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Self-Inflicted Moral Distress: Opportunity for a Fuller Exercise of Professionalism

Jeffrey T. Berger, Ann B. Hamric, and Elizabeth Epstein[1]

Short summary

This article by Berger et al. explores examples of self-inflicted moral distress and the circumstances that may trigger it. They argue that incidences of self-inflicted moral distress may be reduced and outline a number of different strategies that health care institutions and individual health care providers can apply to mitigate experiences of moral distress.

Introduction

To illustrate what is meant by self-inflicted moral distress, the authors outline a case describing an 87-year old patient who is re-admitted to the hospital from a nursing facility. The patient suffers from dementia along with chronic kidney disease and congestive heart failure. The physician asks the family for their instructions in the event that the patient should suffer cardiac arrest even though there is medical evidence that Cardiopulmonary Resuscitation (CPR) is unlikely to be effective for this patient. The physician struggles with moral distress by the thought of potentially having to perform CPR on a patient where it is very unlikely to be beneficial.

Key argument

Berger et al. define moral distress as "the psycho-emotional dissonance that arises when one is unable to act on one's professional core values and obligations due to constraints." (p. 314). They recognize that moral distress is an unavoidable feature of health care, but argue that some cases of moral distress are self-inflicted. Self-inflicted moral distress can occur at the individual level as well as at group level. A number of circumstances may contribute to self-inflicted moral distress:

- Limited knowledge about one's obligations and/or what is permitted under the established professional norms.
- Limited skills in communicating with the patients and families around medical decision-making.

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[1] Berger, J.T., Hamric, A.B., Epstein, E. (2019). Self-Inflicted Moral Distress: Opportunity for a Fuller Exercise of Professionalism. *The Journal of Clinical Ethics*, Volume 30:4; p.314-317

- Limited knowledge or lack of willingness to enforce institutional procedures that, if applied, could mitigate the circumstances that are the source of moral distress.
- Following de facto standards of practice that include ineffective medical treatment as the norm.
- Failing to advocate for change in cases where the individual or group of health care providers may be aware of institutional structures or resources that can mitigate morally distressing situations.
- Limited or weak support from organized medicine such as professional organizations. According to Berger et al., the self-inflicted moral distress described in the case could have been prevented if the physician had asserted their professional authority. However, the physician may feel uncomfortable doing so, if the norm of practice among other physicians in the same ICU is to present families with the choice of treatment even though it is highly unlikely to be medically effective. That said, if the physician had looked to guidelines from professional organizations, such as for example the American College of Physicians Ethics Manual, they would not have found any valuable support, as these guidelines provide little guidance in this particular circumstance.

The authors argue that self-inflicted moral distress may be mitigated and offer a number of strategies that health care providers may use for this purpose. Individuals and groups working in health care can mitigate self-inflicted moral distress by:

- Better familiarizing themselves with policies and guidelines.
- Improving their knowledge of relevant laws and regulations for the purpose of self-education.
- Building communication skills to promote self-empowerment and better management of situations that have high potential for moral distress.
- Communicating to those in positions of authority in institutions regarding their responsibility for ensuring that individual health care providers are able to exercise professionalism.
- Promoting norms of professionalism and identifying individual health care providers whose behaviour differs from these norms.
- Seeking consultation with ethics services.
- Seeking self-empowerment through single-professional debriefings to share perspectives and experiences of moral distress.
- Lobbying for clear positions from professional organizations.

Conclusion

Moral distress is an unavoidable feature in health care, but self-inflicted moral distress is not. If individuals or groups that are experiencing moral distress are able to identify and mitigate the aspects of the moral distress that are self-inflicted, this will benefit other health care providers and patients as well.