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Living with conflicts-ethical dilemmas and moral distress in the health care system

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Abstract

During the last decade, the Swedish health care system has undergone fundamental changes. The changes have made health care more complex and ethics has increasingly become a required component of clinical practice. Considering this, it is not surprising that many health care professionals suffer from stress-related disorders. Stress due to ethical dilemmas is usually referred to as "moral distress". The present article derives from Andrew Jameton's development of the concept of moral distress and presents the results of a study that, using focus group method, identifies situations of ethical dilemmas and moral distress among health care providers of different categories. The study includes both hospital clinics and pharmacies.

The results show that all categories of staff interviewed express experiences of moral distress; prior research has mostly focused on moral distress experienced by nurses. Second, it was made clear that moral distress does not occur only as a consequence of institutional constraints preventing the health care giver from acting on his/her moral considerations, which is the traditional definition of moral distress. There are situations when the staff members do follow their moral decisions, but in doing so they clash with, e.g. legal regulations. In these cases too, moral distress occurs. Hitherto research on moral distress has focused on the individual health care provider and her subjective moral convictions. Our results show that the study of moral distress must focus more on the context of the ethical dilemmas.

Finally, the conclusion of the study is that the work organization must provide better support resources and structures to decrease moral distress. The results point to the need for further education in ethics and a forum for discussing ethically troubling situations experienced in the daily care practice for both hospital and pharmacy staff.

Keywords: Ethics; Moral distress; Pharmacy practice; Clinical practice; Ethical dilemmas; Nursing; Sweden

Introduction

During the last decade, the Swedish health care system has undergone fundamental changes. New evidence based medicine and health care quality certification programs have been implemented alongside the development of advanced biomedical techniques. Organizational reforms have been carried out in order to make health care more efficient, often including elements of competitive inducements between health care providers. A more educated population and changes in values have increased the consumer demand on health care services (Forsberg, 2001).

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The changes have made health care more complex and ethics[1] has increasingly become a required component of clinical practice. Demands on first-line professionals, i.e. doctors, nurses and auxiliary nurses, to make decisions concerning priority-setting in their everyday work have resulted. Not only do they have to consider what is best for the present patient, but also consider the future patient's needs and questions of social economics.

Despite the increasing demands for qualified ethical judgements the health care organization often lacks standardized policies for guidelines as well as systematic education in ethics and structures of ethical support for their staff members who are to carry out the decisions. Considering this, it is not surprising that many health care professionals suffer from stress-related disorders. Several studies have shown how fundamental changes in the health care organization have added new stressors to the medical profession. Arnetz (2001) has identified several stressors facing physicians as part of their medical practice. Most stressors identified are psychosocial in their origin, such as workload, unsatisfying tasks, lack of skill development and lack of clear work directives from the immediate supervisor. According to recent studies ethical dilemmas can also cause stress-related disorders among health care professionals (van der Arend & Remmers-van den Hurk, 1999; Raines, 2000; Corley, Elswick, Gorman, & Clor, 2001). Stress related to ethical dilemmas is usually referred to as "moral distress". A well-established definition of moral distress is that it "occurs when one knows the right thing to do, but institutional or other constraints make it difficult to pursue the desired course of action" (Raines, 2000, p. 30).

In this article, the results of an investigation concerning the views of health care professionals themselves on what kinds of situations involve ethical dilemmas are presented. Building on Andrew Jameton's definition of moral distress (Jameton, 1984, 1992, 1993), an analysis of whether these ethical dilemmas could also be considered as creating moral distress among health care professionals of different categories is undertaken. Unlike previous studies on moral distress, which have often focused upon the work situation of the nurse, this study covers health care in a broad perspective and includes both hospital clinics and pharmacies.

[1] According to the conventional definition, morality refers to personal opinions of good and bad, right and wrong, and ethics to the theoretical reasoning over morality. In this article we mainly follow this distinction, but since the concepts often overlap both terms could sometimes be used.

Background

Stress related to ethical dilemmas, or moral distress, has been discussed particularly in relation to nurses. According to Raines (2000) the impact of ethical issues in nursing practice in the United States has increased tremendously during the last decade. Nurses in almost every practice setting spend increasing amounts of their time resolving ethical dilemmas, as well as experience more stress in dealing with ethical conflicts. The trend has continued despite efforts by health care institutions and professional organizations to standardize policies relating to ethical issues in health care.

Job satisfaction instruments for doctors and nurses have often included items of moral value. For example, Berger, Seversen, and Chvatal (1991) measured the frequency of encountered ethical dilemmas among nurses and the degree to which they where disturbed by them. According to Corley (1995) no instrument had until then been developed specifically to measure levels of moral distress. To fill that gap, Corley et al. (2001) developed the moral distress scale (MDS) to measure moral distress as an element of job stress in nursing. When applying this, Corley and co-workers found that 69% of the nurses in their study sometimes had to compromise their values, due to hospital policy or standards, a physician's request or nursing administration requirements. They were also sometimes forced to act against principles, as ethical guidelines (and in some cases even legal requirements) were impossible to carry out because of organizational constraints, such as lack of resources or lack of power (Corley et al., 2001).

Raines (2000) developed a model for stress related to ethical dilemmas: the ethics stress model. The model is an adoption of Wilkinson's (1987/88, 1989) studies of moral distress and describes the relation between moral reasoning, coping style and the amount of stress experienced in ethical decision-making situations in nursing. Raines' study shows that the most frequently experienced sources of moral distress for oncology nurses were pain management and cost containment issues (Raines, 2000). Wilkinson (1987/88) had earlier identified three major types of ethical issues causing moral distress among nurses, namely situations involving prolonging life, performing unnecessary tests, and the desire to tell the truth. Rodney (1988) found that critical care nurses experienced resentment, frustration, and sorrow when they were unable to act on their moral choices.

Theoretical framework

The present research derives from Jameton's (1984, 1992, 1993) concept of moral distress in nursing. A basic assumption is that health care professionals hold values