THE NATURE AND VALUE OF MORAL DISTRESS IN MEDICAL PRACTICE

AN ABSTRACT

SUBMITTED ON THE EIGHTH DAY OF MAY 2018

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This dissertation analyzes the difficult moral decisions encountered predominantly in medical contexts. In particular, the notion of *moral distress* among nurses and physicians has received a great deal of attention in recent literature, and understandably so. Moral distress has been identified as a leading cause of practitioner burnout and staffing shortages, which, in turn, negatively impact patients. Yet, the precise nature and the potentially positive value of moral distress remain relatively unexplored. By incorporating contemporary research on the moral emotions and their significance for moral responsibility, the following work provides a robust account of moral distress, one that challenges the common assessments of its problematic nature.

The project begins by making clear exactly what an account of moral distress should be able to explain and how the most widely cited notions in the existing literature leave significant explanatory gaps. I then propose a comprehensive, analytically robust account that is equipped to explain a wide range of plausible cases. On the view I develop, moral distress is best understood as a tension between agents' negative emotions and their judgments that they are either not morally responsible for any potential wrongdoing or cannot do anything to improve the circumstances. With this account in mind, I argue for the positive value of moral distress. Although the phenomenon may be associated with undesirable effects, the experience itself appears to be partly constitutive of an honorable character and can reveal and affirm some of our most important concerns as moral agents. Additionally, moral distress bears potentially positive value for others. It provides an appropriate response by which practitioners can take the blame for medical error and thereby help patients and families to move forward. Finally, I examine moral distress and its relationship to compassion fatigue, a commonly associated yet importantly distinct

phenomenon. I show that while morally distressed agents are often excused from responsibility, compassion fatigue constitutes a sort of marginal agency. Accordingly, compassion fatigue should be far more alarming and demands policies addressing the condition itself, while the problem of moral distress lies primarily in the circumstances and need not be alleviated directly.

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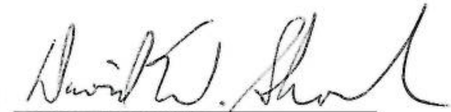
APPROVED: 

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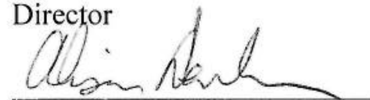

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Chapter 1

The Problem and Explanatory Demands of Moral Distress

Maryann is a registered nurse (RN) working in the intensive care department of a major public university hospital.[1] On a regular basis, Maryann and her team of physicians and fellow nurses treat patients with acute care conditions ranging from birthing complications to cardiac arrest. A recently admitted patient with a history of substance abuse—call him "Patient S" —is said to be experiencing severe opioid withdrawals. As such, Patient S is in a great deal of pain and is being continuously monitored in eight-hour shifts by three different RNs, one of which is Maryann. During her recent shift, Maryann observed Patient S experiencing what appeared to be a particularly extreme episode of pain. In agony, he pleaded with Maryann for help. In fact, she and the other RNs assigned to the patient had been authorized to administer several different treatments, from common nonsteroidal anti-inflammatory drugs to methadone, a stronger but riskier option, for the purposes of patient pain-relief and eventual detoxification. Maryann noticed that since the time of his admittance Patient S had not been treated with any of the available pain-relievers. The other RNs had noted that the patient is "just wanting to get high again," and that he had "not been responsive to directions" for routine procedures and so did not deserve any unnecessary comforts. Still, it appeared to Maryann that Patient S was experiencing

[1] The following scenario is a dramatization of real-life events conveyed to me in conversation at a bioethics conference in 2016. Names have been changed.

excessive pain. Rather than allowing her patient to continue to writhe and beg for relief, she decided to administer a modest dosage of methadone. This treatment was sufficient to subdue the patient for the remainder of Maryann's shift. She returned the next day to learn that he had died, and the causes were said to include the methadone treatment. Although Maryann knew that she was merely part of a team of RNs and physicians responsible for the wellbeing of Patient S, she could not resist blaming herself for the loss. Despite being authorized to administer the dosage, she felt that it was her judgment that led to the patient's death. At the same time, she thought she had done the right thing, for if she had not administered the treatment, as the other RNs had decided, she would have let her patient continue to suffer needlessly. Such troubling situations became unfortunately common for Maryann. Within the first few months of her position, she began to lose sleep. When she did sleep, she would have nightmares, often of her patients in pain and of her being unable to help them. With the hope of finding relief of her own from her feelings of guilt and grief, she sought counseling and was advised to take a leave of absence. Shortly after her return to the hospital, she found herself completely burned-out and she left the nursing profession to pursue a career in non-clinical research.

1. The problem

In recent years, cases much like that of Maryann have elicited throughout the medical and bioethics literature discussions of *moral distress*. Increasing research is being conducted on practitioners' emotional experience and the ethical environment in the workplace, and cases such as this are now seen as far from isolated throughout the medical profession. Indeed, one early study (Corley and Selig 1994) reported that over 80% of surveyed nurses

experience "medium to high levels of moral distress." More recent efforts have expanded the discussion of professionals susceptible to moral distress to encompass not only nurses and physicians, but also pharmacists, psychologists, psychiatrists, physical therapists, social workers, and more.[2]

Moral distress has been identified as a leading cause of professional dissatisfaction, burnout, high turnover rates, and shortages in medical staff.[3] These factors, as we might imagine, negatively impact patients, for example, by contributing to longer hospital stays, increased pain, and a greater likelihood of receiving inadequate attention.[4] For these reasons, moral distress is typically understood as being a purely negative phenomenon. It has been said to involve some sort of 'psychological disequilibrium' or loss of personal integrity.[5] Given the natural desire to avoid shortages in medical staff and inadequate patient care, it seems to most authors that systematic efforts should be made to drastically reduce moral distress, if not altogether eliminate it from the lives of vulnerable practitioners. Such efforts, however, may be problematic, as moral distress is not adequately understood, nor is there agreement among the leading accounts regarding how

[2] See Kälvemark et al. (2004 and 2006), Austin et al. (2005 and 2008), Hamric and Blackhall (2007), Chen (2009), Epstein and Delgado (2010), and Cantu (2018).

[3] For some examples of studies drawing these allegedly strong correlations, see Wilkinson (1987/88), Redman and Hill (1997), Aiken et al. (2001), and Whitehead et al. (2015).

[4] See, for example, Baggs et al. (1999), Raines (2000), and Rubin (2009). Also, Corley (2002) provides a summary of the research on the impact upon patients as a result of practitioners' moral distress.

[5] Wilkinson (1987/88) appears to be the first to describe moral distress as 'psychological disequilibrium.' Corley (2002) accepts this description and the idea that moral distress can result from nurses' effort to preserve moral integrity. Integrity in nursing is also seen in de Raeve (1998), Kelly (1998), Walsh (2010), and Cribb (2011).

to conceptualize the peculiar phenomenon.[6] Moreover, it appears that moral distress is much more than a purely negative experience. As I aim to demonstrate with this project, moral distress can reveal and affirm some of our most important concerns as moral agents. The experience of it is in part constitutive of an honorable character and can allow for crucial moral maturation. Indeed, practitioners experiencing moral distress may often be in the best position to help patients and families, for example, in cases of medical errors. Before advancing these grander claims in later chapters, I must first make clear exactly what a robust account of moral distress should be able to explain and how the most common notions in the existing literature leave significant explanatory gaps. These are the goals of the present chapter. I will then, in Chapter 2, propose an account that can capture a wide range of cases of interest.

2. A few desiderata for an account of moral distress

As seen in the case presented above—call it *Maryann's decision*—nurses are presented with extremely difficult circumstances in which a decision must be made. Often, the situations encountered will involve a patient experiencing pain and suffering, and naturally, nurses are in the business of helping those needing relief from pain and suffering. Fortunately, in *Maryann's decision*, the nurse was in a position to do something about it. Maryann decided to administer the stronger and riskier form of treatment, and although it was this treatment that led to the patient's death, Maryann had been authorized to make such a decision. It was her call, as it were. Making similarly difficult decisions is, of course,

[6] McCarthy and Deady (2008) and Musto and Rodney (2016) help to make clear the disparate conceptions of moral distress in the existing literature. See also Tigard (Forthcoming-a), which is based largely upon this chapter.

commonplace in a number of professions dealing with diverse and sensitive interests. Along with healthcare practitioners, professionals in law, business, and politics are frequently entrusted to carefully consider various courses of action bearing some degree of moral significance. In some cases, one cannot act in the manner deemed to be morally right. In others, it may be that one must act in a way that is seen as wrong.[7] While the deliberative processes and decisions themselves are, naturally, ripe for rich philosophical explorations, my primary concern throughout this project will be with the character of those responsible for making such decisions. To paraphrase Bernard Williams (1978), it matters to us what these people are like, what dispositions they have.[8]

Consider a second case: *Unnecessary blood testing*. A hospital requires a blood test for every incoming patient, despite such a requirement being medically unnecessary for many patients, and likely posing undue risks.[9] A nurse who sees this practice as morally wrong may have no choice but to abide by it, due to his lack of immediate authority and due to the overall power structures that impede his ability to change the existing policy. Reluctantly, the nurse fulfills the hospital's gratuitous requirement and administers a blood test to all incoming patients. Given his view that this practice is wrong, the nurse feels that he too is responsible for the wrongdoing by carrying out his employer's demands. Although

[7] Here I have in mind the problem of 'dirty hands' made famous by Walzer (1973). In Tigard (2016), I argue that moral agents with professional duties—particularly political actors—often experience this phenomenon when their official decisions set back others' interests or even their own. More recently, I have discussed moral distress as a "symptom" of dirty hands (Tigard Forthcoming-b).

[8] In "Politics and Moral Character," Williams explicitly assumes that "it makes some difference what politicians are like, what dispositions they have" (Williams 1978, 54). To a considerable extent, my discussions here will assume the same of medical professionals, and I will occasionally draw upon this analogy.

[9] This scenario is an adaptation of a case presented by Andrew Jameton (1984, 6). I will address some virtues of Jameton's account below and make clear how my account will be set apart from his and others.

he once found fulfillment in a line of work where he could help others in need and could directly see a positive impact, he comes to dread what he must do to his patients.

Andrew Jameton (1984), in his formative work on nursing ethics, highlights cases such as this in order to show that moral distress can be the result of facing institutional obstacles, those that have been systematically imposed by an established collection of individuals. What we also see in *unnecessary blood testing* is what we can think of as an external barrier, given that the obstacle to the perceived right action is beyond the morally distressed subject. Where administering a blood test is medically unnecessary, the nurse would prefer to admit patients without such testing. However, this action is disallowed by the hospital's requirements and not by any feature of the nurse. In this particular case, the institutional obstacle is such that it cannot be overcome without bringing about undesirable consequences. As we can imagine, the nurse's refusal to abide by the hospital's policy may well result in the termination of his employment and the hospital's requirement would remain in effect. This, again, would prevent the nurse from pursuing the perceived right action: admitting some patients without an unnecessary blood test.

In *unnecessary blood testing* we see that an obstacle arises from a source beyond the subject who faces it and that it simply cannot be overcome (at least, it is not within the power of the subject alone to overcome it). Along with such external obstacles, moral distress may well result from facing non-institutional or internal obstacles. Consider a third case: *No-kill care*. Dr. Hobart is a palliative care physician who cannot bring herself to administer a lethal dosage, even when competently requested by her terminally ill patients. She knows the procedure has been legalized in her state, but she is nonetheless unable to overcome a personal moral conviction that she must not directly kill a patient for any

reason. That is, until one day she encounters a patient and family that convince her to go ahead with the assisted death. Dr. Hobart's patient—call her "Patient C" —had been diagnosed with a metastatic stage of pancreatic cancer. It was estimated that she would live only three more months, and likely be in substantial pain throughout that duration. After several consultations with the patient and her family, Dr. Hobart realized that she must put aside her personal conviction in order to help them avoid the months of pain ahead. Still, she maintained that by assisting in the patient's death she was doing something morally wrong, albeit for the purpose of bringing about good outcomes, namely, the cessation of Patient C's pain and suffering and the fulfillment of her request and the family's wishes. Like in the cases of *Maryann's decision* and *unnecessary blood testing*, the action taken by Dr. Hobart brings about a troubling psychological state that we can think of as moral distress.

Given that moral distress may be caused by both internal and external sources, this factor should be taken into account in explaining the presence of moral distress. Additionally, we have seen that obstacles may be overcome (as in *no-kill care*), that they may be immobilizing (as in *unnecessary blood testing*), or that there may be no obstacles presented (as in *Maryann's decision*). An explanatorily satisfying account must, then, include these plausible variations as well. Together these demands can be referred to as

> The *Causal Circumstances desideratum*: a robust account of moral distress must be able to accommodate a variety of causal circumstances that typically bring about moral distress.

In *no-kill care* we see a non-institutional obstacle, a barrier that arises from within the subject, obstructing some morally relevant action. Notice, in this case, the obstacle itself is

what the subject takes to be the most morally appropriate action; that is, the physician's personal conviction motivates her to *not* administer the lethal dosage. By administering the dosage, and thereby overcoming the obstacle, then, the subject acts against what she sees as the most morally appropriate action. By contrast, in *unnecessary blood testing* the subject is presented with an obstacle – in this case, one that is institutionally imposed – where the obstacle blocks what the subject takes to be the most morally appropriate action, that is, admitting patients without unnecessary blood tests. Here, it is by acting within the confines of the obstacle that the subject acts against what he sees as the most morally appropriate action. Given that both cases present plausible instances of moral distress, explanations of the psychologically troubling experience should allow not only for a variety of obstacles and for overcoming or remaining confined by them, but also the possibility that an obstacle may be in accord with or in stark contrast to what the subject perceives as the most morally appropriate action.

Attempts to explain the causes and the presence of moral distress are often aimed at an understanding of how to more effectively reduce or eliminate the experience. For example, nursing professor and former clinical practitioner Ann Hamric (2000, 201) refers to moral distress as "a powerful impediment to ethical practice" and even as a "devastating phenomenon."[10] Mary Corley et al. (2001, 256), in concluding their development of the moral distress scale, claim that "Given the role that moral distress may play in nurse resignations and the importance of ethical practice, reducing moral distress is an important

[10] Hamric adopts the "devastating phenomenon" description from pediatrician William Bartholome. In Bartholome's words, "One mark of moral progress in a community or society might well be the extent to which measures are taken to reduce the incidence of moral distress" (Hamric 2000, 201). Following this line of thought, it would appear that the most morally advanced society is one in which we have altogether eliminated moral distress. However, on the view I will develop herein, the elimination of such an edifying experience would be far more devastating than the experience itself.

priority." Shortly thereafter, Corley called for "*preventive* solutions" (2002, 648, emphasis added). Others have followed suit, similarly demanding "Strategies to mitigate moral distress" (Elpern et al. 2005). These developments are defended as the means by which we might decrease practitioner burnout and staffing shortages, and thereby improve the overall quality of patient care. While these downstream objectives are, no doubt, worthy of pursuing, doing so by means of reducing or eliminating moral distress is often suggested by those who have yet to settle upon an adequate understanding of the condition. Indeed, many authors recommend efforts to reduce or eliminate moral distress without making clear exactly what it is that should be reduced or eliminated, other than the negative effects. The causal circumstances, some of which I have surveyed here, and the generally negative effects are commonly taken to be of primary importance, to the extent that the causes (and even the effects) appear to be confused with the nature of the condition itself.[11]

In *Maryann's decision* we see that moral distress – whatever it actually is – has been caused by facing difficult decisions, and sometimes troubling results, concerning patient care and pain management. Although in treating Patient S Maryann was not hindered by any identifiable obstacle, being in a position to make a decision that turns out to have tragic consequences is enough to bring about an uncomfortable state that causes her to lose sleep. Similarly, in *unnecessary blood testing* and in *no-kill care*, the subjects experiencing moral distress have been faced with difficult situations, those that would likely have most of us stopping to ask ourselves: "What should I do? What is the morally best action to take?" But along with the descriptions of the circumstances that tend to elicit

[11] Carina Fourie (2015, 93) aptly applies this line of criticism to Jameton 1984 and 1993. See, also, Musto and Rodney (2016, 80-81) for an articulation of the fallacy in "conflating the measures of moral distress with what moral distress actually is."

moral distress – the specifications of what the subject was experiencing *prior* to being in distress – we want to know what the precise nature of her condition is at the time that she is experiencing it. In the following chapter I will offer an account of the nature of moral distress. At present, the demand being made here can be established as

> The *Paradigmatic Nature desideratum*: a robust account of moral distress must provide a detailed description of paradigmatic features of the morally distressed subject's state.

Here I have referred to the demand for the nature of moral distress as *paradigmatic* due to the recognition that there are plausible instances of moral distress that do not fit neatly together with some of the more typical cases. While my later efforts will be aimed at identifying features of the psychological state that appear to be extremely common to moral distress, admittedly it will be difficult to definitively pin down any conditions that can be held as necessary or sufficient.[12] Given the great diversity to be found in the human psychological condition, exceptions to commonalities must be allowed. For these reasons, it appears that a fruitful advancement of the topic can be made by developing a paradigmatic profile of moral distress and, with it, being able to better understand the representative cases as well as a host of plausible yet non-paradigmatic cases.

An explanatorily satisfying account will be one which accommodates various causal circumstances and describes in detail the key features of the subject's present state. From these considerations, it is reasonable to expect that an account of moral distress that is able to explain what happens before and what happens during the experience will also be equipped to explain how the peculiar phenomenon develops over time. What can we

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[12] This difficulty points to some limitations in the notion of moral distress advanced by Morley et al. (Forthcoming). Here it is suggested that experiencing a moral event, along with psychological distress, and a direct causal relationship between these experiences are necessary and sufficient conditions. I critique this view in detail in Chapter 3.

expect – again, at least paradigmatically – for the future of the morally distressed subject? Here I am less concerned with the supposed effects (job dissatisfaction, burnout, and so on) and more with the evolving nature of moral distress. On the one hand, in some cases, it likely subsides and perhaps altogether ceases to be maintained by the subject in question. In such cases, the paradigmatic features, as will be seen, can simply no longer be attributed to the subject's psychological state. An example of a common, distinctive emotional state will help to illustrate the point to be made here. Consider fear. When one is in a state of fear, say, of snakes—as opposed to being generally afraid of snakes—he will likely experience some characteristic fearful-response.[13] It may be, for example, that Jones feels a certain uneasiness when in the presence of snakes. Perhaps this feeling is accompanied or even manifested by distinct bodily sensations, say, an increased heart rate or becoming *pale with fear*.[14] Upon fleeing the scene or setting the snake-infested cave ablaze (and so on), Jones's immediate feeling of fear may well subside and perhaps entirely dissipate, even if it is generally true of him that he is afraid of snakes.

On the other hand, some instances of an emotion can be said to persist. While they may subside marginally or considerably from the time of initial onset, some emotional states continue to affect the subject. Consider grief. Unlike distinct episodes of fear, the experience of grief is an enduring condition. It is often aptly referred to as a process. For some theorists, the process of grieving shows us that some emotions are neither occurrent

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[13] I do not mean to dismiss the possibility of fear being a long-term, or dispositional, emotion. Surely, some fears are, in a sense, lifelong states. Here I am interested in the distinct episodes, what are often called *occurrent* emotional states.

[14] Readers might notice here that I am loosely describing what is sometimes referred to as an affective theory of emotions, in both its purely psychic and its bodily versions. In Chapter 2, I will briefly expound upon this and other prominent theories of emotion in order to explain some distinguishing features of moral distress.

(that is, episodic) nor dispositional, in the sense of being maintained long-term and manifested when somehow triggered (cf. Oakley 1992). Grief and other long-term emotional states persist as enduring psychological experiences. They are *with us*, often for an extended period of time, and appropriately so in the case of grieving, given that our experience of grief is a response to the phenomenon of loss.[15] For the time in which we experience some persisting emotional state, it continues to play a role (often unconsciously) in shaping our feelings, perceptions, and motivations.[16]

It may be that some instances of moral distress are experienced rather briefly, and partially subside or entirely dissipate thereafter. Imagine the physician in *no-kill care* coming to convince herself that assisting in her patient's death is the morally appropriate action after all. This process can be seen as a reason for the change in one's distressful state. However, in other cases, moral distress will persist. It will linger perhaps for a substantial span of time after one has faced some obstacle, remained confined by a difficult decision, and so on. As seen in the case of *Maryann's decision*, the nurse's persisting feelings of guilt and grief kept her awake at night. She was continuously *bogged down*, as it were, until she became forced to remove herself from the circumstances. Again, we see distinct reasons for any change in one's distress.[17] Given that our emotional states are

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[15] Unlike fear, where the removal of the fearsome object would allow one's fear to subside, grief may well subside only with the passage of time considering that the object of one's grief (a significant loss, say) is not so easily removed. My thanks to David Shoemaker for discussion on this point.

[16] Justin Oakley utilizes this description of emotional affectivity to show that some non-occurrent emotions are not accurately characterized as dispositions. In Oakley's words, an emotion like grief is a mental *tone* that "permeates our perceptions, desires, and actions in ways which we are not always aware of" (Oakley 1992, 11).

[17] Granted, like in the case of *no-kill care*, Maryann's moral view might change and, thereby, ease her experience of moral distress. The point to be emphasized here is that supposing her moral distress persists, a full account should be equipped to explain what it would mean for one's experience to dissipate, to persist, and so on.

capable of subsiding, dissipating altogether, and of enduring for longer periods, these variations must have their place within a full account of moral distress.[18] With the various ways in which an emotional experience might develop over time, we should expect an explanatory account of the prior circumstances and present state of moral distress to likewise be able to explain its evolving nature. This demand can be stated as

> The *Temporal Development desideratum*: a robust account of moral distress must be able to explain a subject's experience of moral distress as it develops over time, namely, by providing reasons for the condition's subsidence, dissipation, or persistence.

As I supposed concerning the case of *no-kill care*, a subject's moral distress might at least subside as a result of becoming convinced that one's action—or, generally, what has happened—is in alignment with what one sees as morally appropriate. This process may well allow a subject's moral distress to dissipate entirely. In contrast, recall *unnecessary blood testing*. Here the nurse continues to maintain that the hospital's policy is wrong, and that he too is doing something wrong, however reluctantly, in abiding by the gratuitous policy. For the time in which he continues to be restrained by an obstacle enforcing what he perceives as a morally wrong course of action, and thereby dreads his own treatment of his patients, it is reasonable to suppose that his experience of moral distress will persist.

An important contrast between the case of *unnecessary blood testing* and the case of *no-kill care* is that in the former the subject is convinced—say, beyond doubt—of what is morally right. In the latter, however, the subject is not as *set* in her beliefs about the morally right course of action. She has an initial moral conviction (to not kill), which, upon

[18] Jameton (1993) helps to clarify the future state of the morally distressed subject by introducing "initial" and "reactive" distress. However, as I will make clear below, other explanatory demands are left unfulfilled on Jameton's account.

acting against, causes her to experience moral distress. Nonetheless, she appears to be somewhat flexible in this conviction. She may come to see things differently, say, by recognizing that by assisting in her patient's death she is in fact fulfilling the patient's wishes, sparing her of months of pain, and allowing the family to put their loved one to rest rather than watch her suffer needlessly. What initially seemed morally wrong, from the physician's perspective, has come to be seen by her as the appropriate course of action. Still, often it may be that the right action is far from clear.

Consider a fourth and final case: *Maryann's indecision*. Like in *Maryann's decision*, a team of physicians and RNs, one of which is Maryann, is responsible for Patient S, a recently admitted patient in great pain from severe opioid withdrawals. Also similar to the previous case, here too Maryann has been authorized to administer various pain-relievers. However, in the present case, suppose she and the other RNs have been warned that Patient S might have an adverse reaction to any pain-reliever administered. They are not sure of exactly what would happen, given the patient's history and current condition. The possible reactions to any pain-killer could range considerably, say, from relieving his pain and making steps toward detoxification, to inducing a comatose state or even death. Just as we saw in *Maryann's decision*, again, during a recent shift, Maryann observes Patient S in a particularly great deal of pain. He begs for relief and, again, she notices that the other RNs have not administered any of the available treatments. Unlike in *Maryann's decision*, here Maryann does not have a strong sense of the best course of action to take. She is, we can imagine, utterly lost as to what she should do. She could administer a pain-reliever, but thereby risk causing additional harm or death. Alternatively, she could refrain from administering any treatment but thereby allow the patient to continue suffering

needlessly. Such troubling situations, just like those in which Maryann has a clear sense of the right thing to do, nevertheless cause her to lose sleep, to have nightmares, and so on.

What *Maryann's decision* and *Maryann's indecision* help us to see is the fact that moral distress may well come about as a result of being convinced of the right course of action as well as being utterly lost as to which action is morally right. Of course, one's convictions concerning what is morally right often lead one to act in a way that supports what one sees as morally right. However, in cases such as *unnecessary blood testing*, having a sense of what is right does not allow one to decide and to act accordingly. Still, other cases, as we saw in *no-kill care*, display the possibility of our moral convictions being flexible enough to allow for action in accord with what is seen as morally wrong (or right) but later realizing that such actions were somehow right (or wrong). In all cases surveyed here, we see plausible instances of subjects experiencing moral distress. What we need, then, is an account that can capture this variety. Unlike the Causal Circumstances desideratum, where the variety being accommodated is a range of obstacles and the subject either overcoming or remaining constrained, here it appears that an explanation of moral distress should be equipped to account for a range of cases in terms of the subjects' commitment to a moral norm. This demand can be stated as

> The *Moral Commitment desideratum*: a robust account of moral distress must be able to accommodate the varying degrees to which a morally distressed subject is aware of or committed to a moral norm.

In *unnecessary blood testing*, we see that the subject maintains a firm moral conviction, namely that placing patients at an undue risk of harm is wrong. In *Maryann's decision*, the nurse appears to be committed to the relief of patients' pain and suffering, at least where

such relief is available. But in *Maryann's indecision* we see a subject who is either unaware of the moral norm that would be best to act upon, or aware of a moral norm (say, to act with beneficence) but unsure how to employ such guidelines. Indeed, in some cases, it may be that one is presented with several, mutually exclusive courses of action, all of which are morally required.[19]

Given the plausibility and often true-to-life features of the cases surveyed here, the variations presented will be important to take into consideration in explaining the nature and value of moral distress. Thus, for accounts that leave these cases unexplained, we have reason to reject the notion on offer. In the following section, I examine several prominent notions in the existing literature and, with the desiderata established here, I will flag what appear to be some strengths and weaknesses of these accounts.

3. A brief overview of the literature

The concept of moral distress is a relatively young topic of discussion, stretching back just over thirty years. Nearly every article in that timespan, from the more philosophically oriented works in bioethics to the practical writings addressing medical practice, begins with Andrew Jameton's introduction of the term in *Nursing Practice: The Ethical Issues* (1984).[20] Until recently, the definition found here had been received with widespread acceptance. For most authors, it was simply assumed that "*Moral distress* arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984, 6).

[19] Here I have in mind a basic notion of moral dilemmas (cf. Sinnott-Armstrong 1988).

[20] In a recent review of the argument-based nursing ethics literature, McCarthy and Gastmans (2015, 131) found that "like the empirical literature, most authors in this review draw on Jameton's original definition."

Although at first glance Jameton's inaugural definition does not capture the range of cases surveyed above, it can be said that the notion succeeds in fulfilling its established purpose. Jameton explicitly intended to distinguish between various kinds of ethical issues encountered in health care settings. Moral distress, on this account, is distinct from *moral uncertainty*, which "arises when one is unsure what moral principles or values apply," and these notions are both distinct from *moral dilemmas*, described as issues that "arise when two (or more) clear moral principles apply, but they support mutually inconsistent courses of action" (ibid.). Situations wherein the subject experiences moral distress, for Jameton, are such that the nurse is apparently certain about which moral principles or values are at stake. If she was not sure of this, the issue would be one of moral uncertainty. Presumably, then, the knowledge of the moral principles or values in some way allows for the subject to know the right thing to do. Perhaps with her knowledge of the applicable moral principles, the subject finds that she is committed to a particular principle more or less than she is committed to others. However, given the distinction between moral distress and moral dilemmas, a distressed subject knows the right action and the situation is such that there is only one clear moral principle that applies to the case in question. If there were two or more principles, with each of them supporting disparate actions, the issue would be a moral dilemma.

Clearly, Jameton (1984) is interested in drawing attention to a very specific phenomenon, namely, some precise causal situation that brings about a condition specifically in nurses.[21] Given this focus, the inaugural conception partially satisfies the

[21] Jameton later makes clear that he is interested primarily – if not entirely – in the causes of distress, rather than the nature of the condition itself: "Nurses feel guilt and real moral distress *when* they perform procedures that they feel are morally wrong and can find no way to avoid… Incompetent practice and 'medically justified' pain…are common *causes* of nurses' distress" (1984, 283, italics added).

Causal Circumstances desideratum by detailing at least one set of causes. Yet, Jameton appeared to be less interested in a *variety* of possible causes: institutional *or non-institutional* obstacles, taking action or remaining confined, or the subject's distress resulting from something other than the disagreement between her moral convictions and the barrier in place. As we saw in *no-kill care*, the obstacle being faced can arise from within the subject and, as such, she can agree that it would be best not to act in a way that overcomes that barrier. Still, overcoming obstacles, as the physician in *no-kill care* managed to do, may well be a cause of moral distress just as plausibly as being constrained by an institutional obstacle with which the subject disagrees.

While Jameton and others who drew from his account identify moral distress in terms of a single, distinct set of causes, it seems that the development of this important discussion can begin by broadening the scope of potential obstacles contributing to moral distress.[22] In fact, as we saw in *Maryann's decision* and in *Maryann's indecision*, it may be that there is no identifiable obstacle at work. If these scenarios and others like them are plausible cases of moral distress, which they appear to be, we must consider moral distress to be a much wider phenomenon, one that results from a variety of obstacles and, generally, from various causal circumstances which may or may not include the presence of an obstacle. Similarly, although Jameton's (1984) account focuses narrowly on scenarios in which one appears to have a moral commitment, as I have suggested, this explanatory feature is also one that can be expanded in order to accommodate a wider range of plausible cases. *Maryann's indecision* shows us that one can be morally distressed by facing

[22] To reiterate, numerous authors—and institutions, such as the North American Nursing Diagnosis Association (NANDA 2014) and the American Nurses Association (2015)—simply accept Jameton's notion before proceeding to offer suggestions for dealing with moral distress. By showing the narrow focus of Jameton, I mean to likewise call into question those who rely on his account.

situations where one is either unaware of some moral norm, or aware but unsure exactly how to act upon it. From cases like *no-kill care*, we see that one might be aware of and committed to some moral norm, and thereby initially distressed upon violating it, but that our commitments are susceptible to change as we learn more about and contemplate the intricate situations we face. The evolving, variable nature of our concerns and commitments will help to explain moral distress as a dynamic and changeable experience, not one that results only from a single, limited set of circumstances which needlessly exclude cases of moral uncertainty, moral dilemmas, and perhaps even bad moral luck.[23]

Aside from explaining the variety of causal circumstances and moral commitments involved in one's experience of moral distress, providing an account of the paradigmatic nature and its temporal development, I claimed, must also be among our foremost pursuits. In a follow-up to his initial account, Jameton (1993) made efforts to clarify ambiguities arising from his inaugural definition. In doing so, he provided notable insights into the nature of moral distress and suggested at least one way in which it might develop over time. Among the potential ambiguities addressed is whether or not the subject had acted in the face of the institutional obstacle in place. Recall, moral distress was initially seen as arising from cases where it is *nearly* impossible for the subject to pursue the action she considers to be morally right. Expanding upon this notion, Jameton introduced the distinction between *initial* and *reactive* distress. Initial distress, he claimed, "involves feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflicts with others about values" (Jameton 1993, 544). Here I will assume

[23] Fourie (2015) and Campbell, Ulrich, and Grady (2016) similarly argue for expanded definitions of moral distress, in order to accommodate cases of moral conflict, moral dilemmas, moral luck, uncertainty, and more.

that Jameton was describing distress as resulting from institutional obstacles *or* conflicts with others, given that the conjunction of these features would be far too limiting to explain even the most basic sorts of cases of moral distress. With this, it seems that the notion of initial distress improves upon the inaugural definition by considering various potential causes. Another virtue of his follow-up account seen here is the presentation of some possible qualities of the nature of moral distress. We learn at least that it *involves* feelings of frustration, anger, or anxiety (again I am assuming that a disjunction comes closer to capturing the range of plausible experiences). Still, it is not entirely clear what moral distress is. What *else* is involved? How, if at all, we might wonder, does moral distress differ from these other emotional states? Just as the Causal Circumstances and Moral Commitment desiderata appeared to be partially fulfilled in light of Jameton's initial account, we are left here with a useful but incomplete picture of the paradigmatic nature of moral distress.

In terms of temporal development, Jameton's follow-up gives us a sense of one way that moral distress could plausibly be experienced over time within a subject. In contrast to a subject's initial experience, *reactive* distress is thought of as "the distress that people feel when they do not act upon their initial distress" (ibid.). Again, we see an improvement upon the original notion, namely, by acquiring an idea of how moral distress might be experienced in the future. Not acting upon one's initial distress allegedly causes it to be somehow compounded. That is, inaction is at least one explanation of the persistence of moral distress. However, once again, we are left with unanswered questions. As the Temporal Development desideratum demands, we want to know why the condition might persist, as well as what might cause it to subside or perhaps dissipate entirely. Should we

infer from Jameton's follow-up distinction that because reactive distress—that is, the persistence—is explained by *inaction*, the subsidence or dissipation of distress results from *acting* upon one's initial distress? Although this may be what Jameton had in mind, many cases of interest are left unexplained by this inference. What are we to make of cases like *Maryann's decision*, where one takes action but is nonetheless morally distressed? How should we account for cases where moral distress subsides or dissipates but as a result of not taking action upon one's initial distress? Imagine that the nurse in *unnecessary blood testing* continues to abide by the hospital's policy, and eventually comes to accept it, despite the fact that it once brought about distress. Thus, along with the other three desiderata for a robust account, the temporal development of moral distress can be adequately explained by Jameton only on a subset of plausible cases.

Between Jameton's initial and follow-up accounts, Judith Wilkinson (1987/88) provided the first empirical research on moral distress. Importantly for conceptual purposes, her definition shows significant explanatory advantages over Jameton (1984), namely by allowing for a broader set of barriers than those imposed by institutions, and over Jameton's (1993) follow-up, by giving greater insight into the nature of the condition. Wilkinson describes moral distress as "the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision" (1987/88, 16). Here we see that the causes are, perhaps typically, facing some challenging situation and not taking action. Wilkinson aptly considers the possibility of being distressed by non-institutional or internal constraints. It may be that the subject makes a deliberate decision not to act, or that she cannot bring herself to follow through with some decision, as the case

of *no-kill care* might have turned out. Notably, among Wilkinson's findings, nurses were said to suffer moral distress because of what they fail to do, as well as what they do, namely when their actions appear to be morally wrong (ibid. 20). The paradigmatic nature of the condition is clearly a generally negative feeling, which many might accept before demanding additional details, particularly concerning the idea of psychological disequilibrium. And, like Jameton's account, Wilkinson's notion makes clear that the morally distressed subject has some sort of moral commitment.

While three of the four desiderata may appear to be satisfied on Wilkinson's notion, again we see that even among the three fulfilled demands, the focus remains on a limited set of plausible cases. Wilkinson's definition emphasizes situations in which one does not act, yet she considers the possibility of being distressed as a result of taking action. The subject who is distressed from taking action, for Wilkinson, likely acts in a way she feels is wrong. But there seems to be no reason to rule out the possibility of suffering moral distress in cases where one has in fact acted in ways seen by the subject as morally appropriate. The Causal Circumstances desideratum is, in these ways, only partially satisfied. Regarding the nature of moral distress, as I have indicated, it may be readily agreed upon that it somehow involves a negative feeling. But while 'psychological disequilibrium' is an insightful and colorful description of what moral distress might be, we are nevertheless left to wonder: What exactly does it mean to experience psychological disequilibrium? Consequently, the question of the nature of moral distress is simply pushed back and, given the lack of details provided, the Paradigmatic Nature desideratum remains unfulfilled.

Although Wilkinson's account gives us little guidance as to how we might explain moral distress and its development over time, we can suppose that—whatever it means to be in a state of psychological disequilibrium—the subsidence, dissipation, or persistence of distress would somehow depend upon whether or not (or how much) one is able to remedy this sort of disequilibrium. Finally, just as we saw with Jameton, the Moral Commitment desideratum is satisfied on Wilkinson's account, but only to the extent that the cases in question involve a subject making a moral decision. Presumably, this could indicate that the subject is aware of some moral norm; perhaps she is even committed to it to some degree. However, on the definition Wilkinson offers, we see no room for situations in which a morally distressed subject is committed enough to a moral norm to act in a way that is consistent with the norm and corresponding decision. While, often, a subject will be constrained by various obstacles, it seems there is no reason to rule out cases wherein one has a commitment and is able to take action, yet experiences distress nonetheless. The accounts of both Jameton and Wilkinson, despite the helpful insights they offer, do not adequately accommodate cases where one has acted (namely in ways seen as morally appropriate), where one is uncertain of moral norms at stake, and where one is faced with a multitude of competing norms. Hence, a more robust notion is needed.

Known for her work on developing the first moral distress scale, Mary Corley presents the idea of moral distress being "a consequence of the effort to preserve moral integrity when the persons act against their moral convictions" (Corley 2002, 645).[24] Here

[24] The moral distress scale is found in Corley et al. (2001). The scale consisted of 32 items, each being a situational question or prompt; 214 nurses in U.S. hospitals were surveyed, answering on a 7-point scale. Among the results presented, the item with "the highest mean score (M=5.47) was working where the number of staff is so low that care is inadequate." Notably, fifteen percent of the nurses surveyed had resigned from a position because of moral distress.

it is made explicit that nursing is a moral endeavor, as it includes such goals as providing care and protecting from harm. Thus, when nurses' professional goals are somehow impeded, moral goals are likewise obstructed, and as a result, nurses experience moral distress (ibid. 637). Like Wilkinson, Corley rightly looks beyond obstacles imposed strictly by institutions, which I have suggested will help to accommodate a wider range of cases (such as those resembling *no-kill care*). Corley's account invokes a notion of moral sensitivity to explain apparent connections between a subject's sensitivity, moral competence, and the experience of moral distress.[25] One of the aspects of moral sensitivity, as Corley considers it, is the notion of autonomy. According to Corley, when subjects "have moral sensitivity and commitment, but lack moral courage or moral autonomy, they suffer moral distress" (ibid. 647). This claim suggests at least one strategy for the possible prevention of moral distress, that is, assuring that those who are morally sensitive and committed have moral courage and autonomy. Indeed, as Jameton indicated in his influential (1984) work, nursing is a unique profession in the sense that it was once one of great responsibility and little autonomy; yet, in recent decades we have seen important shifts both toward shared responsibility with physicians and patients and in terms of increasing nurses' autonomy.

Although Corley's work is well-situated to capture a wider range of cases than the accounts of Jameton and Wilkinson, a closer look at her approach in light of the desiderata developed above shows that we can reasonably ask still more of an account of moral distress. First, despite Corley's definition allowing a broader range of obstacles as causal

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[25] Moral sensitivity, as adopted by Corley, is "the ability to recognize a moral conflict, show a contextual and intuitive understanding of the patient's vulnerable situation, and have insight into the ethical consequences of a decision on behalf of the person" (Lützen et al. 2000).

sources of distress, it is not clear that there is room on her account for cases where one has *not* acted in the face of some obstacle. Both Jameton and Wilkinson, as we saw, focus too narrowly on cases where one does not take action. Given that moral distress is plausibly caused by both action and inaction, a robust account must be able to accommodate these situations, along with a variety of possible obstacles facing the subject. These demands, left unfulfilled on Corley's account, were made by the Causal Circumstances desideratum. Second, the notion offered by Corley provides little substance as to the nature of moral distress. At one point she appears to adopt Wilkinson's helpful description (moral distress as psychological disequilibrium). Yet, as I claimed above, even this notion leaves us to wonder what exactly it means to experience moral distress. The Paradigmatic Nature desideratum is, then, similarly unsatisfied.

Just as the accounts of Jameton and Wilkinson did not help us to fully understand the development of moral distress over time, Corley's work leaves the same questions unaddressed. We might infer that if moral distress is a consequence of the presumably *failed* "effort to preserve moral integrity," the persistence of the condition is simply the enduring feeling of one's loss of moral integrity. In this way, the subsidence or complete dissipation of moral distress might be, respectively, the partial or complete retrieval of one's sense of moral integrity. Still, these details are not made clear and, thereby, the Temporal Development desideratum is not fulfilled.[26] Lastly, concerning the subject's moral commitments, on Corley's account we are presented with a case where one clearly

[26] Given that the three prominent accounts surveyed here make little effort to explain moral distress as it develops over time—apart from Jameton's notion of 'reactive' distress—we might wonder whether or not the Temporal Development desideratum is a fair demand. Nevertheless, I take it that a primary point of significance concerning moral distress is its emotional nature. Since psychologists and theorists of emotions have long gone to great efforts to explain the nature of the emotions and how they develop over time within a subject, it seems reasonable to ask of those who study moral distress to give some account of how the unique condition might subside, dissipate, or persist through time.

has a moral conviction (and acts against it). With this emphasis, it is not clear how we should understand cases where one does *not* have a firm moral commitment that directs the course of her decision or action, such as the case of *no-kill care*. Additional plausible cases left unexplained are those wherein the subject might have no moral commitments applicable to the given situation, or where she may have several that appear to support mutually exclusive courses of action, such as the case of *Maryann's indecision*.

4. Conclusion

Since the introduction of these prominent accounts, others have surfaced, although none that appear to be as influential. A great deal of the literature stretching back to Jameton's initial account, and continuing with those seen in recent years, contains references to Jameton's original and follow-up analyses, Wilkinson's early empirical studies, and Corley's development and use of the moral distress scale. Most often, the notions of moral distress presented on these leading accounts are received and transmitted with widespread acceptance. Yet, as I have shown, a number of important desiderata for a robust account are not fully satisfied on these notions. The desiderata developed here resulted from a careful consideration of plausible cases and sometimes true-to-life narratives where subjects are experiencing moral distress. As I have claimed, an explanatorily satisfying account is, then, still needed in order to accommodate the range of cases of interest. This demand appears even more urgent considering that the usual suggestions for dealing with moral distress call for efforts at reducing or even eliminating a natural human condition that is inadequately understood. In later chapters I will challenge these prevailing suggestions by arguing for the positive value of moral distress. First, however, I will

propose an account that can meet the explanatory demands made here. I turn to this task in Chapter 2.

Chapter 2

Moral Distress as a Complex Psychological State

With the first chapter, I introduced the general problem concerning moral distress, namely that the experience of it is seen as closely correlated with such phenomena as practitioner dissatisfaction in the workplace and burnout, which, in turn, lead to inadequate attention and increased pain for patients. I also showed that the leading accounts in the literature, despite some of their explanatory strengths, do not capture the full range of cases of interest. Without agreeing upon or adopting a fully satisfying notion, many of these and later accounts nonetheless agree that moral distress is somehow a negative experience. Because of its association with undesirable states of affairs—like practitioner burnout and patient pain—most authors recommend efforts to reduce or even eliminate it. These recommendations are made far too hastily. Once we have an explanatorily satisfying account of moral distress, we may well find that the peculiar psychological condition is much more than a negative phenomenon.

Before proceeding to develop my account, a brief reconsideration of key details should help to establish the explanatory work to be accomplished here.[1] Recall from the outset of Chapter 1 the case of *Maryann's decision*. As the story goes, Maryann made a decision she had been authorized to make, namely to administer a dose of methadone to

[1] For suggesting the following framing, I am extremely grateful to Alison Denham.

her patient. Unfortunately, it was this decision that contributed to the patient's death. As we would expect, naturally, Maryann experiences some kind of negative response. It might be a great sadness or grief, perhaps even guilt, considering that she takes herself to be responsible, at least in part, for the loss of life. But why think Maryann's response is anything other than, say, sadness, grief, or guilt? After all, if her experience could be described in these more commonly understood terms, it would appear that we gain little by referring to her state as one of moral distress. To be sure, applying the term 'moral distress' where simpler terms could accurately describe her state would only complicate our understanding of the situation and of the agent's experience.

As I postulated, the case of *Maryann's decision* illustrates a unique sort of response. In particular, I claimed, Maryann believed that she had done the right thing, but she blamed herself nonetheless. I take it that being conflicted in this way, being somehow *at odds* with ourselves, is an entirely plausible reality, given the diverse and often messy nature of our psychological makeup. Indeed, the tensions we find within ourselves might take on a variety of forms, from a conflict between our feelings and sincerely held beliefs, to experiencing multiple, incompatible motivations to act in some way or another. It will be these sorts of tensions which differentiate moral distress from other, perhaps closely related negative responses. As I will show in this chapter, moral distress is a complex psychological state best understood as an internal tension. That is, the subject may experience feelings associated with or implicating her wrongdoing—like guilt, shame, or regret—but at the same time believe that there is nothing she can do about it or that she did nothing wrong. Alternatively—or in some cases, additionally—she might be motivated to act in various, incompatible manners, while perhaps feeling herself to be powerless to

follow through with any such actions. Just as many moral theorists characterize the pain of tragic heroes as a sort of inner turmoil, moral distress on my account will be profitably seen as a tension within agents who take themselves to be somehow responsible for undoubtedly troubling circumstances.[2] The reality of this condition will have significant philosophical and practical implications regarding an agent's sense of moral responsibility, as I will explore in subsequent chapters.

To begin, a brief note on the structure of the present chapter and my overarching argument should be stated. In section 1, I will establish several important theoretical considerations and proposed use of terms. Next, in order to undertake the task of providing a robust account of *moral* distress, it seems that a promising basis of analysis is to proceed, in section 2, by making clear the nature of *distress*, that is, without the moral qualification. Here I will take seriously several suggestions provided by the leading theorists on moral distress and will work to advance the notion from its widely accepted but incomplete roots in the literature. I aim to develop what I shall consider a highly plausible hypothesis concerning the nature of distress and, more importantly, of moral distress. This hypothesis can then be tested for accuracy by applying my account to a number of cases where subjects are said to experience moral distress. Should the notion I develop here succeed in explaining the diverse cases of interest, we will have substantial reason to accept my account over those that fail to capture this range. Distress, as a natural psychological condition, appears to be related to such emotional states as frustration, anger, and guilt,

[2] Again, in some cases, the tension might be more apparent in one's motivations to act in some way in the future. I will occasionally draw upon this manner of parsing out the internal tension. Here, also, the sorts of *tragic* decision-making I have in mind—often referred to as 'dirty hands' decisions—are seen, most notably, in Nagel (1972), Walzer (1973 and 1977), Stocker (1976 and 1990), Williams (1981 and 1993), Gowans (1994), and de Wijze (2005). I address moral distress in dirty hands scenarios at length in Tigard (Forthcoming-b).

among other negative responses.[3] By drawing upon the distinguishing features of these better understood emotions, we can come to understand distress through its relationship to them.[4] While I do not intend to defend distress *per se* as something especially unusual or valuable to the human experience, I will be interested in the uniqueness—and later the value—of *moral* distress. In section 3, then, I will show distress in its "moralized" form. Here I will articulate what exactly makes moral distress *moral* and why it seems to be a psychologically troubling condition. Finally, in section 4, I will conclude by showing how my account of moral distress meets the explanatory demands established in Chapter 1.

1. Theoretical backdrop and terminology

In recent work on the theory of emotions, some of the most prominent positions are those that have merged a plurality of the constitutive features that have been proposed through the ages. Although it is beyond my present purposes to provide a novel argument in favor of this widely-accepted pluralism, we can postulate at least that some emotions are best known as a compound psychological syndrome. On this multidimensional view, such emotions—better known as sentiments—are typically said to have an affective quality (or feeling), a motivational disposition, and an evaluative appraisal of the object or state of

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[3] These relationships were first posited in Jameton's work (1984 and 1993). As I showed in Chapter 1, while frustration, anger, and many other emotions provide helpful analogs, Jameton leaves open the question of how moral distress differs from these states. My account will serve to shed light on such important distinctions.

[4] In this way, my method in this chapter resembles a traditional sentimentalist approach to the moral emotions, following Hume (1740) and Smith (1759). However, I want to refrain from making any firm metaethical commitments, as my overarching project is more practical and comparatively simple, namely, to identify a plausible understanding of a unique human experience and to posit some of the goods that might be associated with it.

affairs.[5] This multidimensional view provides us with rich descriptions and, indeed, highly plausible sets of features that clearly distinguish some of our most theoretically important and commonly experienced psychological states. Considering the widespread support for the multidimensional view, I will assume the general accuracy of this approach. Specifically, I can grant here that in order to define a sentimental state in a way that shows its distinctiveness from other perhaps similar states, one must provide the characteristic affectivity, motivation, and the way in which its target object or situation is being evaluated. Fear, for example, can be characterized as the feeling of uneasiness or panic at a perceived situation or object. Motivations, then, are likely aimed at fleeing or otherwise guarding against the feared object, given that the subject appraises it as a threat. Consider also guilt. In experiencing guilt, a person feels somehow bad about herself, typically for what she has done or decided. Along with such feelings, a guilty person is usually motivated to make amends in an effort to somehow "undo the deed," and she characteristically evaluates herself as a bad person or as blameworthy (cf. Frijda 1986 and 1988).

While the multidimensional theory appears to be better situated to explain the nature of various emotions than, say, views that posit only one of the three components, several stipulations should be made before acceding to it outright. First, often one of these features is considerably more noticeable or definitive than the others. For example, anger seems to be best characterized in terms of its constitutive action tendency: when one is

[5] Support for this sort of theory is found, for example, in Oakley (1992), D'Arms and Jacobson (2006), Shoemaker (2015), and Szigeti (2015). Additionally, it should be noted that the three-part 'syndrome' describes what are often thought to be basic, pan-cultural emotional responses. See Eckman (e.g. 1977 and 1992) and Frijda (1986) for accounts of universality in emotions.

angry, one is typically motivated to communicate the offense to the offender.[6] These inclinations for action are surely sometimes accompanied by the subject's feeling of his "blood boiling" or by the thought that someone has culpably offended. Still, in their most characteristic forms, some of our emotional responses are best known by a single one of these components, for it seems that in comparing several generally similar states, we find that some pairs will share a common feature. For example, anger and frustration might often feel generally the same. Similarly, fear and anxiety can both be said to evaluate a current or anticipated situation negatively, as potentially threatening (cf. Roberts 2003; Kurth 2016).[7] Given these similarities and the many others we might experience, the task of consistently identifying a given emotional state will be most effectively accomplished by specifying as many of its components as possible, and often with an emphasis on one component that is not shared by others of a similar sort.

An additional stipulation for accepting the multidimensional view can be seen by stressing my development of the *paradigmatic* form of moral distress.[8] Once we have articulated an emotion's distinguishing features, we may find that there appear to be plausible deviations that still fall generally under a natural psychological kind. It may be

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[6] These motivations to communicate may be efforts to seek retribution or to elicit guilt in the offender. Such action tendencies are definitive of what Shoemaker (2015, 90) dubs 'agential' anger. By including the tendency to confront the object of one's anger, and by taking the object to be a person who has *slighted* another, the notion of agential anger helps to make clear its distinctiveness from other sorts of anger. After all, one can be angry at or about innumerable things which cannot sensibly be the target of communication; Shoemaker refers to this sort as "goal-frustration" anger (ibid.).

[7] Granted, anxiety is not usually thought of as a properly "basic" emotion, but this helps to make the present point clear. In order to distinguish a basic (or non-basic) state from another, we rely upon some unique characterization, which will likely consist of describing one or several of its features. In any case, my interest will be less in which emotions are properly basic, and more in what *any* emotionally-laden state tells us about how an agent perceives himself and the immediate or proximate circumstances.

[8] Paradigm-based approaches—namely, to characterizing notions of moral responsibility—can be seen in the work of McKenna (2012 and 2013) and Fricker (2016).

that we can identify what makes some instance of an emotion a deviation by referencing one of the features that would normally be present but is either not seen or appears somehow abnormal in the case in question. A subject may feel, say, the certain uneasiness of fear and be inclined to stand guard against something appraised as a threat, but all the while assent to the fact that there is no real threat of danger. This particular deviation, of course, is commonly thought of as a phobia, a sort of irrational psychological state wherein we see a distinct tension between one's emotion and one's sincerely held conscious beliefs. Consider also misplaced anger. We can imagine a person who feels that she has been wronged and is inclined to express this to the person she appraises as the offender. Still, she may come to learn that the alleged offender meant no harm, yet her feeling of being wronged persists nonetheless. In this way, her anger is *recalcitrant* (D'Arms and Jacobson 2003). As Daniel Jacobson summarizes the phenomenon, "an agent can be in the grip of a sentiment contrary to his better judgment" (Jacobson 2013, 103). Importantly, this feature provides one explanation of what makes some responses irrational. That is, one's emotions might be incorrectly appraising an object or state of affairs. Fear of harmless spiders or anger at a well-meaning friend are inappropriate or unfitting.[9] But this fact alone in no way indicates that the person *does not* experience fear or anger, only that she *should not* experience them. Notice, however, that this way of describing an emotion—that is, as rational or irrational—seems to suggest that fittingness is an objective feature.

For my proposed terminology, I will adopt what I take to be a more subjective approach to judgments of fit.[10] In doing so, I will often invoke the language of paradigms.

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[9] Here I have in mind the *rational sentimentalism* advanced by D'Arms and Jacobson (e.g. 2000 and 2006).

[10] For discussion that helped me to make explicit the distinction between objective and subjective fittingness, I thank Chad Van Schoelandt.

In short, an emotion's paradigmatic form can be thought of as the instances where one's emotional state is experienced consistently with her sincerely held beliefs. That is, the person responds to the object of her emotion in a way that shows that her emotions "agree" with her judgment or beliefs about that object. By contrast, we can think of the non-paradigmatic form of an emotion to be the instances where there is a "disagreement" between one's emotions and sincere beliefs. Such inconsistencies may well be the result of an emotion lacking one or two of its three key features.[11] For example, imagine a person who feels wronged and is motivated to communicate her feeling of offense, while appraising no one in particular as the offender. She may sincerely assent to the fact that there has been no wrongdoing, despite feeling somehow angered. Here, the person appears to be experiencing recalcitrant anger but it is not necessarily misplaced, for she is not directing her anger at any specific target. Instead, it is a generally non-paradigmatic instance of anger, in the sense that some feature of her emotional state disagrees with her sincerely held beliefs.

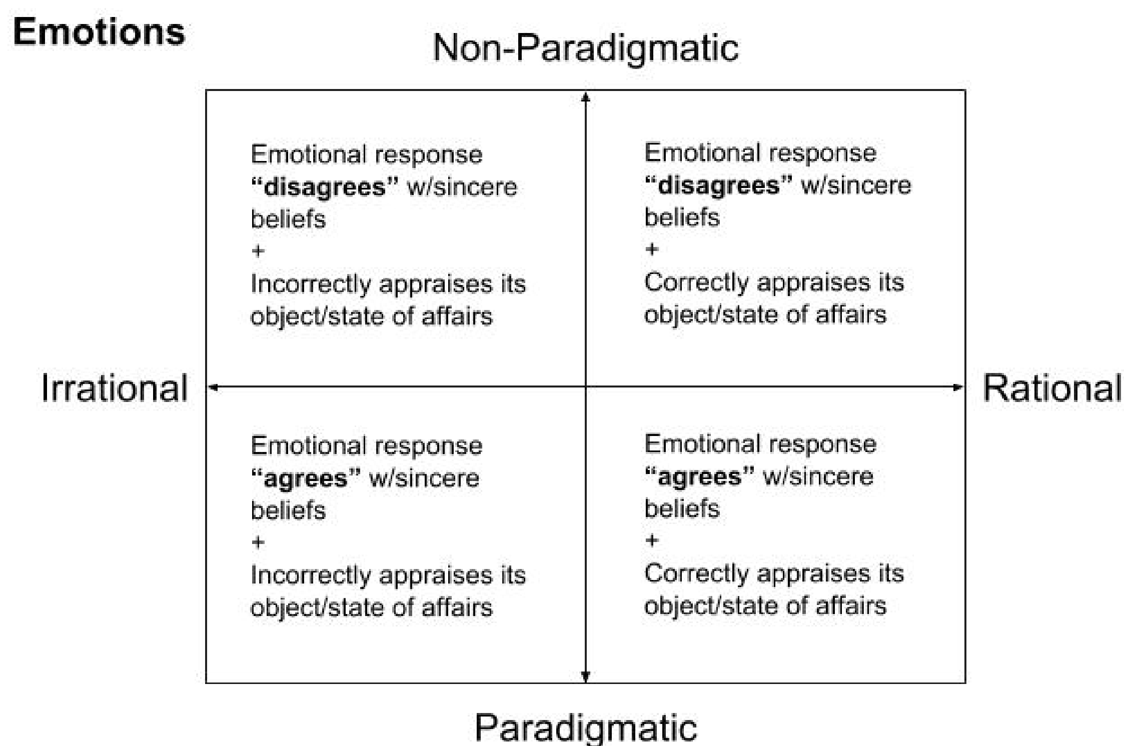
By taking consistency (or inconsistency) within the subject to be the defining feature of an emotion's paradigmatic (or non-paradigmatic) form, we can see an instance of an emotion as identifiable along a range—either closer to or farther from the paradigm—based upon the extent of agreement or disagreement. In the case of a phobia, we see definite tensions which can now be parsed out into two distinct continuums. On the one hand, the fear is *irrational*; the subject experiences an emotional response toward something that objectively misrepresents that object. Phobic fear appraises the harmless spider as a threat while *it is in fact not a threat*. On the other hand, a phobia can be said to constitute a *non-*

[11] I thank David Shoemaker for suggesting this way of thinking about non-paradigmatic cases.

paradigmatic instance of fear in the sense that the subject's emotional state disagrees with her sincerely held beliefs. Phobic fear appraises the harmless spider as a threat while *the subject believes that it is not a threat*.

The two distinctions made here can be summarized as follows. Objective fittingness tracks an agent's emotions as more or less *rational* based upon how accurately they appraise the world. On my proposed terms, a more or less *paradigmatic* emotion reflects the extent of agreement or disagreement within the subject herself. Given these two scalar distinctions, a map of four quadrants would represent the various possible combinations (see Figure 1).

Figure 1: Paradigmatic/Non-Paradigmatic and Rational/Irrational Emotions.



The paradigmatic emotions will be rational (lower-right quadrant) in cases where they agree with the agent's sincere beliefs and accurately represent the world, but irrational (lower-left quadrant) where they agree with one's beliefs and misrepresent. Non-paradigmatic but rational emotions (upper-right quadrant) are those that disagree with one's sincere beliefs but accurately represent the world. And non-paradigmatic irrational emotions (upper-left quadrant) both disagree with sincere beliefs and misrepresent the world. To conclude the establishment of my proposed terminology, it can be said that the notion of objective fittingness serves as a useful guide in assessing correct and incorrect emotional appraisals. However, the notion of paradigmatic, or subjectively fitting, emotions will be focal to my explication of moral distress as a state of inner turmoil.

2. The state of distress

Given that we can effectively identify many of our natural psychological states—fear, anger, even phobias—by referring to their characteristic features, it would seem that distress too can be known by the unique collection of its features. What might those be? How do they come together as a state distinct enough to merit a sort of *term of art*? How do we set distress apart from the emotions that may share many of its distinguishing features? First, we can establish the features of similar states, understood on their own, then note how they might be seen at work in cases of distress. As I set out in Chapter 1, Andrew Jameton claimed that moral distress "*involves* feelings of frustration, anger, and anxiety" (1993, 544, emphasis added). Here I will assume that distress of the non-moral sort similarly involves—not the conjunction, but a disjunction between—feelings of

frustration, anger, *or* anxiety.[12] By granting Jameton's widely accepted suggestion, these three emotions provide the first set of comparisons to distress.

A second set is found in the relationship drawn between distress and guilt. In his early account, Jameton said "Nurses feel guilt and real moral distress when they perform procedures that they feel are morally wrong" (Jameton 1984, 283). With this, it appears that distress is not constituted by guilt but that the two are very closely related. Notice, however, there are important differences between feelings of guilt and feelings of frustration, anger, or anxiety. Guilt and related states, like shame and regret, indicate the presence of—and perhaps the subject's responsibility for—some sort of wrongdoing, failure, or loss. One might be frustrated, angry, or anxious about any number of things, without the presence of these more serious (and perhaps morally significant) circumstances. However, to be guilty, ashamed, or filled with regret appears to require that something is perceived as morally wrong.[13] Thus, guilt, shame, and regret, will be a second set of emotions to which distress can be compared, as I will expand upon in the following section.

What clearly unites the emotions listed here is that they all are generally negative. For most of us they are ordinarily undesirable, for they each constitute a sort of pain. If given the choice, other things being equal, one would choose to avoid frustration, anger, and anxiety. As we can imagine, one would likely be even more averse to experiencing guilt, shame, and regret. Frustration, to begin, has been said to involve the feeling that one's

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[12] As I noted in Chapter 1, for the sake of being charitable to Jameton's notion, I am assuming that the disjunction between frustration, anger, or anxiety more effectively captures the plausible cases.

[13] Another feature to note regarding guilt, shame, and regret is that unlike frustration, anger, and anxiety, the former are typically directed at oneself.

goals are being blocked or, generally, that one's concerns are somehow violated (cf. Roberts 2003; Shoemaker 2015). Motivations, then, are likely aimed at removing or overcoming the perceived barrier, or perhaps working to reestablish the priority of one's thwarted concerns. Finally, frustration appraises a person's situation negatively, as something one desires to overcome. Together, these three features provide a plausible understanding of what it is to experience frustration. Anger similarly involves the feeling of blocked goals or being "heated" by a rush of blood, perhaps due a fellow moral agent committing some offense. In its moral form, anger will involve an inclination to seek retribution or at least communicate the offense. Anger at inanimate objects, on the other hand, may still motivate one to somehow lash out, say, at one's malfunctioning phone or at *another* traffic light turning red.[14] The point to be made here is that in both moral and non-moral anger, a person appraises the situation negatively. Lastly, while the feeling of blood rushing is also typical of anxiety, this state can be set apart from anger by its characteristic action tendencies. According to Charlie Kurth, when one is anxious, one engages in "general risk minimization efforts" as well as information gathering activities in order to better understand or avoid a potential threat (Kurth 2016, 3). Like frustration and anger, anxiety is most often a negative appraisal of one's situation.[15]

If distress *involves* feelings of frustration, anger, or anxiety, which for many cases we can easily grant, several questions must be addressed. What else makes up an

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[14] What makes 'lashing out' at such *things* somewhat comical—at least to some of us, and only after the phone resumes working or the light turns green—is that the object is not a fitting target of anger. Phones and traffic lights, of course, cannot (yet?) show disrespect; although they can certainly frustrate our goals. Still, they cannot *slight* us, and they are thereby not eligible for 'agential' anger. See Shoemaker's notion (in Shoemaker 2015, 90), outlined here in note 6.

[15] Still, as Kurth (2016) argues, anxiety may well produce some notable individual and social benefits. An anxious person may come to learn more about the perceived circumstances and will likely acclimate well to social pressures and expectations.

experience of distress? How does distress differ from these related states? It seems that a distressed subject will typically be motivated to act in ways that "follow" the specific manifestation of her distress. What I mean by this is simply that where a subject's distress is experienced as frustration, her action tendencies can be expected to include efforts at removing or overcoming some perceived barrier. In being distressfully frustrated, so to speak, our subject may feel that her concerns have been set back and, so, she will likely work to reestablish these concerns as a priority among her projects.

Consider, for example, the case of *unnecessary blood-testing* encountered in Chapter 1. The nurse, recall, is forced to administer a blood test to all incoming patients, despite the fact that the required procedure poses undue risks. We can image the nurse's resulting state to involve the feeling of frustration, given that his concern, say, for patients' wellbeing, is being thwarted by the hospital's policy. It would be natural, then, for this person to be motivated to act in a way that increases the likelihood of satisfying his concern for patients' wellbeing. He might be strongly inclined to admit patients when a blood test appears too risky, to work toward repealing the existing policy, or to quit the position and seek one where his concerns better align with hospital policy.

Similarly, where a subject experiences distress in the form of anger, we can expect her to be motivated to express herself or even to seek retribution. In *unnecessary blood-testing*, this might entail the nurse not only working to repeal the existing policy but also demanding that the hospital somehow compensate the patients who were put at risk and the employees who were burdened with carrying out the requirement. Lastly, where a subject's distress is made up of a feeling of anxiety, again, we should expect that her action tendencies will follow this emotion. This manifestation of distress is likely present, for

example, in the case of *Maryann's indecision*. Given that Maryann is utterly lost as to how she should treat the patient experiencing great pain from withdrawals, she is likely compelled to take action that minimizes any risks or to gather more information on his condition and what should be done about it.[16]

So far, I have detailed various possible affective qualities, motivations, and evaluative appraisals that would in part make up an experience of distress.[17] What sorts of judgments or beliefs could we expect a distressed subject to maintain? On the one hand, we might think that the accompanying judgments that help to characterize distress would, like the action tendencies, follow whatever emotion a subject experienced. In this way, a distressfully frustrated person, if able to articulate any specific belief about the frustrating object or situation, would assent to the fact that her goals are less attainable or that her concerns are harder to satisfy. A distressfully angered person would think someone has offended. And a distressfully anxious person would believe that some negative state of affairs is likely or imminent, even if the object is unknown. On the other hand, if these general judgments complete our understanding of distress, at least in three of its possible manifestations, there is nothing that clearly differentiates distress from these more specific emotional experiences. Why, then, should we bother speaking of distress? What advantages are there, if any, of identifying someone's psychological state as one of distress?

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[16] Echoing Kurth (2016), here we see plausible examples of how anxiety can be extremely valuable, at least instrumentally. I discuss the instrumental value further in Chapter 3.

[17] Here it seems important to point out that, on my account, moral distress, while bearing key features related to natural psychological kinds, is not one in itself. Indeed, I have not made a case for moral distress being a basic, pan-cultural response, and I do not take moral distress itself to be an emotional state. I expand upon this point, below.

I take it that there must be something to an experience of distress that sets it apart from experiences of frustration, anger, and anxiety (also from guilt, shame, and regret).[18] Consider for a moment the word itself, defined as the "*overpowering* pressure of some adverse force, as anger, hunger, [or] bad weather."[19] It seems that distress as such is a natural human response to an object or situation over which *the subject has no control*. To be distressed, in this way, is for a person not only to experience feelings of frustration or anger (and so on) and to be motivated to act according to this affectation, but also to be somehow unable to change the circumstances that brought about these negative feelings.[20] In her frustration, a person has the feeling of goals being blocked and is at least inclined, if not determined, to do something about it. If one were utterly complacent, it would be odd at best to think she is in fact frustrated. She may have the thought that some particular goal is impeded, and she might have ideas as to how the barrier might be removed or overcome. However, a distressed person experiencing the condition as frustration likewise consciously judges—or perhaps simply has a sense or unconscious belief—that the barrier *cannot* be removed or overcome.

With frustration, anger, and anxiety *simpliciter*, it is possible—even if incredibly difficult—for the situation to be improved. Should one be aware of this possibility, the thought of improvement may well contribute to a rather optimistic stance concerning the

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[18] If there were truly nothing, it would be a wonder why medical scientists and authors, for years, have been concerned enough to conduct empirical research and to theorize about a purely folkloric psychological condition.

[19] Oxford English Dictionary, emphasis added.

[20] With this conception of *dis*tress, we can think of *stress* (or the state of being "stressed out") as negative feelings – like frustration or anxiety – along with motivations to do something to improve the stressful situation, and *where the subject is able to turn things around*, as it were. Being "under stress" is, in this way, to be under pressure, but the pressure does not overpower one. The subject simply has not yet fulfilled inclinations to improve things, to meet a deadline, and so on.

potential outcomes of acting upon one's frustration, anger, or anxiety. Indeed, it seems we often maintain an implicit hope in following through with a negative emotion's characteristic action tendency, namely the hope that we will eventually find relief from the negative emotional state. By expressing oneself to an offender or by seeking retribution, we might be relieved of our anger, at least to some extent. By gathering information or taking precautions to reduce incurring damage from possible risks, we might be relieved of our anxiety, perhaps just a bit. The point to be emphasized here is that with simple experiences of frustration, anger, or anxiety, the situation is manageable in principle. We are capable of doing something about it, whether or not such inclinations in fact compel us to act accordingly.

In being distressed, a person is similarly experiencing the feeling of frustration, anger, or anxiety (and likely a host of additional possibilities). One is likewise motivated to act in a way that relieves these undesirable emotions. Still, along with these emotional responses which appraise one's situation as negative, the distressed subject is one who maintains a sincere belief that nothing can be done to change the unfortunate situation.[21] Although she may be inclined to act in a way that removes obstacles, communicates or brings about retribution, or minimizes risks, she also has a faint or perhaps intensely vivid awareness that *there is nothing I, alone, can do about it.* This feature helps to explain why distress, whether speaking of a human psychological state or of a sinking ship, is fundamentally a cry for help from others. Just as a sinking ship is overpowered by icebergs

[21] Granted, the distressed nurse in *unnecessary blood-testing*, for example, could quit his position, and so no longer face the distressing situation. Nonetheless, given that he recognizes his powerlessness to change the circumstances, he would presumably know that by removing himself, the unfortunate situation would remain unchanged. In this way, we see that distress can be manifested not just as a tension between one's emotions and beliefs, but also as a tension between several incompatible motivations to act. I thank Alison Denham for pointing out the variety of possible tensions at work.

or bad weather, a person can be overpowered by negative circumstances. Despite her strongest motivations or actual efforts to take action, a distressed person alone is often powerless to directly improve her condition, which is a natural response to some adverse object or negative state of affairs.[22] Whether or not she seeks distress relief from others, she is somehow aware that this instance of frustration or anger (and so on) is unlike related episodes of such emotional states. In their simpler forms, these negative emotions are manageable. As instances of distress, such negative emotions overpower the subject and leave her at the mercy of help from others or simply the passage of time.

As a unique and troubling psychological state, distress is an experience of an inner conflict. Inclinations to act are often accompanied by a sincere judgment or unconscious belief that nothing can be done to improve one's situation. Here we see that distress takes paradigmatic negative emotions and adds an internal disagreement within the subject. In this way, the state of distress is unlike paradigmatic emotions in several key ways.[23] First, distress itself is not an emotion. Instead, it is a complex psychological state characterized by an inner tension. Often, as I have claimed, we see some negative emotion along with a sincere (conscious or unconscious) belief that the negative state of affairs is beyond one's control. Due to this lack of control over the situation that brought about one's negative emotion, the subject can do far less to improve her emotional state than where she is able exert some degree of control over the situation (by effectively removing obstacles that

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[22] Here I say she is powerless to *directly* improve her condition, for it might be thought that in cases where one's moral beliefs are the primary source of distress (e.g. *no-kill care*), one *does* have some power to improve the situation, namely by changing one's beliefs. Of course, concerns arise here over doxastic voluntarism, which cannot be addressed in detail. In short, I take it that even if changing our beliefs can improve our situation, this process cannot occur directly and immediately. I thank David Shoemaker for comments concerning these points.

[23] I am extremely grateful to David Shoemaker for helping to develop the following points.

frustrate, communicating anger, and so on). Second, distress creates an inconsistency where one would normally be motivated by the emotion's characteristic action tendency. Because one's emotions disagree with one's sincere beliefs, the subject will be "torn" to some extent over which actions would be best to pursue.[24] If one is frustrated, for example, one evaluates the situation negatively and is inclined to go to efforts at removing some obstacle, while at the same time being aware that such obstacles cannot be overcome. Thus, we can say that the complex psychological state marked by inner turmoil represents the paradigm of distress. This label will be useful in identifying less extreme states of distress as non-paradigmatic, namely, where the subject evaluates a situation negatively but may not believe that it is entirely beyond control.[25]

To summarize, the distressed subject feels some negative affectation and is inclined to act in a way that improves her circumstances; yet, at the same time, she alone is helpless. Although she may be inclined to act, and indeed she might follow through with such inclinations by taking action, only time or the help of others will allow for her negative emotions to be relieved. Until then, she remains conflicted, motivated to work towards improvement but somehow aware that the hope of improvement is forlorn. With this, it appears that the state of distress is accurately characterized as something like a tragedy.[26] In the following section, I will apply this conception of general distress to the experience of *moral* distress. As I have indicated, a second set of simpler, baseline emotions will help

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[24] In other words, the tension distinctive of distress might, in some cases, be most apparent in one's competing motivations to act, rather than in the agent's conflicting appraisals.

[25] In such cases, non-paradigmatic distress will look more like the simpler negative emotions that in part comprise the complex state. Indeed, in much of the literature, negative emotions alone are often taken to be 'distressing' yet it is unclear why. By distinguishing paradigmatic from non-paradigmatic distress, my account can accommodate what appear to be varying degrees of distress. I soon expand upon this point.

[26] See, for example, Williams (1973) and Denham (2014).

to articulate what makes moral distress *moral*. Following the paradigm of general distress outlined here, in paradigmatic instances of moral distress we will likewise see a tension within the subject's experience.

3. Moral distress

With the first set of emotions I outlined—frustration, anger, and anxiety—I took seriously Jameton's (1993) suggestions for how a subject might feel when experiencing moral distress and I developed a paradigmatic notion of distress, generally, as an overpowering state where one's emotions disagree with her beliefs concerning the prospects of improving her negative condition. As I briefly explained, nothing about these particular states indicates that the subject has participated in morally significant wrongdoing, failure, or loss. Thus, frustration, anger, and anxiety prove to be useful in articulating the key features of being in a state of *distress*, but not of being in *moral* distress, given that these emotions and the objects to which they respond often lack moral significance.[27] In the event of a person's frustration, anger, or anxiety responding to some morally significant object or state of affairs, we might begin to see the moral form of distress.[28] Nevertheless, in order to make clear the moral nature of moral distress, in this section, I turn to the second set of emotions I introduced: guilt, shame, and regret. Again, I will draw upon the distinguishing

[27] One may be frustrated, say, by disagreeable weather if rain hinders the goal of going out for a run. Surely, however, the rainy weather is not in itself morally significant, nor is one's frustration. An Aristotelian might try to argue that since health and fitness are virtuous, one's frustration at being prevented from pursuing such goals contains some moral significance. Still, it appears to be a stretch of the term to consider one's frustration here morally significant to the extent of qualifying as *moral* distress.

[28] As I have said, some forms of anger are certainly morally significant, namely when they are a response to *slights* from others. See the discussion of Shoemaker (2015) in notes 6 and 14.

features of these emotional states as a means of coming to understand various manifestations of distress; however, as we will see, given the sense of wrongdoing, failure, or loss at work in cases of guilt, shame, and regret, a subject experiences these forms of distress in a way that carries a distinct moral weight.

Like the feelings of frustration, anger, and anxiety, feelings of guilt, shame, and regret are painful. Unlike the first set, the latter are typically directed at oneself, one's own actions or decisions. Guilt is perhaps the clearest example of this self-directedness, for shame is often experienced on behalf of others and one can regret things generally, without being responsible for them.[29] In experiencing guilt one feels somehow bad about oneself, what one has done or decided. But beyond feeling guilt for one's actions or decisions, a guilty person has the feeling that he has violated a justified law or norm and that his *self* is thereby morally spoiled (Roberts 2003, 105, 223). As David Shoemaker explains, guilt is often brought about by the anger of a person who has been *slighted*. In coming to fully appreciate a person's anger, via an "empathic leap," the guilty person feels a sense of self-directed anger which may then motivate him to beat himself up (Shoemaker 2015, 111).[30] In similar ways, a guilty person may be motivated to make amends, in an effort to somehow "undo the deed" (Frijda 1988, 351). No doubt, guilt evaluates its object—namely, oneself—in a negative light, as the person experiencing guilt often believes that he is a bad person or that he is blameworthy (Roberts 2003, 225).

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[29] The general sense of regret, famously contrasted with 'agent-regret' by Bernard Williams, targets states of affairs, which "can be regretted, in principle, by anyone who knows of them" (1981, 27).

[30] As a result, the pain of being confronted by one who has been slighted is often not entirely attributable to being the object of someone *else*'s anger, but also to being the object of one's own anger.

While one may be ashamed of others—likely by association, say, with one's friends, family, or country—shame as a self-directed state resembles guilt in the sense that it is a painful sensation. As opposed to feeling at fault when experiencing guilt, being ashamed is to feel that one has a defect and possibly to think of oneself as having failed to be respectable or worthy (Roberts 2003, 227). Thus, shame is aptly characterized by a motivation to disappear from sight (Frijda 1988, 351). Whether one is ashamed of what she has done or of who she is, an experience of shame indicates the presence of some shortcoming, perhaps one with great moral significance.

Finally, regret may be experienced generally, as mentioned, or as a response to one's own decisions or actions. At its core, it is generally a feeling of loss, much like grief (Roberts 2003, 240). But where one regrets her own actions or decisions, she is motivated to change her decision-making policies (Shoemaker 2015, 18). The characteristic thought of the kind of regret one feels toward herself has been aptly stated as "If only I had done or decided otherwise."[31] Like shame, this form of regret is a response to some kind of failure, and while one may or may not be morally responsible for the regretted decision or action, in her experience of regret one wishes for past events to have proceeded differently, or at least for things to proceed differently in the future. Given that one might appropriately regret events for which she is not fully responsible, in many cases regret is best seen as a response to the phenomenon of morally significant losses, rather than error (cf. Jacobson 2013).

[31] Shoemaker (2015, 67-8) calls it 'agential' regret. This formulation makes clear that what is regretted is the agent's own actions or decisions, as opposed to states of affairs that can be generally regretted by anyone. The latter is captured by Williams's phrase "how much better if it had been otherwise" (1981, 27). However, Williams notably takes this to be the *constitutive thought* of regret, which the multidimensional view of emotions is committed to rejecting. Indeed, it would be odd to think one could truly regret with only a thought, without feeling a certain discomfort and being motivated to do things differently in the future.

If, as I am supposing, moral distress is closely related to the experience of guilt, shame, or regret, again the question is: What distinguishes moral distress from its related emotional states? Being in a state of distress (of the non-moral sort), I claimed, is paradigmatically characterized by an inner tension or disagreement. A subject feels some negative affectation and is inclined to act in some way or another, while at the same time having the sense that she is helpless to improve her condition. The guilt involved in some experiences of *moral* distress is undoubtedly a negative feeling and, depending upon the circumstances and the subject's response, she may be motivated to make amends for wrongdoing, to try to undo the deed, or to beat herself up. Moral distress experienced as shame is a painful feeling and motivation to hide, given that who she is or what she has done fails to be respectable or worthy. And moral distress manifested as regret is the negative sensation of loss and a drive to improve the future, either generally or one's own future decision-making. However, like the complex state of distress, being morally distressed is a psychological state in which the subject has the sense that nothing she alone can do will bring about relief from these negative feelings. Here, again, we should expect to see an inconsistency within the morally distressed subject. Like the person in a general state of distress, the morally distressed subject is compelled to improve her condition in ways that follow her specific emotional state, but at the same time, she is aware (faintly or vividly) that she alone is helpless. To be morally distressed is to be overpowered in one's efforts to improve upon moral failures, morally significant losses, or one's morally spoiled condition.

In addition to having the conflicting sense that *I cannot improve the situation*, the morally distressed subject may have an alternative (or additional) source of inner conflict,

namely the thought that *I shouldn't have to*. For example, one's morally distressful guilt is in part the negative appraisal of what she has done; however, she may also have the sincere belief that she is not morally responsible for it. With this, she might appropriately think *I shouldn't feel guilty*. As opposed to the genuinely guilty person who likely beats himself up and could honestly agree that he deserves such treatment, the subject whose moral distress takes on resemblances of guilt has the feeling she has violated some moral norm and the motivation to make amends or beat herself up, while sincerely judging that she in fact did nothing wrong.[32] While she should not feel as though she has done wrong, she cannot help it. Having served as a causal link, or simply failing to prevent what may be unavoidable negative circumstances, gives her the feeling that she is guilty. The same can be said of morally distressful shame or regret. Notice that these sorts of negative feelings, despite their potential irrationality, appear to show that the subject cares about those who might be affected by the unfortunate situation. She might care a great deal about the other people involved, the values or norms that have been breached, or how those affected will perceive her. If she did not care, she would not feel bad in these ways and surely would not be (at least) inclined to do something that she hopes will improve the situation. Indeed, if one were utterly insensitive, it would seem that emotional responses resembling guilt, shame, and regret are somehow unavailable. I will expand upon these points in the following chapter, in arguing for the value of morally distressing responses.

At present, the ideas concerning the nature of moral distress to be emphasized here are the following. What helps us to see the *distressing* nature of moral distress is that it is

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[32] In a recent study on the "lived experience of blame" in cases of medical error, Collins et al. found that many physicians "express both repudiation and acceptance of guilt." One interviewee was quoted saying "I was definitely feeling guilty and worried…even though I knew, logically, that I was not to blame" (Collins et al. 2009, 1289).

an overpowering, adverse psychological experience, one that takes a paradigmatic negative emotion and adds a distinct inner conflict. One appraises the situation negatively, yet believes either that nothing can be done or that he shouldn't have to do anything since he thinks he shouldn't feel bad in this way. Correspondingly, one may be motivated to act in several, mutually exclusive manners. What allows us to see the *moral* nature of moral distress is that the condition is experienced because of the moral significance of the perceived situation and, ultimately, because of the subject's morally significant concerns. In this way, although guilt, shame, and regret best highlight the moral significance, even the feelings of frustration, anger, and anxiety can in part constitute moral distress. Where one is frustrated, angry, or anxious about a situation where others' interests or values are at stake, her attempts to promote them, to overcome barriers (and so on) appear to have genuine moral importance.

In the first chapter, I briefly surveyed Wilkinson's (1987/88) early empirical studies, wherein moral distress is characterized as a sort of psychological disequilibrium, a unique sense of inner turmoil. Although what exactly it means to experience psychological disequilibrium is left unclear on Wilkinson's account, I can grant her helpful characterization and fill out the details with the framework I have developed here. Like the person in a general state of distress, the morally distressed subject is at odds with herself in a troubling way. Despite experiencing emotions like guilt, shame, or regret, the morally distressed subject maintains a sincere belief that she did nothing wrong or that the circumstances cannot be improved and, accordingly, that her negative emotional state is beyond her control. Notice, this sort of inner conflict may well describe cases where the morally distressed subject is not at fault, as well as those in which the subject is in fact at

fault.[33] It may be, for example, that one feels guilty or regretful for making a decision that truly should have been made differently. Consider the case of *Maryann's decision*, where the nurse administers a dosage of methadone to subdue her patient in great pain. Given that the patient's death was attributed to this treatment, it appears that something went terribly wrong, perhaps both procedurally and morally.[34] Granted, Maryann can be said to share the responsibility with those who authorized her to make this decision. Still, here we see that one can be morally distressed where it is appropriate for the subject to experience negative self-directed emotional responses.[35]

It might be thought that in cases where one's negative emotions are appropriate or fitting, the subject is merely experiencing the simpler emotional state (guilt, regret, and so on). On my account, however, we can still effectively distinguish guilt or regret (and so on) as manifestations of moral distress from the simpler instances of these emotions alone. As I outlined the paradigm of general distress, one experiences some negative emotion, which may well be a fitting response to the circumstances, while maintaining a sincere belief that is somehow inconsistent with this emotion. In *Maryann's decision* we can affirm that the nurse's guilt or regret would be perfectly rational to the extent that her emotion is correctly appraising the situation, which it appears to be if she truly did something morally wrong.[36] Still, unlike common cases of guilt or regret, where one is motivated to make

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[33] My thanks to David Shoemaker and Chad Van Shoelandt for comments and discussion that helped to develop this point.

[34] In Chapter 4, I will address the relationship between moral distress and medical error.

[35] Relatedly, in a recent work, Bennett (2018) argues that caregivers, particularly those with patients in palliative care, often appropriately experience a unique sort of guilt, albeit without blame.

[36] Of course, we can call into question whether or not she in fact did something morally wrong, but that is beside the point to be made here.

amends or change one's deliberative processes and thereby improve the situation, here the subject is aware that nothing she can do will improve the unfortunate state of affairs. Indeed, while Maryann might apologize to the patient's family or work to improve the hospital's procedures for determining recommended treatments, she cannot change what happened to her patient. She must live with her guilt and regret, and can only hope that with the passage of time her negative appraisal of herself will subside. In this way, we see that moral distress is often far more psychologically troubling than cases of the simple negative emotions that in part constitute the condition.

On the other hand, suppose Maryann thinks *there must be something I can do*. As we can imagine, in such a scenario one might be extremely motivated to take action, if not in an effort to undo what happened, at least as a means of improving things for the future.[37] Does this indicate that one is not experiencing moral distress, that is, where one is fittingly guilty or regretful while maintaining that the circumstances to which these emotions are responding *can* be improved? If so, this would appear to be an unnecessary limitation, particularly for cases like that of Maryann who might be inclined to take action precisely *because* of her experience of moral distress. On the account I have developed, the paradigmatic state of moral distress involves a distinct tension, often a disagreement between one's emotions and one's sincerely held beliefs. However, by taking a paradigm-based approach to conceptualizing the phenomenon, my account makes room for plausible deviations.

Where Maryann's negative emotions correctly appraise her decision and action as morally wrong, and she maintains that she can do something to improve the circumstances,

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[37] This sort of response will be an important feature of practitioners *taking the blame*, namely for the occurrence of medical error. I discuss this process in Chapter 4.

she may still be experiencing moral distress but in its non-paradigmatic form. That is to say, the inconsistency within the subject is not as apparent or as extreme as it is in cases of paradigmatic distress. In her guilt, she is inclined to make amends or beat herself up for what has happened. In responding with regret, she is inclined to change her manner of decision-making, and so on. To a considerable extent, she may well maintain a belief that such actions will serve to improve the state of affairs that caused her guilt or regret. However, she cannot sincerely believe that her actions will completely resolve the unfortunate event in which she played a causal and morally significant role. She cannot undo the death for which she is in part responsible. To some extent, then, her awareness of being unable to completely improve things will conflict with her motivations to repair the wrong. To this extent, she experiences moral distress in its paradigmatic form. But insofar as her beliefs agree with her motivation to bring about improvements, her moral distress is less paradigmatic; she does not believe she is utterly helpless to improve things, nor does she maintain the other (or additional) conflicting belief that she shouldn't have to.

4. Conclusion

In this final section, I will briefly revisit the four key desiderata established in Chapter 1. As I argued there, a robust account of moral distress should be able to explain the typical causal circumstances, the paradigmatic nature, and the temporal development of moral distress, along with the varying degrees to which a morally distressed subject maintains a moral commitment. With the account developed here, these explanatory demands are fulfilled. Given that the notion of moral distress as a complex psychological state marked by an inner tension allows us to better understand a wide range of cases, we see substantial

reason to favor my account over those that leave the nature of this peculiar phenomenon only partially explained.

First, as I showed, because moral distress appears to result from a variety of causes, we should expect a full account to be able accommodate them. In the case of *unnecessary blood testing*, for example, we see moral distress being caused by an institutional obstacle; this is the sort that occupied Jameton's (1984) concerns. On my account, the nurse's moral distress is seen as negative emotions—which appraise his actions as wrong—experienced alongside the belief that he is not fully morally responsible. He remains confined by the external obstacle and, in doing so, he plays a causal and morally significant role in putting patients at risk where it is medically unnecessary. In *no-kill care*, the subject faced an obstacle of a different sort; it was non-institutional or internal to the subject, I claimed. Wilkinson's (1987/88) influential work aptly expanded the set of potential obstacles to include those of an internal sort. Indeed, I have granted and expanded upon her helpful characterization of moral distress as psychological disequilibrium. The physician in *no-kill care* is initially, internally obstructed by her moral conviction to not administer any lethal treatment. As it turns out, she overcomes the obstruction (and assists in her patient's suicide) and is left with a guilt-like feeling for having violated her own moral values.[38] Nonetheless, this feeling differs from simpler instances of guilt, for here she has the sense that any action motivated by her guilt will fail to completely resolve the circumstances. In the cases of *Maryann's decision* and *Maryann's indecision*, we see moral distress being caused by a difficult moral situation where no obstacle is being presented. Where she

[38] This is the essence of the phenomenon I have referred to as internal or self-induced guilt (Tigard 2016). In short, one can feel guilty (or ashamed, regretful, etc.) and genuinely blame herself for one's complicity in acting against her own values—a sort of 'dirty hands' case—despite the potential irrationality of these emotional responses.

makes a decision and undesirable results follow, she understandably regrets what she did, despite knowing she did what she had to do. Where she remains at a loss of knowing what to do, her moral distress likely resembles frustration or anxiety. For each of these cases my account is able to explain the subject's condition and how it was brought on by various causes: external or internal barriers (or none at all), which may or may not be overcome, and which might agree or disagree with the subject's moral convictions. Unlike accounts that limit moral distress to an experience caused by one specific sort of situation, my notion broadens the potential causal circumstances and is able to explain the wider range of cases.

Second, I showed that the existing accounts fail to adequately capture the nature of moral distress. Some have offered what appear to be partial suggestions or analogies, such as Jameton's idea that it *involves* frustration or is *related to* guilt. Still, none have explained exactly what it means to be in a state of moral distress. Naturally, the experience is most often understood as being somehow negative. With the account I have offered, we get a clear sense of what distress is, what makes moral distress *moral*, and why it is typically seen as psychologically troubling.

As I indicated in Chapter 1, it seems that it would be extremely difficult, if even possible, to specify a set of necessary and sufficient conditions for being in a state of moral distress. Given the great diversity to be found in the human condition, our emotional responses vary enormously and will surely be much more complex than the picture I have developed here.[39] Due to these recognitions, I have sought to provide a paradigmatic profile of a condition that has remained relatively unexplored. On my account, moral distress is paradigmatically an inner conflict, wherein a variety of negative emotions are met with

[39] For some, no account of the emotions will adequately capture what it means to experience an emotional state as a distinct natural psychological kind (e.g. Griffiths 1997 and 2004).

disagreement by one's sincerely held beliefs. With this, we can see less paradigmatic cases to be those where one's emotions are more consistent with one's beliefs about the relevant state of affairs. Consider, again, *Maryann's indecision*. The distressed subject might feel, say, anxious because of some difficult moral situation and engage in risk-minimizing actions, while believing that such efforts *could* succeed in improving the situation. Anxiety here is rational or fitting. But to the extent that Maryann thinks something akin to *my efforts will not help*, or perhaps *I'm not morally responsible for this morally significant situation*, her experience becomes closer to the paradigm of moral distress.

Third, although prior accounts of moral distress do not articulate precisely how the condition develops over time, as I showed in Chapter 1, it is reasonable to expect that an account of moral distress will be equipped to explain why distress might subside, dissipate, or persist. Considering moral distress to be a complex psychological state marked by inner tension allows us to explain—and perhaps also to promote—such temporal developments. If moral distress occurs where one's emotions are truly at odds with her thoughts or beliefs, the persistence of the condition can be seen as the ongoing occurrence of this disagreement. Additionally, the subject will likely be continually "torn" in her motivations to act. She feels that something is the case (often that she has done wrong) and so should act accordingly, but has a conflicting sense that nothing can be done about it. By contrast, one's experience of moral distress will subside, or perhaps entirely dissipate, to the extent that her negative emotions and her sincere beliefs about the situation no longer conflict. This might happen in one of several ways.[40] On the one hand, a subject's emotional

[40] For helping me to think through these points, I am grateful for my commentator, Ryan Nelson, at the 2017 APA Pacific Division Meeting.

response might no longer be experienced. With time, she overcomes her feelings of guilt or frustration (and so on). This seems to be the more satisfying route for those who wish for moral distress to be completely overcome. However, by holding time to be the primary means of relief, we leave no direct means of overcoming distress.[41] On the other hand, the subject's internal conflict may become a thing of the past. She might come to believe something about the situation that no longer disagrees with her emotional appraisal. That is, she can come to believe that something *can* be done to improve the negative circumstances or that something *should* be done by her (perhaps she has accepted responsibility, which better coheres with her emotional appraisal). Notice, with these temporal developments, her distressful guilt or regret (and so on) become less paradigmatic instances of moral distress, as her psychological state becomes one of greater consistency.

Finally, like the demand to account for various causal circumstances, a robust account of moral distress, I showed, must accommodate the varying degrees to which a subject is aware of or committed to a moral norm. As seen in the case of *Maryann's decision*, one can maintain a firm moral commitment which is upheld in her resulting decision and actions. Nonetheless, as the situation may turn out, she can feel a sense of regret for what she did, while knowing she is only causally responsible for the outcomes. From *no-kill care* we see that one can maintain a moral commitment with some flexibility. The physician was committed to carrying out her practice without directly inducing death, and acting against this may well leave her with a feeling of guilt or shame. Still, she may well believe that she did the right thing, which can allow her commitment to develop in ways that influence her future practice. In *Maryann's indecision* we saw a subject who

[41] Although other routes—therapy, meditation, and so on—appear to be similarly indirect (however deliberate they may be). I will discuss general suggestions for addressing moral distress in Chapter 5.

simply does not know which action among a host of incompatible courses would be best to pursue. This could be because she is not aware of the norm that would be best to act upon, or she is aware of a moral norm (such as acting with beneficence) but unsure exactly how to act upon it. On my account, a subject may be unaware of moral norms or unsure how to act upon one, and be correspondingly motivated to minimize risks or gather additional information, while at the same time believing that risks cannot be mitigated or that no new information can be obtained. In these ways, one's awareness of moral norms or how to employ them in a given situation will vary. Yet there is no reason to say moral distress is experienced only when one knows (or doesn't know) the right thing to do, as many existing accounts maintain. Just as my expansion of the possible causal circumstances allows us to explain a wider variety of cases, expanding the varying degrees of moral commitments will likewise allow for the inclusion of cases that are needlessly overlooked.

In conclusion, my notion of moral distress as a complex psychological state can be seen as satisfying each of the demands for a robust account. With this theoretical versatility, my account is equipped to explain a wide range of cases of interest. As I have suggested only in passing thus far, a better understanding of the nature of moral distress should help to grasp its practical value, both positive and negative. Although most authors on the topic portray it as a negative experience, as something that should be drastically reduced or even eliminated entirely, these suggestions are made without a fully coherent conception of what moral distress is. By invoking my hypothesis of moral distress as a complex psychological state marked by an inner tension, we will see how these prevalent suggestions can be

effectively challenged. In the following chapter, I argue for the positive value of moral distress.

Chapter 3

The Positive Value of Moral Distress

Very few authors have questioned the value of moral distress. As the literature reveals, the experience of it is almost unanimously characterized in a negative light. Among the few exceptions are nursing specialists Patricia Benner (1991) and Cynda Rushton (1992), who both suggest that distress among nurses might somehow contribute to personal or professional growth. Benner, for example, says that being "open to new experience implies learning from failure" and adds that "there is no way to get it right, without sometimes getting it wrong" (Benner 1991, 8-10). Nonetheless, as I established in Chapter 1, moral distress has been found to be closely correlated with medical practitioner burnout, high turnover rates, and staffing shortages, which, in turn, contribute to a greater likelihood of patients receiving inadequate attention.[1] Thus, to some extent, the common judgments concerning its negative value are quite natural.

My goal in this chapter is to add some considerations in favor of the positive value of moral distress. In short, moral distress appears to be much more than a purely negative experience. Despite its ostensibly negative effects and prima facie objectionable quality for those who endure it, as I argue here, moral distress can reveal and affirm some of our most important concerns as moral agents. Indeed, the experience of it under some circumstances

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[1] A number of studies support these correlations, from Judith Wilkinson's (1987/88) early research on moral distress to several more recent accounts (e.g. Corley 2002; Unruh 2010; and Whitehead 2015).

appears to be partly constitutive of an honorable character and it can allow one to undergo a crucial life process of moral maturation. In other words, the potentially positive value of moral distress is twofold; moral distress carries both aretaic value as well as instrumental value.[2]

In order to make this position clear, in section 1, I will expand upon my paradigmatic account of moral distress and critique several recent works calling for a broad yet conceptually useful notion. In section 2, then, I argue for the aretaic value by relying primarily upon my conceptual analysis of moral distress and related psychological responses to undoubtedly troubling circumstances. In support of the instrumental value, in section 3, I will invoke a consequential argument that depicts moral distress as a personally edifying good for the agent who undergoes it. Granted, my position on the positive value of moral distress is not without important caveats, as I establish in section 4. But by making these clear, my account will provide a novel framework for policy recommendations regarding when, if ever, we should work to reduce the experience of moral distress.

1. Invoking the paradigmatic approach

Early accounts of moral distress—still some of the most widely-cited notions in the literature—have come under criticism for their narrow scope. The basis for such criticism is easy to see. Recall, from Chapter 1, Andrew Jameton's introduction of term: "*Moral distress* arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984, 6). Similarly, Judith Wilkinson considered moral distress to be "the psychological disequilibrium and negative

[2] With my use of the term 'aretaic' I refer to considerations of one's character, generally following Watson (1996), Shoemaker (2011 and 2013), McKenna (2012), and Jacobson (2013).

feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision" (Wilkinson 1987/88, 16). As I showed, we have little reason to think moral distress could not result from *taking* action or from being faced with a non-institutional constraint. Indeed, it seems that one could plausibly experience moral distress as a result of various decisions or actions, and without being subjected to any sort of constraint.

Carina Fourie recently raised such issues concerning the overly narrow scope of existing definitions. As Fourie argues, "moral constraint is *not* a necessary condition of moral distress" and we should expand the definition to include moral uncertainty as a potential cause (Fourie 2015, 92).[3] Still, as Fourie points out, her proposed expansion is not a complete definition, but instead a recommended starting point. In a similar vein, Campbell, Ulrich, and Grady suggest that the *types* of moral distress may well range considerably, from mild distress and distress by association to distress resulting from moral dilemmas or bad moral luck (Campbell et al. 2016). Again, a general expansion to the definition is proposed, in order to accommodate the range of cases. And while it appears there is good reason to heed these recommendations for broadening the notion of moral distress, we begin to see the need to somehow delimit the working definition.

Moral distress might be said to include the experience of moral uncertainty, moral dilemmas, and so on. Yet, it is not clear whether such phenomena are intended to describe the causes of moral distress, aspects of the experience itself, or perhaps both. As Denise Dudzinski aptly states, the "symptom of moral distress should not be confused with the source" (Dudzinski 2016, 323). For these reasons, in Chapter 1, I argued that a robust

[3] See, also, Fourie (2017) for a further critique of Jameton's notion and corresponding recommendations to expand the definition.

conception of moral distress must be able to accommodate a range of causal circumstances while still providing a useful description of its nature. Narrow definitions—like those offered by Jameton and Wilkinson—leave out what seem to be plausible instances. Yet, as some authors have worried, broader proposals run the risk of becoming "diagnostically and analytically meaningless."[4] What we are searching for, it may seem, is the Goldilocks of moral distress. We want the definition to be narrow enough to satisfy our interest in meaningful explanations and wide enough to cover just the right amount of cases. However, the expansive approaches as well as those that delimit the range of related phenomena are both relatively unhelpful for specifying the nature of moral distress in terms of some other experience. A more direct approach would be to stipulate a straightforward analysis of the individual terms, then determine what sorts of phenomena are covered by the composite.[5]

One attempt to define moral distress in such a straightforward manner is seen in a recent work by Georgina Morley et al. (forthcoming). Here it is stipulated that "(1) the experience of a moral event, (2) the experience of 'psychological distress' and (3) a direct causal relation between (1) and (2) together are necessary and sufficient conditions" (Morley et al. forthcoming, 15). On the one hand, this suggestion derives plausibility from its independence from related notions like moral uncertainty and moral dilemmas. As a result, the scope of what to include as causes of moral distress need not be specified, and

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[4] This concern was raised by McCarthy and Deady (2008) against the overly broad definitions of *ethical dilemma* and *moral distress*, as proposed by Kopala and Burkhart (2005) for inclusion in NANDA's nursing diagnoses and classifications. While the term "ethical dilemma" has not been adopted, "moral distress" is now defined—in a way that mirrors Jameton and Wilkinson—as "Response to the inability to carry out one's chosen ethical/moral decision/action" (NANDA International 2014, 368). Similar charges are made by Lucia Wocial (2016) against the broadening recommended by Campbell, Ulrich, and Grady.

[5] Although, as Johnstone and Hutchinson (2015) argue, it might turn out that the term is only a social or linguistic construct, one that should be abandoned for having caused more confusion than clarity.

charges of being overly narrow or broad are avoided, at least at first glance. On the other hand, crucial questions remain unanswered, several of which Morley et al. readily admit. As the authors acknowledge, what it means to experience a 'moral event' and the nature of the causal relationship are not clear (ibid.). But further, as I claimed in Chapter 1, positing the experience of 'psychological distress' simply pushes back the problem of clarifying the nature of *moral* distress. And while the direct account on offer sidesteps the usual worries over definitional scope, it is far from obvious that the search for necessary and sufficient conditions is a fruitful approach for dealing with complex conditions bearing upon our psychological makeup.[6]

We might think it is simply an analytic truth that moral distress entails the experience of a moral event. Nonetheless, we have little reason to think that the moral aspect of moral distress must be derivable from *events* that causally influence one's psychological state. Consider, for example, *crying over spilt milk*. Putting aside all philosophically embellished thought-experiments, surely the act of spilling milk has no immediate moral significance. Yet, as we can imagine, an especially sensitive person may be incredibly upset over spilling milk, to the extent that she truly feels she has committed a moral wrong. No doubt, such overly sensitive reactions are likely displayed only by children with undeveloped moral compasses, or perhaps by adults who are irrationally sensitive. Some of us are simply too hard on ourselves. But although the overly sensitive person appears quite irrational, it is not an entirely unreasonable stretch of the term to

[6] The search for necessary and sufficient conditions is also seen in Thomas and McCullough (2015).

describe her feelings of moral wrongdoing—like guilt or regret—as an experience of moral distress.[7]

Granted, cases like that of *crying over spilt milk* are somewhat bizarre, but this is precisely the point to be made here. By maintaining that moral distress is an experience of a moral event and of resulting psychological distress, one must deny *full stop* that crying over spilt milk could ever be morally distressing. Indeed, a great number of borderline cases—those that cannot be neatly captured by the proposed conditions—will need to be somehow explained away. Otherwise, if we are to maintain these three conditions as necessary and sufficient, events like milk spilling must be admitted as having moral significance.

An easier, much more natural route remains open. Rather than denying a host of cases plausibly seen as instances of moral distress, however bizarre the cases may seem, we can preserve the advantageous starting point of positing a direct, analytic characterization, but invoke the paradigmatic approach to the condition, as I outlined in Chapter 2. Moral distress, I argued, is profitably seen as an inner tension, typically where one's negative emotional responses are somehow at odds with her sincerely held beliefs. In the most paradigmatic cases, the conflict will be quite stark. That is, one will feel some negative response like shame or guilt, and be motivated to act accordingly, but while consciously maintaining that nothing can be done to improve the situation. Naturally, being prevented from acting in a way one sees as morally appropriate would suffice to bring about this sort of conflict. Similarly, one might feel a sense of guilt or shame as result of performing some action, while sincerely believing that no wrong was in fact done. In less

[7] To think otherwise is to risk what Shoemaker calls 'emotion-term chauvinism' (e.g. Shoemaker 2015, 40).

paradigmatic cases, the conflict is less apparent, say, where one experiences a negative response but is simply at a loss as to what should be done about it. For example, while one is typically moved to make amends in her guilt-like feelings, in her experience of distress she may have no one to whom amends can or should be made. Consider those who feel indebted through guilt toward the dead. In this way, one is helpless to improve her condition and can only await the passage of time.[8]

At present, it may seem that such potentially irrational psychological states are simply painful and cannot bring about any good. Yet, these intuitions are precisely what I mean to challenge. Before doing so, several additional advantages of the paradigmatic approach can be briefly pointed out. First, on my account, moral distress clearly admits of degrees. Depending upon the extent of one's involvement or the severity of the situation, one may be more or less morally distressed. This appears to align closely with the range of our lived experiences. Consider a combat medic who must help a comrade die peacefully on the battlefield, as opposed to an ordinary citizen reading about the tragedy in the newspaper but still feeling somewhat troubled by it. Second, on a paradigm-based approach to moral distress, there is no need to rule out the bizarre yet plausible cases where one is morally upset over non-moral events. It may be that the irrationally sensitive person experiences moral distress. Notably, by taking moral distress to include irrational emotional responses, we understand more clearly why moral distress is often so distressing. Given the account established here, we can say that those who are too hard on themselves—

[8] As I discussed in Chapter 1, grief is a response that persists, and it provides a useful illustration of this sort of helplessness. Additionally, some cases certainly *call for* grief, in the sense of indicating one's moral sensitivity and helping one to process the experience of loss. For helpful comments on this point, I am grateful to Alison Denham.

those who hold themselves accountable beyond what we (or even they) could reasonably expect—experience a more or less paradigmatic instance of moral distress.[9]

2. The aretaic value

With the paradigmatic approach to moral distress in mind, in this section, I argue for the connection between moral distress and what it means to have an honorable character. As I noted at the outset, my use of the term ‘aretaic’ follows, among others, Gary Watson’s famed work “Two Faces of Responsibility.” Here Watson wanted to make sense of our ambivalence towards those whom we see as having a bad character yet, for some reason, do not deserve additional forms of blame. For many of us (or perhaps for all of us) who we are and what we care about is due to factors largely beyond our awareness or control.[10] When one performs an action that seems clearly wrong, we are likely to attribute the conduct to the agent herself—that is, we make aretaic appraisals which “implicate one’s practical identity,” what it is they value or *stand for* (Watson 1996, 271). Beyond making assessments of an agent’s character, however, we might *or might not* hold her accountable for her conduct, for example, by communicating the offense or imposing punishment, for in some cases it seems unfair to do so. In this way, moral responsibility can be divided into assessments of an agent’s character, on the one hand, and our accountability practices, on the other.

[9] In Chapter 5, I will expand upon moral distress and accountability, along with attributability and answerability as they pertain to moral distress (cf. Shoemaker 2011 and 2015).

[10] Consider some of the recent work on responsibility and implicit biases, for example, Doris (2015), Levy (2017), and Vargas (2017).

Putting aside our practices of holding each other accountable, I want to focus on the appraisals—both the negative and the positive judgments—that we make of an agent's character, of who she is and what she cares about. According to David Shoemaker (2003), it is the things we care about that motivate us to act in some way or other, at least in situations that matter to us. Our caring renders us susceptible to various emotional responses, which ultimately "make us the agents we are" (Shoemaker 2003, 94). When one succeeds in supporting something she judges to be valuable, naturally, she feels a sense of satisfaction, like pride. When one betrays her values, she likely feels a sense of shame or guilt. Importantly, our emotional reactions toward the successes and failures of a given object are indicative of the cares we maintain. As Shoemaker states, "caring is simply a way of referring to the range of emotional reactions one is expected to have with respect to the fortunes of the cared-for object" (ibid.).

Turning to the experience of moral distress, I can grant here that it is usually—perhaps even *always*—an extremely adverse phenomenon. It is often related to or assumed to be partly constituted by some negative emotional response. Andrew Jameton, recall, claimed that initial distress involves "feelings of frustration, anger, and anxiety" (Jameton 1993, 544). I will not here belabor questions of whether or not and how initial distress might make up a distinct form of moral distress.[11] Instead, I want to acknowledge a few general points about the nature and value of moral distress. While the following points, understood on their own, should appear rather uncontroversial, taken together they suggest an outlook on moral distress that clearly runs against some of the most commonly held positions.

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[11] These questions were explored in Chapter 1. See, also, Campbell, Ulrich, and Grady (2016) and Tigard (Forthcoming-a).

First, it appears widely accepted that the morally distressed agent undergoes some "negative" emotional experience. In some cases, such as those where one faces an obstacle to morally appropriate action, one likely feels something akin to frustration or anger, as Jameton suggests. In others, one might experience moral distress as a feeling of guilt or regret, say, where some action had to be taken, despite seeming somehow wrong.[12]

Second, these sorts of reactions are naturally undesirable. It may be difficult to say exactly why we desire to avoid such feelings. I will posit simply that they are phenomenologically objectionable. They constitute a sort of pain. Still, it remains to be seen why these sorts of pain—understood on their own or as instances of moral distress—must be characterized only as objectionable. Surely, we can imagine a young adult learning and growing, say, from the pains of heartbreak. I will return to this point below, in arguing for the instrumental value of moral distress. For the moment, what is important to notice is that while the pains of anger and frustration, guilt and regret are certainly undesirable, there is much more to them than their negative phenomenology.

The third point to be made here, following Shoemaker's (2003) notion of agency, is that our emotional responses tell us something very important about the things we care about and the ways in which we care about them. Some of the most commonly experienced emotional states—indeed, what are often thought to be universal human experiences—serve as key indications that something we care about has been harmed or benefitted, or otherwise noticeably affected. As Justin D'Arms and Daniel Jacobson explain, psychological states like anger, envy, pride, fear, joy, guilt, and regret "both descry and circumscribe a distinctive realm of human values" (D'Arms and Jacobson 2006, 107). A

[12] This point was explained in detail in Chapter 2.

morally distressed nurse might be angry, say, at a patient's family for requesting an aggressive cancer treatment when she knows her patient would rather choose all efforts to minimize the struggle and pain. Among a host of morally significant judgments, what the nurse's anger effectively reveals is that she cares about honoring her patient's wishes, or generally, about her patients' wellbeing. When she sees that a patient is being made worse-off, as we should expect, she likely feels a great deal of anger or frustration toward the source of the harm, given the way she cares about her patients. What sets these instances of frustration or anger apart from the more common episodes of such states is that here she is especially troubled. She alone cannot resolve the harmful circumstances. Indeed, she is in a state of distress, for she would need some form of help to resolve the situation. She might seek additional support for her patient or at least find counseling that can alleviate some of her frustration. Otherwise, it may be that only the passage of time will ease her distress. Still, in that time of distress, her anger and frustration reveals to others—and likely affirms to herself—the degree and the ways in which she cares about her patients' wellbeing.

Fourth and finally, because our susceptibility to various emotional responses is so intimately tied up with the things we care about, it seems that if we did not feel so frustrated or angry when seeing certain persons or objects harmed, it would indicate that we in fact do not care. This point might sound somewhat obvious or trite. However, consider that some of the most common accounts of moral distress recommend systematic efforts to drastically reduce or even eliminate the experience from the lives of healthcare professionals. For example, Mary Corley and others who worked to develop the so-called 'moral distress scale' suggest that "reducing moral distress is an important priority"

(Corley et al. 2001, 256). Corley later called for *preventive* solutions (Corley 2002, 648). Similarly, Musto and Rodney cite the need for “comprehensive actions to prevent and ameliorate moral distress” (Musto and Rodney 2016, 81).

As I have granted, moral distress is undoubtedly a negative phenomenon for those who must suffer it. But imagine we somehow succeed not only in reducing moral distress but in altogether eliminating the experience. Certainly, this could not mean eliminating morally distressing *situations*, for it seems safe to assume that troubling moral circumstances are simply part and parcel of navigating occupations that directly impact sensitive interests and other lives.[13] Perhaps, then, we should strive to eradicate the *experience* of moral distress. Here we begin to see an added complexity of the problem. What would it mean for healthcare professionals to not be particularly troubled or to not need help coping with the difficult decisions and situations they inevitably encounter? On the paradigm of moral distress and on many prominent accounts, this would mean that they do not feel great frustration, anger, guilt (and so on) when observing or being involved in morally significant situations. And for some, this result is exactly what we want, for although healthcare professionals are personally involved, they do not bear moral responsibility for the difficulties and harms to be encountered. Nevertheless, we often think it quite appropriate for a person to feel terribly upset—even to feel morally troubled—where she was not morally responsible for the upsetting events.

Consider Bernard Williams’s popularized case of the lorry driver who accidentally hits and kills a child (Williams 1981). While the driver is not at fault, his uniquely terrible

[13] Bernard Williams often appears to have these sorts of considerations in mind in his investigations of the character and dispositions we expect of one who faces extremely difficult decisions (e.g. Williams 1978 and 1993).

feeling for being causally involved—what Williams calls "agent-regret"—is seen as completely fitting. I will address this response in more detail in the following chapter. At present, it is important to notice that any bystanders to the tragedy should comfort the driver and counsel him away from his bad feelings. Equally important to note is that such counseling should not succeed, at least not immediately. Should the driver's knowledge that he is not at fault allow him to shrug off the events without hesitation, we would rightly question his sensitivity, in the sense of thinking he is not sufficiently recognizing and appreciating how others are affected (cf. Shoemaker 2015). To be sure, we would have significant reason to think poorly of the quality of his character.[14] At the same time, the fact that he beats himself up even over things he cannot control shows that he is sensitive to others and to the morally relevant losses that were incurred. Granted, we would not want the driver to beat himself up too much. That being said, his guilt or remorse (or agent-regret, and so forth) shows that he cares for the others affected and perhaps for the wellbeing of persons, generally. Despite having done no wrong, the fact that he is particularly troubled by morally significant losses and the perceived hardships of others is surely the mark of an honorable character.

It seems clear that, in many cases, the same can be said of those who experience moral distress. While many authors suggest efforts to reduce or eliminate moral distress, the reduction or elimination of it would risk discounting or obstructing important features of one's character. Rather than working to prevent our natural affective responses, very often, we should offer comfort and even praise to those who find themselves especially

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[14] Shoemaker aptly states that the driver would be "quite *callous*" to perk up upon being counseled away from feelings like regret (Shoemaker 2015, 86). Relatedly, Rentmeester (2007) argues against healthcare professionals learning to be callous and claims that *inurement* is a more appropriate response for those who repeatedly face emotionally distressing workplace environments.

troubled in light of the unfortunate circumstances.[15] Of course, some of the most extreme instances will call for exceptions, to which I will return in conclusion. First, I will show that along with its aretaic value, moral distress can be instrumentally valuable.

3. The instrumental value

I claimed above that in being morally distressed, one's outward emotional responses reveal to others the degree and the ways in which one cares for something or someone. Upon reflection, this process of *revealing* our cares may already indicate an instrumental good to be achieved. We want others to know that we care and, often, how much we care. Yet, if this feature alone was the extent of the instrumental value of negative emotional states, it seems that the best-case scenario would be one in which a person successfully *displays* the appropriate emotional response—and thereby displays that she cares—while in fact not suffering the negative phenomenology of the state.[16] While a case could be made, I think, for a truly effective display of an emotion being one where the agent in fact experiences it, I will focus instead on the instrumental goods of moral distress to be realized by the agent herself. Doing so should help to make clear that it is the actual experience of moral distress, and not merely the display of it, that bears potentially positive instrumental value. Then, in Chapter 4, I will turn to moral distress among practitioners as a means of achieving

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[15] In Tigard forthcoming-b, I argue that the sort of comfort provided to the morally distressed might be nothing more than knowing that there are others who have blamed themselves when it was not entirely appropriate to do so. Indeed, in some cases, it seems that only those who have undergone a similarly distressing experience can appropriately offer comfort. While some responsibility theorists speak of victims having *standing to blame*, here we see a plausible notion of bystanders having (or not having) *standing to comfort*.

[16] For raising this worry, I thank David Shoemaker and Chad Van Schoelandt.

consequential goods for others, namely the patients needing assurances of improved clinical practices in the wake of medical error.

First, a relatively straightforward comparative account can be offered in support of instrumentally valuable moral distress. The basic idea is that the experience of an undesirable, painful psychological state can help one to understand and appreciate the more pleasurable emotional states. A similar move has been made by theologians attempting to explain why evil would exist in a world created by an omnipotent and praiseworthy god.[17] It may be that we need evil to know the good, or that we are better off in a world with both than we are in a world of pure pleasure. Still, as commonly noted, this explanation fails to account for gratuitous suffering, that which is obviously excessive or has no apparent purpose. Similarly, we might think, we can surely understand and appreciate pleasurable emotions—joy, pride, happiness—without ever experiencing something as troubling as moral distress. Perhaps just a bit of frustration or occasional anger would do the trick.[18]

Indeed, the experience of moral distress does not seem necessary for acquiring an understanding of and appreciation for pleasurable emotional states. It may, however, be sufficient for this purpose, and this possibility alone reveals some minimal degree of instrumental value. Nonetheless, while the basic comparative account gives some reason to think moral distress might carry positive instrumental value, at least in a minimal sense, it appears that a stronger case can be made.

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[17] See, for example, Hick (1977).

[18] Those with more Stoic or Buddhist inclinations would submit here that an appreciation for states like happiness is achievable without *any* degree of frustration or anger. For arguments supporting the occasional fittingness of all sentimental states, see D'Arms and Jacobson (2006).

Along with seeing moral distress as helping one to better understand and appreciate pleasurable emotions, the particularly troubling psychological state can be seen as helping to develop a deeper understanding of oneself. In being morally distressed, one affirms what one is emotionally invested in and realizes the extent of one's investment. Given that our emotional responses directly implicate our cares, moral distress is equipped to help one understand the things she cares about and the ways in which she cares. But again, we might wonder, couldn't a simpler, less troubling experience of anger, frustration, guilt, or regret allow for the very same sort of personal development? If so, again, moral distress may be sufficient but not necessary for achieving this sort of instrumental value, namely an increased understanding of oneself.[19]

What is important to notice here is that the experience of moral distress is phenomenologically distinct from the emotions thought to be closely related to or partly constitutive of it. Moral distress feels different from the more commonplace episodes of anger, frustration, guilt, and the host of others. The ways of spelling out this difference vary, of course, but on the paradigm developed here—and, indeed, on most accounts—the morally distressed agent is taken to be especially troubled. She is faced with a dire situation, likely one bearing great moral significance, and she needs help from others. If she felt that the situation is entirely manageable, it would be odd at best to describe her experience as distressing. Whereas one who is simply frustrated or angered (and so on) might be

[19] I am extremely grateful to David Shoemaker for raising these sorts of concerns.

reasonably left to deal with the situation on her own, the morally distressed person needs help to improve the difficult circumstances.[20]

In these ways, the experience of moral distress is certainly unique and undoubtedly troubling for those who must suffer it. Nevertheless, the painful phenomenon can also serve as an extremely powerful and distinctive educational experience. Unlike one who is simply frustrated or angered upon seeing the object of her cares harmed, the morally distressed person comes to know exactly what it is like to care about something and to be helpless with respect to its fortunes. Unlike one who is ridden with guilt or regret upon acting against her values, the morally distressed person learns what it is like to know that the right thing was done, despite being regrettable. Acquiring such an intimate understanding of these ways of caring for something, and thereby better understanding oneself and what one would do in such circumstances, is surely an instrumental good for those who are fortunate enough to suffer in this way. Consider, for example, a variation of the case of *no-kill care*, established in Chapter 1. Call it *pro-kill care*. Here, a palliative care physician values helping her patients in any way possible, but cannot legally administer a lethal dosage that would allow a dignified death for her long-time patient who competently requested the treatment. Naturally, the physician may feel a sense of frustration or even guilt for not being able to honor her patient's wishes. Through this experience, she might learn that she cares too much about patients' dignity to let certain laws govern the duration of their lives. Perhaps she becomes increasingly invested in the political movement as an outspoken advocate for the right to receive aid-in-dying. Despite the pain of her morally distressing

[20] Here we see one explanation of why moral distress is often associated with the feeling of powerlessness. See, for example, McCarthy and Deady (2008), Wilkinson (1987/88), Dudzinski (2016), Johnstone and Hutchinson (2015), Burston and Tuckett (2013).

experience, the physician undergoes a crucial life process of uncovering and openly affirming some of her most deeply-held values. As we can imagine, without her experience of moral distress, she might have never learned just how much—or in what ways—she cares about the causes she finds so dear to herself.

It remains to be seen why moral distress must be characterized only in a negative light. To be sure, some cases of moral distress show that the distinctive sort of psychological pain can be positively good. We can and often do learn and grow when our cares are put to the test. We can come to better understand and appreciate the contrasting, pleasurable experiences in life. But moreover, the troubling state of moral distress may well help us to develop a distinctive and profound awareness and affirmation of the things we care about and, indeed, of who we are.

4. Caveats and conclusion

Certainly, some instances of moral distress are simply too much to handle. They may often be nothing but painful, with no foreseeable good to come about as a result. These recognitions allow for several rudimentary but important qualifications to the account I have offered here.

Although the experience of moral distress, under various circumstances, is closely aligned with what it means to have an honorable character, to be sensitive to morally significant circumstances and moral losses, surely we can imagine a degree of sensitivity beyond that which fosters an honorable character. Consider, once again, Williams's lorry driver, who understandably beats himself up over what happened and who should not be immediately consolable. While we know him to be a good person by his sincere emotional

reaction, however irrational it is to feel guilt or regret, there comes a point when we expect him to move forward. Dwelling on and on about tragedies long passed, even if one was morally responsible, seems to show that one is excessively sensitive or disturbed. In such cases, it is only natural that we work to help someone away from their lingering negative feelings. When exactly that point has been reached will depend upon the situation, the distressed individual and surrounding community, among other factors. But until that time, we should recognize and encourage—indeed, we should praise—the moral goodness of a person who is appropriately sensitive to moral losses.[21]

Further, while the experience of moral distress carries the possibility of allowing one to learn about themselves and to grow in terms of moral maturity, these are merely speculative prospects among a host of possibilities. It is of the utmost importance that we account for them in our efforts to implement institutional policies aimed at addressing moral distress. For it may be that one's distressing experience effectively reveals to others and affirms to oneself what one truly cares about and to what extent. Nevertheless, it cannot be denied that some experiences of moral distress have either no instrumental value, or are such that the good to be achieved is not worth the cost of the pain. Again, in these sorts of cases, it is a natural and humane response for individuals and institutions to carry out efforts to mitigate the difficult psychological states we experience.[22]

What I have said here is surely not the end of the story to be told about moral distress. Much more remains to be said, and indeed more remains to be seen, regarding the

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[21] Jacobson (2013) makes a convincing case for Williams's lorry driver aptly feeling irrational but praiseworthy guilt.

[22] In Chapter 5, I establish several general guidelines for how moral distress can be most effectively addressed.

value of the troubling experience, in both its negative and positive lights. Still, with the considerations offered here, I hope to have shown several ways in which we might at least call into question the prevailing assumptions concerning this peculiar phenomenon. The experience of moral distress may well be a painful one, but under certain circumstances it can in part constitute an honorable character and to suffer the experience can allow one to undergo a crucial life process of moral maturation. In these ways, moral distress bears significant positive value, both aretaically and instrumentally. With the positive value in mind, in the following chapter, I turn to a specific context in which a practitioners' experience and expression of moral distress can be particularly beneficial, namely, the occurrence of medical error.

Chapter 4

Moral Distress and Medical Error: Taking the Blame

Like our errors in everyday life, errors in medical contexts are extremely common. As reported by the Institute of Medicine, an estimated 44,000 to 98,000 deaths per year in the U.S. alone are attributed to medical error.[1] Perhaps surprisingly, the body of bioethics literature addressing moral responsibility for medical error is quite sparse. Of the attention that has been given, much of it has focused on the importance and legal requirement of informing patients, and on what exactly should be said when something goes wrong (cf. Josefson 2001; Edwin 2009; Petronio 2013).[2] In a recent account, Nancy Berlinger and Albert Wu suggest that medical education should include learning how to disclose errors, apologize, meet injured patients' needs, and "confront the emotional dimensions" of one's mistakes (Berlinger and Wu 2005). On this account, it is even said that "physicians should *take responsibility* for their own errors by personally disclosing and apologizing for them" (ibid. 107, italics added). Still, what it means to *take responsibility* is not entirely clear, particularly when Berlinger and Wu claim that "responsibility should not be confused with

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[1] Institute of Medicine (1999: 26). The lower estimate—which nonetheless makes up the 8th-leading cause of death, according to the report—is based on hospital admissions in Colorado and Utah, while the higher figure is based on New York hospitals.

[2] Josefson (2001, 9) states that "over 95% of medical errors went unreported." Considering this finding, we see good reason to support the rules requiring hospitals to inform patients of errors, issued in 2001 by the Joint Commission on Accreditation of Healthcare Organizations.

blame" (ibid.). In fact, this work is one among a larger shift in recent times away from notions of blame in healthcare.

In a follow-up to the Hastings Center's report, "Promoting Patient Safety" (Sharpe 2003), Mark Meaney argues that we must transition from a 'culture of blame' to a 'culture of safety' (Meaney 2004, 358). Yet, it seems indisputable that ensuring patient safety should be an obvious and ongoing objective. Further, the shift away from notions of blame stands to deprive us of a crucial resource for promoting systematic improvements, on both a personal and an institutional level. As I argue in this chapter, the practitioner who truly *takes the blame* is in the best position to disclose medical errors to harmed patients and families, whether or not she is directly responsible for the error in question. Building upon my discussions of the nature and value of moral distress, I will establish an account of 'taking the blame' wherein the practitioner who exhibits moral distress shows that she and the institution she represents are committed to improvement. In these ways, my account will echo the recent work of Elinor Mason, who argues that—even in cases where we are not strictly culpable—we should take responsibility, namely "because of the goods to be realized" (Mason 2018, 2). In short, exhibiting a genuine sense of moral distress can be seen as an effective means of taking the blame and, thereby, as one of the most appropriate manners in which errors are disclosed.[3]

My argument for the importance of moral distress in disclosing medical error will proceed as follows. First, in section 1, I will adopt a straightforward understanding of medical error and some examples to set the stage. I will then, in section 2, critique the

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[3] Admittedly, there will be a host of empirical questions lingering. For example, do morally distressed practitioners actually improve? Do they help others more than unaffected practitioners? Given the nature of this project, my purposes are to offer primarily conceptual considerations. I will suggest possible directions for future research in the closing chapter.

arguments for prioritizing safety rather than blame as the most appropriate response to errors. As I have suggested, I do not intend to dismiss the need to work toward increased safety. Instead, my purpose will be to reestablish the significance of blame in healthcare settings. In section 3, I will appeal to Mason's account of taking responsibility and provide several important adjustments, which will help us to see how moral distress can and often should be used as a mechanism for taking the blame. I conclude, in section 4, by applying this mechanism to the responses offered to patients and families harmed as a result of errors.

1. Medical error

Our understanding of medical error need not be complex nor controversial; however, the analysis to follow will be made clearer by establishing several basic points. First, following the Institute of Medicine's report, *error* can be known as the "failure of a planned action to be completed as intended…or the use of a wrong plan to achieve an aim" (Institute of Medicine 1999). Second, errors in healthcare settings, of course, often lead to *adverse events*, namely, harms "caused by medical management rather than the underlying condition of the patient" (ibid.). Third and finally, unlike the widely-cited report issued by the Institute of Medicine, I will not assume that all adverse events occurring as a result of medical error are preventable. Indeed, some cases show that a patient's injury or death may be an extremely adverse event brought about by medical error, but also one that could not

have been prevented given the circumstances.[4] This brings me to the first of several examples to be presented here.

Consider Martha, an oncology nurse at an understaffed hospital.[5] On a particularly unfortunate shift, Martha finds herself responsible for tending to five patients, two of which suddenly need immediate life-saving attention. Naturally, Martha cannot be in two places at the same time, and she chooses to tend to Patient-1 while Patient-2 has a cardiac arrest and dies. While Patient-2's death is an adverse event to the extent that it was caused by medical management, it is not obvious that Martha should apologize for her actions. After all, it was simply not possible for her to fulfill every competing demand that had been placed upon her. Still, given that the death of Patient-2 occurred on her watch, it seems she owes at least an explanation to the family. I will return to this example, below, in arguing that the explanation offered to Patient-2's family would be best received where the nurse experiences genuine moral distress.

For the moment, consider a second example, one wherein the practitioner clearly owes not just an explanation, but also an apology for the error and resulting adverse event. Dr. Robert administers insulin to her diabetic patient after failing to see that an attending nurse has already administered the appropriate dosage.[6] While overdosing can have lasting and even fatal effects, Dr. Robert's patient experiences moderate but temporary discomfort.

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[4] Along with the cases discussed in Chapters 1 and 2, such situations are illustrated by Fredriksen (2006), who argues that the problem of "medicalization"—namely, our increasing reliance upon medical solutions—is best understood in terms of tragedy, where irreconcilable conflicts are faced.

[5] The following scenario is an adaptation of real-life events portrayed in "Widespread Understaffing of Nurses Increases Risk to Patients" by Roni Jacobson (2015).

[6] This case is presented in Bjorksten et al. (2016). Elsewhere, errors in medication—including "wrong patient, time, dose, drug, or mode of delivery"—have been identified as the most common form of medical error (Cook et al. 2004, 36).

Unlike the previous case, here it is obvious that the adverse event could have been prevented, say, by Dr. Robert double-checking with the attending nurse. And while, intuitively, the preventability or lack thereof might allow us to clearly distinguish cases where practitioners owe an apology from those where they do not, both cases can be said to demand the same sort of response. Exactly what that common response should be remains an unsettled issue in the existing literature.

2. To blame or not to blame?

Is it appropriate to blame medical practitioners for harmful errors? On the one hand, as the examples above suggest, we might think blame is entirely fitting, at least in cases where the practitioner could have reasonably prevented the adverse event. But beyond the potential fittingness of blame, some claim that medicine is a "learning culture in which everyone makes mistakes, and from which everyone is expected to learn" and, importantly, that "blame can be useful as a stimulus for learning and improvement" (Collins et al. 2009, 1289; Bosk 1979). I will return to this sort of consequential line of argumentation in discussing how and why one might *take* the blame. For the moment, it must be pointed out that, on the other hand, blame itself is often seen as contributing to the ongoing harms. Indeed, a common theme to the arguments supporting the shift away from blame is the idea that it may actually hinder our attempts at systemic change. It is claimed that medical professionals fear being blamed due to the risk of malpractice lawsuits or because of the stigma attached to having one's expertise called into question. Clinical nurse specialist Lisa Day, for example, says "if providers fear a punitive response from management they will be more likely to hide their errors…*blame-free error* and the elimination of shame by

shifting inquiry to the system is an important step toward a safer hospital environment" (Day 2010, 298, italics added).[7]

Recent literature shows that the shift away from personal blame and toward a "systems" approach to safety is gaining prominence. Because blame is said to allow errors to remain hidden, many authors support more comprehensive reforms instead, such as non-punitive reporting and collective accountability (cf. Liang 2001; Day 2010). However, it is not clear that removing or avoiding blame in medical settings is possible, nor is it necessary for improvements in safety or patient-practitioner relations. Further, removing notions of blame threatens to drastically reduce the efficacy of apologies and forgiveness in cases where such exchanges are entirely fitting. In other words, blame-free errors in healthcare are not possible or necessary, nor are they desirable. Before explaining what it means to take the blame, allow me to expand upon each of these points.

Blame-free errors are not possible

Along with leaving the nature of blame undefined, what the blame-free arguments fail to account for is that blame directed at medical practitioners can have various sources. Practitioners might be blamed for errors, of course, by the harmed patient or family, by fellow practitioners or the general community, or simply by themselves. The thought of being blamed by others—the patient, family, one's colleagues or community—may well reinforce a practitioner's fear of receiving some sort of punishment. However, self-blame should be largely inescapable for the practitioner who truly values the wellbeing of her patients. By self-blame I have in mind the process by which one responds negatively with

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[7] Some version of this argument is also seen in Liang (2001), Meaney (2004), Hoffman and Kanzania (2014), Hubbeling (2016), and Friesen (2018).

some sort of reproach toward her own decisions and actions.[8] Emotional responses such as guilt, shame, and regret fit this profile of self-blame by definition. As discussed in Chapter 2, these negative self-directed emotions characteristically appraise one's decisions and actions as faulty or oneself as having some sort of defect. Accordingly, such responses are distinguished by the subject's motivation to act in a way that repairs the wrongs or improves future decision-making procedures. In this way, self-blame can serve as a powerful impetus for change, a point to which I will return.

In a recent study on blame in palliative care, Collins et al. (2009) conclude that blame towards colleagues is rare and blaming the "system" lacks emotional content, which would appear to strip it of its characteristic motivation to incite change. Physician self-blame, however, was found to be "ingrained…as a response to perceived errors" (Collins et al. 2009, 1290). Indeed, for the practitioner who truly cares for patients' wellbeing and whose erroneous action brought harm to her patient, it is hard to imagine her being without some response akin to guilt, shame, remorse, or regret. To be sure, where practitioners do *not* blame themselves, it seems that others—the patient or family, colleagues or community—would then have even more reason to blame, that is, both for the error itself and for the practitioner not responding appropriately to harmful decisions and actions. In this way, it seems that where there are errors we should expect to see blame.

Granted, it might be thought, surely cases where an error could not have been prevented are such that the attending practitioner will not be blamed, either by herself or others. Consider, again, the overwhelmed oncology nurse who did all she could do, despite

[8] Following P.F. Strawson's famed account of the reactive attitudes, the general view of blame I have in mind can be thought of as an affective account (cf. Tognazzini 2013). However, as I will explain, the experience of moral distress—by which one *takes* the blame—also involves distinct cognitive and motivational components.

her patient dying as a result of medical mismanagement. Because the death is properly attributable to the staffing shortages, a *responsible blamer* would be more inclined to blame, say, hospital management than to blame the practitioner who finds herself stuck in a tragic dilemma.[9] Nonetheless, it is only natural that the nurse's reaction to herself will be one marked by some degree of self-blame, even where she knows she is not morally at fault for the patient's death.[10] Of course, many will think, the nurse too—along with the family and community, and so on—*should* blame the hospital's management for allowing such devastating staffing shortages to occur. And while the nurse may well respond negatively to hospital management, as Collins et al. make clear, practitioners typically take a highly personalized approach to their work and "tend not to think of errors in a systems context" (ibid. 1290). Importantly, they add, the transition to a "blame-free culture requires a systems perspective" (ibid.). Thus, it appears that blame is too thoroughly embedded in healthcare to be eradicated with a shift in focus toward the "system." In all likelihood, then, blame will be cast, at least upon the institution if not also upon individuals, namely where blame is not already taken. In other words, blame-free errors are likely impossible.[11]

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[9] Here I have in mind Marilyn Friedman's notion of blaming *responsibly*, namely her proposed condition of requiring "warrant" for blame, in the sense that the potential blamer must be justified in thinking "that the wrongdoing really occurred, the blame recipient did it," among other things (Friedman 2013, 274).

[10] For a related account of "carer guilt" (namely in palliative care), see Bennett (2018). I thank Nick Sars for bringing this recent work to my attention.

[11] Perhaps I should qualify this conclusion to read: blame-free errors are likely impossible *where we maintain the ability to hold someone accountable*. Considering an absolute "systems" approach to healthcare—or a not-too-distant future where artificially autonomous systems decide one's fate—we can certainly imagine the impossibility of coherently assigning blame. However, here we begin to see how such an approach may well be undesirable.

Blame-free errors are not necessary

Contrary to the fears of punishment cited by those who oppose blame in healthcare, self-blame expressed through an apology may well decrease blame from others and even stands to decrease the risk of malpractice lawsuits. According to one study (Gallagher et al. 2007), patients expressed a preference for an apology that signals the practitioner's "sense of regret and a desire to do better going forward" (Robbennolt 2009, 377). Elsewhere, it was found that almost half (40%) of malpractice claimants say "they would not have *felt the need* to file the suit" if they had received an apology.[12] As it turns out, most patients harmed as a result of an error "wanted to prevent the same thing from happening to someone else, to receive an explanation for what had happened, or for the doctors to realize what they had done" (ibid.). Should practitioners readily blame themselves, they would be in a better position to convey to patients that the error is being taken seriously and that they are committed to improving their practices.[13] Retaining notions of blame—namely, self-blame—is, in this way, a means of avoiding the punitive measures often feared by practitioners who error.

[12] See Vincent et al. (1994), cited from Robbennolt (2009). Italics added here to note the skepticism of those (namely, Nathan Biebel) who call "bullshit" on the idea of apologies leading to fewer lawsuits. Indeed, respondents seeking compensation for medical negligence may well feel less of a *need* to file suit upon receiving an apology. This, of course, does not necessarily indicate that apologies would in fact decrease the number of malpractice suits.

[13] One might object here that if the goal is to avoid lawsuits or blame from others, practitioners must only *look* as if they're engaging in self-blame. I thank David Shoemaker for raising this worry. No doubt, it would be difficult (and would require a degree of empirical support) to assess whether or not actual self-blame appeases harmed patients more than the appearance of self-blame. As I briefly mentioned in Chapter 3, my intuition is that we're quite good at detecting genuine emotional responses versus a *show* of emotion. In either case, the key point here is that where we hold increased patient safety as the goal after error, such improvements can certainly be pursued whether or not errors are met with blame. Those who argue for the shift away from blame would have us think otherwise.

As suggested above, some argue that blame will only upset the erring practitioner and that it would hinder any impetus to improve, on either a personal or systemic level. Jill Klein, for example, claims that for "a *growth mindset* clinician, a serious error…is likely to be motivating" and that a "culture of blame is the opposite of a growth mindset culture" (Klein 2017, 983, italics added). On this line of thought, blame is apparently not likely to be motivating; thus, allowing errors to go blame-free might represent a step toward safer healthcare. However, doing away with blame is not necessary for improvements. Surely, efforts can be made to increase patient safety without moving away from the so-called "culture of blame" that is said to *pervade* healthcare (cf. Meaney 2004). In fact, some have found that practitioners who accept responsibility are *more* likely to improve their practices than those who do not (Wu et al. 1991). Self-blaming responses like guilt and regret motivate one to repair the wrongs committed and to change the ways in which one makes decisions in the future.[14] Those who engage in these sorts of negative self-directed responses are inclined to learn from their mistakes, and by conveying such motivations the reasons to be blamed by others can be alleviated. That is, victims of harmful errors can be assured that erring practitioners will likely improve in ways that help to protect future patients from similar events.[15] Thus, removing blame is not only unnecessary, it may well work against the goals of reestablishing patient-practitioner relations and of improving clinical practices after harmful errors. Meanwhile, efforts to increase patient safety can be made independently from any shift away from notions of blame. Indeed, continual

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[14] Cf. Frijda (1988), Roberts (2003), and Shoemaker (2015). In Chapter 2, section 3, I detailed the affective, motivational, and evaluative components of these emotional responses.

[15] Again, however, this claim is highly speculative and stands open to empirical confirmation or denial. This worry was raised in footnote 3, above, and will be addressed in my concluding chapter as a possible area for future research.

improvements in safety should not depend upon whether or not we do away with any sort of blame.

Blame-free errors are not desirable

Moral theorists have often thought that in order to be forgiven, one must show an understanding of the harm caused, apologize for and repudiate the action in question, make amends for the damages, and so on (cf. Swinburne 1989; Murphy 2003; Griswold 2007). The very idea of apologizing seems to entail an admission of one's fault or, at least, an acknowledgment of what one has put the other through.[16] Without a genuine sense of guilt, shame, regret, or some related response, it may appear that one who errs does not fully understand or admit the harm she caused. Without notions of blame in healthcare, then—in a world where practitioners' mistakes bring about adverse events, yet they remain blame-free—the process of offering an apology is without the meaning and value it possesses in ordinary interpersonal exchanges. And if apologies are indeed a key component of forgiveness, doing away with blame is likewise to remove the possibility of forgiveness in such contexts. For these reasons, rendering errors blameless looks to be far from desirable.

Berlinger and Wu maintain that the goal after medical error has occurred is to enable patients' forgiveness. With this in mind, they recommend that physicians take 'prospective' responsibility, namely by discussing mistakes, improving practices, and fulfilling such role obligations as the duty to disclose errors (Berlinger and Wu 2005,

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[16] Shoemaker (2015, 107) makes clear that an offender's acknowledgment must be prior to any of our "sanctioning" aims, such as scolding or punishing.

107).[17] Still, they claim, responsibility "should not be confused with blame" (ibid.). Yet, here we must ask whether or not we truly want practitioners to be entirely blame-free. For those like Dr. Robert—those who could have and clearly should have acted differently—it is at best unclear why or how one could be held responsible but blameless.[18] No doubt, in ordinary interpersonal exchanges, being morally responsible but without self-blaming responses (like guilt or regret) would render apologies far less effective and forgiveness less appropriate. But for cases like Dr. Robert, and even for those more like Martha, some sort of apology from the practitioner and forgiveness from the victims appear to be entirely fitting and useful for moving forward. If our goals in the wake of medical error are to increase patient safety and improve severed patient-practitioner relations, it seems that we must utilize all resources at our disposal.[19] Systemic efforts, including more efficient reporting and disclosure of errors, are, of course, one obvious route. Allowing for practitioner self-blame, perhaps even encouraging it, is yet another. In this way, the removal or avoidance of blame serves only to decrease the means by which we might help patients and families to move forward.[20]

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[17] Berlinger and Wu (2005, 107) note that informing patients of errors—or even "unanticipated outcomes"—is now required by the American Medical Association and American College of Physicians, and that in the U.K. disclosure *and apology* are considered professional obligations. See also Josefson (2001).

[18] McKenna (2012) offers an example of Joe strolling and encountering a man needing help, which would require a supererogatory act. At the same time, Joe could easily rob the man. Joe does neither and, according to McKenna, he is responsible but does not merit praise or blame. While this case helps to establish the conceptual possibility of responsibility without blame, the same cannot be said of Dr. Robert (or Martha), for surely practitioners have duties that play a role in their responsibility status. I will address professional duties, specifically, below.

[19] Rebecca Dresser (2008) considers support for apology laws, namely that apologies might promote trust in physicians and institutions, but also notes that such laws "are just one component of a broader regulatory and institutional effort" needed to address the occurrence of medical errors (Dresser 2008, 6).

[20] For encouraging me to make this point clear, I thank Nick Sars.

In the following section, I argue that practitioners who *take the blame* are in the best position to disclose errors, apologize, and to demonstrate a commitment to improvement for themselves or their institutions. As I will show, my account of moral distress provides an effective mechanism by which blame can be *taken*, specifically, in cases where one could not have been expected to act differently.

3. Taking the blame

In the previous section, I argued that allowing medical errors to go blame-free is likely impossible, given practitioners' propensity for self-blame and the fact that others would blame where the practitioner fails to blame herself. Additionally, allowing for blame-free errors is not necessary, namely, for pursuing the obvious goal of increased patient safety. And finally, allowing for blame-free errors is not desirable, considering in particular the need to repair patient-practitioner relations and the fact that blame enables effective apologies and appropriate forgiveness. I take it that these points help to reestablish the significance of blame in cases of medical error, against those who would encourage us to shift altogether away from a 'culture of blame' in healthcare. Nonetheless, it may seem that all three of these arguments apply much more clearly—and perhaps exclusively—to cases (like Dr. Robert) where the practitioner could have and should have done things differently. Thus, in what remains of this chapter, I want to set such cases aside and address the situations that do not fit the arguments above as neatly. I will argue here that even in cases (like Martha) where the practitioner could not have prevented the adverse event, one can and should *take the blame* for the occurrence of medical error. In doing so, I follow the recent work of Elinor Mason (2018), who makes a strong case for the plausibility and

significance of *taking responsibility*. As I will explain, my account will be set apart with several important adjustments.

"Taking responsibility"

Central to Mason's notion of taking responsibility is the idea that there are cases of "ambiguous agency."[21] That is, there are situations in which one is not strictly liable in the sense of owing reparations, perhaps monetary compensation, for some harm. At the same time, a harm has been inflicted and it is somehow connected to the agent. Still, the agent does not maintain a poor quality of will and, thereby, cannot be considered blameworthy, at least not immediately. As Mason explains, we see "acts that are plausibly the agent's acts, and yet the badness of them does not seem traceable to the agent in any meaningful way" (Mason 2018, 8). At first glance, such scenarios appear to be precisely the sort described by Bernard Williams as instances of bad moral luck. Recall Williams' famous example of the lorry driver who accidentally hits and kills a child (Williams 1981). Of course, the driver is not blameworthy for the unfortunate state of affairs; yet he feels appropriately bad in a way that differs from the bad feelings of any bystanders. With this difference, Williams claims that regret can be experienced "in principle, by anyone who knows of" the accident, but 'agent-regret' is the sort of response that targets one's own actions and "can extend far beyond what one intentionally did" (ibid. 27-28). As opposed to the general sense of regret plausibly experienced by any bystander to unfortunate circumstances, agent-regret highlights the fact that one might be causally involved in—but

[21] Not to be confused with Shoemaker's concept of 'marginal agency' which I will discuss in Chapter 5. Mason credits the term '*penumbral* agency' to David Enoch, but takes this notion to be too broad, as it includes the actions of one's child, dog, or country (see Mason 2018, note 22).

not morally responsible for—bringing about some harm. Nevertheless, agent-regret does not exactly capture the phenomenon Mason has in mind. Likewise, it seems that much more can be said of the practitioners who do their best but still play a causal and even deliberate role in events that result in harm to their patients.

Mason asks us to imagine the case of Perdita, who borrows a necklace bearing sentimental value from a friend but then loses it (Mason 2018, 9). As the story goes, Perdita meant no harm; the loss of the necklace was just a *glitch*, Mason calls it. She "simply forgot where she put the necklace" and, as Mason aptly suggests, she "should feel really bad about what she did, *even though* there was no bad will" (ibid.). But what sort of bad feeling should Perdita experience, and how does this help us to understand what it means to take responsibility? On Mason's account, Williams' notion of agent-regret is not enough, for Perdita should not respond in a way that indicates only causal involvement. Indeed, upon reflection, we see significant differences between Perdita's situation and that of the lorry driver. Most importantly, the lorry driver does not maintain a personal relationship with those who are harmed as a result of his actions. By contrast, Perdita lost something valuable that belonged *to her friend*. As Mason explains, being in a personal relationship—namely, being a friend or a spouse—entails a number of requirements, most notably duties that require "attitudinal back up." That is, many of our duties in relationships are simply practical and we negotiate them, like who will take out the trash or how frequently the in-laws ought to be visited. Still, some of our duties are accompanied by distinct attitudes and feelings in the sense that they demand our *investment*. But being invested in a duty, Mason says, is not only a matter of maintaining certain attitudes and feelings about *having* or *doing*

one's duty; instead, "investment in our duties has implications for how we should react to *failure* to do our duties" (ibid. 15, italics added).

With agent-regret, it may be that one still sees herself as somehow removed from the negative circumstances and harms she brought about. In other words, she might recognize her causal involvement, while nonetheless seeing her actions merely as links in an unavoidable causal chain stretching far beyond her control. But remorse, on Mason's account, shows that one is seeing some action with a sort of *ownership*. In its cognitive aspect, remorse is known as an experience where one believes that an action is wrong, that one performed the action all the same, and accordingly that one should not have acted in this way.[22] Mason explains that it is "conceptually possible to feel remorse even for acts that were not under our control," namely in cases of ambiguous agency (Mason 2018, 12). No doubt, this possibility raises significant questions for how we ought to respond to harms occurring in a variety of relationships. Where an agent's inadvertent actions cause harm to her friends or family, as in Perdita's loss of the necklace, she can see the action as her own. Crucially, seeing an action as one's own allows us to "voluntarily extend our responsibility zone in order to secure the respect and trust of others" (ibid. 14). *Taking responsibility* in this way is, according to Mason, required by our investment in the duties that go along with personal relationships. In short, we should often take responsibility—by *owning* certain actions and feeling remorse—because of the "goods to be realized."

This account provides a highly plausible mechanism by which medical practitioners might apologize for errors (including those beyond their control) and in a way that conveys

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[22] This is the general characterization of remorse adopted by Mason, which seems uncontroversial, at least when setting aside the affective and motivational components. Related descriptions are found in Roberts (2003, 222) and on de Wijze's notion of 'tragic-remorse' (de Wijze 2005).

a commitment to improving patient safety and repairing patient-practitioner relations. Nonetheless, it appears that the mechanism can be strengthened by making two key adjustments. The first will require a bit more legwork, as it involves making room for moral distress as the appropriate response to inadvertent harms. But the second will be relatively straightforward, as I intend simply to expand the scope of applicability to encompass professional relationships.

Taking responsibility via moral distress

Holding remorse as the operative response is far too narrow and, as I will show here, the experience of moral distress provides a more accurate characterization of one truly *taking* responsibility. Mason claims at the outset that often "we should take responsibility" and, as it turns out, this process "*requires* owning our failures, *feeling remorse*" (ibid. 2, 15, italics added). From these two claims, it can be said that often we should feel remorse, namely when agency is ambiguous and when the respect or trust of others can be secured. However, to say we should feel remorse under *any* given circumstances is a rather bold prescription. "Feelings," Mason points out, "notoriously, cannot be commanded" (ibid. 14). Perhaps this is why the account of remorse is focused primarily on its cognitive aspect: one should often believe that she performed an action that was wrong and that she should not have done so. Even then, it is far from clear that the experience of remorse can be commanded.[23] But more importantly, the expectation that one should experience some specific negative self-directed response appears overly restrictive and unnecessary for achieving the goods that stand to be realized. Allow me to explain.

[23] Commanding such cognitively-laden experiences would appear to require doxastic voluntarism, and I simply cannot go down that road (in terms of theoretical commitment and with respect to this chapter).

In making the case that Perdita should feel remorse, Mason appeals to McKenna's (2012) conversational model of responsibility and envisions the exchange that ensues from Perdita's loss of the necklace. In the first version, when Perdita apologies and the friend asks 'what happened?' Perdita responds with no negative self-directed emotion, saying "I spaced out…it was just a glitch" (Mason 2018, 16). Undoubtedly, here the friend would be reasonably upset, not simply at the loss of her sentimentally valuable necklace but also at Perdita's *heartless* apology. It may be true and understood by both parties that Perdita had no ill will and that the loss was entirely inadvertent. Still, the friend can expect that Perdita will respond to herself negatively in light of the situation. She can expect Perdita to not use the 'glitch' as an excuse, and to take her perspective and the loss seriously.[24] In the second version of the conversation, this is precisely what happens. The friend asks 'what happened?' and Perdita makes clear that she is making no excuses, saying "I wish I could undo it." For Mason, Perdita fittingly feels remorse, as she "should be thinking about the harm to others, not focusing on her own innocence" (Mason 2018, 10).

However, it is not at all clear that remorse alone is necessary for taking responsibility. Indeed, remorse appears to be one among a host of plausible responses that would effectively convey to others that one is thinking about the harm inflicted and that one feels ownership of the action, even where it was completely inadvertent. As I outlined in Chapter 2, shame is characteristically a feeling that one is defective or has failed to be respectable (Roberts 2003). As such, the ashamed person is often motivated to disappear, perhaps especially from the sight of those harmed as a result of one's failures (Frijda 1988).

[24] Relatedly, Shoemaker describes 'taking someone seriously' as taking others' "normative perspective to bear a weight" in one's deliberative perspective, that is, as an exercise of *evaluational* or *emotional* regard (Shoemaker 2015, 97-99). In terms of 'taking' responsibility, taking others seriously can be seen as taking their normative perspective to bear weight upon our responses to inadvertent harms.

Further, although Mason dismisses guilt with the thought that "we could say [guilt] requires voluntary action" (Mason 2018, 12), the key to taking responsibility is seeing an action as one's own and feeling *really bad* despite having no ill will. In this way, even if guilt fittingly responds only to voluntary action, we can certainly imagine one responding to inadvertent harms with unfitting guilt and thereby taking ownership of the action.[25] Importantly, the experience of shame or guilt—no matter how fitting—stands to achieve the same consequential goods realized by the experience of remorse. For that matter, while agent-regret is *merely* a response to one's causal involvement, there seems to be no good reason to think agent-regret would be utterly ineffective at securing the respect and trust of others.[26] After all, responses resembling regret characteristically motivate one to change decision-making policies (Shoemaker 2015). And surely, an agent's motivation to improve her future decisions would at least help to repair and secure the respect and trust of others.

Imagine, again, the case of Perdita (version two) but where somehow the friend is able to detect that Perdita's emotional response resembles guilt and not remorse. Would the friend in this version (say, 2.1) really think that Perdita is any *less* invested in the duties of their friendship than where she responds with remorse? It seems that she would not. Remorse may well attach fittingly to "less voluntary or involuntary sins" (Mason 2018, 12). However, experiences of guilt, shame, or regret—even if less fitting—effectively convey to the harmed parties that one is not making excuses, that the action is being *owned*,

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[25] See Jacobson (2013) for a persuasive account of irrational but praiseworthy guilt, namely as experienced by Williams' lorry driver.

[26] In fact, considering again the case of the lorry driver, it seems that the driver's experience and display of agent-regret would be quite effective at helping others—even the deceased child's parents—to see the driver in a positive light. This is at least one reason why others understandably counsel him away from feelings resembling regret; they see him as a good person (respectable, trustworthy) for experiencing something like regret.

even where it was inadvertent. As I argued in Chapter 2, moral distress is plausibly characterized as an experience of any one of these negative self-directed responses—guilt, shame, or regret—together with one's judgment that one is somehow not responsible or that nothing can be done to improve the unfortunate situation. If Perdita (in 2.1) can convey her investment in the duties of friendship just as well with guilt as she can with remorse, as it seems she can, the focus on remorse alone is overly restrictive as an account of taking responsibility. Indeed, guilt, shame, or regret provide equally effective "attitudinal backups" to one's failed duties. Because moral distress encompasses this range of negative self-directed emotions, it appears that moral distress captures the notion of taking responsibility just as well as does the experience of remorse.[27] In fact, before proceeding to my second adjustment, I want to suggest that moral distress provides the most accurate account of what it means to *take* responsibility.

In cases resembling Perdita and the lost necklace, the loss can be described as a 'glitch' (in Mason's terms), that is, as an honest mistake involving no ill will. It is a case where agency is ambiguous, perhaps, given that the loss is connected to the agent without the badness of it being traceable to her. Yet, assuming that no third party intervened in any way, surely the loss was no one *else's* fault. If anyone is to blame, clearly it is Perdita. Indeed, Mason often says things like "being invested in the duties of personal relationships…requires owning *our* failures" (ibid. 15, italics added). But, then, if the failures are truly our own, it begins to sound less accurate to say we can *take* responsibility

[27] Note, however, that moral distress, on my account, characteristically involves a judgment that conflicts with one's emotional state. Thus, one might wonder if guilt or regret (and so on), together with the subject's judgment that she is *not* responsible, succeeds in taking responsibility. Still, considering that the goal of such exchanges is to secure the respect and trust of others, it seems that often these goods can be best achieved precisely *because* one is willing to take responsibility where he believes he is not responsible in the first place. I expand upon this suggestion in what remains of this section.

for them. Granted, in cases like Perdita's glitch, we might say that responsibility is ours *for the taking*. Still, this notion conveys that responsibility is indeed readily available to us. To say that responsibility can be "taken" here is simply too strong of a locution, particularly when we think one *should* feel bad about what they are taking responsibility for, as Mason says of Perdita. Instead, where losses are no one's fault but your own, a more natural understanding of the situation is that you are *accepting* responsibility.

By contrast, consider cases where agency is far more ambiguous, where harms are somehow connected to one, yet the badness cannot plausibly be traceable to her. Martha, the overwhelmed oncology nurse, recall, took action in the most morally appropriate way possible. Given her valiant efforts to save as many of her patients from harm as she could, we see not only that she had no ill will but that her will was positively good. Nonetheless, a patient died *on her watch*, giving the family a legitimate claim to hear at least an explanation of why their loved one died in a way that appears to them to have been preventable. After all, Martha could have tended to this patient rather than the other. Again, following McKenna's conversational model, we can imagine the family asking Martha 'what happened?' Here Mason's account would correctly suggest that in her response Martha can think not of her own innocence but of the losses incurred. She can see the action, even the harm, with a sense of ownership. Doing so, it would seem, should help to secure the respect and trust of the grieving family. But notice two final observations.

First, we cannot say here that the loss was no one's fault but Martha's. Instead, we would trace it back to the staffing shortages and, thereby, to the hospital management that allowed such hazardous circumstances to transpire. Nevertheless, like with Perdita's glitch, it seems that Martha should not make excuses, despite there being one available to her.

Mason claims that the "onus is clearly on Perdita to indicate how she thinks the loss of the necklace should be taken" (ibid. 16). Similarly, upon being asked 'what happened?' the onus is on Martha to indicate how the patient's death should be taken.[28] Remorse would seem fitting, particularly if this response attaches to either inadvertent or deliberate actions. However, remorse is certainly not the only response that stands to improve her relationship with the family and help them to move forward.

Regret, guilt, or shame would serve the same ends as remorse. As I claimed above, these sorts of responses make up instances of self-blame.[29] In this way, where Martha responds to the harm to her patient with regret, guilt, or shame, she not only takes responsibility, she also takes the blame for the harm. With any one of her self-blaming responses, Martha can indicate that she is taking the harm seriously. Although she did the best she could do—and so has an excuse—she can convey her commitment to improving the future, say, by seeing to it that such tragic decisions do not arise again. Of course, to the extent that Martha would not actually change *her own* decision-making policies, her regret will be somewhat irrational.[30] To the extent that she does not see *herself* as having a defect, her shame is not entirely appropriate, and so on. The conflict she experiences here is precisely the sort of inner turmoil I have identified as constituting moral distress. On the one hand, we cannot command one to feel guilty, ashamed, or regretful in cases like that

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[28] Granted, unlike the case of Perdita, Martha and her patient are not in a close relationship. Nevertheless, as I explain below, it appears that investing in one's duties, displaying an attitudinal back-up, can and often should be expanded to encompass professional duties.

[29] I am, of course, not alone in seeing guilt, shame, and regret (and related responses) as instances of self-blame. McKenna, for example, makes explicit that "guilt is the self-reflexive emotion whereby one holds oneself morally responsible and blameworthy…In short, it constitutes self-blame" (McKenna 2012, 72).

[30] As Daniel Jacobson explains, "sentiments can be recalcitrant, in that an agent can be in the grip of a sentiment contrary to his better judgment" (Jacobson 2013, 103).

of Martha—it seems plainly incorrect to say she *should* experience any one of these emotions understood on their own. On the other hand, we might plausibly think she should experience moral distress, in that she should experience a negative self-directed emotion while maintaining a sincere judgment that she is not morally at fault. Suffering this sort of response, where we cannot say the losses were no one's fault but her own, shows that one is doing more than merely accepting responsibility. Here, responsibility and blame for the losses are truly taken.

Investing in professional duties

The second of the two adjustments to be made, as I prefaced above, is more straightforward than widening the operative response beyond remorse. Simply said, it seems that we can and should expand the "attitudinal back up" expected of our duties in personal relationships to encompass one's investment in professional duties. Several considerations can be offered in favor of this expansion.

First, it is clear that some professional domains entail duties that bear significance expanding beyond the merely practical. As Bernard Williams points out, "lawyers and doctors have elaborate codes of professional ethics…[because] clients need to be protected, and be seen to be protected, in what are particularly sensitive areas of their interests" (Williams 1978, 55). To fulfill one's duty in law or medicine, and perhaps in some branches of politics, is often to promote others' interests in a way that bears directly upon their wellbeing. I take it that these sorts of interests—health, financial security, and the like—need not be discussed in detail. The point to be made here is simply that the duties held while occupying certain professional offices are such that their failure to be fulfilled stands

to cause great harm to those who depend upon their fulfillment. Given this sort of dependence, there will be situations in which one's failure to deliver on those duties demands an explanation and offering of reassurance. Importantly, such demands are plausibly made in cases of deliberate or inadvertent harms, and they are often most effectively met by an expression of some negative self-directed response, that is, by one who takes the blame for the unfulfilled duties.[31]

Second, professional actions often involve ambiguous agency, perhaps even more frequently and more severely than in personal domains. In the political realm, ambiguous agency is likely the result of politicians acting on behalf of others (or at least claiming to do so).[32] It is, of course, no small question how we should understand harms that are connected but where the badness cannot be traced back to an agent. Still, the process by which one truly takes the blame provides us with a plausible mechanism for addressing such puzzling harms. As I argued above, inadvertent harms where we can nonetheless say it was no one's fault but your own, such as cases of personal 'glitches', are not entirely ambiguous. In situations like Perdita's loss of the necklace, the friend can expect Perdita to respond with something like remorse. To say she *should* feel bad in these ways goes to show that, when she does, she is merely accepting responsibility and not that she is taking the blame. However, where inadvertent harms are truly ambiguous—where they are in fact

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[31] Here I have in mind 'dirty hands' dilemmas in politics or war. But consider, also, the tragedies all too familiar recently in the U.S., namely mass shootings. While the failed duty to protect innocence lives may be more or less attributable to current politicians, being truly invested in the duties of some political offices surely entails taking responsibility for the harms. The respect and trust of others—of victims' families and of the nation at large—are more effectively secured by one who expresses an "attitudinal back up" (recall Obama's tears in the statement following the 2012 Sandy Hook Elementary School shooting).

[32] Michael Walzer had this consideration in mind when he observed that political actors are unlike the rest of us, namely that they are "a good deal worse, morally worse" (Walzer 1973, 64).

the fault of no *one*—it may be especially important to allow for someone to take responsibility and, often, to take the blame. Appointing and recognizing individuals in certain professional offices allows us to accomplish this task.[33]

Finally, as I suggested above, individuals acting in professional capacities are often charged with the burden of having to indicate how some harm or loss should be taken. Just as Mason says of Perdita, it is *up to* Martha to respond to the victims of the harm in a way that shows an understanding of the situation. She could focus on her innocence and use the excuse available to her, but thereby leave those who were harmed with no one to trust, with no sense that the future will be any better. Alternatively, she can limit what "will count as an excuse," as Mason says (2018, 17), and thereby give hope for an improved future to those who clearly need such hope. Importantly, this mechanism is just as readily available to those who invest in their professional duties as it is to those who would take responsibility in personal relationships.

4. Conclusion: the benefits of moral distress

My adjustments to Mason's account of taking responsibility can be summarized in the following manner. Mason claims that "being invested in the duties of personal relationships in the right way, requires taking on extended responsibility…owning our failures, feeling remorse" (2017, 15). On the view I have offered, being invested in one's duties encompasses both personal and professional relationships, given that in both domains, the process of taking responsibility stands to achieve significant consequential goods. Being invested in personal or professional duties often requires owning much more than *our*

[33] Consider the flight attendant's request: "Is there a doctor on board?"

failures, for taking ownership of our failures is merely to accept responsibility. Rather, where harms are truly ambiguous, we can see them as our own and, in doing so, we take the blame. This requires not simply feeling remorse but experiencing moral distress. Given that moral distress is characteristically a negative self-directed response—guilt, shame, or regret—along with the judgment that one is not morally at fault or cannot improve the circumstances, we can say of the practitioner who invests in her professional duties that she should experience moral distress. In this way, moral distress provides a highly plausible mechanism for responding appropriately to patients and families harmed as a result of an error.

In cases like that of Dr. Robert, where harms were preventable, the patient and family should expect an acknowledgement of the mistake and a genuine apology. That is, the erring practitioner should admit her distinct role in the event and should experience some negative self-directed response, like guilt, remorse, or regret. Accordingly, she should be motivated to improve her practice. Following through with such motivations will likely help to improve the circumstances of her future patients. Still, in order to secure the respect and trust of the harmed patient and family, she should maintain a recognition that the errors of the past cannot be undone. This appears particularly true of preventable errors that result in a patient's death. In other words, the erring practitioner should find herself morally distressed by the harms she brought about. Granted, we would expect and likely hope for her to eventually move on. Indeed, she should not be morally distressed forever. At some point, we would be concerned that she is somehow psychologically damaged.[34]

[34] I will explore related impairments—namely moral distress and compassion fatigue—in the following chapter.

As we can imagine, such extreme distress may well hinder good practice, say, by causing one to be too ashamed to go to work or to refuse especially risky cases in order to avoid self-blame.[35]

Why, then, must those who could not have prevented the adverse event be morally distressed? Can Martha not apologize to the family of Patient-2 without experiencing moral distress? After all, it was not her action alone that led to the patient's death. It is, as I have said, a case of truly ambiguous agency. Still, on the account I have offered, moral distress is an experience that may well affect those who are somehow connected yet not morally responsible for adverse event. And in cases like that of Martha, an apology is best offered to the family where the practitioner clearly takes the blame, despite the potential irrationality of self-blame.[36] That is, apologies are effectively offered and commitments to improve are conveyed where the practitioner experiences some degree of moral distress.

Of course, it may be that those who could have done no better in playing their part within a tragic causal chain are entirely without some emotional response like guilt or regret. The notion of *compassion fatigue*, for example, has received considerable attention in recent literature, understandably, in relation to moral distress. As I explain in detail in the following chapter, compassion fatigue is typically seen as a form of traumatic stress, where caregivers have given too much.[37] The excessive degree or duration of their caring has, in a very real way, exhausted their ability to provide additional care. While this unfortunate reality is important to recognize and address (as I will do in Chapter 5), the

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[35] For raising this set of concerns, I am extremely grateful to David Shoemaker.

[36] Analogously, consider Williams' lorry driver and how much more effective an apology to the child's parents would be where the driver clearly beats himself up—however irrationally—rather than where he simply explains what happened.

[37] Charles Figley (1995) labelled it the "cost of caring." See Najjar et al. (2009) for a review of the extensive literature.

claim to be made here is simply that where one is emotionally unaffected by morally significant losses, she is no longer in a position to effectively apologize to those who care for the victims. If proper apologies are those that involve some negative emotional response, clearly one who is entirely unaffected cannot offer an effective apology. Without some degree of self-blame, however irrational it may be, practitioners are less able to allow harmed patients and families to forgive and to move forward in the wake of medical errors than those who take the blame.

As I have argued, the contemporary shift away from notions of blame in healthcare should be resisted. In fact, if the minority of commentators (with whom I align) are right about the positive merits of blame, we should embrace blaming practices and encourage medical professionals to blame themselves for erroneous actions and even inadvertent harms. Where harms appear to be the fault of no one in particular, it will be especially important for someone to step up and take responsibility. Rather than fearing blame as a punitive response from others or as a potential liability, practitioners can invest in their professional duties and respond to unfortunate circumstances with moral distress. Those who take the blame in this way are in the best position apologize and to assure that their practices and the institutions they represent are committed to improvement.

Chapter 5

Moral Distress, Compassion Fatigue, and Responsible Agency: Some Thoughts for Policy

Nurses and physicians are at a high risk of becoming overwhelmed or stressed out. It has even been said that healthcare professionals commonly experience various sorts of trauma due to their difficult decisions and the morally challenging situations they must face. Two phenomena in particular, moral distress and compassion fatigue, are seen in recent literature as being especially problematic for practitioner wellbeing and retention, and thereby for the quality of patient care (cf. Abendroth and Flannery 2006; Maiden et al. 2011; Mason et al. 2014). As a result, policies aiming to ease practitioners' work and improve patient care have targeted both moral distress and compassion fatigue. Yet, these two sorts of experiences, while certainly related, bear important differences, both conceptually and in practice. By making these differences clear, in this final chapter, I show that compassion fatigue is altogether distinct from moral distress and should be a much greater cause for concern. Accordingly, policies aiming to improve the delivery of healthcare and overall workplace environment for practitioners must address the unique features of each condition, if such policies are to be truly effective.

Both moral distress and compassion fatigue appear to elicit in us a certain sort of ambivalence. That is, we may be inclined to respond to those who are morally distressed

and those who are compassion fatigued in a way that indicates that we hold them responsible in some senses but not others. But what exactly is the basis for our ambivalent responses? Should we conclude that because both conditions are somehow traumatizing, the individuals experiencing them are to be regarded as equivalents in their status as morally responsible agents? The position I will advance here is that those who are morally distressed are often excused from responsibility, while compassion fatigue constitutes a sort of ‘marginal agency’ in the sense of exempting one from responsible agency. Following David Shoemaker’s investigation of conditions such as psychopathy, autism, and clinical depression (among others), I mean to show exactly how those who are compassion fatigued are “at the boundaries of our interpersonal community” (Shoemaker 2015, 4). Those who are morally distressed, however, appear to be fully responsible. Thus, while moral distress and compassion fatigue might generate similarly ambivalent responses, it would be a mistake to not draw a clear conceptual distinction between the two, and a further mistake to treat the two conditions alike when constructing policies for easing the challenges confronting healthcare professionals.

My project thus far has focused on the experience of moral distress, what it is and the ways in which it bears potentially positive value. By framing moral distress here as an indication of an ordinary excuse, I hope to build upon my earlier discussions with principled suggestions for when and how moral distress should be managed. I begin, then, in section 1, with some background on excuses and exemptions from responsible agency. Here I will draw upon what Gary Watson (1987) referred to as “type-1” and “type-2” pleas, and I will outline the ‘tripartite’ theory of responsibility developed by Shoemaker (2013, 2015), since, as I have suggested, this will provide a means of analyzing our ambivalent

responses to a variety of puzzling conditions. With these tools in hand, in section 2, I will revisit the notion of moral distress I developed in Chapter 2 and show the ways in which the phenomenon indicates merely an excuse from responsibility. This will allow me to put forward some thoughts concerning when and how we should—or should not—work to manage the condition. In section 3, I turn to an explanation of compassion fatigue and what sets it apart from moral distress. By showing how compassion fatigue constitutes a sort of marginal agency, I argue that this condition should be far more alarming than cases of moral distress. Accordingly, I develop some principles for policies addressing compassion fatigue. I conclude, in section 4, with a summary of this crucial distinction.

1. Excuses and exemptions

In Chapter 3, I sketched Watson's "Two Faces of Responsibility." In doing so, I highlighted an advantage of the Watsonian account, namely, that it allows us to make sense of our ambivalence toward agents that appear responsible but perhaps are not appropriately *held* responsible. We can, for example, attribute some harmful action to a person's character while stopping short of engaging in other, more overt forms of blaming practices. This might be due to a recognition that the potential blamee was raised in a world—an abusive family, perhaps—where the harmful action—say, insulting others—was a normal part of life. As a result, he may be seen a bad person in light of his propensity to insult others, but outwardly resenting him for it seems inappropriate.[1] What these sorts of cases show, on Watson's picture, is that the project of locating responsible agency comes apart into two

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[1] This position has been met with criticism. See, for example, Sher (2006). While on Sher's account blame is a belief-desire pair and not a function of the reactive attitudes, we can—and often should—blame people for maintaining bad traits.

faces. On the one hand, we can assess a person's character by thinking some conduct is *attributable* to him and, on the other hand, we can hold him *accountable* by blaming, praising, or otherwise maintaining a "readiness to respond" (ibid. 274).

Beyond showing us the plausibility of responsibility's two faces, however, what the Watsonian examples also provide is a significant challenge to P.F. Strawson's renowned account of the reactive attitudes. No longer can we attend only to our attitudes and feelings toward others, and thereby recover "*all* we mean, when, speaking the language of morals, we speak of desert, responsibility, guilt, condemnation, and justice" (Strawson 2003, 91, emphasis in original). For Strawson, we demand good will from others, and being responsible just is a function of being susceptible to a variety of "natural human reactions to the good or ill will or indifference of others towards us" (ibid. 80). We resent others for insulting us. We are grateful when others go out of their way to help us. In responding with resentment or gratitude, among a great many responses, we hold others responsible according to whether they have met or failed to meet (or perhaps exceeded) our demands for good will. But as some cases show, some of us are properly excused or altogether exempted from these demands, despite the apparent display of ill will. It cannot be, then, that our reactive attitudes respond *only* to others' wills in the process of determining whether or not—or in what ways—a person is responsible.

In order to make accurate determinations of responsibility, we need to carefully consider features that pertain to the situation at hand. It may be that a person is somehow coerced in the performance of his actions or perhaps ignorant of some relevant fact. An erratic driver might cut me off in traffic, but only in an effort to deliver his critically injured passenger to the hospital. Or consider, for example, a neighbor who mistakenly thinks it is

my dog that continues to soil her flowerbed. When she angrily confronts me, I might be initially inclined to respond with a similar degree of anger; that is, until I learn that her ill will is founded upon a falsity. Such cases show that our reactive attitudes toward others should often be withdrawn, namely because of something unusual about the situation. Following Watson (1987), we can refer to the range of conditions that *excuse* us from the basic demand as “type-1” pleas.[2]

But along with the conditions that bear upon a given situation, we need to consider features that pertain to an agent’s psychological make-up, such as mental health, sanity, maturity, or one’s “formative circumstances” (ibid. 228). Surely, we do not simply react with resentment to an insult launched by a random passerby and, upon learning of the passerby’s Tourette’s syndrome, continue to resent him. Likewise, upon learning of an insulter’s unfortunate formative circumstances, it may seem that resentment is simply not appropriate, but for very different reasons than our withdrawal of resentment in cases of unusual circumstances. By attending to the psychological make-up of those with whom we engage, we notice that some individuals are properly exempted from the basic demand. As Strawson observed, pleas such as ‘He’s only a child’ or ‘He’s a hopeless schizophrenic’ “invite us to suspend our ordinary reactive attitudes towards the agent” (Strawson 2003, 78). Where one is ‘psychologically abnormal’ or ‘morally undeveloped’ we find that one is not as eligible for the sorts of responses that would allow us to hold them responsible. Again following Watson (1987), we can refer to the range of conditions whereby one is

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[2] Excusing conditions are taken here to include justifications. The erratic driver, for example, is appropriately seen as *justified* in cutting me off, given the emergency at hand. In his famous work, “A Plea for Excuses,” John Austin (1957) distinguished between excuses and justifications. For present purposes, the two are treated similarly.

exempted from the basic demand as "type-2" pleas.[3] For the Watsonian, the fact that we adjust our responses to concrete situations and to distinct individuals shows that our determinations of responsibility are not simply a function of our reactions to the good or ill will of others. And if we must account for something other than an agent's will, the *quality-of-will* approach must be abandoned.

As Shoemaker explains, in establishing the basis of his pluralistic account, several different versions of the quality-of-will approach can be seen as efforts to rescue Strawson's basic view of responsibility. Indeed, the "will" can be understood in (at least) three different ways: as an agent's judgment, as his regard for others or for moral considerations, or as the traits and dispositions that make up his character.[4] Here the notion of responsibility fractures not only into two faces, as Watson showed, but instead into three distinct types. Still, each one remains susceptible to the Watsonian challenge, as each purports to capture the full range of our responses, yet many cases of ambivalence are still left unexplained.[5] But rather than appealing to something other than an agent's will in order to explain responsible agency and thereby abandoning the quality-of-will approach, Shoemaker proposes we make use of all three interpretations. Given that each understanding of the will implicates a unique feature of an agent, the resulting pluralistic

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[3] As Watson conveys (1987, 227-228), the type-2 pleas present a greater difficulty for Strawson, as it remains unclear how to include the necessary *explanations* in the exemptions.

[4] Shoemaker (2013, 98; 2015, 10) traces the quality-of-judgment theory to T.M. Scanlon's "The Significance of Choice," which builds upon his contractual account, wherein one is expected to govern his behavior based upon "principles which no one, suitably motivated, could reasonably reject" (Scanlon 1988, 352). The quality-of-regard account is seen in Michael McKenna's conversational theory, where the quality of an agent's will is revealed by his "regard, lack of regard, or disregard for others' interests" or "for moral considerations generally" (McKenna 2012, 19-20). And the quality-of-character account was introduced by Jeanette Kennett and Nicole Vincent, who focused on one's "character traits, personality, temperament, and behavioral dispositions" (Shoemaker 2015, 13).

[5] Watson and Shoemaker both invoke the case of psychopaths, who—like the person raised in unfortunate formative circumstances—can be held responsible in some senses but is not appropriately resented.

picture allows us to pinpoint exactly why we often find agents responsible in some senses but not others.

First, on Shoemaker's tripartite theory, one can be responsible in the 'attributability' sense when a decision or action stems from his character, or what some theorists have called the "real self" or "deep self."[6] Here one reveals the things that truly *matter* to him, what Shoemaker refers to as one's "care-commitment *clusters*" (2015, 57). As such, he is the object of others' admiration or disdain, given that these sorts of responses target a person's character. Secondly, one is responsible in the 'accountability' sense when he is appropriately targeted with blame as a result of exhibiting a poor regard. Typically, he has *slighted* someone, either by being inconsiderate of her perspective or insensitive to her fortunes, both representing failures of empathy.[7] One's *lack* of empathic abilities, in particular, will help to clarify why those who are compassion fatigued are not eligible for responses such as anger and resentment. Finally, one is responsible in the 'answerability' sense when he is called upon to defend or *answer for* some exercise of judgment. Here one must be capable of citing reasons for deciding as he did. In Shoemaker's words, he must be able to recognize "instead of" reasons (ibid. 76). Where one has this capacity, but fails to properly utilize it—say, by not considering some reason pertaining to the situation or by making a judgment that does not reflect the stronger reasons—he will likely regret his decision. Those who demand his answers will naturally disapprove.

[6] Shoemaker (2015, 44-45) distinguishes two versions of the "deep self" view: one being primarily Humean or volitional, advanced by Harry Frankfurt (1971); the other being Platonic or evaluative, advanced by Watson (2004).

[7] See Shoemaker's rich explanation of slights as failing to 'take someone seriously' (2015, 97-103).

Together, the three types of responsibility allow us to make sense of our ambivalence in a host of cases, from psychological abnormalities to many commonplace interactions. We might, for example, disapprove of a friend's decisions when he fails to show up for a weekly meeting, but if his failure is a rare occurrence, surely we do not hold him in contempt for it. Naturally, we might say "This isn't like you!" as we demand to hear his reasons, which may well turn out to be legitimate excuses (traffic, an unexpected but important phone call, and so on). In other words, we take him to be answerable for his conduct, yet we would not likely attribute the action to him in a deep sense, given that (we would hope) his failure to show up does not accurately reflect his underlying cares or commitments. Still, given that he has the capacity to maintain cares and commitments that issue in distinct attitudes and actions, our friend is seen as a fully responsible agent in terms of attributability. Because he is able to entertain and act upon various reasons, he is fully responsible in terms of answerability. And given that he can see things from our perspective, he is fully responsible in terms of accountability. By contrast, where one is lacking in any of these capacities, we find various exemptions from what it means to be a responsible agent. Accordingly, where one is exempt, we see far greater causes for concern.

As I will show in the following section, cases of moral distress show that one is often excused from responsibility but not that one is somehow exempted from our demands. This analysis will prove to be informative for how we can and should construct policies aimed at addressing practitioners' experience of moral distress.

2. Moral distress and being excused

The concept of moral distress I developed in Chapter 2 took as its starting point the widely accepted idea that moral distress is a state of psychological disequilibrium or inner turmoil (cf. Wilkinson 1987/88; Jameton 1993; Corley 2002). Given this description, it may seem that moral distress is just as problematic as compassion fatigue and that measures must be taken to alleviate both sorts of conditions. However, as I will show in this section, cases of moral distress reveal that one is merely excused from full responsibility. That is, the problem of moral distress lies in the circumstances and not in the agent herself.

Recall that moral distress, in its paradigmatic form, is a complex psychological state wherein the subject's emotions are at odds with her sincerely held conscious beliefs. The specific emotions experienced might be frustration, anger, or anxiety directed at some morally significant object or state of affairs. These particular states were adopted by taking seriously the suggestions advanced by Jameton (1993). Otherwise, the emotional state itself may be one that clearly contains a degree of moral significance. Guilt, shame, and regret, as I showed, represent more obvious examples of an agent feeling that she is somehow morally spoiled. Often, I claimed, an agent will also experience a tension in her competing motivations to act in some way or another. With the range of potential responses, my account lends some support to those who characterize moral distress as an "umbrella" concept (e.g. Hanna 2004; McCarthy and Deady 2008). However, the possible range of negative emotions and corresponding motivations are not enough to distinguish moral distress. Here is where we must be clear on what it means to be in a state of distress *simpliciter*. As I argued, distress itself is a state where one is overpowered by some adverse force. Nothing can be done to improve the negative circumstances. Being overpowered in

this way may be consciously known or otherwise maintained as a faint awareness. In some cases, we can imagine, one may well believe not *that nothing can be done*, but instead *that I should not have to do anything*—likely because a belief concerning one's innocence is maintained, namely *that I did nothing wrong*. Given that our emotional states involve—and, indeed, are effectively defined by—some distinctive tendency to act, when one is morally distressed she is characteristically conflicted in her behavioral motivations. Where she believes, for example, nothing can be done but feels frustrated nonetheless, she is likely at odds with herself over whether or not she should work to remove the perceived obstacle. Where she believes she is innocent of wrongdoing but is nonetheless filled with regret, she is likely torn between tendencies to change her decision-making policies or to proceed in the very same way in the future.[8]

Next, recall also that the causes of moral distress vary widely, from cases of moral dilemmas and uncertainty to bad moral luck. One may be morally distressed as a result of remaining confined by an institutional obstacle, as Jameton (1984) first suggested, by taking action where the morally appropriate course was not clear, or where the morally best action to take entailed the violation of some competing interest or value.[9] While considering all such variations is likely unnecessary, fleshing out the details of just a few should reveal the variety of excuses at work in cases of moral distress. Consider again the case of *no-kill care*. Dr. Hobart, recall, a palliative care physician committed to not killing, is faced with the decision to assist in a patient's death and thereby relieve him and his family of months of inevitable pain. As the story goes, Dr. Hobart brings herself to follow

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[8] This description is, admittedly, just a crude gloss on what I take to be a complex psychological state. For details on my account of the nature of moral distress, see Chapter 2, sections 2 and 3.

[9] See Chapter 1, also Fourie (2015), Campbell, Ulrich, and Grady (2016), and Tigard (Forthcoming-a).

through with the decision but is nonetheless left in a state of moral distress. She feels a sense of guilt or regret for having violated a value to which she had been committed. At the same time, she consciously recognizes that what she did was necessary under the circumstances.[10]

What should we make of Dr. Hobart's responsibility, considering her conflicting responses to the difficult decision? Given the sense of ambivalence seen here, it appears that the tripartite theory is well equipped to explain the ways in which Dr. Hobart may or may not be responsible for her decision. In what follows, then, I will briefly consider the agent's attributability, answerability, and accountability; though it should be noted that the tripartite account is primarily a means of explaining psychological abnormalities, or type-2 pleas. Nevertheless, where we find that one maintains the relevant agential capacities, and is thereby fully responsible in these ways, we will see substantial reason to look to the circumstances in seeking potential remedies to her condition. This process should help to generate considerations against the common accounts of moral distress which fail to adequately recognize that in her experience of moral distress, one may well be a fully functional, responsible agent.

To begin, it can be said that Dr. Hobart is capable of displaying a good or ill will in the sense of maintaining a certain regard for the various interests at stake. That is, regardless of the decision that is made, she has the capacity to empathize with those involved.[11] She can understand others' interests and values, and she can take them seriously

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[10] Given the relevantly similar details, we can take the following analysis of responsibility to apply roughly to cases of political action made famous by Nagel (1972) and Walzer (1973). How exactly moral distress relates to the problem of 'dirty hands' I discuss at length in Tigard (forthcoming-b).

[11] At present, it is not of central importance whether empathy is considered to be a more cognitive or emotional capability. I will address these two conceptions further in discussing compassion fatigue.

in coming to a decision. Still, among the values at stake are her own. Given that she is capable of taking her own interests and values seriously, the fact that she chooses to act against them shows her guilt or self-directed anger to be somewhat fitting (cf. Tigard 2016). After all, she let herself down in a sense. She failed to fulfill a demand of her own, even if it meant helping others. But because her guilt is in conflict with her belief that she did what is necessary, she likely beats herself up less than she would where she experiences pure guilt. Nevertheless, given her unimpaired capacity to take others seriously, she is a fully responsible agent in terms of being accountable for her decisions.

Considering her attributability, things may seem a bit more complicated. While Dr. Hobart has deeply-held cares and commitments pertaining to the situation, it is not entirely clear that she is able to act in a way that stems from them. This may simply be a result of her apparent conflict of commitments: she is committed to not killing, but presumably also to the relief of patients' pain. In this way, she is faced with a sort of moral dilemma, except that one of the competing requirements appears to be overridden.[12] That is, somehow she *brought herself* to follow through and, as established above, she recognized the importance of her action, despite the guilt it brought about. Rather than failing to advance her interest in not killing, then, the action can be said to promote her interest in relieving patients' pain—an interest she may come to realize bears more weight upon her deliberations than she had previously appreciated.[13] She might feel a sense of pride at successfully promoting her concern for patient pain relief, while still regretting having to sacrifice a demand of her

[12] Here I am taking moral dilemmas to entail mutually exclusive requirements, neither of which can be overridden (Sinnott-Armstrong 1988).

[13] As I argued in Chapter 3, in the experience of moral distress one may well affirm, or come to better understand, one's most deeply-held cares and concerns.

own. Again, though, the fact that she has cares and commitments that issue in actions and attitudes pertaining to the situation shows that she is capable of full responsible agency in the sense of attributability.

When it comes to answerability, it is important to notice that Dr. Hobart is capable of making a judgment, one that took into account a number of reasons for and against providing her patient with assistance in dying. When called upon to answer for her decision, she can cite the reasons that prevailed over the competing reasons that were at stake. And while she might experience a sense of pride in her promoted concerns as well as some degree of regret in the commitments that were sacrificed, bystanders might be fully inclined to approve (or disapprove) of her judgment. Further, we might think, although she can be called upon to answer in principle, because the demand that went unfulfilled was hers alone to sacrifice, she alone can properly disapprove of her decision. Ultimately, her unimpaired capacity for making a judgment that reflects her consideration of reasons reveals again that she is a fully responsible agent in terms of being answerable.

While this covers just one case of moral distress, several key takeaways can be seen as generalizing to other cases. First and foremost, although one may experience a sort of ambivalence in her morally distressing responses, the condition itself is such that one's capacities for responsibility are not impaired. That is, there is nothing truly defective about the morally distressed *agent*. One may feel a great sense of guilt or regret (and so on) while maintaining nonetheless that the right action was taken. In some cases, it may be that this sort of inner conflict serves to confirm that one's capacities for responsible agency are indeed fully functional. In other words, one's experience of moral distress may reveal precisely that she has cares and commitments governing her attitudes and actions, that she

is empathizing with the relevant others, and that she can make a judgment based upon deliberations over competing reasons. Second, because the morally distressed agents' capacities are not impaired yet we might be inclined to absolve her of responsibility, moral distress should be seen as an indication of a possible excuse. In short, moral distress can be categorized as a type-1 plea, for it is the circumstances and not the agent herself that show her to be less than fully responsible. In the case of *no-kill care*, it was simply not possible for Dr. Hobart to fulfill both of the competing demands that had been placed upon her. Thus, while she may experience a sense of guilt in her consideration of the unfulfilled demand, with careful reflection upon the situation, both she and others should find that she is excused from her apparent failure.

The same sort of excusing mechanism can be seen in a range of cases where one is morally distressed. Briefly, consider again the case of *Maryann's decision*, where the nurse must decide whether or not to administer a pain-reliever to her patient experiencing severe opioid withdrawals. Recall, the patient was in excessive pain and begging for relief, which she had been authorized to administer, and so she does. She later learns that he died as a result of complications related to the treatment. Although she sincerely maintains that she did the right thing, she understandably feels a sense of guilt at the loss. As several commentators point out, moral distress may plausibly result from instances of bad moral luck, as seems to be the case here.[14] And again, it is clear that while Maryann is inclined to hold herself responsible in a way that exceeds what we could expect, she is likely seen by many (and perhaps even herself) as absolved of responsibility, given the occurrence of luck

[14] Most notably, see Campbell, Ulrich, and Grady (2016). In a follow-up to this paper, McAninch argues that moral distress resulting from moral luck points to "the limits of what institutional or cultural reform can accomplish to prevent or mitigate" moral distress (McAninch 2016, 30).

in this unfortunate situation.[15] Along with those who face competing demands or uncertainty of the right action, those who suffer moral distress as a result of moral luck can be seen as excused from responsibility.

Before turning to the experience of compassion fatigue, I want to utilize the notion of moral distress as a type-1 plea in my establishment of several recommendations for managing the frequently troubling experience. While my intention is not to advance any concrete prescriptions, the thought here is simply that the development of policies addressing moral distress can be effectively undertaken by observing the following general guidelines. First, as I have suggested only in passing so far, *if our interest is in better understanding the state of moral distress itself, we should focus policies on promoting an understanding of the morally distressed agent's self-directed responses.* Moral distress, as I have argued throughout this project, is paradigmatically a condition wherein one is typically at odds with herself concerning her responsibility for some negative state of affairs. In order to grasp what it is like to experience such a state, we would need to better understand exactly how the distressed agent perceives herself and her involvement. To what extent does she blame herself? Does she believe she is at fault for some moral wrong? What this guideline points towards, generally, is the need for implementing measures like discussion forums, ethics-based education, and perhaps some form of mentoring in many professional domains, particularly in healthcare (cf. Hamric 2000; Corley 2002; Kälvemark et al. 2004). Importantly, unlike accounts that have recommended these sorts of measures, my suggested guideline does not in any way entail the need to reduce or eliminate the experience of moral distress. Indeed, if I am right about the potentially positive value of

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[15] On Nagel's classification, the loss can be attributed to "resultant" luck (Nagel 1979).

moral distress, we should not engage in efforts to reduce or eliminate it, except in the most extreme circumstances.[16]

Second and relatedly, *policies ought to make clear that the problem of moral distress lies not in the agent herself, but instead in the causal circumstances*. While the range of morally distressing circumstances is wide, cases of moral distress are "type-1" pleas, in the sense that the circumstances are somehow abnormal, but the agent is fully capable of responsible agency (Shoemaker 2015, 8). As I have argued, those who are morally distressed often maintain a uniquely honorable character in light of their sensitivity to morally significant losses. While they may be ambivalent with respect to their status as morally responsible—and, indeed, others may likewise respond to them with ambivalence—the ambivalence is generated by the circumstances and not directly by any feature of the agent. In our institutional measures and in our everyday interactions, we would do well to assure that those who are morally distressed are not treated as if something were wrong with them as a person.

Accordingly, third, *if our interest is in remedying moral distress, policies should aim to help us understand and alleviate the circumstances thought to bring it about*. As I established in Chapter 1, the range of morally distressing circumstances is wide. Arguably, the domains in which it is most frequently experienced (namely, medicine and politics) will always carry a risk of presenting such circumstances. Moral dilemmas, institutional obstacles to morally appropriate action, and related troubles, at least in theory, can be addressed by careful policy development. We might, say, work to ensure that obligations placed upon a single individual come into conflict less frequently or severely. However,

[16] I argued for these points in Chapter 3.

aiming to remedy moral distress by focusing policies on repairing some feature of the agent (her sensitivity or beliefs concerning responsibility) is a forlorn endeavor, for in being morally distressed there is nothing wrong with the agent herself.[17]

In other, related conditions, it may well be that something about the agent is amiss. With this in mind, in the following section, I turn to compassion fatigue.

3. Compassion fatigue as marginal agency

A number of authors have framed moral distress and compassion fatigue as being closely related phenomena. One recent study found "statistically significant correlations between moral distress [and] compassion fatigue" (Maiden and Connelly 2011, 339). Another appeared to run the two experiences together, claiming that both "Compassion fatigue *and* moral distress are described as overwhelming feelings of being powerless to do what is believed to be right" (Mason et al. 2014, 217, italics added). No doubt, the relationship is a natural one to draw, as both sorts of experiences are thought to occur commonly among healthcare professionals, particularly nurses. As I will argue, however, compassion fatigue is altogether distinct from moral distress and should be a much greater cause for concern. Specifically, it can be shown that compassion fatigue constitutes a sort of marginal agency. But before addressing its implications for one's agency, allow me to briefly explain the condition.

The notion of compassion fatigue was first introduced as a type of burnout occurring in occupations where one regularly plays the role of caretaker to those who are suffering. Upon interviewing nurses about their emotional reactions to patients' troubles,

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[17] As Chad Van Schoelandt has suggested to me, moral distress may be much like seeing an illusion. One is functioning properly where she is responding to the circumstances in ways that are somehow abnormal.

Carla Joinson (1992) observed that some of them were not coping well with the effects of their professional duties. They were devastated by their patients' situations and, at the same time, they felt helpless, knowing there was only so much they could do to improve the troubling circumstances. In response, some grew 'cold' to the difficulties and "stopped crying over patients" after sharing in their despairs for so long (Joinson 1992, 116). And while it may seem that learning to control one's emotional responses in such a way might allow for a more tolerable work life, it was not the sort of control that would foster a healthy psychological life overall, nor would it enable them to be truly effective in caring for others.[18] Some nurses sought counseling or made use of other support systems, such as social or religious groups, in order to manage their emotions and to *recharge*, so to speak. This allowed them to continue caring even when caring became difficult. Others were not as conscious of the fact that caring for those who suffer had left them emotionally exhausted and simply unable to provide additional care. As Joinson explains, those who "stepped into compassion fatigue" lost their "ability to nurture" (ibid. 119).

The most prominent definition of compassion fatigue is that of trauma psychologist Charles Figley, who identifies the experience as *secondary traumatic stress* "resulting from helping or wanting to help a traumatized or suffering person" (Figley 1995, 7). That is, those who are exposed to persons suffering from traumatic stress may undergo a form of stress of their own. Some have likened the symptoms of secondary traumatic stress to posttraumatic stress disorder, the main difference being that those suffering from secondary traumatic stress are exposed to traumatic events indirectly through the experiences or stories of someone who is traumatized, rather than direct exposure to the event itself

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[18] Rentmeester (2007) argues that healthcare professionals should learn to be *inured*—and not callous—in order to negotiate the emotional difficulties of caring for patients.

(Jenkins and Baird 2002). According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, posttraumatic stress disorder occurs when one experiences "exposure to actual or threatened death, serious injury, or sexual violence" along with "recurrent, involuntary, and intrusive distressing memories of the traumatic event" (American Psychiatric Association 2013). If secondary traumatic stress is "nearly identical," this too should be a significant cause for concern (Jenkins and Baird 2002, 424). But why exactly is *secondary* traumatic stress so problematic?

Some professional caregivers are constantly exposed to others' trauma and often without experiencing a sense of relief or the emotional rewards of their caring, such as seeing a 'change for the better' in a patient or family.[19] Naturally, the constant secondary trauma takes a toll on caregivers' wellbeing. Figley (1995), accordingly, labelled compassion fatigue as "the cost of caring," an expression that has reverberated throughout the literature. Indeed, as outlined in a more recent analysis, the costs can be extensive. Emotional effects are believed to include decreased enthusiasm, irritability, and desensitization; social effects are seen in one's inability to aid or share in others' suffering; intellectual effects include decreased attention, boredom, and impaired concentration (Coetzee and Klopper 2010, 241). While it appears that these costs would be readily classified as undesirable, the costs alone do not provide a deeper, more theoretically satisfying explanation of why compassion fatigue itself is so objectionable. Understanding its implications for one's sense of responsible agency will help to see the true devastation of compassion fatigue and how it differs from being morally distressed.

[19] This has been referred to as *compassion satisfaction* (e.g. Slocum-Gori et al. 2011; Stamm 2002).

To begin, consider the nature of compassion. Figley has said, very simply, that "compassion is to bear suffering" (Figley 2002, 1434). While this notion is rather vague, on many accounts, even Figley's own, compassion appears to be equivalent to empathy.[20] In a recent review, Nadine Najjar et al. (2009) established that for many forms of trauma experienced by healthcare professionals, empathy is the starting point.[21] And although some have taken empathy to be distinct from compassion (e.g. Ekstrom 2012), for present purposes I can grant that both serve similar, crucial functions and that both might bring about a state of secondary traumatic stress. What, then, is the function of empathy? The literature on the topic is, of course, extensive. In the interest of making clear its significance for responsible agency, I will focus here on Shoemaker's distinction between 'detached empathy' and 'identifying empathy.'

In one sense, what it means to be empathetic is to engage in a detached sort of perspective-taking. This, Shoemaker explains, is what most psychologists have in mind when speaking of empathy as a cognitive capacity; it is "a merely epistemic tool, one method of figuring out various sorts of moral reasons" or what others are going through (Shoemaker 2015, 157-158). According to Shoemaker, it is a *detached* form of empathy, for it does not require one to *identify* with the cares and commitments of the relevant others. In this way, he claims, it is typically the sort of empathy that clinical psychologists and anthropologists employ (ibid. 158). Yet, in much of the research on compassion fatigue, nurses and social workers are said to be involved much more closely and emotionally with

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[20] In Figley's words, "The very act of being compassionate and empathic extracts a cost" (Figley 2002, 1434).

[21] This is said to be true of compassion fatigue, burnout, secondary traumatic stress, and other sorts of traumatization (Najjar et al. 2009, 268).

their patients. Simon et al. (2005, 10), for example, found that "the use of empathy and the emotionally intense contact with oncology patients and their families can produce STS [secondary traumatic stress]." Similarly, Figley (2002, 1433) claims that psychotherapists' compassion fatigue often results from their "emotional investment in helping the suffering." Of course, it may be that a less detached form of empathic engagement contributes more forcefully to the onset of compassion fatigue.[22]

Putting aside the sort of empathy that might *bring about* compassion fatigue, what can be posited at present is that, as a *result of* their exposure to and interaction with those who suffer, some healthcare professionals are left with impaired empathic abilities. Here the research is quite clear that the sort of empathy practitioners become incapable of is not merely empathy as a cognitive tool. It is said that practitioners become less "emotionally connected to the patients" (Simon et al. 2005, 11). Indeed, some have indicated that those who are compassion fatigued might be *permanently* impaired in their compassionate abilities (Coetzee and Klopper 2010). So, what exactly is the other, more involved form of empathy that appears to be lacking in cases of compassion fatigue?

On Shoemaker's account, the sort of empathy that allows us to truly *identify* with others ('identifying empathy') is the sort that is implicated in assessing one's *regard*, and it has two distinct forms. On one hand, there is evaluational empathy. When functioning properly, we can "take up" others' normative perspectives as our own and see their goals as worthy of pursuing (Shoemaker 2015, 158-159). On the other hand, there is emotional empathy. Here, we "*feel* what the world feels like" for others; we come to share their cares

[22] However, this is a largely empirical question, one on which the literature is not entirely clear, given that the precise nature of empathy is rarely specified. Still, it has been suggested that practitioners' trauma results from emotional investment (Figley 2002) or "exposure to emotionally engaging clients" (Jenkins and Baird 2002, 425).

and are thereby emotionally affected in similar ways (ibid. 159). Now, if in fact those who are compassion fatigued are utterly incapable of both forms 'identifying empathy,' on the tripartite theory, we would see that they are altogether exempt from accountability-responsibility. This is because, as established above, in order to be properly held accountable, one must be able to consider others' perspectives or show an emotional sensitivity to the fortunes of what others care about. Being exempted from this type of responsibility would be an extremely significant implication for healthcare practitioners who are compassion fatigued, for they would be ineligible for responses akin to anger and resentment. Indeed, it is precisely this sort of impairment and exemption that Shoemaker identifies as applying to psychopaths. And while it may seem that likening compassion fatigued practitioners to psychopaths is too farfetched to hold ground, it appears that the two sorts of conditions show a similarly marginalized sense of agency.

In terms of emotional empathic deficits, the type of burnout distinctive of compassion fatigue has been characterized as "emotional exhaustion…followed by depersonalization" of patients (Payne 2001, 397). But beyond negatively affecting one's relations with patients, some have made clear that those who care for traumatized patients may experience "changes in their relationships to their selves, their families, friends and communities" (Gentry 2002, 41).[23] As listed above, the emotional effects include lessened enthusiasm and desensitization. In Figley's work, it is claimed that one who experiences compassion fatigue is less able to bear others' suffering or *less interested* in doing so (Figley 2002, 1434, emphasis added). Clearly, practitioners exhibiting such impairments

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[23] McCann and Pearlman claim that the deficits are both cognitive and emotional, and that the problem goes well beyond relationships to patients. As they state, "all therapists working with trauma survivors will experience lasting alterations in their cognitive schemas, having a significant impact on the therapist's feelings, relationships, and life" (McCann and Pearlman 1990, 36).

are hindered in their abilities to share others' cares and to be emotionally invested in what others are invested in. While we may be rightly skeptical that their emotional deficits are as extreme as those of psychopaths, it can be said that compassion fatigue leaves one at least highly impaired in terms of emotional empathy.

Still, as Shoemaker makes clear, one may be able to exercise 'identifying empathy'—if not by *feeling* what others feel—by *seeing* the world as the other sees it; that is, by engaging in evaluational empathy. Do those who are compassion fatigued maintain this ability? Perhaps, but again only in a mitigated fashion, and this mitigation can be seen in the same two disabilities that pertain to the psychopath. Psychopaths are typically "unable to care about other people," Shoemaker explains, and because caring for other people *would* allow one to take up their perspectives, the perspectives of others "and regarding them generally—cannot matter" (Shoemaker 2015, 160). Those who are compassion fatigued might still care for others on some level, but if they are truly desensitized and less interested in bearing others' suffering, surely their capacity for evaluational empathy is at least impaired.

Along with their impaired ability to care for others, psychopaths are characteristically "impaired in regard for *themselves*" (ibid. 161). Shoemaker makes this point with the stories of two 'successful' psychopaths who "just do not care when their pursuits are derailed" (ibid.). Similarly, compassion fatigued practitioners typically show a "chronic lack of self-care" (Figley 2002). Many have been reported as "falling prey to compulsive behaviors such as overeating, overspending, or alcohol/drug abuse" (Gentry 2002, 48). Compassion fatigue appears to disallow, then, both caring for others as well as properly caring for oneself. Again, though, does this mean that those who are compassion

fatigued are *as* impaired as psychopaths in terms of evaluational empathy? We can of course hope not. On some accounts, compassion fatigue is seen as a scalar process, progressing from compassion *discomfort* to compassion *stress*, and finally to *fatigue*, where the power of recovery is thought to be lost (Coetzee and Klopper 2010; Mason et al. 2014). Thus, it may be that one is gradually rendered impaired in her empathic capacities. However, in reaching a stage of full-fledged compassion fatigue, it appears that one is (at least) severely impaired in terms of both emotional and evaluational empathy. In this way, those who are compassion fatigued are eligible for only highly mitigated accountability responses such as anger and resentment.

Can compassion fatigued practitioners be held responsible in terms of attributability or answerability? It would seem that, although anger and resentment are unfitting, they may be eligible for responses akin to admiration or disdain. Whether compassion fatigue is experienced temporarily or as a permanent impairment, they might grow ashamed of themselves—or others may well come to disdain them—and appropriately so if they could no longer care for themselves or others. In general, then, attributability appears to be unmitigated. Whether or not one who is compassion fatigued could be fittingly called upon to answer for his judgments would appear to depend upon the extent to which he could still obtain and utilize reasons in his deliberations. In the worst cases, we can imagine, one's lack of care may well cause him to no longer feel the force of reasons (cf. Rentmeester 2007). If he truly cannot care for himself or others, it would seem that he simply would not regret, for he would not be (as) motivated to do things differently in the future. Accordingly, answerability is at least mitigated in many cases.

It should be evident, then, that in one's experience of compassion fatigue his sense of responsible agency is severely compromised. If, as the research surveyed here suggests, his impairments are such that he is incapable of engaging empathetically with others, this deficit alone is enough to cause great concern. With this in mind, before concluding, I will offer some thoughts on how policies might be constructed in order to effectively address compassion fatigue. Like my general guidelines outlined for addressing moral distress, the notions offered here are intended to be broad principles upon which policies might be based.

First, *policies should aim to assess the extent to which one's empathic capacities are impaired*. Where one is truly unable to engage empathically—emotionally or evaluationally—with others, he will not be a fitting target of anger and resentment, or even gratitude where it seems he displays a positive regard. Unlike the morally distressed practitioner, one who is compassion fatigued cannot be held accountable, although he may be held responsible in terms of attributability or answerability, either by himself or others. In this way, his agency is severely compromised, and prior to taking measures toward remedying his condition, we would do well to understand the extent of his disabilities.

Second, then, *given our reasonable concern for remedying compassion fatigue, policies can utilize the assessments of empathic capacities in providing targeted measures based upon the extent of one's impairment*. That is, where one is merely having difficulties providing compassionate care but can still take up patients' perspectives in his deliberations, we may move to implement precautionary measures.[24] By contrast, where

[24] Such measures might include taking time off, developing support networks, maintaining exercise regimens, or simply increasing awareness of one's own sense of fatigue (cf. Joinson 1992; Gentry 2002; Abendroth and Flannery 2006; and Coetzee and Klopper 2010).

one appears to be no longer capable of engaging empathically with others, it seems clear that we must work to restore the subject's emotional and interpersonal capacities. Indeed, without these crucial agential features, one would be psychologically damaged in a way that hinders her ability to care for herself and disallows her full engagement in meaningful relationships with others. For these reasons, until one's empathic abilities are restored, we must recognize their exemption from accountability. And if we value being able to hold healthcare practitioners accountable in light of their actions and attitudes, it may be that compassion fatigue disallows some individuals from holding some of the most emotionally demanding positions.[25]

Third and finally, *unlike with moral distress, policies ought to make explicit that the problem of compassion fatigue lies primarily in the agent herself*. It is a "type-2" plea, in the sense that the circumstances may be normal, but features of the agent show her to be less than fully capable of responsible agency (Shoemaker 2015, 8). This, in short, can be seen as the key difference between compassion fatigue and moral distress, which reveals merely excuses or "type-1" pleas. Granted, the research is only tentative in claiming that full-fledged compassion fatigue is a condition wherein the "power of recovery is lost and full restoration of the previous level of compassionate functioning is unattainable" (Coetzee and Klopper 2010, 241). Still, even if recovery is attainable, the temporary loss of one's empathic capacities would be alarming nonetheless, in that one would inconsistently maintain a discernible quality of regard. It has been suggested that certain personalities are more susceptible to compassion fatigue than others (cf. Joinson 1992;

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[25] This claim might appear highly controversial, as it may be taken to suggest extremely paternalistic measures, hiring practices, and so on. Hence, my tentative, conditional wording. I thank Nathan Biebel for discussion on these issues.

Keidel 2002). Again, if our ability to hold healthcare practitioners accountable is a value to be promoted, which I can only here assume, we must maintain an open dialogue—including hiring requirements and periodic checks—on who should and should not be occupying certain high-demand positions in healthcare. Though, given the existing and projected shortages, particularly among nurses (Abendroth and Flannery 2006), such recommendations are not likely to be met with open arms.

4. Conclusion

Both moral distress and compassion fatigue have been identified as extremely problematic for healthcare practitioners' wellbeing and, thereby, for patient care. Because of this, it seems clear that we ought to develop and implement measures to address both phenomena. Yet, as I have argued, the two sorts of experiences, while both generating ambivalent responses, bear crucial differences, conceptually and for practical purposes. No doubt, it would be a mistake to run the two experiences together or, worse, to treat the two conditions alike in the construction of policies for easing the challenges confronting healthcare professionals.

As I showed, the problem of moral distress lies primarily in the troubling situations and difficult decisions being faced. With this, I can reiterate the conclusions of my earlier discussions which aimed to establish that the experience of moral distress itself is not something we should attempt to alleviate directly. Indeed, it is a natural and often honorable response to one's predicament. By contrast, compassion fatigue is a condition wherein features of the agent herself effectively compromise her responsible agency. It is a much greater cause for concern, as the characteristic agential impairments are disabilities

in empathic engagement. Those who are compassion fatigued typically cannot care for others or for themselves. In some of the worst cases, it might be that one is permanently impaired emotionally and, as such, cannot be held accountable. While we ought to be concerned enough to develop policies addressing both sorts of experiences, in doing so we must account for the distinct features of each condition, if policies are to be truly effective.

Conclusion

Since this project began, the subject of moral distress has retained a prominent place in the literature. Some of the recent works are attempts to synthesize the plethora of research and to bring forward a unified undersstanding of the phenomenon (cf. Oh and Gastmans 2015; Morley et al. forthcoming). Others are reports of new empirical studies, which commonly invoke one of the many disparate definitions (cf. Cantu 2018; Wands 2018). Still other recent works have begun engaging critically with the concept, as I have endeavored to do here (cf. Campbell et al. 2016; Dudzinski 2016; Fourie 2017). In this brief closing chapter, I want to summarize the results of this project, along with some implications for policies, and suggest what appear to be fruitful directions for future research.

I began in Chapter 1 by identifying the initial problem of moral distress, namely that the experience of it is seen as closely correlated with practitioner burnout and staffing shortages, among other negative effects. These factors, naturally, increase the likelihood of adverse outcomes for patients. Thus, it seems that something must be done to address moral distress among practitioners. However, the condition is not adequately understood. As I showed, the leading accounts leave significant explanatory gaps and are often at odds with one another. I presented several case studies, some of which were drawn from true-to-life narratives, and I established four key desiderata for an explanatorily satisfying account. A robust account, I argued, must be able to accommodate a range of causal

circumstances, the paradigmatic nature of moral distress, how the condition might develop over time, and the ways in which the subject maintains a moral commitment. Given that the current notions on offer cannot adequately meet these demands, we see the persisting need for a fully satisfying account of moral distress.

In Chapter 2, I aimed to provide such an account, one that could fulfill the established desiderata and thereby explain the range of cases of interest. Here I appealed to contemporary research on the moral emotions and I took seriously some of the plausible yet incomplete suggestions concerning the nature of moral distress. In Andrew Jameton's foundational work (1984 and 1993), it is said that moral distress might involve feelings of frustration, anger, anxiety, or guilt. With these and related emotions in mind, I detailed the possible affective, motivational, and evaluative components of the experience of moral distress. In short, the range of associated emotions characteristically evaluate one's circumstances or oneself negatively and prompt one to make efforts at somehow improving the situation. Still, I claimed, there must be something more to an experience of distress, and indeed, something more to being *morally* distressed. I then considered the idea of moral distress as "psychological disequilibrium" (Wilkinson 1987/88) as well as our common understanding of what it means to be in a state of distress, namely, to be *overpowered* by some adverse force. On the account I developed, moral distress is best understood as a tension between one's negative emotions and one's sincere judgments concerning the prospects for improving the situation or repairing a moral wrong. Admittedly, this conception, while broadening the definition of moral distress, may well explain some cases—those exhibiting blatant or extreme experiences of inner turmoil—more than others.

For this reason, as I made clear, my definition should be taken to represent a paradigm of moral distress.

With the paradigmatic approach in mind, in Chapter 3, I showed how my account enjoys significant advantages over recent proposals regarding both the nature and the value of moral distress. Here I argued that moral distress bears potentially positive value in two distinct senses. On the one hand, the experience of moral distress appears to be partly constitutive of an honorable character; it bears positive aretaic value, in the sense of comprising desirable qualities of agents responsible for navigating morally difficult or tragic situations. To be morally distressed under some circumstances is to be appropriately sensitive to others' interests and values or to morally significant losses. On the other hand, moral distress stands to reveal and affirm some our most important cares and commitments; it bears positive instrumental value, in the sense of contributing to one's moral maturation. Relatedly, one's experience of moral distress might stand to achieve consequential goods for others, as I argued in the following chapter.

With Chapter 4, I turned my attention to a specific context wherein a practitioners' experience of moral distress might be especially beneficial, that is, in the wake of medical error. According to a 1999 report issued by the Institute of Medicine, the occurrence of medical error is alarmingly frequent. In response, many authors have called for a wholescale reformation in our approach to patient safety. As I showed, a prevalent theme has emerged, namely, a shift away from notions of blame in healthcare and toward a focus on the "system." Against this shift, I argued that we can *and should* have it both ways. Allowing errors to go blame-free is not possible or necessary, I established. But further, removing notions of blame merely decreases the means by which practitioners can commit

to increased safety and improved patient-practitioner relations and thereby help harmed patients and families to move forward. The question, then, is how can practitioners effectively convey their commitment to improvement where they might not be entirely responsible for the error? With a critique of Elinor Mason's (2018) recent work, I suggested a notion of *taking the blame* whereby practitioners who are truly invested in their professional duties must own up to harmful actions, whether their own or those of their institution. My account of moral distress provided a plausible mechanism by which practitioners can apologize and assure others that they are committed to improvements.

Finally, the aim of Chapter 5 was to dispel the connections between moral distress and the commonly associated experience of compassion fatigue. Both phenomena are said to be extremely problematic for practitioner wellbeing and, thus, for the quality of patient care. However, there are crucial divisions to be drawn, I argued. Most notably, cases of moral distress often show that an agent is somehow excused from responsibility, whereas compassion fatigue constitutes an exemption, a distinct sort of marginalized agency. This key division was made with an application of David Shoemaker's (2015) tripartite account of responsibility. In short, it appeared that those who are morally distressed retain all three capacities for responsible agency. They are able to govern their actions and attitudes based upon cares and commitments; they can make judgments that reflect a consideration of reasons; and they have the capacity to empathize with others and take their interests seriously. This last capacity, I showed, is typically impaired—perhaps quite severely—in cases of compassion fatigue. As Shoemaker explains, our empathic capacities allow us to be held accountable, in that we can be appropriately targeted with responses like anger or gratitude. Accordingly, where one's capacities for empathy are impaired or lacking, one

cannot be held accountable. And if we value being able to hold healthcare professionals accountable, it may be that compassion fatigue, unlike moral distress, disallows some individuals from holding certain offices and positions.

With the distinction between moral distress and compassion fatigue, I sketched several general guidelines for each condition, based upon their unique features. In doing so, I emphasized that while the problem of compassion fatigue is found in the agent, the problem of moral distress lies primarily in the circumstances and not in the agent. As I stated, the recommended guidelines are intended to serve as foundations upon which policies could be developed and implemented. Here I want to reiterate and briefly expand upon some of these recommendations. Along with outlining further thoughts for policies, this exploration should help to establish fruitful directions for future research.

First, as I suggested, policies for addressing moral distress should aim to advance our understanding of the morally distressed agent's self-directed responses. While this suggestion may run contrary to what I have identified as the problem of moral distress—namely, the circumstances—it seems that coming to understand the agent's responses should serve also to better understand the situation. That is, where one engages in self-blame while believing herself to be innocent or helpless, we may have some indication that the circumstances involve an obstacle to morally appropriate action, an experience of a moral dilemma, or perhaps bad moral luck. Research agendas for moral distress should, then, include inquiries concerning the extent to which morally distressed agents blame themselves and in what ways. As I suggested above, we might ask: Do they believe they are at fault for some moral wrong? Do they judge that they are powerless in some way, perhaps to improve the situation or to rectify perceived wrongs? Additionally, we will want

to know more about the specific emotional response one undergoes. Does one feel, for example, something closer to frustration and anger, or something more like guilt and regret? If the former, we may have reason to think that someone or something else is implicated in the situation, given that frustration and anger are characteristically directed at others just as easily as oneself. By contrast, where one's emotional responses resemble guilt, regret, or remorse, yet responsibility remains unclear, we might think of the circumstances as genuinely tragic, in the sense that an irresolvable conflict was being faced. In short, coming to learn more about the subject's emotional responses and sincerely held beliefs should help us to better understand the troubling circumstances in question.

Next, admittedly, the proposed investigations into agents' emotional responses and coinciding beliefs stand to confirm or discredit my account of the nature of moral distress. After all, on the account I developed, moral distress is paradigmatically a tension between one's emotions and one's sincerely held beliefs. This notion, I claimed, is what I take to be a highly plausible hypothesis deserving of our attention. As it may turn out, some might experience moral distress, for example, as an extreme episode of guilt or regret, without any sort of internal conflict. In such cases, however, the onus is on the proponents of this notion to say what, if anything, distinguishes moral distress from its allegedly related states. A key virtue of the account I have offered is that it can effectively delineate cases of moral distress from the range of responses thought to be associated.

Another virtue of my account is likewise one that calls for substantial future research, much of which will require empirical support. That is, with the account developed here, we see numerous proposals for how moral distress might be seen as possessing positive value, either aretaically or instrumentally for oneself or for others. Nonetheless, a

host of questions remain open in light of these proposals, some of which I have addressed only in passing. For one, we might wonder, even if moral distress partly constitutes an honorable character—a contestable claim, no doubt—at what point is the experience of it no longer a boon? As I advised in my caveats to the positive value, one who dwells on and on is likely overly sensitive or even disturbed. Determining the point at which moral distress is no longer a desirable state for one to endure is no small task, and one that may not admit of a clear research agenda.

We might see productive routes for future research arising from my discussion of moral distress as instrumentally valuable. We could, for example, posit some distinct set of outcomes—perhaps a better understanding of one's values or commitments—then test for whether or not moral distress in fact helps to bring these about. Here we would need to specify precisely what notion of moral distress we are investigating. Further, we should be interested to learn whether or not some other experience does equally well at producing these outcomes. As I discussed in Chapter 3, one may well arrive at a better understanding of one's values as a result of experiencing frustration or guilt, and not necessarily from experiencing moral distress. Alternatively, we can imagine, where moral distress is experienced, subjects might not consistently come to better understand their values or commitments. In these ways, again, my account is open to being confirmed or called into question, based upon a variety of future studies.

Along with the potential explorations of moral distress as instrumentally valuable for oneself, we might construct future studies for determining the extent to which a practitioners' moral distress helps others. In my discussion of blame and medical errors, the questions raised likely outnumbered the questions resolved. For the latter, I hope to

have shed some light on how moral distress might be valuable, how it can be harnessed as a mechanism for achieving distinct goods for those in need. If I am right, moral distress might make up a unique sort of self-blame, one which helps patients and the community at large to see a practitioner's commitment to improvements, despite being less than fully responsible for harmful actions. Still, we might wonder, generally, is it the case that morally distressed practitioners improve their practices more than, say, those who have become inured by the difficulties? Does moral distress for medical errors in fact decrease others' propensity to censure or punish? And just how much moral distress is appropriate or useful for bringing about the possible consequential goods? Resolving these questions and others that concern the instrumental value of moral distress would surely require further theoretical and empirical work.

My proposed guidelines included the recommendation that we make clear that moral distress is a result of troubling circumstances and not in itself a cause for alarm. Abiding by this suggestion, it seems, would allow institutions to encourage a growing dialogue among those who experience moral distress and those who study it. That is, if the morally distressed find that their experiences are seen as natural, healthy responses to understandably difficult situations, they might be in a better position to speak up and thereby give rise to policies addressing such troubling circumstances. Again, though, much more work is needed, both conceptually and in practice. Ultimately, what I hope to have achieved with this project is some progress in the debate over what constitutes moral distress and in the question of how, if at all, the experience of it might bear positive value. As things stand at present, discussions of moral distress show no sign of waning.

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Biography

Daniel Tigard was born on August 19, 1983 in Mountain View, California and raised in the Pacific Northwest. After several years of contributing to the Seattle music scene, he finished his B.A. in philosophy at the University of Washington in 2009. He then earned his M.A. in philosophy at Brandeis University in 2012 before moving to New Orleans to pursue his doctorate. It was there he met the love of his life, Katharina Hammler, a fellow doctoral student at Tulane University. They were married in 2017 and currently reside in Vienna, Austria. Daniel's research lies primarily at the intersection of moral responsibility and moral conflicts, with particular attention to issues in bioethics.