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Helping Clinicians Cope With Moral Distress Can Improve Patient Care

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A colleague of mine recently shared a story with me from her training. She told me that when she started caring for patients during her 3rd year medical school clerkship rotations, a resident sat her down and instructed her, "It's not about you anymore." For her, that was the first of many steps in her professional identity formation as a physician, when she learned that physicians should put their patients first. She learned that the authority, legitimacy, and respect that the medical professional enjoys are grounded in its obligation to ensure that the patient's well-being comes before individual self-interest. The patient should be the center of all of a physician's efforts. At the same time, she learned that her needs or her feelings were still relevant and important because they could serve as crucial clinical data to use in service of better patient care. Moreover, her ability to care for herself would allow her to take better care of her patients.

I found this story useful because it effectively illustrated some of the challenges with how moral distress can be misunderstood and misused by health professionals. In my previous column I introduced moral distress, which is described as a perceived violation of one's core values and duties, concurrent with a feeling of being constrained from taking ethically appropriate action. Because there is often moral ambiguity or moral diversity with ethical disagreements, defining moral distress as what one individual believes as "wrong" can be misleading and often distracts from achieving a resolution.

Distinguishing between health care workers' professional and personal values is central to appropriately responding to moral distress in health care because both should be addressed differently. Health care professionals identify, practice, and profess the shared values of the profession – a commitment, for example, to competence, truth telling, respect for persons, beneficence, and so forth. Put another way, those are the core tenets of the profession that help to maintain the integrity of the profession. Individual members of a profession, however, each have their own diverse personal values that are central to their *personal* integrity, but are not necessarily shared by every member of a profession.

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As discussed in the last column, moral distress rooted in professional values is particularly concerning. Such moral distress developed among some health care professionals during the COVID pandemic when they believed that they could not appropriately care for patients according to usual standards of practice either because of resource constraints or simply because of the necessary isolation requirements for safe patient care. This distress was not based on a moral position just held by an individual, but rather by the entire profession – that the medical profession should provide high quality care to all patients. Attempting to provide care without adequate resources or according to established standards of care was contrary to the broad shared values of the profession.

At the same time, some individual clinicians may feel moral distress as a result of their own deeply held personal values. This can be more challenging for these health care professionals because of their obligations to put their patients' interests before their own self-interest. These professionals are often aware that their personal values are not determinative when helping patients make their own decisions. So, for example, deciding to withhold a particular treatment from a patient simply because it is contrary to a physician's personal values would be ethically problematic. Withholding that same treatment because providing it would violate a clear professional standard, however, is more likely to be ethically supportable.

A central objective of addressing moral distress is to permit clinicians to effectively perform their professional functions and thus better help patients. Clinicians and the institutions that support them are responsible for ensuring that that any moral distress does not affect the quality of their care or inadvertently shift providers away from their primary commitment to patients. Responding to moral distress, however, depends on whether it is based on one's personal moral integrity versus distress based on violation of one's professional integrity. Last month's ethics column focused on the latter situation.

With distress based on a violation of personal moral integrity, the goal is to support the individual clinician in their distress while ensuring the provision of the requested, appropriate care. Although the distress a clinician feels should not be ignored, it should not determine what medically appropriate choices are available to the patient. Consider a physician who is morally distressed over a patient with a substance use disorder who chooses to leave the hospital prematurely. This provider's distress happens to be based on their idea that drug use is immoral and they wonder how much effort they are expected to expend in caring for patients who choose to live this way. In this case, the physician should be empathically supported in caring for patients who may be "difficult to help" because of a substance use disorder by confidentially helping the provider process their concerns and helping them manage their values in the context of providing needed care. This supports the clinician who is ultimately, and most importantly, the one who is best positioned to support the patient.

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