment or having to "carry" a burned out team member by taking on extra work. For obvious practical reasons, then, other health care professionals involved in the situation should also take part in the process of resolution in order to maintain team cohesion and thereby the highest quality of care for the patients.

There are also reasons above and beyond restoration of team cohesion and its

positive impacts on patient care to include the other health care professionals in the

resolution process. Recall that the definition of moral distress posited in this dissertation

starts with the notion that a morally distressed person "believes she knows the ethical

course of action to take." The word "believes" in the definition leads to an important

reason for the inclusion of other health care professionals in moral distress resolution: in

some cases, moral distress may arise not from a discordance of individuals' values, but

instead from individuals having incomplete information. As Helft and colleagues state

when discussing one mechanism to address moral distress, "It is common that several

participants are only partially informed about the details of the case under discussion and

that such partial understandings contribute in important ways to feelings of [moral]

distress and, in some cases, to judgments that do not follow logically from a deeper

understanding of the facts."[6] That is to say, a morally distressed individual, believing she

knows what the ethical thing to do is, may lack information held by other team members

that has led them to choose a different course of action. Including those team members in

the conversation can perhaps bring this information to light, whether that information is a

new diagnosis or prognosis, previous conversations had between the patient and one of

the providers, or simply a different understanding of the underlying medical facts.

Including team members who may be able to provide that information, and by "probing

for details and inviting other staff to provide missing parts of the story,"[7] it is possible to

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[6] Helft et al., "Facilitated Ethics Conversations," 29.

[7] Helft et al., "Facilitated Ethics Conversations," 29.

draw a fuller picture of what went into choosing option A instead of B which in and of itself may resolve moral distress and may, in fact, lead a morally distressed person to come to the decision that A is the "better" option.

In addition, the other health care professionals involved in the situation can provide not only information, but interpretation of, and rationale for the importance of, that information. They may, by explaining more carefully the basis of their ethical thinking about the matter (perhaps because their reasons, both generally and specifically ethically, come from different past experiences and different reflection on those experiences from the morally distressed person's), bring about a different ethical judgment in the morally distressed person—or their exchange may enable both to change in a manner both can accept. As Cowley states, "Moral reasons and judgements [sic] are always declared within an embodied moral perspective on the situation."[8] The fact that moral reasoning is applied differently by different people is not a relativist flaw in how ethics is done; instead, it allows one person to help another see the same situation from a more nuanced angle. Different perspectives allow for different vantage points on the same set of facts, and each perspective may be relevant in a moral distress situation. Therefore, given that all health care professionals (like all people) are moral reasoners with experience reflecting on ethical issues, if any practitioner feels she can contribute to the resolution of moral distress via her experience, she should be included.

In other words, including both the morally distressed individual(s) and the other health care professionals involved in the situation is by far the most efficient method to

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[8] Cowley, "A New Rejection of Moral Expertise," 276.

approach the situation, that is, the method most likely to achieve resolution of the

moral distress. This is partly because those involved in the situation are more likely to see

its nuances, both factual and ethical, and also because, if outside actors have hierarchical

authority to determine what ought to be done in the case, the absence of the other health

care professionals involved in the situation will be more likely to produce the negative

consequences of hierarchal responses criticized in Chapter Two and above.[9]

Bringing the Morally Distressed and Other Health Care Professionals Together

This chapter has argued that when addressing moral distress, both the morally

distressed individual(s) and other health care professionals involved in the moral distress

situation ought to be included. Furthermore, Chapter Two showed that attempting to

address a moral distress situation through a hierarchical system is an ethically inadequate

response, and this implies (and will be made explicit in the next section) that a response

should acknowledge all participants as equally important to the resolution process. In

other words, whatever response is ultimately chosen, it must be one in which the morally

distressed individual(s) and other health care professionals can engage in dialogue *with

each other*. That is to say, if an ethically appropriate response includes all participants in

a non-hierarchical format, this would minimally require a process that includes discussion

among and between all participants. A discussion of this sort would instantiate the

reasons for including all participants in a moral distress situation, including giving voice

to those morally distressed, and allowing other health care professionals to share their

clinical expertise and their experience as moral reasoners.

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[9] The previous two sections owe thanks to David Ozar for his thinking on this subject of
moral reasoners.

What is needed, then, is an understanding of how this discussion can take place. In order to build this understanding, the next section will introduce and defend the necessary moral framework for the discussion. Chapter Four will explore the participants' relationship to each other within that discussion, and Chapter Five will provide process and procedural rules to guide the discussion with the goal of resolving moral distress in health care professionals.

The Content-Thin Common Moral Framework

This chapter has allowed for, and in fact relied on, differences in ethical viewpoints between the morally distressed person(s) and other health care professionals involved in a moral distress situation. At several points the claim has been made that these differences are not insuperable, that is, that moral distress does not presuppose moral relativism. This section will make explicit the reasons that moral relativism is not an inherent feature of such situations and does not undercut the significance of the above arguments. The following discussion of what will be described as a "content-thin common moral framework" provides the philosophical foundation for the arguments offered above for inclusion of both the morally distressed person and the other health care professionals involved, as it explains why and how it is possible for them to successfully discuss their differing moral views. It will also serve as a bridge to Chapter Four's exploration of what kinds of moral discussion are possible for "moral friends," "moral strangers," and "moral acquaintances," with the last category then being used as the grounding for processes of moral distress resolution structured according to the premises and rules that will be explained in Chapter Five.

This section will posit and defend the thesis that among health care

professionals (or at the very least health care professionals practicing in our society and

societies like it) there is a mutually agreed-upon (either explicitly or tacitly) content-thin

common moral framework that health care professionals understand and adhere to.[10] This

content-thin common moral framework does two things for purposes of the present

discussion. First, it delineates the types of experiences of moral distress that an ethically

serious health care organization should be held accountable to address and resolve (i.e.,

those that can appeal to a perceived violation of part of the framework), even when the

experience of moral distress itself is, as shown above, variable and subjective in an

important sense. Second, if this moral framework can be shown to be common to the

health care professionals involved in moral distress situations, it can provide the means

for creating a peer-to-peer non-hierarchical forum in which discussions about morally

distressing situations can take place. That is, if health care professionals are in basic

(though at times, *very* loose, and perhaps not even explicit) agreement about what is

meant by ethical health care practice—due to similarities in training and professionally

assumed moral commitments—then in any discussion of a moral distress situation it is

reasonable to accept as a starting point that the participants are equipped with a

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[10] As will be made clear, this framework decidedly is not THE answer to all moral quandaries. This is a looser understanding, based on the shared moral obligations of health care professionals. In fact, "common moral framework" may not be the most exact term—if a different, more explicative term could be thought of, it could replace the term in this dissertation. One possibility is "shared convictions": in addition to removing the objection that health care professionals do not, in fact, explicitly use a moral framework, this phrase implies that all health care professionals are imbued with the same convictions about their role in fulfilling the goals and values of professional health care, which will be discussed later in this chapter.

professional moral compass that is, very broadly speaking, the same. Such a common

ethical grounding will also be a further reason for saying that the health care

professionals participating in the discussion are equal, and all should be treated as peers

in that discussion addressing the moral distress situation.

Before describing the framework itself, it is important to understand what is

meant by the expression "content-thin" when referring to that framework. Here, the word

"thin" is being used the same way that Michael Walzer uses it in *Thick and Thin*.[11] It will

therefore be useful to explain Walzer's meaning of the term, which will be the first step

in explaining how a content-thin common moral framework will be used by the "moral

acquaintances" discussed in Chapter Four.

Walzer builds his definition of "thin" by recalling a picture he saw on the news in

the lead-up to Czechoslovakia's Velvet Revolution in 1989. He saw people marching in

the street, carrying signs reading "Truth" and "Justice." Walzer states, "I knew

immediately what the signs meant—and so did everyone else who saw the same picture.

Not only that: I also recognized and acknowledged the values that the marchers were

defending—and so did (almost) everyone else."[12] The realization that an understanding of

concepts such as "truth" and "justice" was available to Walzer, even though he had never

experienced the oppression the Czechoslovakian marchers were facing, led him to realize

that this is, in part, because the marchers weren't appealing to a specific theory of truth,

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[11] In this dissertation, the word "thin" is almost always being used in conjunction with "content" (as in "content-thin"), and as such refers to ethical concepts and meanings that are being shared in the common moral framework.

[12] Walzer, *Thick and Thin*, 1.

or to a particular understanding of justice. Instead, the call for justice was a call for, as Walzer puts it, "common, garden variety justice."[13] This, Walzer states, is a thin, minimal meaning (as opposed to thick, maximal meanings) of moral terms.

But thick and thin, Walzer explains, are not representative of two distinct moralities; instead, "minimalist meanings are embedded in the maximal morality."[14] The thin, minimal expression of morality is shallow, yet connects with the experiences of (almost) everyone. The thick, maximal expression is deeper and comes with "qualification, compromise, complexity, and disagreement."[15] That is, as meanings become thicker, they also become more precise and the communities that support them become smaller. Thus, thin moralities may be shared across different historical, cultural, or political views, while at the same time they point to thicker concepts that will make clear those differences in viewpoints once the participants dig deeper. Walzer expresses this dichotomy eloquently, referring again to the marchers in Prague:

> Clearly, when they waved their signs, they were not relativists: they would have said…that everyone in the world should support their cause—should join them in defense of 'truth' and 'justice'…But when they turn to the business of designing a health care system or an educational system for Czechs and Slovaks or arguing about the politics of their union or separation, they will not be universalists: they will aim at what is best for themselves, what fits their history and culture, and won't insist that all the rest of us endorse or reiterate their decisions.[16]

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[13] Walzer, *Thick and Thin*, 2.

[14] Walzer, *Thick and Thin*, 3.

[15] Walzer, *Thick and Thin*, 6.

[16] Walzer, *Thick and Thin*, 3-4.

Or, put more simply, "Minimalism makes for a certain limited, though important and heartening, solidarity. It doesn't make for a full-blooded universal doctrine."[17] Though they are limited, thin accounts of moralities can be helpfully shared by almost everybody; indeed, over 25 years after the Velvet Revolution, an article in *The Economist* reported on a protest in Argentina where marchers once again "carried signs demanding 'truth' and 'justice'" from their government.[18] And though any observer can understand what the marchers are asking for in both protests, clearly the specific applications in both scenarios are different—the thick, maximal meanings of "truth" and "justice" are different in 1989 Czechoslovakia than they are in Argentina a quarter of a century later. When thin meanings are used, specificity is sacrificed for accessibility. As Stephen Hanson states, "Though all rational moral persons may well agree that justice is important, they do not agree on precisely how justice should be defined, much less on how to derive specific consequences from it; though they all may agree that beneficence is important, they do not agree on how important it is relative, to, say, the importance of respecting the autonomy of one who is refusing a beneficent act."[19]

Thin moral concepts use generic, common understandings as their starting point—they are "broad and bland."[20] In this regard, thin moral concepts are "reasonable

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[17] Walzer, *Thick and Thin*, 4.

[18] *The Economist*, "Silent, but seething," 35.

[19] Hanson, *Moral Acquaintances and Moral Decisions*, 11.

[20] Moreno, "*Is There an Ethicist in the House?*" 91.

enough and universal enough" for all participants to come to a moral discussion with a baseline consensus about the thin meaning of those concepts.[21]

This dissertation will argue that health care professionals in our society (and in other similar societies) share thin ethical principles related to their professions, and enough so to form a framework—the content-thin common moral framework outlined below. The content that is shared, and the framework that it builds, rests on what will be referred to in this dissertation as a "common professional morality," a term itself which needs unpacking. Here, the "common morality" of common professional morality is used in a way similar to how Tom Beauchamp and James Childress use the phrase in *Principles of Biomedical Ethics*. As the authors state, "All persons who are serious about living a moral life already grasp the core dimensions of morality. They know not to lie, not to steal property, to keep promises, to respect the rights of others, not to kill or cause harm to innocent persons, and the like…Because we are already convinced about such matters, the literature of ethics does not debate them. Such debate would be a waste of time."[22] Any morally serious person, Beauchamp and Childress state, knows that certain ethical rules are basic building blocks for an ethical life, and they need not be proven or defended.

It is beyond the scope of this dissertation to ask whether or not there is a truly common morality spanning all "morally serious" people and generations; but it is also not

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[21] Walzer, *Thick and Thin*, 64.

[22] Beauchamp and Childress, *Principles of Biomedical Ethics*, 3.

necessary for what is being argued for here.[23] Instead, in discussing a "common

professional morality," this dissertation follows Beauchamp and Childress's narrower

view regarding the ethics of health care professionals (in ours and similar societies). They

state, "Just as the common morality is accepted by all morally serious persons, so most

professions contain, at least implicitly, a professional morality with standards of conduct

that are generally acknowledged by those in the profession who are serious about their

moral responsibilities."[24] While the foundations of a general, or universal, common

morality can be—and are—debated and denied by people who consider themselves

"morally serious,"[25] the relevance of a common professional morality within a given

society is implied in the concept of professionalism itself.[26] In health care, specifically,

one cannot join a given health care profession while simultaneously disavowing the

ethical commitments that come with it. A professional is obligated, because of the

autonomy afforded professions and professionals by society, to work within the common

professional morality toward the goals of professional health care.[27] Importantly, for the

discussion that follows, common professional morality, and the content-thin common

moral framework it supports, does not explicitly appeal to any one general moral theory

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[23] Saying that one must be "morally serious" in regard to universal morality is a troublingly vague statement, especially if Beauchamp and Childress can only define people as morally serious as those that buy into their proposed common morality.

[24] Beauchamp and Childress, *Principles of Biomedical Ethics*, 5.

[25] Indeed, the discussion of moral friends and moral strangers in Chapter Four is based on Engelhardt's denial of a common morality.

[26] See Ozar, "Profession and Professional Ethics," 2526 and 2529.

[27] See Ozar and Sokol, *Dental Ethics at Chairside*, 20-22.

for its support; it is simply the requisite for practicing in a given profession. The framework ensures that each member of a profession shares in a basic moral agreement regarding their profession and what it means to act ethically as a member of it.[28]

Thus, because society grants professions and professionals a large degree of autonomy based on the assumption that the members of the profession will police themselves on matters of practice, conduct, and ethics, upon entering a profession the newly-minted professional is expected to take up certain moral obligations, a commitment often sworn symbolically by oath. These professional moral obligations are what the various professional organizations' codes aim to express, often in vague or bland ways. But they are certainly expected to be treated as substantive when practiced.

Thus, a content-thin common moral framework for health care professions can be described in this way: the broad, shallow ethical obligations and values that all health care professionals necessarily commit to, and share, by reason of being health care professionals.

Having defined it as such, two counter-arguments against the content-thin common moral framework for health care professionals (in ours and similar societies) can

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[28] It should be noted that this is not the same as claiming that all health care professionals share the exact same set of (thick) ethical commitments. For example, bioethics literature traditionally states that doctors have healing as a primary obligation (with different specialties even having differing notions of what that means), while nurses focus first on caring. However, returning to Walzer's notion of "thin" mutual understanding, then the claim can be made that all health care professionals are committed a (thin) set of overlapping convictions that include the aforementioned healing and caring, among other various moral concepts that are a part of the content-thin common moral framework and will be discussed later in this chapter. A person from one health care profession could be understood by a person from another health care profession when using these (thin) concepts even if their rank order, for example, differs from profession to profession.

be put forward and need to be carefully considered. The first is that the framework

doesn't exist in the first place (much like one could argue against a general common

morality), and the second is that it is devoid of content, because its content either hasn't

or can't be determined. Explaining why these two counter-arguments fail will help

expound upon the framework and its content.

In making the first counter-argument, one might say that what is considered

ethical in health care is a moving target (e.g., withdrawing artificial nutrition or

mechanical ventilation in a brain-dead patient was once considered immoral but now is

generally accepted by health care professionals as ethically appropriate). There is no

common framework, the counter-argument goes, because health care professionals accept

different ethical standards at different times, not one that is shared by health care

professionals across time; this is why such shifting ethical standards may lead to

confusion regarding what is professionally correct at any specific point in time.

In response, it is easy to concede that what is considered ethical in health care

can, in some instances, shift. But professional ethics are grounded in the professions

themselves (and/or possibly in the agreement between society and a profession on what

role the profession should fill), as they exist and are understood at a given point in time.[29]

Professions (and societies) gradually change over time and some of these changes yield

adjustments in the moral framework they support. What matters is that health care

professionals agree on what constitutes the ethics of the health professions at that time,

and the commitment to uphold those ethical obligations remains constant. Taking on a

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[29] See Ozar, "Profession and Professional Ethics," 2535-36.

professional role demands the acceptance of certain obligations, even if the content of those obligations can and does change over time. That obligations might change does not mean that *fulfilling* those obligations is optional for health care professionals.

As Beauchamp and Childress explain, "Health care professions typically specify and enforce obligations for their members, thereby seeking to ensure that persons who enter into relationships with these professionals will find them competent and trustworthy. The obligations that professions attempt to enforce are role obligations, that is, obligations determined by an accepted role."[30] The content-thin common framework exists *because* the profession exists, and part of what it "means" to be a professional is to conduct oneself in accord with the framework.

A more direct response to the claim that health care professionals' moral standards vary too much to support the argument being made here can be found by how health care professions actually function. There are numerous examples of the application of the content-thin common moral framework that point to the existence of shared ethical commitments of health care professionals, and these examples come at many different levels of the health care system. One obvious example has already been given: namely, that the professions themselves often have their members commit to certain ethical precepts, with the most notable examples being the Hippocratic and Osteopathic Oaths for physicians. Professional associations, as well, prescript moral obligations for their members, from the American Nurses Association's *Code of Ethics for Nurses* to the American Association for Respiratory Care's *Statement of Ethics and Professional*

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[30] Beauchamp and Childress, *Principles of Biomedical Ethics*, 6.

Conduct. These few examples provide evidence that, for one who is a health care

professional, there is an obligation to think about the ethics of the profession as a basic

stipulation of being a member of the profession, and this in turn supports the idea that all

health care professionals should be attuned to that obligation, and have the same (broad

as it may be) commitment to ethical thinking. As Ozar and Sokol claim, "Many people,

both inside and outside of professions, hold that professions and professionals have

special obligations and consider this to be a central feature of their being professions and

professionals. When a group becomes a profession, this view holds, it is precisely in

doing so that it undertakes certain obligations. Similarly, when an individual becomes a

professional—a member of a profession—precisely in doing this he or she undertakes

certain obligations."[31]

The second counter-argument to the content-thin common moral framework is the

notion that the actual (or at least current) content of the framework hasn't been, or can't

be, determined, and thus is in fact empty of content. An initial response to this is the

reminder that the content is, by its very nature, "broad and bland," and thus can't be *fully*

fleshed out. But a further response to this counter-argument is that the thin content of

what moral commitments health care professionals share today can in fact be found by

thinking about how the goals and the values of professional health care are articulated

and similar across the different health care professions. A look at the concepts provided

in typical statements of this sort can help uncover what is currently considered ethically

important to health care professionals. Delineating the *goals* of professional health care

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[31] Ozar and Sokol, *Dental Ethics at Chairside*, 14.

can help provide a language for *what* health care professionals are trying to do, generally speaking, while the *values* can give voice to the *why* and *how*. Together, describing these two facets of the ethics of the health care professions can reveal the scaffolding of the content-thin common moral framework used by health care professionals in our society (and similar societies) today.

The Goals and Values of Professional Health Care

The following survey of goals and values that health care professionals appeal to is meant to give examples of what currently makes up the content in the content-thin common moral framework, rather than provide an exhaustive study. Moreover, because the examples provided here are for descriptive purposes, where they come from—that is, whether internal to the morality of medicine and/or given from the outside (i.e., society)—is unimportant.[32] Instead, this is an attempt to describe how health care professionals are actually talking about goals of professional health care and what they actually value. These descriptions of goals and values may be "broad and bland," and different individuals may imbue the goals and values with different meanings once beyond the superficial level and into a "thick," substantive discussion. But the thin framework is, as explained above, minimal and serves as the scaffolding for more substantive (thick) discussions. For it is purposely thin on content *so that* it can be shared by all health care professionals.

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[32] Though comments in this dissertation make it relatively clear that its author thinks that these goals (not to mention the role of the professions themselves) come from a dialogue between society and the professions, this is not a resolved issue, but it also is unimportant for this dissertation. For an excellent summary of the debate, see the *Journal of Medicine and Philosophy* 26, no. 6 (2001), which includes commentary from such leaders on the subject as John Arras, Robert Veatch, Tom Beauchamp, and Edmund Pellegrino.

In regard to the goals of medicine, in 1996 the Hastings Center, in partnership with the World Health Organization, worked on a project searching for "general consensus" on what those goals are.[33] The Hastings Center did not take a stance on whether the goals of medicine are internal or external to medicine itself, noting that even though "medicine still has the capacity from within significantly to determine its own course, it is highly influenced by the mores, values, economics, and politics of the societies of which it is a part."[34] The report also states that it grounded its search for goals not in a common morality, per se, but in the "common human nature" which "sooner or later" leads all of us to get sick, go through physical deterioration, and experience pain and suffering.[35] Ultimately, the report identified four primary goals of medicine, and thus of professional health care (see footnote 33): "The prevention of disease and injury and the promotion and maintenance of health; The relief of pain and suffering caused by maladies; The care and cure of those with a malady, and the care of those who cannot be cured; The avoidance of premature death and the pursuit of a peaceful death."[36]

A survey of the literature shows that others thinking about the issue generally agree with the Hastings Center and World Health Organization, and because the aim here

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[33] The Hastings Center, "The Goals of Medicine," Preface. This section reviews literature on the goals of medicine, as it is assumed it is the goal of professional health care to fulfill the overall goals of medicine. Though the focus or expertise of a specific health care profession may mean it works to support or achieve these goals in different ways, professional health care is still working toward these goals.

[34] The Hastings Center, "The Goals of Medicine," S6.

[35] The Hastings Center, "The Goals of Medicine," S6.

[36] The Hastings Center, "The Goals of Medicine," executive summary. Formatting and punctuation altered.

is provide examples of what builds the content-thin common moral framework, the fact that consensus arises across the spectrum lends credence to the fact that these goals are, indeed, correctly considered to be some of the goals of medicine and professional health care at this time. It is also worth noting that some of these thinkers interpret and apply the goals differently (even when using basically the same vocabulary to define the goals), which is a reminder that the content of the framework is necessarily thin and minimal, not thick and maximal.

Brülde, for example, attempts to build a normative theory of the goals of medicine in response to the Hastings Center report, as he finds that it "is lacking in certain respects."[37] And yet, his seven goals map closely to the Hasting Center's four: the goals of medicine are "to promote functioning, to maintain or restore normal structure and function, to promote quality of life, to save and prolong life, to help the patient to cope well with her condition, to improve the external conditions under which people live, and to promote the growth and development of children."[38] In another context, Varelius comes up with seven of his own goals, which are very similar to the goals listed by The Hastings Center and Brülde: "(1) avoidance of premature death, (2) preservation of life, (3) prevention of disease and injury, (4) promotion and maintenance of health, (5) relief of pain and suffering, (6) avoidance of harm, and (7) promotion of well-being."[39]

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[37] Brülde, "The Goals of Medicine. Towards a Unified Theory," 1.

[38] Brülde, "The Goals of Medicine. Towards a Unified Theory," 1.

[39] Varelius, "Voluntary Euthanasia, Physician-Assisted Suicide, and the Goals of Medicine," 126-27. Punctuation altered.

This brief survey of the goals of medicine provides a glimpse at what health care professionals generally agree that professional health care should be working to achieve. The values of the health care professionals, however, may differ among the professions, given that each profession may have a different primary focal point. As Ozar and Sokol point out, because of the specialization necessary to become a professional in any given field, "there is always necessarily a certain limited set of values that are the specific focus of each profession's expertise."[40] However, in reviewing the discourse of various health care professions, there are more similarities than differences in values.

Among the most-often referred to values in health care are the four ethical standards proposed in Beauchamp and Childress' version of principlism that guides so many bioethical discussions: autonomy, nonmaleficence, beneficence, and justice.[41] Beauchamp and Childress, however, also offer a list of virtues, which could also be considered values for health care professionals, including "compassion, discernment, trustworthiness, integrity, and conscientiousness."[42] In both discourse and practice, these values are instrumental to both patients and other health care professionals, and an ability to appeal to these values often provides the language for how to frame the obligations of a given profession (e.g., "We need to listen to what the patient wants in order to respect her autonomy"). They are not specific to any one health care profession, but to professional health care generally, and thus all health care professionals.

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[40] Ozar and Sokol, *Dental Ethics at Chairside*, 64.

[41] That they are called "principles" in Beauchamp and Childress' text does not change the fact that they are, in regular discourse and practice, considered values.

[42] Beauchamp and Childress, *Principles of Biomedical Ethics*, 30.

Even when looking at specific health care professions, it can be argued that examples of each one's values are, in fact, a part of the content-thin common moral framework for all health care professionals, in that their values are thin enough to be understood, and perhaps even appropriated, by other health care professions. Speaking about physicians, Beauchamp states that they share values "of healing, palliation, rehabilitation, removing discomfort, diagnostic testing, and the like."[43] In regard to nursing, Benner and colleagues state that central moral principles for expert nurses include "a concern for revealing and responding to patients as persons, respecting their dignity," and "caring for them in ways that preserve their personhood."[44] Yet nurses must also possess "clinical knowledge, knowledge of the particular patient, science, and clinical evidence" in order to provide excellent care.[45] These values seem more complimentary with those of physicians than contradictory or foreign.

The American Physical Therapy Association, as well, lists seven core values that are easily recognizable by other health care professionals: "accountability, altruism, compassion/caring, excellence, integrity, professional duty, social responsibility."[46] Ozar and Sokol enumerate the central values of dentistry, in rank order: "the patient's life and general health; the patient's oral health; the patient's autonomy; the dentist's preferred

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[43] Beauchamp, "Internal and External Standards of Medical Morality," 611.

[44] Benner, Tanner, and Chesla, *Expertise in Nursing Practice*, 145.

[45] Benner, Tanner, and Chesla, *Expertise in Nursing Practice*, 96-97.

[46] APTA, *Professionalism in Physical Therapy*. Formatting and punctuation altered.

patterns of practice; aesthetic values; efficiency in the use of resources."[47] Though

some of these values refer specifically to dentistry, if stripped of their thick, substantive

specification, they could easily be understood by, or even affixed to, any other specialty

in health care. The thin values of health, autonomy, habituation, and just allocation are

not specific to any one profession, but to all of them. It is only when the content is

"thickened"—which is not required for the common moral framework to stand—that

divergences appear, which is to expected given Walzer's discussion of thick and thin.

It should once again be stressed that the values discussed here are not meant to be

a definitive or comprehensive listing, but instead they are examples of the general values

presented by leaders in health care ethics and the specific health care professions. What

these examples show is that the values of different health care professionals coexist

within the same content-thin common moral framework: Even the profession-specific

values point back to "thinner" values shared by all health care professionals. And because

these values exist as a central feature of each of the health care professions prior to any

health care professional joining their chosen profession, "it is [those] values…that he or

she accepts and commits to, not some set of values of the individual practitioner's own

devising."[48] That is to say, that each health care profession has identified these values as

those to be honored by its professionals *is enough* to say that they are the values that

should be honored, and the fact that the values across different professionals are *similar*

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[47] Ozar and Sokol, *Dental Ethics at Chairside*, 68. Formatting and punctuation altered.

[48] Ozar and Sokol, *Dental Ethics at Chairside*, 65.

enough to one another is enough to say that those health care professionals could easily

engage one another through the language of these values.

It is also important to remember that the above survey is not making a judgment

whether these goals and values *should be* the goals and values of professional health care.

Instead, these examples provide empirical evidence that there are goals and values that

are, circularly enough, being talked about as the goals of professional health care and the

values of health care professionals. Thus the idea of a content-thin common moral

framework has empirical support and can be posited as a starting point for discussions

about ethical issues and, of course, moral distress. That is to say, in voicing moral

distress, a health care professional will often appeal to a non-fulfillment of one of those

goals, or a violation of one of those values, and will expect to be understood by other

health care professionals because they share this content-thin common moral framework.

In one moral distress conversation, for example, the facilitator stated that "the

conversation helped the nurses articulate their feelings in terms of a violation of the code

of nurses that obliges nurses to respect their patients even in death."[49] Here a common

concept across health care professionals—respect for patients—was explicitly appealed

to, with the expectation that such language and meaning could be shared. The content of

the framework, and thus the shared understanding of the goals and values, is thin, and

thus digging into each health care professional's particular (thick) use of the concepts

will expose differences. But as a starting point for discussion, this content-thin common

moral framework gives all health care professionals a shared basis of meaning that can be

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[49] Helft et al., "Facilitated Ethics Conversations," 29.

used to anchor ethical discussion. As Hanson aptly notes, in health care ethics, "At their hearts, different concepts cannot differ too dramatically—e.g., one cannot legitimately understand 'respect for autonomy' as 'providing the most good for the most persons' or 'justice' as 'being as unfair as possible.'"[50]

Conclusion

Chapter Two of this dissertation made the claim that health care organizations' responses to moral distress are ethically inadequate if these responses are hierarchical, do not include the morally distressed individual, or they ask health care professionals to attempt to resolve their own moral distress within those hierarchies that may have caused the moral distress in the first place. This chapter laid out additional reasons that using hierarchies to respond to moral distress would be ethically inadequate, starting with a second kind of argument for including the morally distressed health care professional, and continuing with an argument for including other health care professionals involved in the morally distressing situation.

Once both of these parties are to be included, it became clear that they will be engaged in a discussion, or dialogue, of some sort. This realization raised the question whether there is any common framework in which moral distress and the ethical differences underlying it can be discussed. The fact that there is a content-thin common moral framework for health care professionals (in ours and similar societies), a framework that outlines those professionals' shared ethical obligations and common professional morality, means that the parties to a moral distress discussion can work from

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[50] Hanson, *Moral Acquaintances and Moral Decisions*, 87f.

a shared starting point to discuss their moral views, their perceived obligations, and their violations. In addition, this shared framework not only makes it possible for the inclusion of both parties in productive dialogue, it also provides an *argument for equality* among health care professionals. In that all health care professionals have access to this content-thin common moral framework, they are peers in their ability to appeal to the framework, and use it to discuss and resolve ethical issues, including instances of moral distress. With this framework, a peer-to-peer, equality-based resolution of moral distress situations may be accessible, and able to replace hierarchical mechanisms.

The question becomes, then, what that peer-to-peer, equality-based resolution of moral distress might look like. To begin answering that, Chapter Four will appropriate the content-thin common moral framework for health care professionals described in this chapter, and apply it to the body of literature by H. Tristam Engelhardt and Kevin Wm. Wildes on moral friends, moral strangers, and moral acquaintances, to show that because of the framework, all health care professionals can be considered moral acquaintances. The implications of this on the theoretical underpinnings of moral distress resolution will then be fleshed out in Chapter Five.

CHAPTER FOUR

MORAL STRANGERS, MORAL FRIENDS, AND MORAL ACQUAINTANCES

Chapter Two of this dissertation argued that a health care organization that responds to moral distress in its health care professionals with a hierarchically-based solution can and should be judged as providing an ethically insufficient response. Chapter Three provided further grounding for this argument and also argued for the inclusion of all health care professionals involved in a moral distress discussion in its resolution, a discussion that can be based on the content-thin common moral framework they share as members of their health care professions.

In this chapter, then, it must then be asked: if a hierarchical response is ethically insufficient, what is it to be replaced it with? What sort of discussion is needed and then what sort of organizational strategy can be identified to provide for such discussions, so that health care professionals engaged in the process of resolving moral distress will be able to do so in a non-hierarchical, equality-based, inclusive way? This chapter proposes that the philosophical foundation to begin answering these complex questions can be uncovered by studying the writings of H. Tristam Engelhardt, Jr. and of Kevin Wm. Wildes.

Englehardt's *Foundations of Bioethics* introduced the categories of moral friends and moral strangers into bioethical discourse, and Wildes added moral acquaintances to fill in the gap between Engelhardt's two extremes of moral relationships. The following

sections will provide exegesis and analysis of this discussion, as well as link these

concepts to those presented in Chapters Two and Three. Engelhardt's distinction between

moral strangers and moral friends, as summarized below, fails to provide space for the

kind of discussion needed for responding to moral distress (and this was not his intent).

But by expanding on his work in light of Wildes' contribution of the concept of moral

acquaintances, a procedure for involved health care professionals' resolution of moral

distress can be created, one that starts from the content-thin common moral framework

for health care professionals like the one described in the Chapter Three. Working from

these ideas as a theoretical basis, Chapters Five and Six will be able to propose a

methodology for these discussions and a practical answer to how health care

organizations can address moral distress in health care professionals.

Moral Friends and Moral Strangers

Engelhardt's *Foundations* builds an approach to bioethics that grows out of the

observation that there is not a common morality in today's world. Engelhardt looks at the

contemporary secular, pluralistic world, and believes that a universal content-full

morality is impossible given the multitude of ethical viewpoints and the lack of an

agreed-upon moral authority.[1] He holds that it is simply not the case that, given the vast

moral differences among the globe's inhabitants, any overarching agreement about moral

standards could ever be reached. The Enlightenment project of finding a content-full

morality through rationality is doomed to failure, according to Engelhardt:

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[1] Engelhardt often uses the term "secular" in reference to the world of moral strangers
that he observes around him, and not in a specific non-religious sense.

It is not possible rationally to discover a canonical, moral account with content. Appealing within moral reasons to moral intuitions fails; appealing outside moral reason to consequences or to nature fails as well. Nor is it possible to appeal to the structure or character of reason in order to secure content for the moral life. It becomes impossible to establish any act or condition as intrinsically wrong by appeal to generally available secular considerations. Against this failure of the Enlightenment project to provide a secular grounding for morality, it is not feasible to establish a secular humanist bioethics as one might have hoped.[2]

Engelhardt, himself a born-again Orthodox Christian, does believe that a "particular religion, faith tradition, or ideology" could easily justify content for a bioethical system,[3] but as he will show, for better or for worse (and for Engelhardt this is certainly "for worse"), Engelhardt does not see the possibility of a uniform ethic, even if limiting his scope to the realm of bioethics. As Engelhardt expresses it, there are not enough "moral friends" in the world to agree on the content to build any universally shared ethics. So the task that Engelhardt's sets for himself is to find a way for bioethics to be conducted among "moral strangers," that is, humans who find themselves interacting with one another without any shared ethical content, frameworks, or authority. Engelhardt explains this terminology as follows:

> Moral strangers are persons who do not share sufficient moral premises or rules of evidence and inference to resolve moral controversies by sound rational argument, or who do not have a common commitment to individuals or institutions in authority to resolve moral controversies…Moral friends are those who share enough of a content-full morality so that they can resolve moral controversies by sound moral argument or by an appeal to a jointly recognized moral authority whose jurisdiction they acknowledge as derived from a source other than common agreement.[4]

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[2] Engelhardt, *Bioethics and Secular Humanism*, 110-11.

[3] Engelhardt, *Bioethics and Secular Humanism*, 111.

[4] Engelhardt, *Foundations of Bioethics*, 7.

In effect, moral friends adhere to the same ethical belief system or ethical authority, and thus share "thick" notions of morality (and obviously therefore also share common "thin" views as well). Thus, in the (relatively rare) case of ethical disagreement between moral friends, the common morality between the disagreeing parties provides not only a framework for resolution, but also with sufficient reflection, a correct answer, whether by discussion, education, or a shared appeal to authority.

Since moral strangers (which from Engelhardt's point of view is almost everyone) do not share a common morality, appeal to authority is not feasible. Discussing and educating about moral concepts will fail, as moral strangers start from radically different frameworks, moralities, premises, etc. For example, think of a person of a given religious faith trying to convince an atheist of her position on some ethical matter with the argument "Because God says so" or trying to teach the atheist the relevant passages of her sacred and authoritative text as justifying evidence. It doesn't get her very far.[5]

It is important to stress that, beside the lack of common moral authority, even appeal to rational argument cannot change the situation of moral strangers because their rational arguments will appeal to non-shared moral theories and/or interpretations of experience, such as in the example above. In his *Foundations*, Engelhardt analyzes a number of moral theories, ranging from utility to intuitionism to hypothetical choice theories to consensus theories, and concludes that all these content-full theories that claim

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[5] Engelhardt does make sure to state that moral strangers can "be the best of affective friends" (Engelhardt, *Foundations of Bioethics*, 7). The term "moral stranger" is not meant to imply actually non-knowing of the other person. Again, think of a religious person and atheist, and now, instead of them arguing about ethics, picture them sharing a meal or cheering on the same team at a baseball game together.

to be based solely on reason or common sense will fail to resolve differences between

moral strangers due to their inability to couch any moral theory on grounds that can be

accepted by everyone.[6] Instead of coming from reason alone, Engelhardt finds that "each

presupposes exactly what it seeks to justify: a particular moral content."[7] As each of their

arguments begs the question of moral content in that at least *some* content must be

assumed for the theories to find a foothold (even if each theory claims to come from pure

rationality), this moral content smuggled into the theory will not be shared by everyone

and thus each theory fails among moral strangers.

In the face of the multitude of religions and ideologies in the world each with its

own moral code, and humans' apparent inability to base a content-full ethic on rationality

itself, Engelhardt is nevertheless determined to find a way for moral strangers to interact

and resolve ethical controversies, to bring us back from "the brink of nihilism" about the

mere possibility of there being any morality at all.[8] The new ethic must, however, avoid

the pitfalls of any of the failed theories; namely, it must avoid smuggling *any* moral

claims held to be true into its premises. As Engelhardt states, "universality is approached

at the price of content."[9]

Engelhardt articulates four possible ways moral strangers might be able to resolve

a given ethical controversy—force, conversion, rational argument, or agreement—and

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[6] See Engelhardt, *Foundations of Bioethics*, 40-65.

[7] Engelhardt, *Foundations of Bioethics*, 42.

[8] Engelhardt, *Foundations of Bioethics*, 65.

[9] Engelhardt, *Foundations of Bioethics*, 59.

argues that only agreement offers any hope of a successful resolution.[10] Force does

not actually answer the underlying ethical question of why the imposed solution is

correct, even if it were effective in producing the appearance of consensus. Conversion

seems empirically to have failed, and even when conversions do occur, they don't

produce conviction in the same moral content for each convert. And, as shown above,

rational argument doesn't work as moral strangers are starting from different

foundational premises. Thus, Engelhardt is left with only one way to resolve moral

controversies in a secular world: by agreement. When moral strangers agree to

collaborate to answers a moral question, that agreement can create the (secular) moral

authority to guide those participating in the agreement.

Engelhardt's authority of agreement is, in a sense, uncomplicated. It is "simply

the authority of the agreement of those who decide to collaborate."[11] That is it: if people

agree to, they can collaborate; but that is *all* this authority is—people agree to do what

they agree on, or agree on what is allowed or forbidden, and the authority created is

nothing but the authority of the agreeing—but for Engelhardt it is *all* there can be. So to

resolve a specific ethical dispute, it has to be enough—because there is nothing else—that

the participants agree to be governed by the decision they freely reach: they have granted

the decision authority by consenting to grant the decision authority. The parties involved

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[10] Engelhardt, *Foundations of Bioethics*, 67-68.

[11] Engelhardt, *Foundations of Bioethics*, 68. As Engelhardt uses the term "authority," he is referring to a "secular authority for moral content and moral direction" for moral strangers via the procedure of agreement, even though Engelhardt would also argue that the content only exists because it was agreed upon, and not because it stems from any pre-existing content-full morality (Engelhardt, *Foundations of Bioethics*, 68).

do not need to share any particular worldview, and in fact need to share nothing aside

from each choosing to agree and abide by what is agreed to; they share nothing other than

that they gave themselves permission to come to an agreement. But it is important to note

that permission, in Engelhardt's use, is not a morally grounded act: "The appeal to

permission as the source of authority involves no particular moral vision or

understanding. It gives no value to permission."[12] Instead, it is the bare minimum of

scaffolding needed to support a secular ethic.

Thus, by way of participants' permission to agree with one another to reach a

resolution on something, in which the mere fact of reaching a resolution via agreement

grants the authority of that resolution, Engelhardt believes that he has provided a purely

procedural method of adjudicating ethical disputes between moral strangers. He

summarizes his insight: "The principle of permission provides the minimum grammar for

secular moral discourse."[13]

Engelhardt describes his theory as "procedural" because the principle of

permission is necessarily devoid of moral content so that his framework has the ability to

process moral dilemmas without referring to any widely-accepted content-full ethic (as

he has shown that they all fail among moral strangers). It is a method of resolution

without any content-full instruction on what is to be done or thought in each step. But

Engelhardt does posit, as the only real rule needed in this secular morality, that agreement

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[12] Engelhardt, *Foundations of Bioethics*, 69. It may provide some clarity for Engelhardt's meaning that in the first edition of *Foundations*, written in 1986, he used the term "autonomy" instead of "permission."

[13] Engelhardt, *Foundations of Bioethics*, 123.

must be the result of permission—one's own freely-given permission. No one can be required to act (or be acted upon) without her permission, that is, no one can be required to act based on an agreement to which she has not willingly agreed. But for Engelhardt this is an entailment of what is meant by permission and agreement. Thus, Engelhardt places extremely strong emphasis on personal liberty. Indeed, Engelhardt states that freedom from non-consensual interference in one's life is all that is left of morality when it is (necessarily) secular.

Because moral strangers cannot agree on moral content, and can only grant permission for themselves to be used consensually in collaboration with others, whatever consenting humans agree to do cannot be contested or stopped by anyone else outside of that agreement who may find that collaboration repugnant—they have not consented to be part of the agreement that gets its authority from the mere fact of that consent. They have declined to enter into agreement with the others, and since they cannot appeal to force, conversion, or rational argument to get their way, and as moral strangers lack a common moral authority, they must stand aside from the other consenting persons' agreement. Those that do not agree are on the outside, looking in on those that do grant permission to be used.

Turning specifically to bioethics, Engelhardt believes that the primary tension in bioethics is between permission and beneficence, because moral strangers have "no common understanding…of the meaning of beneficence"[14] even as health care

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[14] Engelhardt, *Foundations of Bioethics*, 12.

professionals "have committed themselves to achieving the best interests of patients."[15] At the end of the day, however, Engelhardt says, "In the context of general secular morality, the principle of permission always trumps the principle of beneficence."[16] That is, since the concept of "doing good" carries no universal understanding if one accepts the premise that moral strangers don't share a content-full idea of goodness, Engelhardt's (or anyone else's) personal views on beneficence cannot be used to stop consenting humans from exercising their right to agree to grant authority to their decision. No matter how repugnant Engelhardt finds their actions, in secular morality it is beyond his power to stop them.[17] It follows from this that the rallying cry of secular ethics is "X has a moral right to do A, but it is wrong."[18] That is to say, in Engelhardt's own content-full version of morality, act A is a grievous wrong; but because person X and Engelhardt are moral strangers, and have *not* granted each other permission to use each other in agreement to create the authority of that agreement, as long as X has reached agreement with other consenting humans to perform act A, X is allowed to do so.

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[15] Engelhardt, *Foundations of Bioethics*, 103. See Engelhardt, *Foundations of Bioethics* Chapter 3, for a longer discussion on this tension. Note, however, that even as Engelhardt denies common morality, he states that professional health care does have beneficence as a value. In this regard, even in his secular ethics, Engelhardt cedes the possibility of a common professional morality.

[16] Engelhardt, *Foundations of Bioethics*, 127.

[17] For Engelhardt, this is not merely academic. As a born-again Orthodox Christian, he states explicitly and repeatedly that he considers suicide and abortion moral evils, but that they cannot be prohibited in a secular morality filled with moral strangers (for an example, see Engelhardt, *Foundations of Bioethics*, 288).

[18] Engelhardt, *Bioethics and Secular Humanism*, 124.

Given how minimal ethics can be for Engelhardt, and given that anyone who does not enter into an agreement based on permission cannot have a say in the decision that is made, with no ability to alter it—that is, they may believe that what is being done is wrong but they cannot stop it or do otherwise—it should be easy to see that the principle of permission, as formulated by Engelhardt, could actually *cause* moral distress in health care professionals. In fact, Engelhardt seems to agree. In *Bioethics and Secular Humanism*, he discusses a clinical scenario as it might play out within the principle of permission:

> Imagine, for example, an atheist patient asking a Catholic physician for euthanasia within a secular social fabric that does not overstep the limits of its authority. If the Catholic physician has prudently informed the patient in advance of the physician's moral commitments, the matter will be quite straightforward. The physician will simply say, "Remember that my moral commitments forbid me from either helping you or suggesting how you can secure help. That you must see to on your own. Remember also that, although there are many euthanasia societies that may assist you, and though the state will not interfere, all the costs will have to be privately borne. Moreover, for the sake of your eternal salvation, I sincerely suggest you reconsider the matter." As the example shows us, there is much that society must tolerate, given the limits of secular reason. The limits of secular reason do not undermine moral commitments.[19]

Even if the above were truly "quite straightforward," which is debatable given the moral residue that would likely linger in such a situation, the scenario actually suggests a number of other situations in which a health care environment populated by moral strangers could engender even more moral distress in health care professionals. Perhaps the physician might not consider the matter resolved after "simply" lecturing the patient on religious doctrine (if the physician is allowed to do so in the first place). Or there might be another physician involved in the case, or a nurse, or a respiratory therapist,

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[19] Engelhardt, *Bioethics and Secular Humanism*, 138.

who believes the patient is requesting something reasonable, and are distressed by this uncompromising physician who is refusing the patient's request to relieve her suffering.

That is, Engelhardt's primacy of permission and its trumping of professional health care's value of beneficence, instead of *creating* an ethic for health care professionals, could lay the groundwork for still more moral distress (even as he stresses the equality of all people in their ability to enter into agreement). Thus, Engelhardt's proposal for how moral strangers might interact is not a useful strategy for the health care professionals who, as shown in Chapter Three, ought to be participating as equals when discussing a moral distress situation (unless one counts as resolution the option of refusing to the agreement or its authority and walking away—but disengagement is a symptom of, not a solution for, moral distress). Thus, an organizational solution to moral distress cannot be built solely on Engelhardt's secular ethics.

For his part, Engelhardt probably wouldn't disagree with this criticism, since he states that "secular morality is a wasteland without moral content, without the possibility of moral guidance."[20] However, Engelhardt believes he is providing as much morality as is possible in a pluralistic world, noting "the impossibility of discovering *the* secular, canonical, concrete ethics" and that humanity must live with these consequences.[21] He is describing what secular morality looks like, not proposing an ideal and it is clear that Engelhardt would build a content-full (and Christian) morality, had he his druthers, but

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[20] Engelhardt, *Foundations of Bioethics*, 288.

[21] Engelhardt, *Foundations of Bioethics*, vii.

on his view it's just not possible. What we have is what we have, because what we

don't have is any universally-shared content on which to build a morality.

However, when thinking about his theory in the more limited context of health

care professionals, it is clear that Engelhardt is wrong to argue there cannot be content

grounding basic moral agreement. As shown in Chapter Three, health care professionals

share a content-thin common moral framework. Health care professionals need not share

enough in the way of moral conviction to be moral friends, but there is enough in

common given their professional moral obligations to assume a morality that isn't

content-less and purely procedural in Engelhardt's sense.[22] In fact, in numerous places

Engelhardt allows for some version of shared goals and values specific to health care

professionals, stating, for example, "The idea of a profession carries with it commitments

to particular views of beneficence and proper action,"[23] and as already stated, that "in

joining the health care profession, [doctors and nurses] have committed themselves to

achieving the best interests of patients."[24] Even more explicitly Engelhardt states,

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[22] Engelhardt addresses professional codes of ethics, but dismisses them as a possibility for the content of morality: "When these rules are articulated as canons of probity for professional conduct, and when the focus is primarily on issues of professional decorum, ethics is best understood as etiquette" (Engelhardt, *Foundations of Bioethics*, 34). He also questions the authority of such codes, as well as their foundations. However, this dissertation does not focus merely on the professional codes of ethics, but also on the shared professional moral obligations that are inherent in the practice of health care professions. These need not be strictly codified in order to show that they are necessarily shared by those that choose to, and are allowed to, enter a health care profession. Such morality expands beyond mere "etiquette," which seems a trite term to hand-wave away something that seems quite substantial to the endeavor of professional health care.

[23] Engelhardt, *Foundations of Bioethics*, 291.

[24] Engelhardt, *Foundations of Bioethics*, 103.

"Medicine in particular and health care in general are goal-oriented undertakings. They are focused on curing and preventing diseases and on caring for the worries, pains, and anxieties of patients."[25] Professional commitments are necessarily shared insofar as to decline them is to refuse to be seen as a health care professional, and if those commitments involve obligations to certain values—even if the values are as content-thin as "respecting autonomy" or "preserving life" or any of the other goals and values examined in Chapter Three—these are common values that bind health care professionals to the same broad moral commitments.[26] Referring to a Seventh Day Adventist or a Catholic hospital, Engelhardt acknowledges "they must recognize that they have created, and are sustaining, a special moral exclave."[27] Yet Engelhardt fails to see that if health care professionals share a content-thin morality, *any* health care organization could become itself a "moral exclave," albeit it one with thin moral concepts, if that is meant to contrast with the secular morality Engelhardt has described. For as has been argued above, there is no opting out of the common professional morality if one wants to continue being a professional in the field.

In response to this criticism, Engelhardt might argue that health care professionals are simply granting authority to the agreement consented to by health care professionals upon entering the profession, and that those that do not agree to the commitments and obligations of the profession merely are excluded from the agreement, and thus are

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[25] Engelhardt, *Foundations of Bioethics*, 310.

[26] See Ozar and Sokol, *Dental Ethics at Chairside*, Chapter Five.

[27] Engelhardt, *Foundations of Bioethics*, 82.

outside the group (i.e., not allowed to become a health care professional). However, in regard to health care, this ignores two facts: first, society at large *does* expect health care professionals to uphold the values they have agreed to uphold, and, in fact, has a vested interest in them doing so; that is to say, society is not excluded from whatever agreement health care professionals give their permission to.

Second, it is not solely up to the discretion of those that agree to enter the health care profession to decide what their agreement entails—that is, those who become health care professionals do not then unilaterally decide what the obligations of professional health care are. While each health care profession is given a great deal of autonomy to police itself and set its own standards and practices, this is due to the expertise and knowledge necessary to effectively monitor the profession, and not because of the principle of permission. Society at large is still part of the process of determining what is or isn't considered professional behavior, and who can undertake professional activity (e.g., society doesn't allow surgeons to perform unnecessary operations, and conversely does not allow non-professionals to perform surgery on others, regardless of the parties' permission or agreement).[28] So it cannot be the case that health care professionals can rely on the authority of agreement to guide their professional ethical obligations.

Engelhardt's secular morality of moral strangers, it seems, is not a good fit for how professional ethics work in practice. But because common professional morality is

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[28] See Ozar, "Profession and Professional Ethics." Even if this premise is debated (i.e., even if one disagrees that society plays a part in determining the role of professional health care), it would still be the case that the obligations of health care professionals would be predetermined by their professions, and would not be re-agreed upon each time a new professional entered the field.

broad and content-thin, it is not the case that health care professionals share all that

would be necessary to be moral friends in Engelhardt's theory. And unfortunately for this

project, Engelhardt leaves out the middle ground of a content-thin way of addressing

moral disagreement. But a few authors have noticed this gap, and a line of scholarship

has attempted to fill in that middle ground between moral friends and moral strangers

with a category called "moral acquaintances." One philosopher, Kevin Wm. Wildes, has

explored the category of moral acquaintanceship in a way that is helpful in finding health

care organizations a forum for a kind of discussion that health care professionals involved

in a moral situation can employ to resolve the moral distress.[29]

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[29] Another bioethicist (and physician), Erich H. Loewy, discusses the notion of moral acquaintanceship in his book *Moral Strangers, Moral Acquaintances, and Moral Friends: Connectedness and its Conditions*. Like Wildes, Loewy believes there ought to be a middle ground between the moral friends and strangers described by Engelhardt, and attempts to determine what makes up the shared-by-all-humans content of moral acquaintanceship. The content Loewy decides on is necessarily extremely broad, as his project extends to all of humanity: "These six existential a prioris which constitute the framework in which we act…are our (1) drive for being or existence; (2) biological needs; (3) social needs; (4) a desire to avoid suffering; (5) a basic sense of logic; and (6) a desire to live freely and to pursue our own interests" (Loewy, *Moral Strangers, Moral Acquaintances, and Moral Friends*, 141). He is attempting to lay the groundwork for a social contract that results from, and also strengthens, connectedness of both individuals within communities and communities with each other. Loewy's project, then, is one of crafting an ethic for a full-fledged community (hopefully, Loewy says, a democracy) in which the existential a prioris do, contrary to Engelhardt's argument, salvage the enlightenment project in that there is enough commonality among people that rational argument—tempered with compassion that necessarily arises from being human—can be used to build a framework for dialogue and social connectedness. However, given that Loewy is building an ethic that can affirm individual rights in a society while keeping commonality and community as a necessary component of that framework, his text is far more political than what is needed (not to mention broad and impractical, given the disagreements about such foundational concepts in ethics that Engelhardt justifiably points out) to incorporate into a more limited scope of moral distress in health care professionals. The commonalities among professionals highlighted in Chapter Three focus this dissertation much more on the content for moral acquaintanceship among

Moral Acquaintances

Like Engelhardt, Wildes understands that moral pluralism means that there can

never be full agreement—and thus no moral friendship—between all people for a host of

ethical issues. Unlike Engelhardt, however, Wildes does not want to concede that a

content-less procedural bioethics is the only workable solution in a world of moral

pluralism. Understanding that the world will never all be moral friends, Wildes doesn't

want to relegate people to being moral strangers. The task he sets himself, then, is to find

the middle ground between the moral relativism that comes with finding only radical

pluralism in the world and the impossible option of somehow enforcing a single morality

for all people. This middle ground, Wildes argues, can be filled with the concept of moral

acquaintances.

As the subtitle of his book (*Methodology in Bioethics*) states, Wildes is primarily

concerned with the role methodology (i.e., how moral discourse works) can play in

crafting a viable bioethical theory. Further, Wildes is interested in the interplay between

methodology and moral communities. Wildes examines how different kinds of

communities act, in relation to themselves as well as other communities, in the hopes of

affirming a communitarian bioethic.[30] Building on Wildes' understanding of

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health care professionals than Loewy's, and what those commonalities are used for here
is much narrower than those Loewy is interested in. (See Chapter Five of Loewy's book
for a concise description of his project.)

[30] Given that Wildes' discussion of communitarianism is in the context of approving of it
as an ethical system, whenever he says "community" he is specifically meaning a moral
community. That is to say, in Wildes' text, a community is *always* a moral community.
Indeed, the index entry for "communities" in the book states "*See* moral communities"

communities, this section will show that health care professionals do not create a

community of moral friends, but interact in a manner Wildes calls "moral

acquaintanceship." And, if this is the case, then the possibility of resolving situations of

moral distress arises by means of discussions based on this relationship of moral

acquaintanceship.

Wildes begins by noting that there are numerous methodologies available to those

that wish to study bioethical dilemmas. To name but a few, Wildes discusses

utilitarianism, Donagan's Judeo-Christian morality, natural law, contractarianism, virtue

theory, principlism (specifically as found in Beauchamp and Childress), and casuistry.

None of these methodologies, however, are merely procedural accounts like Engelhardt's

theory claims to be, and for Wildes this points to the fact that *no* methodology can be

purely procedural. As he states, "method cannot be separated from content. The choice of

method is a decision to describe and articulate moral experience in one way over

another…rules or methods do not exist apart from a practice or way of life."[31] In

choosing one way to solve a bioethical problem over another, one is necessarily aligning

oneself with more than just a set of procedural instructions on how to solve the problem;

one is also aligning oneself with the assumptions (or with explicit foundational ideas)

about moral experience that are inherent in those instructions.

Wildes is accepting of the reality of multiple methodologies in bioethics, however

he believes each methodology has its limitations and flaws, as well as disagreement with

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(Wildes, *Methodology in Bioethics*, 206). As in Wildes' text, this dissertation will use the two terms interchangeably.

[31] Wildes, *Methodology in Bioethics*, 4.

other methods, and thus no one can be chosen as "best." Because of these limitations,

Wildes states that he prefers a communitarian view of bioethics, where "communitarian"

refers the fact that "how women and men understand themselves is tied to the social and

cultural context in which they live."[32]

Wildes supports this turn to communitarianism because he believes that no human

being truly exists as an isolated, purely autonomous individual, and that the main flaw

shared by most methodologies in bioethics today (including Engelhardt's) focuses

primarily on how the individual as an individual exercises autonomy. Communitarian

thinking, however, acknowledges that humans don't make decisions, or even experience

their moral lives, solely as individuals. By looking carefully at moral communities in

which moral friends reside and also at the realm of moral strangers, Wildes hopes to

better understand the relationship of moral acquaintances. For he believes that "there is a

common morality that is less robust than many assume but more vibrant than Englehardt

concludes,"[33] and this middle ground between full communities and isolation is where he

hopes to find moral acquaintances.

Wildes makes it clear that his notion of "moral community" is a flexible one,

ranging from the very close-knit, separatist group with a very specific (thick) vision of

the good life and a strong understanding of moral authority, to a much looser assemblage

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[32] Wildes, *Methodology in Bioethics*, 125. The logic of the shift from the limitations in other methodologies to communitarianism is not clear in Wildes' text, though the assumption is that a communitarian basis for bioethics allows communities to chose their foundational methods without needing to justify them to all other morally serious people.

[33] Wildes, *Methodology in Bioethics*, 56.

of people with "a great deal of openness about [its moral] vision and its

development."[34] This latter kind of community may be quite open to relationships with

other communities and accepting of a weaker or more democratic form of moral

authority—but there is moral authority and moral content nonetheless, and communities

are still made up of moral friends: "It is moral friendship that grounds the moral

community and moral community that supports moral friendship."[35] As will be shown

below and based on the thinness of the content of their common moral framework, heath

care professionals *do not* form a moral community as Wildes defines it, but his analysis

of communities will lead him to the category of moral acquaintances, and it is here that

health care professionals can find themselves in relation to each other. Thus, it is useful

to examine Wildes' explanation of moral communities.[36]

Wildes identifies three elements that make up a moral community: "the content of

a community's moral vision; a community's understanding of moral authority and the

offices of authority; and the community's self-understanding about how it should relate to

other moral communities."[37] Though communities of moral friends will vary in how they

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[34] Wildes, *Methodology in Bioethics*, 127.

[35] Wildes, *Methodology in Bioethics*, 137.

[36] Though this dissertation argues for a common professional morality and a content-thin common moral framework for health care professionals, the thinness of these concepts precludes moral friendship. Though the phrases are similar-sounding, given the definitions provided by this dissertation and by Wildes, the end result is that though health care professionals have a common professional morality and common moral framework, they do not form a moral community, as Wildes uses the concept.

[37] Wildes, *Methodology in Bioethics*, 127.

interpret their moral content, authority, and understanding, within each individual community this will have been decided and agreed upon in some substantive way.

The content of a community's moral vision, like a moral community itself, can be narrow or broad. A moral community can form around a single issue (gun control, for example) or an entire mode of living that seemingly disconnects its members from society at large (the Amish). Wildes, himself a Jesuit, uses religion most often as his example of a moral community, but stresses that the content of a community can be varied and secular.

Wildes states, "A community not only has a set of moral commitments; it also has a framework that puts [these commitments] in relationship to one another."[38] While it was shown in Chapter Three that the shared moral obligations of health care professionals provides a set of moral commitments (and uses the terminology of a framework), it is not necessarily the case that there is a thick moral framework to put those commitments in a specified relationship to one another. Indeed, the existence of moral distress, at times, begins with a disagreement over which of these commitments ought be prioritized over another. It seems that, in this regard, health care professionals are not members of a Wildesian community,[39] in spite of their shared moral commitments.

In addition to content, Wildes believes communities can be analyzed by the role of authority in a given community. Again, like the community itself, the role of authority

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[38] Wildes, *Methodology in Bioethics*, 130.

[39] In keeping with his definition of community, a Wildesian community is necessarily a moral community.

can be very thick (e.g., the Pope) or far more informal. Whatever authority there is, though, "can be tied to knowledge, example, office, or all three."[40] As shown in Chapters Two and Three, moral distress can be caused, and rarely resolved, by appeal to authority, so again health care professionals coming together to address moral distress fall short of forming a community by Wildes' standard (though professional health care itself, of course, has various authority roles, both in the professions and in the health care organization, as was discussed in Chapter Two).

Finally, Wildes analyzes communities through how they engage with other communities. Recalling the reality of different methodologies and the ethical differences they imply, it is necessarily true that "moral communities in secular societies find themselves living among others who often hold conflicting moral views."[41] Given this fact, Wildes muses that, on first glance, it looks as if there are only two possible responses from a moral community with regard to other communities: either decide that it will withdraw from the secular world, or give in to moral compromise to engage with other communities at the risk of losing its own identity. But Wildes suggests there is in fact a middle ground, where a moral community understands its own positions by learning about other communities of moral friends and what makes them different. This can, hopefully, lead to the discovery of common (yet tenuous) ground between two communities, as each community has discovered which premises align with other communities, and which ones it is willing to compromise on. As Wildes states, "members

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[40] Wildes, *Methodology in Bioethics*, 132.

[41] Wildes, *Methodology in Bioethics*, 132.

of a particular community must recognize their own biases or background

assumptions (e.g., the 'sacredness of life,' or the 'common good') and those of others."[42]

In thinking about how different moral communities can interact with each other

and find common ground, Wildes believes that Engelhardt's dichotomy of moral friends

and moral strangers is too stark to be an accurate depiction of how moral agreement can

be possible in secular society. Though these two categories certainly exist, Wildes argues

that Engelhardt's depiction of moral friends and strangers fails because his notion of

moral friendship is too constrictive, to the point where "anyone not in the category of

moral friends becomes a 'moral stranger' in his account."[43] Wildes believes Engelhardt's

claim that moral strangers adhere to completely different ethics or metaphysical

commitments ignores "the possibility of a moral community that defines itself as open

and eclectic,"[44] and is wanting to engage with members of other moral communities not

as moral friends, but certainly not as moral strangers.[45] Thus, another category of

relationship is needed to accurately assess the moral landscape real people in the world

find themselves meeting in. This category, Wildes states, is moral acquaintanceship.

Wildes provides two different definitions for moral acquaintanceship. The first,

labeled A_1, is when people understand another's moral views, though they do not share

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[42] Wildes, *Methodology in Bioethics*, 134.

[43] Wildes, *Methodology in Bioethics*, 138.

[44] Wildes, *Methodology in Bioethics*, 138.

[45] As Wildes says, "There were, for example, significant metaphysical differences between the Dominicans and Jesuits in the sixteenth-century disputes over grace and freedom, yet it stretches the category to think of them as moral strangers" (Wildes, *Methodology in Bioethics*, 138).

them (e.g., "I get why she voted for that candidate, but I agreed with the other candidate on the issues"). The second, A_2, is when "the parties involved understand another's moral world and share it in part."[46] Wildes believes that it is this latter version of acquaintanceship that is most often at work in secular (in Engelhardt's meaning) bioethics—it is why, he says, there is often consensus when it comes to basic ethical principles and why even wildly divergent viewpoint can be discussed in a common bioethical language. Most bioethical methodologies, Wildes claims, "rely on some assumption of acquaintanceship [A_2]" in order to resolve a given moral dilemma.[47]

Wildes clarifies this by stating that "moral friends may agree strongly on content; moral strangers may be satisfied with procedural agreements; and moral acquaintances may develop limited, overlapping, substantive, and procedural agreements."[48] However, Wildes notes that moral acquaintanceship is often quite shallow in its substance— otherwise, it would be little different from moral friendship. Because moral acquaintances often have differences in the underlying foundations that lead to their overlapping agreement, this overlapping may be superficial: two acquaintances may share a word like "autonomy" and because of that assume that there is deep consensus between the two of them about autonomy's meaning. However, "some patients, physicians, and courts may hold autonomy (i.e., patient choice) is sufficient to justify

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[46] Wildes, *Methodology in Bioethics*, 139.

[47] Wildes, *Methodology in Bioethics*, 139.

[48] Wildes, *Methodology in Bioethics*, 144.

assisted suicide. Others may understand the realm of autonomy in health care as more restrictive."[49]

That is to say, it is not necessary that moral acquaintances share a single deep justification for their moral beliefs in order to agree on the content of a given decision. Mirroring Walzer's discussion of thin "garden variety" concepts, Wildes admits that "Acquaintances can share general principles, yet have different interpretations of the meaning, ranking, and scope of application."[50] They may only share enough to find a common language to make their views understood, and that may be sufficient for a common ground for discussion and perhaps even some measure of agreement—even if this common language and ground is fragile, and digging deeper may quickly uncover differences between the "thick" meanings of their understanding of the concepts.

This dissertation argues that health care professionals should not be considered moral friends or moral strangers, but instead be seen as Wildesian moral acquaintances. As shown earlier, Wildes claims that moral friends agree on moral foundations, reasoning, and justification. As was shown in Chapter Three, health care professionals often do not, nor are they expected to, share foundations of morality, or methods of moral reasoning. Health care professionals come from all different backgrounds with different life experiences shaping their moral foundations, and such diversity in moral reasoners, far from being seen as detrimental, is considered a positive for a profession. While it

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[49] Wildes, *Methodology in Bioethics*, 140. It is quite likely that Wildes chooses this example because as a Jesuit he counts himself as one of the "others" and assumes his readers understand what he means by "more restrictive."

[50] Wildes, *Methodology in Bioethics*, 158.

might not be appropriate to integrate certain personal beliefs into one's professional practice, it is certainly not the case that one loses one's religious commitments, moral foundation, or ethical education upon entering a profession. Thin professional moral obligations are shared by all that enter a professional role, but individuals' moral foundations and moral reasoning are not shed upon doing so. There is a diversity of moral belief in health care professionals that precludes the deep understanding that is the hallmark of moral friendship. In serious moral disagreements among health care professionals, it is not the case that "moral judgments may need little, if any, explanation," as is the case for moral friends.[51] The very existence of ethics cases and conflicts within caregiving teams bears witness to the fact that unexplained moral views are rarely accepted when health care professionals are at ethical odds. Moreover, it seems clear that when there are these moral disagreements, it is not the case that participants "know the authority to which they can appeal to resolve their disputes."[52] Perhaps for this or that hospital or organization there is an ethical authority,[53] but it is clear from, for example, arguments over abortion or physician-assisted death that health care as a whole does not have an agreed-upon authority to solve disputes. Thus, labeling health care professionals as moral friends is not appropriate.

It also seems clear that health care professionals ought not be thought of as moral strangers. The content-thin common moral framework discussed in Chapter Three is

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[51] Wildes, *Methodology in Bioethics*, 137.

[52] Wildes, *Methodology in Bioethics*, 137-38.

[53] Though, as was shown in Chapter Two, this authority ought not be appealed to in order to resolve moral distress anyhow.

enough to guarantee that there is at least a common moral language with which the

goals of professional health care can be generally agreed upon. Quoting Engelhardt,

Wildes reminds us "moral strangers are any who have 'differences in moral and/or

metaphysical commitments.'"[54] But one cannot enter the health care profession without

adhering to at least a minimum of moral commitments; otherwise such a person would

not be welcome in the profession.

Wildes states that "men and women are morally acquainted when they share

enough moral vocabulary and values in common to allow them to understand one

another."[55] The values and vocabulary of health care professionals, this dissertation

argues, are shared through the content-thin common moral framework. While moral

justification does play an important role in decision making in health care and thus it

might seem that this shared vocabulary and values points to moral friendship, what

justification in health care decision making is understood to mean is not something as

deep or foundational as is implied in discussions grounded in moral friendship. Indeed, at

times justification for one decision over another might be quite far removed from

foundational issues of moral theory. But the moral content shared by health care

professionals, while thin, is enough "to speak with one another and to understand the

explanations given by others for the judgments that are made—even though they may not

accept these judgments."[56] That is, health care professionals, as moral acquaintances,

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[54] Wildes, *Methodology in Bioethics*, 138.

[55] Wildes, *Methodology in Bioethics*, 145.

[56] Wildes, *Methodology in Bioethics*, 139.

have enough overlapping training and language that, even when different participants might choose to resolve ethical dilemmas in different ways, the participants in the discussion can understand each other by way of the content-thin common moral framework, in terms of their common professional morality and shared obligations, and thus have the opportunity to treat each other as equals in the work of moral reflection.

Even when there *is* agreement among moral acquaintances, it can often be based, as noted above, on something relatively superficial and "will often lack a common underlying foundation."[57] By way of analogy, Wildes states that a Supreme Court decision "can be unanimous but still admit subtle and important distinctions that the justices will express in their opinions."[58] When the Court unanimously upheld the distinction between killing and allowing death, Wildes notes that though they "agreed," one Justice upheld the distinction based on the role of state legislatures, and another based on ordered liberty. In the face of such different explanations for the same outcome, Wildes is correct in calling this agreement "fragile."[59]

Health care professionals, as moral acquaintances, realize that their common morality has boundaries, and that it does not necessarily extend to moral foundations. And yet, because of the content-thin common moral framework, "Moral acquaintances can know the other's views and positions, and agree on some points while disagreeing on

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[57] Wildes, *Methodology in Bioethics*, 140.

[58] Wildes, *Methodology in Bioethics*, 144.

[59] Wildes, *Methodology in Bioethics*, 144.

others."[60] They will couch their explanations in terms of adherence to goals or values

that are shared, but not in terms of conformity to a deep moral foundation. But even in

disagreement, moral acquaintances will understand why the disagreement exists, though

they may not accept the opposing argument as convincing. In disagreement, health care

professionals can be easily made aware of the distance between moral acquaintances that

doesn't exist among moral friends. That is not to say some professionals are not moral

friends; it is quite possible that many are. However, this is a contingent relationship.

Moral acquaintanceship, however, is a necessary relationship given the shared moral

obligations of health care professionals, and it is on the basis of this relationship that

discussions of moral distress situations by the morally distressed individual(s) and the

other health care professionals involved, as equally qualified to participate in these

discussions, has the possibility of resolving the moral distress.[61]

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[60] Wildes, *Methodology in Bioethics*, 19.

[61] Stephen S. Hanson, another author that has dealt with moral acquaintanceship, argues that moral friends and moral acquaintances ought not be categorized quite so divisively as Wildes argues they should. As he states in *Moral Acquaintances and Moral Decisions*, "Though moral friends and moral acquaintances may initially seem quite different, in fact they are quite similar. I argue that a justification in a given moral acquaintanceship is as valid as the justifications given by moral friends" (Hanson, *Moral Acquaintances and Moral Decisions*, 141). He argues that moral communities and social communities can be separated in order to show that moral communities are, in fact, chosen (rather than inherited like social communities often are), and thus moral friendship and moral communities do not rely on a social quality (Hanson, *Moral Acquaintances and Moral Decisions*, 141-47). Because of this, Hanson argues, moral friends, in essence, choose to overlap their moral views on particular issues, much like moral acquaintances do. Justification of moral beliefs, then, is the same for moral friends and moral acquaintances, because both involve a choice to engage with another on moral issues and agree on content (Hanson, *Moral Acquaintances and Moral Decisions*, 148-49). The only difference in agreement between moral friends and moral acquaintances, it seems, is that "Persons are…not moral acquaintances 'full stop,' but rather are or are not moral

Conclusion

This chapter continued Chapter Three's examination of the relationship that exists

between health care professionals given their adherence to a content-thin common moral

framework. While Engelhardt's vision of moral friends, or on the other end of the

spectrum his description of purely procedural bioethics of moral strangers, might have

seemed like promising avenues to explore; neither category ultimately describes health

care professionals in relation to one another. However, it was shown that a third category,

Wildesian moral acquaintanceship, does accurately describe what health care

professionals have in common, given the shared, thin ethical concepts that are inherent to

joining a health care profession.

There is now a theoretically plausible strategy for the resolution of moral distress;

a non-hierarchical, equal, inclusive discussion grounded in the content-thin common

moral framework of health care professionals. With this theoretical grounding in place,

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acquaintances *with regard to a particular issue or question*," depending on whether a justification is accepted or not (Hanson, *Moral Acquaintances and Moral Decisions*, 149. Emphasis in the original). However, the argument this chapter makes asks for a richer notion of health care professionals as moral acquaintances than Hanson, who is basically calling acquaintances "moral friends for this issue." This is because health care professionals *cannot* separate the moral from the social upon entering their profession. It is not feasible to join a given health care profession and agree to take up the mantle of only the social aspect, or the only the moral aspect. The nature of professionalism, in general, is all-or-nothing: along with the social class one enters into when one becomes, say, a doctor or nurse or physical therapist, comes part and parcel the moral duties inherent in that profession. Thus, contra Hanson, health care professionals cannot be moral acquaintances only "with regard to a particular issue or question." Thus it is Wildes' understanding of moral acquaintances that is adopted in this project (and not Hanson's or Loewy's). Or, to put it another way, by our understanding of professionals being a social group with certain moral commitments, it must be the case that health care professionals are moral acquaintances "full stop."

the next question is to ask how health care organizations can meet their ethical

obligations regarding moral distress and use this strategy *in practice* to resolve and,

ideally, limit or eliminate moral distress among its health care professionals. This will be

the focus of Chapters Five and Six.

CHAPTER FIVE

DISCOURSE ETHICS AS A RESPONSE TO MORAL DISTRESS

Chapter Three of this dissertation argued that health care professionals share a

content-thin common moral framework based in their common professional morality, and

the ability for all health care professionals to appeal to it is one reason that they should be

considered equal participants when working to resolve experiences of moral distress.

Thus, the possibility for non-hierarchical discussions the framework supports means that

the hierarchical responses to moral distress critiqued in Chapters Two and Three can be

set aside as ethically deficient efforts to address moral distress by health care

organizations. Chapter Four argued that in light of this common moral framework, health

care professionals can be considered Wildesian moral acquaintances, which means that,

in relating to one another, they need not rely on the pure proceduralism of moral

strangers. But it also means that they do not have the shared thick concepts of moral

friends to rely on in moral discussion. Instead, they have thin concepts about the ethics

and obligations of health care professionals that can be used as a starting point for

discussion and dialogue, and thus a middle ground of a response to moral distress is

needed, one that allows for thin concepts to be appealed to in and about a moral distress

situation and that can facilitate a resolution. As Wildes states, in such a situation, "we can

identify points of overlapping agreement for moral acquaintances, and we can find ways

to frame and talk about disagreements. A turn to structures [of this kind] creates the

possibility for civil conversation in bioethics. It carries an underlying commitment to inclusion in that no one is, a priori, excluded from the civil conversation."[1]

It is now necessary to determine what this non-hierarchical response to moral distress that respects the equality and moral acquaintanceship of health care professionals might look like. In crafting a replacement to health care organizations' current hierarchical responses to moral distress, this chapter will look to Jürgen Habermas' theories of communicative action and discourse ethics in order to offer a hypothesis for how health care professionals can address moral distress. It will be shown that, in "everyday" communication, health care professionals, because of their sharing in the content-thin common moral framework, interact with each other much in the way described by Habermas in Volume One of *The Theory of Communicative Action* and analyzed by Brand in *The Force of Reason*. However, when moral distress is experienced and a resolution is needed, something more is required. Habermas' theory of discourse ethics, most succinctly described in *Moral Consciousness and Communicative Action* and analyzed by David Ingram in *Habermas: Introduction and Analysis*, can provide guidelines appropriate for discussions by moral acquaintances when addressing a moral distress situation. While it must be acknowledged that Habermas' description of discourse ethics was not being offered as a response to moral distress (since Habermas was discussing discourse ethics prior to Jameton's introduction of the concept of moral distress), Habermas' work can be appropriated to provide the theoretical underpinnings for a practical response to moral distress.

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[1] Wildes, *Methodology in Bioethics*, 173.

Communicative Action

Habermas' account of rationality and the reasoned basis of moral norms is connected with how human beings use language to interact with each other because, he argues, rationality, reason, and moral norms are *communicative* and, as Ingram states, they "cannot be justified by the isolated individual, reasoning alone."[2] Habermas does not believe that monological, theoretical reasoning is sufficient to create rationality; instead rationality has to do with "how speaking and acting subjects acquire and use knowledge."[3] Rationality, Habermas states, is expressed through interpersonal interaction, through what he calls "communicative action."

As a way to better understand what communicative action is for Habermas, it is helpful to separate communicative action from strategic action, which Habermas also differentiates as "orientation toward success ['strategic'] versus orientation toward reaching understanding ['communicative']."[4] Simply put, strategic action is what occurs when each participant in an interaction is interested only in achieving her individual desired outcome, and thus each participant treats the others as means to that end. As Habermas states, "coordination of the subjects' actions depends on the extent to which their egocentric utility calculations mesh. The degree of cooperation and the stability is

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[2] Ingram, *Habermas,* 118.

[3] Habermas, *Theory of Communicative Action*, 8. Emphasis deleted. For Habermas, *acquiring and using* knowledge implies actors engaging with each other, and is contrasted with the mere *possession* of knowledge, which seemingly could be done by an isolated individual.

[4] Habermas, *Moral Consciousness and Communicative Action*, 133.

determined by the interest positions of the participants."[5] Teamwork starts and stops

with how much it benefits each player's own desired end. Indeed, "teamwork" may not

be the correct term here; at one point Habermas calls participants in strategic action

"opponents."[6]

In that each participant in strategic action is only partaking in joint action "to the

degree that this fits with his egocentric calculus of utility,"[7] strategic action resembles

Engelhardt's principle of permission. Recall that for Engelhardt, moral strangers, lacking

common moral concepts, come together only to the extent that they give permission to

use and be used by one another for the specific purpose they have agreed to—only to the

extent their individual utility calculations happen to mesh, as Habermas puts it. As was

shown in Chapter Four, however, this is not the plane on which health care professionals

interact with each other because their interactions are framed by their common

professional morality and shared ethical commitments it entails. Though they are not

moral friends, as moral acquaintances who can appeal to a content-thin common moral

framework, the purely procedural principle of permission (in Engelhardt's terms) and

strategic action (for Habermas) do not accurately describe the type of cooperation that

health care professionals enter into and interact within.

In contrast, communicative action is what occurs "when actors are prepared to

harmonize their plans of action though internal means, committing themselves to

pursuing their goals only on the condition of an agreement—one that already exists or

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[5] Habermas, *Moral Consciousness and Communicative Action*, 133-34.

[6] Habermas, *Moral Consciousness and Communicative Action*, 133.

[7] Habermas, *Theory of Communicative Action*, 88. Emphasis deleted.

one to be negotiated—about definitions of the situation and prospective outcomes."[8]

Communicative action is meant to create mutual, shared understanding of goals that participants agree they ought to coordinate to achieve, and this "process of reaching understanding takes place against the background of a culturally ingrained preunderstanding."[9]

Brand states that the "achievement of shared understanding…is reached in the interpretive efforts of individuals who coordinate their action through criticisable claims

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[8] Habermas, *Moral Consciousness and Communicative Action*, 134. "Internal means" here refers to interpersonal cooperation and mutual participation, as opposed to external means such as "weapons or goods, threats or enticements" (Habermas, *Moral Consciousness and Communicative Action*, 133).

[9] Habermas, *Theory of Communicative Action*, 100. It should be noted that when Habermas makes reference to "the background of a culturally ingrained preunderstanding," he is speaking about what he calls the "Lifeworld," which is the background and context of social action, and more closely describes the world of moral friends than of moral acquaintances. However, Habermas states that, unlike the shared understanding of rules and authority among moral friends, the content of the Lifeworld is not made explicit in the context of social interaction. As Brand states, "Communicative action does not only draw on explicit knowledge. It in fact takes place against the background of an enormous fund of non-explicit, taken-for-granted notions, which have great influence on the interpretation of explicit utterances. Following a phenomenological tradition in philosophy and sociology here, Habermas uses the term 'Lifeworld' to indicate this background. Though this 'Lifeworld' has great influence on the endless range of interpretive activities which constitute social life, we cannot become conscious of it as a whole and sum it up in a series of neat propositions" (Brand, *Force of Reason*, 34). However, even though what Habermas and Brand are pointing to is something more akin to the communication of moral friends than moral acquaintances, the notion of "preunderstanding" is a helpful one when referring to the communications between health care professionals. Because their communications are taking place within their roles as health care professionals, the content-thin common moral framework does create something of a "preunderstanding," especially as concerns the understanding of goals that ought to be achieved and values that guide the care of patients (as was shown in the discussion of the goals and values of professional health care discussed in Chapter Three).

to validity."[10] Shared understanding occurs when a speaker makes a successful speech act; that is, when the hearer of a speaker's assertion accepts it as valid on three different levels: that it is true (in that it correctly relates to the objective world), that it is right (in that it is normatively correct), and that it is authentic (in that the speaker is accurately expressing her subjective experience).[11] Thus, in a real-world situation between interlocutors (recalling that Habermas believes rationality to be found interpersonally through actual dialogue and not monologically), "agreement in the communicative practice of everyday life rests simultaneously on intersubjectively shared propositional knowledge, on normative accord, and on mutual trust."[12]

Though Habermas surely does not have this specific purpose in mind for communicative action,[13] there are clear parallels between the goals and processes of communicative action and the "everyday" moral discourse of health care professionals— though perhaps the term "congruence" is more appropriate, as Habermas' conception of the Lifeworld as a background for communicative action (see footnote 9) simultaneously implies a stronger but also less explicit bond between participants in successful communicative action than is typically to be found in the content-thin common moral framework of health care professionals. That is, in normal practice-related moral

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[10] Brand, *Force of Reason*, 6.

[11] Habermas, *Moral Consciousness and Communicative Action*, 136-37; Brand, *Force of Reason*, 16.

[12] Habermas, *Moral Consciousness and Communicative Action*, 136.

[13] Though Habermas does believe that communicative action applies to any properly structured social (i.e., interpersonal) interaction directed toward shared understanding (Brand, *Force of Reason*, 25).

discourse health care professionals are expected to engage in real, substantive

dialogue regarding: (1) the facts of the case, for example, the facts involved in

determining the correct diagnosis, prognosis, and treatment options; (2) the norms

involved in determining the right course of action; and (3) the belief that all health care

professionals are authentic in their statements about these matters.[14]

In most cases, it is assumed that health care professionals involved in a case will

in fact take for granted that other health care professionals' assertions are spoken in

accord with the above three criteria accurately and in good faith so they can together use

their collective expertise in order to provide the best care for their patients. While it is of

course not always the case that all three of these criteria will be completely fulfilled in

every interaction between health care professionals, it can reasonably be argued that in

"everyday conversation" the moral acquaintanceship of health care professionals allows

for these three criteria of communicative action to be the basis of ethical discussion. That

is, situations of moral distress are exceptions to the ordinary ways in which health care

professionals engage, doing what Habermas calls communicative action. But as will be

seen, if the content-thin common moral framework that enables these interactions to

ordinarily proceed successfully can also be properly introduced into the moral stress

situation, it can provide a basis for non-hierarchical discussion aimed at addressing that

moral stress.

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[14] "Authentic" here means "that the manifest intention of the speaker is meant as expressed" (Habermas, *Theory of Communicative Action*, 99), as concerns her subjective experience. This dissertation will use the word "authentic," though the German is also sometimes translated as "sincerity claims" (Bohman and Rehg, "Jürgen Habermas"), and sometimes as "truthfulness" (Habermas, *Moral Consciousness and Communicative Action*, 137).

The above three criteria describe claims to three types of validity for a given communicative assertion. According to Habermas, from this it follows that the validity of an assertion can be questioned on all three levels. While a person making an assertion should be assumed to be claiming validity on all three levels, she must be able to provide reasons for her assertion on each level if asked. Therefore, participants in dialogue are allowed to argue the validity of those claims if they find them wanting, and this "practice of argumentation" is "a court of appeal that makes it possible to continue communicative action with other means when disagreements can no longer be repaired with everyday routines."[15] However, this practice of argumentation is not meant to be adversarial: "no one would enter into moral argumentation if he did not start from the strong presupposition that a grounded consensus could in principle be achieved among those involved."[16] This presupposition means that communicative action may be an iterative process, in which participants question a speaker's knowledge of the facts, understanding of the norms, or, less likely, the authenticity of her speech, and the speaker (or questioners) may need to adjust accordingly, and be open to being questioned yet again about this new assertion (doubts about a speaker's authenticity ought to be raised only when one's actions do not align with one's words; otherwise, one's subjective assertions ought to be assumed to be dependable as accurately reflecting one's subjective state).[17]

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[15] Habermas, *Theory of Communicative Action*, 17-18.

[16] Habermas, *Theory of Communicative Action*, 19.

[17] It is true of course that one can also be self-deceptive about one's subjective claims, rather than be outright lying. See Habermas, *Theory of Communicative Action*, 21.

Habermas also makes it clear that because rational actors may have their validity claims questioned, there must be "a willingness to expose themselves to criticism and, if necessary, to participate properly in argumentation."[18] That is to say, even when asserting something authentically, a person expressing herself in communicative action must be open to the chance that her understanding of the objective or her interpretation of the normative is lacking and can be corrected through dialogue.

In normal moral discussion, health care professionals may also question and clarify another's claims of truth and claims of moral rightness, and to a lesser extent claims of authenticity (perhaps if, say, a physician claims to care about her patients but fails to attend bedside rounds many days in a row and instead plays games on her phone, her authenticity could be questioned). Claims of truth may rest on determining if a health care professional does, in fact, have all the relevant information about a particular patient or case, and how that informs her understanding of the situation. Claims of moral rightness may be questioned (within the content-thin common moral framework) by citing other ethical principles at stake, or by using a different methodology for ethical decision making that supports a different conclusion. Regardless of the specifics, it is important to remember that—as Habermas stresses—there is in what is here being called "ordinary" communicative action a presupposition that consensus is possible, or that something approaching agreement is achievable, which may mean that some health care professionals will, through this process of questioning, realize that their claims need adjustment, and do so accordingly in order to reach communal understanding.

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[18] Habermas, *Theory of Communicative Action*, 18.

Discourse Ethics

There are times, however, when "ordinary" communicative action fails to achieve

its intended aim of orientating participants toward mutual understanding and action. It is

at this point that speakers may shift to a more rigorous process of argumentation, which

Habermas calls "discourse ethics." As Bohman and Rehg note, "When the offer made by

the speaker [in communicative action] fails to receive uptake, speaker and hearer may

shift reflexive levels, from ordinary speech to 'discourse'—processes of argumentation

and dialogue in which the claims implicit in the speech act are tested for their rational

justifiability as true, correct or authentic."[19] This procedure still involves discussing

claims of validity and as such its basic description above resembles that of

communicative action; but it differs from communicative action in important respects.[20]

It should be once again acknowledged at the start of this section that Habermas'

discourse ethics, as a theory of moral reasoning through argumentation, was not designed

as a response to moral distress. Indeed, from looking at Habermas' principle of discourse

ethics: "Only those norms can claim to be valid that meet (or could meet) with the

approval of all affected in their capacity as participants in a practical discourse,"[21] it may

at first appear that the goal of discourse ethics is at odds with one of the main features of

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[19] Bohman and Rehg, "Jürgen Habermas."

[20] In that the rules and premises of discourse ethics effectively provide a roadmap for non-hierarchical, equality-based, inclusive discussions, they describe a process of discussion, and thus can be termed "procedural." However, this procedural method is *not* Engelhardt's purely procedural methodology. Obviously, having access to the content-thin common moral framework already builds ethical concepts into the procedure; but furthermore, Habermas himself notes that at least some of his premises and rules in discourse ethics are grounded by ethical content (See Ingram, *Habermas*, 132-34).

[21] Habermas, *Moral Consciousness and Communicative Action*, 66. Emphasis deleted.

moral distress. That is to say, the purpose of discourse ethics is to *test* relevant norms

for validity; but when a health care professional experiences moral distress, she already

believes that some norm is being violated, a norm whose validity is not in question for

her. However, this section will show that the rules of argumentation in discourse ethics,

and the requirements for doing discourse ethics that Habermas describes, lend themselves

very well to a method of moral distress resolution for health care professionals.

At the heart of discourse ethics, like the theories of Kant and Rawls, is the

universalization of moral norms. In that regard, Habermas' discourse ethics has the same

deontological goal as Kant's categorical imperative and Rawls' veil of ignorance.

However, as has been noted, Habermas rejects Kant's belief that rationality (and thus

universalizability) can be a monological exercise, as this ignores human rationality's

necessarily social aspects. As Ingram states, Habermas believes that "it is questioning by

others that enables us to become conscious of our interests so that we can responsibly

change them in light of others' interests."[22] Kant's conception of rationality does not

allow the rational thinker to engage with any other people, or even account for their

existence when creating norms, and in that regard, Ingram argues, it "violates our

intuition that norms are intended to advance our common good."[23]

Rawls tries to rectify Kant's error with his own universalizability test, in which

actors create norms under a veil of ignorance, where their individual identities and

idiosyncratic characteristics are hidden. Theoretically, this will result in actors creating

norms based on principles of justice, thus ensuring basic rights and limiting inequality

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[22] Ingram, *Habermas*, 123.

[23] Ingram, *Habermas*, 124.

unless it benefits the worst-off, and so on. However, Habermas is concerned that discourse in Rawls' theory is still hypothetical, and Rawls' reliance on the impartiality of actors (and the logical conclusion that this objectivity means they would all, even as individuals, still ultimately come to identical principles of justice) means "that every individual can undertake to justify basic norms on his own."[24] That is, for Habermas, Rawls does not require real dialogue to come to agreement on norms, and thus falls prey to the same monological fallacy as Kant.

Habermas, on the other hand, claims that properly conducted argumentation in discourse ethics "suggests the perspective of real-life argumentation, in which all affected are admitted as participants."[25] Given this difference, Habermas also must formulate a new principle of universalization that takes into account real dialogue between actual (as opposed to hypothetical) participants. To that end, Habermas introduces the following principle of universalization (U): a valid norm is one where "*All* affected can accept the consequences and the side effects [the norm's] *general* observance can be anticipated to have [in service of] the satisfaction of *everyone's* interests (and these consequences are preferred to those of known alternative possibilities for regulation)."[26] Thus, not only are the actors engaging in real dialogue the ones validating a given norm, but also the actors must take into account those who will be affected by the adoption of the norm, even if they are not present or directly involved in the discourse.

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[24] Habermas, *Moral Consciousness and Communicative Action*, 66.

[25] Habermas, *Moral Consciousness and Communicative Action*, 66.

[26] Habermas, *Moral Consciousness and Communicative Action*, 65.

(U) is a principle, but also acts as a rule of argumentation in discourse ethics.[27] As a rule of argumentation, it states that "rational consensus is to be achieved by each and every person revising their needs and wants in light of the impact their satisfaction would have on the needs and wants of others."[28] As a principle, however, (U) is derived from three premises: a principle of discourse, a content premise, and the rules of discourse themselves.[29] The principle of discourse looks similar to (U) but acts differently; it states the only norms that can claim validity are ones "that meet (or could meet) with the approval of all affected in their capacity as participants in a practical discourse."[30] The content premise defines and delineates what a valid norm ought to do, which is to mutually satisfy the interests of all participants, or to "give the participants the knowledge that they have collectively been convinced of something."[31] The final premise is the rules premise, or the rules of discourse, which is in turn divided into three rules, the third of which is *also* divided into three.

Habermas makes clear that his principle of discourse ethics is "*formal*, for it provides no substantive guidelines but only a procedure: practical discourse,"[32] and the rules premise is what creates that formal procedure. As noted, the rules premise has three

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[27] Technically, (U) is a "bridging" principle between norms and the real world, but that distinction is unimportant in this dissertation.

[28] Ingram, *Habermas*, 132.

[29] Ingram, *Habermas*, 131.

[30] Habermas, *Moral Consciousness and Communicative Action*, 66. Emphasis deleted.

[31] Habermas, *Moral Consciousness and Communicative Action*, 67.

[32] Habermas, *Moral Consciousness and Communicative Action*, 103.

parts. The first is the rule of product, or logic, which means merely that participants

must reason logically, adhering, for example, to non-contradiction and treating like

objects alike. One specific example cited by Habermas, which will be important to the

proposal for moral distress resolution offered here, is that "different speakers may not use

the same expression with different meanings."[33] The second rule of discourse is the rule

of procedure, which states that participants must be authentic and accountable in their

discourse.[34]

The third rule of discourse is the rule of process, and itself is divided into three.[35]

The first part of the rule of process is a rule of inclusion, in which anyone with the

competence to take part in discourse is allowed to do so. The second is a rule of

symmetry, which states that anyone is allowed to assert anything she wants, and anyone

is allowed to question anyone else's assertion, giving each actor an equal opportunity to

participate. The third of these is the rule of participation, stating that all actors must be

allowed to participate free from internal and external coercion, and thus they must be

open-minded in argumentation.[36]

Habermas believes that the above premises (discourse, content, and rules) provide

the basis for accepting (U). As Ingram summarizes, Habermas states that "a valid

(unconditionally binding) norm must be based on rationally universalizable interests that

have emerged out of an inclusive dialogue in which each and everyone's interests have

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[33] Habermas, *Moral Consciousness and Communicative Action*, 87.

[34] Habermas, *Moral Consciousness and Communicative Action*, 87-88.

[35] Habermas credits Robert Alexy for creating this rule of discourse.

[36] Habermas, *Moral Consciousness and Communicative Action*, 89.

been critically modified as far as possible to accommodate their equal harmonious satisfaction."[37]

It is an open question whether or not Habermas manages to prove that his principle of universalization is a "transcendental" concept rather than culturally-determined and limited.[38] Habermas appeals to "the universal and necessary communicative presuppositions of argumentative speech" in order to validate his principle,[39] which themselves rest on "the intuitive preunderstanding that every subject competent in speech and action brings to a process of argumentation."[40] It seems that referring an "intuitive preunderstanding" in order to create "universal and necessary communicative presuppositions" which will validate discourse ethics as universal can be criticized on the grounds that Habermas is claiming the existence of a universal concept in order to prove the existence of a universal concept, thus making his argument circular.[41] Yet importantly, Habermas also explicitly allows for discourse ethics to take place in, and be relevant for, non-transcendental ethics (i.e., ethical questions that arise in particular, concrete contexts), including the situations for which it is being proposed as a guiding theory here, namely situations of moral distress among health care professionals. He writes: "No harm is done, however, if we deny that the transcendental-pragmatic justification constitutes an ultimate justification… If we cease striving for the

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[37] Ingram, *Habermas*, 135.

[38] See Habermas, *Moral Consciousness and Communicative Action*, 78-82.

[39] Habermas, *Moral Consciousness and Communicative Action*, 86.

[40] Habermas, *Moral Consciousness and Communicative Action*, 89-90.

[41] For a more comprehensive critique in this vein, see Ingram, *Habermas*, 136-37.

foundationalism of traditional transcendental philosophy, we acquire new corroborative possibilities for discourse ethics."[42] Thus, the question of whether or not Habermas' discourse ethics are truly universal and transcendent is unimportant here, as this dissertation will use discourse ethics in a more limited scope, where something like a "necessary preunderstanding" has been shown to exist in professional health care given common professional morality and the content-thin common moral framework it supports.

Discourse Ethics and Moral Acquaintances

Chapter Four of this dissertation asked if there existed a practical, non-hierarchical way for health care professionals, as moral acquaintances sharing a content-thin common moral framework, to address and resolve situations of moral distress. Given the above description of Habermas' discourse ethics, this section argues that discourse ethics can provide the arena, and procedural structure, for this to occur. Though Habermas' purposes in describing a methodology for discourse ethics differ from this dissertation's, the procedural method he provides for norm validation can be applied here to moral distress situations, using the premises and rules he lays out.

As moral distress requires a proactive response (recalling that Chapter Two argued that a health care organization that does not adequately address moral distress can be held to be failing its moral obligations), it was shown in Chapter Three that moral distress resolution entails real dialogue, which discourse ethics requires as well—neither discourse ethics nor addressing moral distress can be done monologically. Furthermore, discourse ethics' necessary inclusion of all affected parties via the universilization

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[42] Habermas, *Moral Consciousness and Communicative Action*, 98.

principle avoids the problems presented by a hierarchical response to moral distress (including the distressed party and other involved health care professionals being denied a say in the resolution process, or the inability to have a constructive, real dialogue before the situation is taken over by an organizational entity removed from the conflict, thus also removing the possibility for real dialogue among actual participants). Indeed, the inclusion requirement supports the claim defended in Chapter Three that all involved health professionals, and not just the morally distressed individual(s), should also be included in the discussion of a moral distress situation. Habermas' rules and related premises of discourse, as well, provide helpful rules for participants in a moral distress resolution.

The three premises included in the universalization principle are, as explained above, the principle of discourse, the content premise, and the rules of discourse. The discourse premise includes all affected parties in practical discourse, which was elaborated on in the last paragraph. The content premise is meant to ensure that all participants' interests are mutually satisfied, which is in line with what a successful resolution of moral distress would also aim achieve (i.e., not only would a successful moral distress resolution alleviate a health care professional's moral distress, but all other participants would be satisfied with the outcome recalling that certain hierarchical responses to moral distress may actually create moral distress in other involved health care professionals). The third premise, the rules of discourse, create the guidelines and space for a discussion that can lead to a moral distress resolution. These rules are not just theoretical conclusions within Habermas's account of communicative action and discourse ethics. They provide a set of practical standards that the health care

professionals involved in a moral distress situation can actually use to guide their discussion about the situation to succeed in resolving it.

Habermas' rule of product requires that participants speak logically, but also, as noted above, that speakers must mean the same thing when using the same expression. For health care professionals, ordinarily meeting this requirement of shared meaning is made possible by the content-thin common moral framework, in that all participants are assumed, in their daily dealings with one another, to be generally agreed on the thin meaning of the concepts they use. But if someone *is* using a concept differently than others normally would, this would need to be identified and corrected during the discussion in order for the discussion to continue successfully; and this may, in fact, uncover the cause of the moral distress, if the cause stems from a misunderstanding of the application of a (thin) ethical principle.

The rule of procedure, which states that participants must be authentic, is in fact already accounted for. This is because, as discussed in Chapter Three, adherence to the goals and values of professional health care—which necessarily entail authenticity as Habermas describes it, in that a health care professional's statements and acts must accurately reflect those goals and values—are a part of the ethical obligations necessarily included in joining a health care profession.

Habermas' rules of process—inclusion, symmetry, and freedom from coercion—effectively insist that all affected parties have an equal chance to hear and be heard. Given the moral acquaintanceship and equality of health care professionals, these rules clearly are relevant to successful moral distress resolution as well. That is to say, if any of these rules are broken and discourse becomes in some way asymmetrical, moral

acquaintanceship and the equality of health care professionals are not being respected, and hierarchies will begin to re-emerge in that an asymmetrical relationship means that some are "more than" and others are "less than." Furthermore, the process of iterative argumentation in discourse ethics, in which participants are expected to open-mindedly assert and accept for consideration assertions from all other participants, describes what a real peer-to-peer, non-hierarchical, inclusive, respectful discussion of moral distress should look like, building on the content-thin common moral framework for the language and concepts shared by health care professionals.

At this point, it is once again important to note that, while in discourse ethics the above premises come together in order to add up to the principle of universalization and thus the validation of a given norm, this is not the purpose here. Indeed, it can be argued that the content-thin common moral framework shared by health care professionals has *already* validated the norms they use. Instead, based on the above analysis of discourse ethics and its suitability for application to dialogue among moral acquaintances, Habermas' theory can be seen to provide a plausible structure for what a moral distress resolution can look like in practice. Thus, instead of Habermas' goal of universalization of norms as an outcome, the goal in a moral distress situation is a resolution that has been reached communicatively in accord with these standards of successful discourse ethics. That is, when all parties in a moral distress situation are included in its discussion, though individual interests and assertions may have to be modified to be harmonious with other individuals' by process of iterative argumentation, the procedure itself, as it follows the formal rules and premises of discourse ethics, would be judged as fair and respecting the equality and contributions of all. The outcome would be one mutually agreed-upon by all

parties as being at least an acceptable-by-all solution (though a higher level of

agreement may emerge), because all parties will have heard and been heard, and ideally

all will have understood and been understood. In this regard, a successful moral distress

discussion will precisely mirror successfully implemented discourse ethics, as defined by

McCarthy: "Habermas's discourse model, by requiring that perspective-taking be general

and reciprocal, builds the moment of empathy *into* the procedure of coming to a reasoned

agreement: each must put himself or herself into the place of everyone else in discussing

whether a proposed norm is fair to all."[43] This empathy and reciprocity of understanding

is the basis for health care professionals being able to arrive at the conviction that a moral

distress situation can be resolved even if total agreement about the specific case that is a

catalyst for the moral distress is out of reach. But the required empathy and commitment

to reciprocity are already characteristics of how health care professionals (including those

in differing health care professions who continually depend on one another's

characteristic expertise in the interest of their patients' best interests) routinely strive to

interact. While a moral distress situation is, as has been noted, an interruption of these

relationships, if it becomes understood that a non-hierarchical, mutually respectful

methodology is still available for the resolution of moral distress situations, there is good

reason to believe that both the morally distressed person and the other involved health

care professionals will be able to approach the discussion with the empathy and

commitment to reciprocity that McCarthy speaks of.

One last point made above ought to be emphasized: in a moral distress situation, it

is possible that an agreement on a course of action in the specific case under discussion is

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[43] McCarthy, introduction to *Moral Consciousness and Communicative Action*, viii–ix.

not found. Health care professionals are, after all, moral acquaintances, and not moral

friends. Disagreement may exist regarding the application of concepts beyond the thin

and superficial.[44] Instead, by using the rules and premises of discourse ethics, this chapter

attempts to lay out a procedural solution grounded in the content-thin common moral

framework shared by health care professionals, at the end of which the parties in the

moral distress situation have had the opportunity for mutual and respectful

communication, in which each participant is included and affirmed as an equal moral

actor. But as Helft and colleagues recount after creating a forum in which health care

professionals could come together to discuss a moral distress situation,[45] even if the kind

of resolution just described was not achieved, "the conversation has 'worked' because it

led to clarity about the issues underlying the participants' distress. Participants emerge

with a better sense of how divergent views on the case derive from equally valid

considerations, and with some conviction that respectful discussion of different views and

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[44] Though it is also possible that this process may lead to a new agreement on a concept that the participants had not previously considered. This kind of resolution of a moral distress situation has yet another parallel with Habermas' account of discourse ethics; namely, Habermas' two-stage explanation of the justification and application of a norm (See Habermas, *Justification and Application*, 35-39). In justifying a norm, participants affirm it as able to be universalizable, generally speaking, with the knowledge that their temporal and mental finiteness limit their ability to reason perfectly. In application, participants apply the norms available to a specific situation "to select the one prima facie norm that is most appropriate" (Ingram, *Habermas*, 140). If two justified norms conflict in application, the discussion can move to a process of reconciliation of the norms, possibly justifying, and then applying, a new norm that the parties can all agree on. This might be akin to two health care professionals sharing a thin concept, but realizing that their thick conceptions are different, and through a reflexive dialogue, coming to a new thin concept such that their thick concepts no longer conflict in practice, or coming to a new understanding of a thick concept that they both can share. However, this process does not need to occur for a successful moral distress resolution, and in any case it is only in a discussion that conforms to the rules for discourse ethics that it is likely to occur.

[45] This forum will be discussed in depth in Chapter Six.

of the feelings a case has engendered has been an important and valuable exercise."[46] That is, moral acquaintances may, at the end of the day, still disagree, but if the discussion has conformed to the rules of discourse ethics, they will understand *why* they disagree and the morally distressed person will have far less reason to feel isolated or disrespected as a moral person or as an inadequately committed health care professional.

Conclusion

Having identified health care professionals as moral acquaintances that interact within a content-thin common moral framework in Chapters Three and Four, this chapter examined what kind of discussions could be had given health care professionals' common professional morality. It was proposed that, in "everyday" discussion, health care professionals use a model similar to Habermas' theory of communicative action to speak about their judgments of what ought to be done. However, when a moral distress situation occurs disrupting this communication and thus needs resolution, health care professionals can turn to the rules and premises of Habermas' theory of discourse ethics to create a forum in which this discussion focused on resolution can occur. With this theoretical explanation in place, this dissertation now must turn back to the health care organization, which has an obligation to address moral distress in its health care professionals. The question then becomes, how should the health care organization do so in practice? This will be the focus of Chapter Six.

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[46] Helft et al., "Facilitated Ethics Conversations," 30.

CHAPTER SIX

PRACTICAL PROPOSALS FOR HEALTH CARE ORGANIZATIONS

Chapters Three, Four, and Five of this dissertation built an argument for non-hierarchical, inclusive, equality-based peer-to-peer discussions among health care professionals as a model for responding to, and resolving, moral distress. Chapter Two showed that efforts to resolve moral distress using an organization's hierarchical system are likely to be unable to do so. Given that health care organizations have an obligation to address moral distress in its health care professionals for the reasons provided in Chapter Two, it follows that health care organizations have an obligation to create and foster an environment in which these discussions can take place. However, in order for an institution to effectively address moral distress, it needs not only to be responsive, but also proactively build the structures within which its health care professionals can resolve moral distress by means of the kinds of equality-based discussions described in Chapters Three, Four, and Five. Furthermore, if a health care organization adequately fulfills this obligation, it may be that moral distress is not only resolved, but also in some instances lessened or avoided in the first place, thus strengthening the relationship between the organization and its health care professionals it is obligated to promote.

This chapter will examine and endorse practical recommendations for ways in which health care organizations can respond to moral distress in health care professionals. To do so, first a case of a poor institutional response to moral distress will

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be analyzed, in order to highlight inadequate structures for addressing moral distress. Following this, positive methods to respond to moral distress will be offered, and in doing so, proactive ways for health care organizations to address and lessen, and at times eliminate, moral distress in health care professionals will also be explored.[1] Before concluding, some unresolved questions raised in this dissertation will be acknowledged, and areas for further investigation identified.

A Case Analysis of a Negative Response to Moral Distress

In this section, an example of a poorly handled moral distress response (on the part of the health care organization) will be analyzed. In highlighting the institutional failings in this case, this section will show how insufficient responses to moral distress can be rectified, which will lead to suggestions of how a health care organization can positively respond to moral distress. Thus, the succeeding section will examine some possible strategies health care organizations can implement in order to properly address situations of moral distress and create an environment that would be actively supportive of the proposed procedure for their resolution.

For this negative case example, this dissertation will analyze a moral distress situation based on a case from the American Medical Association's Virtual Mentor—the only case, in fact, in the AMA's archives that discusses moral distress (perhaps reflecting the lack of attention this issue has received). In the case, Claire is an intensive care unit (ICU) nurse caring for Mrs. Smith, an 80-year old woman with no significant past

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[1] Up to this point, this dissertation has mostly used the language of "responding to" moral distress. However, as just noted and as will be shown later in this chapter, in that an ethically adequate organizational response to moral distress may lessen or avoid moral distress in the first place, it is not only being "responded to" but also "addressed," so this chapter will use both these expressions.

medical history admitted for a myocardial infarction (heart attack). After her

admission to the ICU, Mrs. Smith soon became hypotensive (very low blood pressure)

with evidence of cardiogenic shock (an inability for the heart to pump enough blood) and

altered mental status. The attending physician in the ICU, Dr. Jones, recommends

catheterization to open a closed artery "to make her feel better and…give her the best

chance at living the longest," to which Mrs. Smith's children agree.[2] Following the

procedure, Mrs. Smith falls into respiratory distress and is diagnosed with flash

pulmonary edema (fluid in the lungs), and so she is intubated (a breathing tube and

artificial respiration with a ventilator is put in place) and sedated (to avoid respiratory

distress and so she does not disturb the breathing tube). Claire is Mrs. Smith's primary

caretaker, and at this point it becomes known that Mrs. Smith's advance directive, filled

out years ago, refuses resuscitation or ventilation if she is in the process of dying. Dr.

Jones, however, doesn't think Mrs. Smith is in the dying process and sees the intubation

as temporary—which it in fact is, as Mrs. Smith's condition improves enough to remove

the breathing tube the next morning.

Following the removal of the breathing tube, while Mrs. Smith is stable and

awake, she tells Claire that she feels terrible and that it is near her time to die. Soon

thereafter, Mrs. Smith's condition worsens, and she is re-intubated and diagnosed with a

pneumonia. Antibiotics are started, though Mrs. Smith consistently shakes her head

against receiving any new drugs or lines. At this point, Claire asks Mrs. Smith directly if

Mrs. Smith wants to continue life-saving measures: she shakes her head "no." Claire tells

Dr. Jones of Mrs. Smith's wishes, but Dr. Jones refuses to change the course of care,

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[2] AMA, "Moral Distress and Nurse-Physician Relationships," 6.

maintaining her full code status (full resuscitation if her heart and breathing should stop), stating that Mrs. Smith was getting better, will eventually be able to breath on her own, and her desire to stop treatment stems from her misunderstanding of her situation.

The following day, Mrs. Smith's children tell both Claire and Dr. Jones that their mother was clear in her advance directives and would not want to be ventilated. Dr. Jones, however, states her hope Mrs. Smith's recovery, causing the children to cede to her judgment. Claire, however, is unsure of how to proceed. She would like to talk to Dr. Jones again or an administrator about this case, but is afraid of getting in trouble for unprofessionalism or impeding patient care if she continues to push the matter with Dr. Jones or anyone else. Se feels that she knows this is not what Mrs. Smith would want, and as her advocate, Claire wonders what she can possibly do in this situation.

The first step in moral distress resolution is to clearly identify and articulate the cause of moral distress. In this case, Claire believes she has strong evidence and reasons for believing that Mrs. Smith would not want the continued invasive treatment that the medical team is providing, that the correct decision is to stop treatment of Mrs. Smith's pneumonia, remove her breathing tube, and focus on comfort and allow Mrs. Smith to die. The attending physician, Dr. Jones, disagrees and overrides Claire, and so she cannot act on her belief. Furthermore, Claire feels institutionally prohibited from escalating the issue given her concerns of being labeled "unprofessional" or impeding patient.

In a moral distress resolution process based on discourse ethics, Claire would have the support of her health care organization and leadership for there to be a discussion about the ethical issues in the case with the members of the health care team. All health care professionals providing care for Mrs. Smith would be invited. Indeed,

though not mentioned in the case, it goes without saying that respiratory therapists,

interns and residents, cardiologists and infectious disease physicians, other nurses, and

more would be involved in Mrs. Smith's care and might like to join the conversation. In

accordance with a notion of inclusion and the refutation of hierarchical responses to

moral distress, every person attending should be mindful to (or, if moral distress

discussions are assisted by a facilitator, should be reminded to) leave her job title and

status at the door, though each participant is *not* leaving her professional ethical (or

medical) judgments outside of the discussion. In fact, it would be helpful for the

participants to be reminded of their professional ethical obligations and the content-thin

common moral framework they can appeal as a point of agreement among all members.[3]

Using this content-thin common moral framework and its language and concepts

as a starting point, the members of the health care team could begin to talk about both the

case and Claire's moral distress (and if any other team member also is morally

distressed). Each health care professional would use the framework to understand the

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[3] It is important to note that this discussion is not the same, in goals or in structure, as an ethics consultation. Facilitation of a moral distress discussion will be explored later in this chapter, but for now it is enough to say that, most often, an ethics consultation is called so that trained ethics consultants can assist caregivers and/or families or patients in ethical thinking about what is the best decision for their situation—the starting point of an ethics consultation is usually, in some form another, a "moral dilemma" as was discussed in Chapter One. In a moral distress situation, a health care professional has already come to a decision about what the best plan is (and that plan is not being followed), and so a moral distress discussion will be framed differently. Indeed, if a health care organization had the resources, having ethics consultants and moral distress facilitators as separate entities within the organization would be ideal, given that blurring the lines between the two roles (if they are filled by the same person or persons) may create confusion as to the goals of an interaction between a health care professional and a facilitator of a moral distress discussion on the one hand, and a health care professional and an ethics consultant or ethics consultation team, on the other. Generally speaking, however, an ethics consultation may uncover moral distress that a health care organization then would have an obligation to respond to.

other professionals' understanding and application of their shared concepts, and

where those concepts differ, are in discord, or are possibly misunderstood, thus

potentially leading to the conflict at hand in Mrs. Smith's case. Following the rules and

premises in Habermas' discourse ethics and its requirement that assertions must fulfill

certain validity claims, the participants would open-mindedly and respectfully question

and authentically respond when questioned regarding their knowledge of the facts of the

situation and their ethical judgments about the situation, and through this iterative process

refine their understanding and judgment. This reciprocal questioning would, hopefully,

allow each participant to empathetically hear and be heard, toward the goal of mutual

understanding of, and satisfaction with, the process of discourse. This in turn would

ideally lead all participants to judge the outcome of the discussion as one arrived at fairly,

as everyone involved in the process would have approached each other, and been treated

as, moral equals with the ability to contribute meaningfully to the resolution of Claire's

moral distress (and that of any other morally distressed health care professionals that may

now voice their distress when given a non-hierarchical, inclusive forum in which to do

so).

When using the word "outcome" here, it is important to remember that the goal of

this moral distress discussion is explicitly *not* to determine a plan of treatment for Mrs.

Smith, or even to determine what the right thing to do is, much less to create a consensus

judgment on that question. The purpose is to provide a procedural framework to address

the participant health care professionals' moral distress, and for the members of the team

to have a space in which to be understood and to understand the other participants in Mrs.

Smith's care. It is possible that this process of asserting, questioning, refining, and

understanding everyone's ethical concerns and stances might lead to a consensus and acceptance of a plan of treatment or other action. In practice, though, this may not be achievable—Dr. Jones may not agree with Claire's reasons for thinking that the present course of treatment is not in accord with Mrs. Smith's wishes, and so may choose to continue Mrs, Smith's intubation and to maintain her full code status.

If this were to occur, however, the pragmatic outcome of the discussion in relation to Claire's moral distress may be that, at the very least, Claire can better understand Dr. Jones' position and rationale for it, and will know that her concerns had been heard but not agreed with for specific reasons, consistent with the content-thin common moral framework, that have at least been openly discussed with all health care professionals caring for Mrs. Smith. Though she does not have the power to alter the decision in this case (recalling that health care organizations are still necessarily hierarchical in their authority structure and that ultimately someone will hold decision making power with regard to patient care), she will have been treated as a moral equal to the rest of the team members, and the reason for her distress will have been empathetically listened to and considered.

If Claire feels that a fair procedure has been followed in which Dr. Jones, the health care team, and the organization understood her concerns and responded to them appropriately, her moral distress may be resolved. However, this also depends on Claire knowing that not only the other participants in the conversation but the organization itself views moral distress as an important ethical matter worth both individual and organizational effort to address.

In the description of this example as written by the AMA, the organization was obviously described in negative terms in how it handled moral distress. Not only was there no mechanism in place for properly addressing moral distress when it occurs, but there is a suggestion that the culture of the organization discourages open moral disagreement and discussion, or even views it as an interference. Obviously, this dissertation argues that the organization ought positively assist its health care professionals in addressing situations of moral distress. What this might look like in practice will be discussed more fully in the next section. But it is possible, especially if the organization's culture does in fact discourage moral discussion, that the hospital in the case did not know that Claire was experiencing Dr. Jones' decisions as a moral problem, much less that such situations of moral distress had come up before. However, the literature makes it clear that moral distress is a widespread and persistent occurrence and so the hospital would do well to see if this is also the case within its walls and then to analyze which policies or patterns of practice lead to moral distress in the institution. Some questions that might be asked include: What recourse do concerned members of the health care team have in cases of care they feel to be ethically inappropriate? Are there pressures or relationships that prevent morally distressed health care professionals from raising moral questions in the course of daily patient care, and what sort of organizationally supported mechanism can rectify this?

More specifically, in relation to characteristics of Mrs. Smith's case and previous cases like it, the hospital might find specific policies (or lack thereof), including policies about clinical matters, contributing to the prevalence of moral distress among its health professionals. For example, how are teams structured in the ICU, and how much power is

granted solely to the attending physician? What checks are in place to an attending physician's decision making? Are team atmospheres collegial or intimidating? Do the hospital's policies support the role of advance directives in planning the course of care, or do they not? Are there institutional policies in place that treat artificial ventilation as an all or not-at-all decision or is there room for limited ventilation trials? What are the procedures involved in changing a patient's code status?

Having looked at such questions, both generally about opportunities for health professionals to discuss morally distressing situations and specifically about particular kinds of situations or structures that may have led to moral distress in the past, the organization could determine first of all how to directly respond to situations of moral distress. It could determine how to best support appropriate kinds of discussion among its health care professionals, including the potential value of trained facilitators assisting teams of professionals in constructing discussions that conform to Habermas' rules and premises of discourse ethics. But in addition the organization could learn how to change its culture so that its policies and patterns of practice actually prevent or at least lessen moral distress in the first place.

With these suggestions for areas of improvement in mind, it is time to address the larger question, posed in Chapter Two: What are health care organizations obligated to do in order to address moral distress experienced by their health care professionals? Since a central thesis of this dissertation is that health care organizations do in fact have obligations to address moral distress, it is important to examine the positive proposals

that have been offered to this end, most notably by Hamric, Epstein, and White, and

by Helft and colleagues.[4]

How Health Care Organizations Can Positively Address Moral Distress

In a recent book chapter titled "Moral Distress and the Healthcare Organization,"

Hamric, Epstein, and White offer practical strategies for health care organizations that

align with the theoretical discussion undertaken in this dissertation.[5] The authors are

aware that organizational responses like those criticized in Chapters Two and Three of

this dissertation are likely unhelpful: "Strategies that have been adopted by nurses and the

clinical professions…may be inadequate to address what appears to be a pervasive

phenomenon from a systems perspective."[6] In regard to hierarchical initiatives

implemented by the organization, they state that "top-level administrative dictates will

not necessarily lead to unit-level changes without clinicians seeing the need and having

the skills to address moral distress."[7]

Hamric and her colleagues argue that organizations must address moral distress

both on a case-by-case level and on a system-wide level. In individual cases, the authors

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[4] As was noted at the outset of this dissertation, very little has been written about organizational responses to moral distress. But one positive response that has been mentioned in the literature will not be addressed here: the University of Virginia Health System has created and instituted a moral distress consultation service (Hamric and Epstein, "Moral Distress, Moral Residue, and the Crescendo Effect."). Unfortunately, the moral distress consultants have not yet published a thorough description or analysis of this service, and thus it cannot be discussed here.

[5] These authors gave their chapter the same title as this dissertation, but the book containing the chapter was not published until after the title for this dissertation had been chosen and approved.

[6] Hamric, Epstein, and White, "Moral Distress and the Healthcare Organization," 151.

[7] Hamric, Epstein, and White, "Moral Distress and the Healthcare Organization," 147.

state that health care organizations ought to promote dialogue among its health care

professionals, and their suggestions on strategies to do so support dialogue that closely

mirrors the discourse ethics-inspired discussion defended in the preceding chapters. They

state that discussions about moral distress need to focus on dialogue that is founded on

"open and respectful communication… Ground rules may need to be established to create

a safe space where every person is respected, heard, and does not fear reprisal."[8] The

authors do not state what these ground rules are, or what the safe space looks like, but if

the goal is for open and respectful communication, it seems that the proposals offered in

this dissertation about the equality of health care professionals as moral acquaintances

committed to a content-thin common moral framework and about Habermas' premises of

discourse ethics would go a long way toward achieving this.

Regarding system-wide responses, these authors state that the health care

organization, in addition to fostering dialogue and reciprocal respect, must be supportive

in allowing staff time and space to have these discussions, as well as offering educational

opportunities so that health care professionals can learn to understand and recognize

moral distress in themselves and their colleagues. These educational opportunities

potentially could be beneficial for health care professionals in another way as well, in that

by better identifying their own moral distress they will be better prepared to initiate a

resolution process like the one described in this dissertation. This would, of course, be

possible only if the health care organization has fulfilled its other obligations to address

moral distress. For if a health care professional can identify her moral distress but cannot

resolve it, this could create the feedback loop of moral distress discussed in Chapter Two.

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[8] Hamric, Epstein, and White, "Moral Distress and the Healthcare Organization," 148.

So while moral distress education may very well be useful for health care professionals, it is only a piece of a health care organization's obligation to address moral distress, and must also be packaged with the proposal offered in this dissertation and with the other suggestions that Hamric and her colleagues provide.

The authors also state the important, though obvious point, that health care administrators can play a crucial role in promoting interdisciplinary communication and collegial practices, which can in turn possibly prevent the communication errors that sometimes cause moral distress. Moreover, they can in this way help the organization develop the atmosphere in which a moral distress resolution process like the one described in this dissertation can occur.

In offering strategies on how to address moral distress on a systems level, however, Hamric and colleagues acknowledge that, because every health care organization is structured differently and each has a unique culture, no one-size-fits-all solution exists. They note, for example, that a teaching hospital's response to moral distress might be different than a hospital that is focused on highly skilled patient care, as the former places emphasis on training health care professionals (e.g., it has a residency program), while the latter emphasizes the expertise of its health care professionals and service delivery, and thus focus on maximizing different values. However, both of these types of organizations need to have leaders who can champion the mission and values of the particular health care organization, and one "important aspect of this advocacy role is to apply the organization's mission and values to all levels of the organization, from

high-level administration to individual units."[9] So if incorporating ways of properly

addressing moral distress and adjusting organizational culture to support them is a

priority, then the specific moral distress interventions at each organization can be tailored

to the mission and values of that organization. One result of this would be that those

organizational values can be integrated into the content-thin common moral framework

of health care providers at that institution, yielding something much closer to a system-

wide agreement on what values ought to be prioritized and contributing in this additional

way to the language and concepts available to health care professionals in their

discussions of moral distress situations.

The observation that there are no one-size-fits-all solutions to moral distress, and

the fact that health care organizations will need to determine how to disseminate and live

its mission and values based on how it is structured, are stark reminders that health care

organizations (like all organizations) operate hierarchically, and thus of the difficulty

organizations may experience in breaking free of current responses to moral distress that

produce the negative results associated with hierarchically structured interventions. The

thesis of this dissertation is that health care organizations have an obligation to create

non-hierarchical responses to moral distress, and while the theoretical groundwork for

this to occur has taken place in the preceding chapters, it must be acknowledged that in

practice it may be difficult. Indeed, as Rushton and Brooks-Brunn state, a collaborative

health care environment is the ideal, and the mission and values of a health care

organization may espouse to strive for such an environment, but "where hierarchical

decision-making…and traditional power structures are valued, there may be

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[9] Hamric, Epstein, and White, "Moral Distress and the Healthcare Organization," 149.

incongruencies between the stated philosophy, values and goals of the organization,

and the reality of the work place."[10]

That is to say, regardless of how committed an organization may be to supporting

a mechanism for responding properly (according to this dissertation's suggestions) to

moral distress when it occurs, it will remain a serious challenge for health care

organizations to determine how to implement these mechanisms without it appearing to

be committed to "top-down," purely hierarchical solutions and thus falling into the same

inappropriate hierarchical patterns criticized in Chapter Two.

A possible way to address this concern is through the creation of an

organizational culture (also referred to as moral climate or moral culture), as proposed by

Hamric, Epstein, and White. By creating a moral climate of the proper sort, ideally health

care professionals within the organization will see the example set by administration and

take seriously the ethical issues of other health care professionals. It should be noted,

however, that typical strategies to create a moral climate that takes ethical issues

seriously "are not explicitly aimed at managing moral distress. …[Nevertheless] leaders

and managers who develop a culture anchored in sound ethical decision making and

procedures to use when ethical issues arise should find it easier to manage moral

distress."[11] Thus, while it is outside the scope of this dissertation to delve into what

organizational characteristics constitute such a moral culture, it is interesting to note that

"a culture anchored in sound ethical decision making" will probably not only find moral

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[10] Rushton and Brooks-Brunn, "Environments That Support Ethical Practice," 23.

[11] Hamric, Epstein, and White, "Moral Distress and the Healthcare Organization," 151.

distress easier to manage, but also will probably see instances and/or severity of moral distress decrease.

This hypothesis is based on the notion that health care professionals in, and acclimated to, a moral climate of this sort will be more likely to have open dialogue regarding potentially troubling ethical issues *before* they become morally distressing. That is to say, morally attuned health care professionals will be better at identifying situations that may create ethical tension, and will also feel able to raise these concerns with other health care professionals in a culture that values addressing those tensions and contribution to ethical discourse. As Rushton and Brooks-Brunn concede and as was discussed in Chapter Three, while there will always be differences in opinions, judgment, and moral deliberating in health care professionals, within a moral culture these differences "could be openly acknowledged and truthfully communicated in order for harmony to exist."[12] This harmony would exist because differences would be uncovered and discussed *before* decisions were made and moral distress was created.

Another way in which a health care organization can properly address moral distress is to proactively identify the contexts within the institution where it is most likely to arise and to see if changing how these contexts operate will also reduce or even eliminate those instances moral distress. In determining how to do this, Hamric and her colleagues propose that health care organizations look carefully at the IntegratedEthics Initiative developed by the US Department of Veterans Affairs, which is a system-wide ethics program that combines an ethics consultation service, preventive ethics measures, and ethical leadership, the last of which has already been mentioned. Though it is argued

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[12] Rushton and Brooks-Brunn, "Environments That Support Ethical Practice," 24.

here that ethics consultations and moral distress resolutions are conceptually and

practically separate (see footnote 3), observations of an ethics consultation service and an

organizational commitment to preventive ethics may be a way to avoid some future

instances of moral distress. For even though the primary goal of an ethics consultation is

to assist decision-makers in making the best moral decisions they can in a particular

situation, ethics consultants are well-placed to observe reoccurring causes of moral

distress. These reoccurrences can then be looked at via root cause analysis, and then those

root causes can be addressed by the organization. As Rushton explains, root cause

analyses of morally distressing situations, can "explore the systems that have contributed

to moral distress. Root cause analysis is a process for identifying what, how, and why an

event happened in order to prevent its reoccurrence. Using a neutral process, [the analysis

would] identify interpersonal factors, interdisciplinary dynamics, policies, or practices

within the system. This type of process can lead to documentation of institutional

constraints that lead to moral distress and identify workable solutions."[13] Preventive

measures based on surveys, root causes analyses, and other sources of information within

the organization can then be used to target prevalent and frequent causes of moral

distress. For example, studies have shown that proactive ethics consultations reduced the

length of ICU stays and unnecessary treatment in terminally ill patients, thus alleviating

some cases of moral distress in health care professionals caring for patients in these

settings.[14]

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[13] Rushton, "Defining and Addressing Moral Distress," 166.

[14] See Scheiderman, Gilmer, and Teetzel, "Impact of Ethics Consultations in the
Intensive Care Setting: A Randomized, Controlled Trial" and Dowdy, Robertson, and

Unit-Based Ethics Conversations

Another positive institutional response worth examining has not only been

discussed in literature, but has been put into practice. Helft and colleagues began a

program for nursing staff in their health care system (Clarian Health in Indianapolis) that

they called unit-based ethics conversations, or UBECs.[15] In this space provided by the

organization, conversations regarding ethical issues nurses faced that led to moral distress

were facilitated in such a way that that "reflective dialogue and sharing of experiential

narratives are encouraged."[16] In examining the methodology of the UBECs, many

positive practical responses to moral distress align with the philosophical suggestions

offered in this dissertation, and would be beneficial for other health care organizations to

consider implementing. For example, though the conversations were facilitated by

different members of the health care system staff who were not necessarily themselves

nurses and thus occupied different positions in the institutional hierarchy, the facilitators'

intent was specifically not to "teach a formal ethics curriculum or content, but rather to

provide a forum for processing and discussing the ethical issues…with no didactic

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Bander, "A Study of Proactive Ethics Consultation for Critically and Terminally Ill
Patients with Extended Lengths of Stay."

[15] Note that this program was set up for nurses. As was noted in Chapter One, such a
program would not encompass all health care professionals who might benefit from the
service being offered (though the authors do state that non-nurses have attended UBECs;
the positive and negative effects the attendance of members of other health care
professions had, and potential ramifications of these effects on moral distress resolution,
will be discussed later in the chapter).

[16] Helft et al., "Facilitated Ethics Conversations," 28.

goals."[17] Thus, though the health care organization had implemented this response,

the response avoided trying to "fix" moral distress via education from outside staff (i.e.,

hierarchically). Instead, the participant health care professionals were given a forum in

which to have an "open and honest conversation" on moral distress situations via

reflective dialogue[18]—the listening and being listened to asked for in discourse ethics.

It is also interesting to note that, when they were starting the UBECs, a physician-

ethicist acted as the primary facilitator even though the participants were mostly nurses,

and the authors "noticed that participants were less spontaneous in early meetings but

became less guarded over a period of 3 or 4 sessions."[19] The authors are most likely

correct in hypothesizing that this was because nurses were initially wary of a

conversation facilitated by a physician due to entrenched hierarchies and hierarchical

mindsets, and that it took time to acclimate to thinking of the facilitator as an equal and

no more than an equal.[20] This is an important point for any organization that would offer

facilitators for moral distress discussions: A positive organizational response to moral

stress would need to be aware of the potential perception of the inequality of participants

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[17] Helft et al., "Facilitated Ethics Conversations," 28; Helft et al., "Facilitated Ethics Conversations," 29.

[18] Helft et al., "Facilitated Ethics Conversations," 28.

[19] Helft et al., "Facilitated Ethics Conversations," 28.

[20] It is worth quoting the authors at length: "We have theorized that, because a great deal of nurses' ethical experiences are shaped or affected by interstaff relationships and communication, particularly with physicians, each group of nurses needed time to build trust with the physician-facilitator to trust that the environment was 'safe' and that issues that might be perceived as negative or critical of physicians could be voiced without fear of negative responses. Thus, over time, the conversations have become more comfortable and more open" (Helft et al., "Facilitated Ethics Conversations," 28).

in the discussion, and to deliberately work to create a non-hierarchical environment,

like the one examined here, where equality can (perhaps over time) become presumed by

the participant health care professionals.

Indeed, as Helft and colleagues found, once participants were comfortable with

the facilitator and with the group environment, "there is a free exchange of feelings,

emotions, information, and insight."[21] As a part of this exchange, the facilitators refine

and define the participant health care professional's statements "to help participants

uncover and put into words the issues that actually underlie their distress."[22] Thus, this

process of facilitation closely follows the guidelines based on Habermas' premises and

rules of validity for discourse ethics recommended in this dissertation, in that the goal is

for participants to engage in authentic, mutual, and respectful iterative communication.

Furthermore, the facilitators assisted the participants in being able to give name to their

concerns in order to appeal explicitly to concepts and language of the content-thin

common moral framework to be able to share with one another the experiences,

information, and reasoning germane to the moral distress situation.

Helft and colleagues also provide a number of specific facilitation techniques that,

if used effectively, correspond to some of the procedural guidelines described in

discourse ethics. They include clarifying details, "pushing" participants, reflective and

supportive statements, resisting answers and solutions, and best practices.

As in discourse ethics, where the truth claim of a speaker can be questioned and

the speaker is expected to be receptive to this questioning and adjust her claims if

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[21] Helft et al., "Facilitated Ethics Conversations," 29.

[22] Helft et al., "Facilitated Ethics Conversations," 29.

necessary, UBEC facilitators are aware that partial understandings of the facts of a

case can lead to moral distress, and in *clarifying details*, a fuller understanding of the

facts may resolve the distress. Importantly, however, in UBECs, correction of factual

misperception "is done without a chart or medical records review, but by iterative

discussion with participating staff members."[23] That is to say, correcting an inaccurate

understanding of a situation is not done via appeal to an institutional document (i.e., the

medical record) or to a different member of the institutional hierarchy (i.e., the attending

physician on the case), but instead via an equality-based discussion where positions are

refined and adjusted as more information is provided by participants and their peers.

In *"pushing" participants*, the facilitators state that their goal is to gently coax

participants to "reflect out loud and articulate the central ethical issues" at stake while

still "allow[ing] the participants to remain in control of the direction of the

conversation."[24] This, again, is an attempt to have participants voice their experiences of

moral distress via the concepts and language of the content-thin common moral

framework so that their moral distress can be better understood by other health care

professionals who have access to the framework and concepts within it as well.

Furthermore, the act of gently "pushing" on participants to name their feelings mirrors

discourse ethics' requirement that participants validate the claims they are making. That

is to say, if a health care professional says "Something didn't feel right," in both this

facilitated conversation and in discourse ethics another person may ask to probe that

feeling, and have the health care professional validate it by naming it, so all involved can

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[23] Helft et al., "Facilitated Ethics Conversations," 29.

[24] Helft et al., "Facilitated Ethics Conversations," 29.

share in understanding. Yet by not taking charge and not acting as a conductor, but allowing participants to maintain control of the discussion (by allowing them to answer open-ended questions and stopping at any time), the facilitator does not take on a hierarchical role, but instead remains peer interlocutor for the participants.

Reflective and supportive statements from the UBEC facilitator, which occur when the facilitator carefully listens and responds to participants with a summary of their meaning and support of it, "fosters an atmosphere of trust and mutual respect,"[25] which is necessary to create a peer-to-peer conversation in an equality-based forum. By validating participants' expressions of experience as authentic, the UBEC facilitator is making a concerted effort to show participants in a moral distress conversation that they are in a safe environment built on trust, in which participants can feel comfortable expressing their moral distress and know that they are being not only listened to but understood, and ideally can work toward shared understanding.

Importantly, Helft and colleague state that UBEC facilitators *resist offering answers or solutions* to the moral distress-causing situation, but do solicit ideas for *best practices* from participants. As was made explicit in Chapters Two and Three, a health care organization attempting to "solve" a health care professional's moral distress is an inappropriate hierarchical response that not only marginalizes the *experience* of moral distress in a person, but also marginalizes the morally distressed *person*. Thus, an institution that recognizes its own inability to "fix" a person's moral distress and leaves the resolution of moral distress with the individual and other health care professionals is providing a more ethically appropriate response to moral distress than the hierarchically

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[25] Helft et al., "Facilitated Ethics Conversations," 30.

structured organizational responses examined in Chapter Two. Yet at the same time,

the facilitators "intentionally invite discussion of strategies for handling of difficult

situations."[26] They do so in order to provide the participant health care professionals a

space to offer advice and learn from each other, thus creating proactive solutions that

come out of this equality-based inclusive discussion rather than institutional hierarchy.

And given that health care professionals are sharing their clinical expertise in accord with

their shared professional obligations to the goals and values of professional health care,

the best practices that they arrive at are "consistent with ethical principles and with core

nursing values."[27] Here, the health care organization realized that it cannot adjudicate a

moral distress situation, but *can* offer the forum and the facilitators to provide a safe

space for health care professionals to come together with each other in order to think of

ways to resolve moral distress, and best practices to lessen or eliminate future causes of

moral distress. Importantly, these solutions are owned by the health care professionals

precisely because they were developed in a non-hierarchical manner, even though the

organization was present and involved.

Though the UBECs Helft and colleagues describe mostly attracted nurses, they

were open to all health care professionals, and the authors note "discussion is enriched

through participation of others who collaborate with the nurses in patient care."[28] While

this bolsters the hypothesis explored in Chapter Three that health care professionals from

different professions can come together and interact within the content-thin common

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[26] Helft et al., "Facilitated Ethics Conversations," 30.

[27] Helft et al., "Facilitated Ethics Conversations," 30.

[28] Helft et al., "Facilitated Ethics Conversations," 32.

moral framework, Helft and colleagues did notice that the presences of physicians as

participants sometimes challenged the inclusivity of the dialogue.

> The conversations seem more guarded when physicians are present, and deference to physicians' opinions or personalities can interfere with more open airing of views and opinions. Occasionally, physicians have monopolized discussion, making it more difficult for nurses and others to present their own views. We have observed that nurses in particular seem to be more reluctant to speak openly when the physicians the work with are present.[29]

In response to this concern, it is worth recalling Hamric and colleagues' proposal above

regarding the creation of a positive moral organizational culture. If health care

organizations are able to create a moral culture as discussed in this chapter, as a part of

this moral culture the organization could instill a more inclusive environment of respect

among its health care professionals that may alleviate some of the tensions associated

with physicians in attendance at UBECs. While a possibly fruitful avenue to pursue, as

stated above, determining what would characterize an organization with an appropriate

moral culture is beyond the scope of this dissertation.

Additional Questions

In addition to the concern just mentioned, there are a number of further questions

that are raised by this dissertation but that are beyond its scope to address. One is the

empirical question about what exactly is included in the content-thin common moral

framework argued for in this dissertation, and if and how it is actually used. Though

Chapter Three provided some examples of the content of this framework, answering

these questions fully and carefully would require some additional philosophical work to

achieve enough conceptual clarity about the contents of the framework that a meaningful

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[29] Helft et al., "Facilitated Ethics Conversations," 32.

empirical instrument could be designed to test the claim made here that it is "common" to health care professions in our (and similar) society. But actually supporting this claim with empirical evidence would require the skills of social psychology. It is also possible that the preliminary philosophical work might prove to be a much larger project than this dissertation has suggested.

Another set of questions that this dissertation has not attempted to answer derives from the fact that contemporary health care teams include, in addition to health care professionals, many non-professional employees of the health care organization. It is reasonable to assume that these non-professional health care workers also experience moral distress. But can the non-professional health care workers (such as patient care technicians, support personnel in other departments of the organization, home health workers, nursing home employees, etc.) who assist in the direct care of patients be correctly said to share in the same content-thin common moral framework as the health care professionals, or only to some extent and, if so, to what extent? And if not, how can their moral distress be resolved?

One place to look for an answer to these questions is the moral framework potentially formed through an institution's own distinctive moral culture and mission and values ("potentially" because a particular organization's culture, mission and values may not have enough cohesion or breadth of application to constitute even a thin moral framework). If a health care organization is able to clearly define and create a moral culture around its mission statement and institutional values, it is possible that each staff member, regardless of professional status, would be able to have moral distress discussions (employing discourse ethics as has been argued) with other employees on the

basis of the moral content of the organization's vision or understanding of its mission

and values, especially if the organization's culture strongly supported moral discussion

throughout the organization. It needs to be said, however, that most organizations,

including many health care organizations, view their non-professional employees

primarily in terms of their contractual relationship to the organization rather than in terms

of a shared moral framework, and so this possibility is likely more aspirational than

feasible. In any case, since health care organizations often vary greatly in other respects,

it is a complex empirical question (that will depend on preliminary philosophical work, as

was noted above) whether their respective moral frameworks are sufficiently developed

so that more can be said about such organizations' obligations to address non-

professional employees' moral distress. But if the answer to this question were to be in

the affirmative, the practical suggestions offered earlier in this chapter would seem to be

equally relevant to these organizations acting appropriately.

Another important question still unresolved is whether a discourse ethics

approach only reaches a satisfactory resolution if patients and families are also satisfied.

As was shown in Chapter One, acting on the wishes of patients and families for

interventions (or stopping or not starting an intervention) that a health care professional

sees as harmful to the patient can often be a catalyst for moral distress. But patients and

families have been excluded from discussion in this dissertation (necessarily so) because

the proposed resolution process depends on the content-thin common moral framework

and there is no reason to assume that patients or families share the framework of health

care professionals in our (and similar) societies. However, Habermas is explicit that *all*

affected should be invited to participate—or at least should be taken into account. In

discourse ethics, as Ingram notes, when validating a social norm the participants must pay attention to consequences of adhering to the norm, and "not only as these affect the interests of those directly involved, but of other persons as well."[30] Does this mean that a resolution that addresses a health care professional's moral distress, restores team cohesion, and allows all team members space to hear and be heard, is still ethically insufficient if the patient and/or family is unsatisfied? Or can the case be made that, since patients and families don't adhere to the same content-thin common moral framework, they are not "affected" in the same way as health care professionals? Here again an adequate answer to these questions would require addressing a number of complex philosophical and empirical issues. But given the central role of patients and, especially for patients incapable of participating in decision-making, of family members in making health care decisions for hospital patients, this seems like a topic well worth careful examination.

Conclusion

It may be very useful to investigate these questions, among others. However, because of the prevalence of moral distress in health care professionals and its negative effects on patient care, which is a matter of the highest moral priority for a health care organization, this dissertation focused its attention on these themes and argued that health care organizations have obligations to address this moral distress. In order to demonstrate this, a definition of moral distress was offered, as well as descriptions of its causes and effects. It was shown that these effects have a significant negative impact on a health care organization's ability to provide quality care for its patients and to respect the expertise of

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[30] Ingram, *Habermas*, 126.

its health care professionals. In order to make claims about organizational obligations, and an organization's ability to fulfill or fail those obligations, the concept of group agency was explained, and widely supported arguments for this position were summarized. Since health care organizations typically have a decision structure closely similar to the Corporate Internal Decision Structure that these arguments refer to, it was found reasonable to conclude that health care organizations can be morally evaluated and correctly charged with an ethical failing if they do not respond to moral distress in an appropriate way.

In light of this, examples of insufficient organizational responses to moral distress situations were examined, and it was shown that these responses were insufficient because they relied on the hierarchical structure of health care organizations. Hierarchical responses to moral distress risk excluding both the morally distressed individual(s) and the other health care professionals involved in the moral distress situation. It was then shown that the argument for including all the health care professionals involved in the moral distress situation in a discussion of the situation rests in part on the existence of, and health care professionals sharing, a content-thin common moral framework, which is turn is based on a common professional morality and the shared goals and values of professional health care.

Following this, a philosophical understanding of the relationship of those involved in the process of moral distress resolution was found in the argument that health care professionals interact with each other as Wildesian moral acquaintances and thus can use the shared concepts and commitments of their content-thin common moral framework as a starting point for discussing moral distress situations. In order to provide

a philosophical grounding and a practical procedure for these discussions, Habermas'

theories of communicative action and discourse ethics were appealed to in order to

describe how health care professionals can interact with each other, both in "everyday"

circumstances (communicative action) and in situations of moral distress (discourse

ethics). The rules of discourse ethics, it was shown, can be used to structure health care

professionals' discussions about moral distress situations in order to resolve moral

distress.

The line of argument developed in this dissertation provides both a theoretical

basis and practical procedural rules for discussions aimed at resolving situations of moral

distress in health care professionals. Combined with the practical suggestions offered in

this chapter or embodied in other practical mechanisms that institutions might design, the

inclusive, non-hierarchical, equality-based discussions proposed here offer a way to

properly address moral distress that could be adopted by health care organizations

immediately, and there is a clear ethical obligation for them to do so.

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