Moral Distress among Healthcare Managers: Conditions, Consequences and Potential Responses

Souffrance morale chez les gestionnaires de la santé : conditions, conséquences et solutions potentielles

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Abstract

Moral distress – the physical and emotional response to feeling prevented from carrying out ethically proper action – can have serious consequences for health professionals and healthcare organizations. We investigated perceived moral distress qualitatively with managers in two BC health authorities.

Respondents described conditions under which they experienced distress: when they set priorities within highly resource-constrained environments, when they observed inequities between budget allocations and management responsibilities, and when organizational priorities did not align with their personal values. When coping proved insufficient, managers would respond by leaving positions, organizations or the healthcare field altogether.

Respondents asked for leadership development and the creation of spaces in which moral distress could be openly discussed. However, formal training in priority setting did not appear to be helpful on its own. Rather, it increased managers' awareness of the ethical dimensions of resource allocation without (in this instance) entrenching supports that would help them resolve these concerns.

Résumé

La souffrance morale – réaction physique et émotionnelle liée au fait de se sentir incapable d'accomplir éthiquement une action – peut avoir de sérieuses conséquences pour les professionnels de la santé et les organismes de soins de santé. Nous avons étudié la perception qualitative de la souffrance morale chez les gestionnaires de deux autorités sanitaires en Colombie-Britannique.

Les répondants ont décrit les conditions dans lesquelles ils éprouvent de la souffrance : quand ils établissent des priorités dans un contexte où les ressources sont très restreintes, quand ils observent des iniquités entre l'engagement des dépenses et les responsabilités de gestion et quand les priorités organisationnelles ne concordent pas avec leurs valeurs personnelles. S'ils se sentent incapables de faire face à la situation, les

gestionnaires peuvent envisager de laisser leur poste, l'organisme ou même le secteur de la santé. Les répondants demandent plus de formation en leadership et la création de lieux où ils peuvent discuter ouvertement de la souffrance morale. Cependant, la formation officielle portant sur l'établissement des priorités ne semble pas aider en soi. Elle semble plutôt augmenter la prise de conscience, chez les gestionnaires, des aspects éthiques de l'engagement des dépenses sans pour autant (dans ce cas) offrir le soutien qui les aiderait à résoudre leurs préoccupations.

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HEALTHCARE MANAGERS FACE DIFFICULT CHALLENGES AND DISTRESS IN determining how best to allocate limited public resources. There is little likelihood that public sector spending in industrialized countries will grow by much over the next few years. Any recovery from the 2008 global recession is likely to be long and shallow, and the deficit spending incurred in the name of economic stimulus may be replaced, as it was in the 1990s, by significant public sector cuts. Managing and setting priorities in straitened times will be the norm.

In this study we sought to determine whether the concept of moral distress, previously identified and studied primarily in the clinical literature, is also relevant to mid- and senior-level managers. Building on previous work (Jameton 1984; Nathaniel 2002; Rushton 2006; Rodney et al. 2004), we defined moral distress as *the suffering experienced as a result of situations in which individuals feel morally responsible and have determined the ethically right action to take, yet owing to constraints (real or perceived) cannot carry out this action, thus believing that they are committing a moral offence.* Moral distress is rooted in one's sense that his or her value commitments are compromised (Webster and Baylis 2000). The suffering or personal anguish this perception entails presents as feelings of anger, frustration, guilt and/or powerlessness associated with a decreased sense of well-being. We are interested, in this study, in what these managers felt to cause them distress and how they were affected by it. We make no judgments regarding whether their views on ethically proper action are, or should be, shared by others.

Studies in clinical settings have related moral distress to low morale (Rodney and Starzomski 1993; Gaudine and Thorne 2000; Gaudine and Beaton 2002) and challenges with turnover and retention (Gaudine and Thorne 2000; Decker 1997; Corley et al. 2001). For example, Corley and colleagues (2001), in developing a quantitative scale to measure moral distress among nurses, found that 15% of their sample had left a previous nursing position for this reason. Other studies have found that up to half of nurses reported leaving a job, or the profession altogether, as a result of moral distress (Millette 1994). Pauly and colleagues (2009), using instruments developed by Corley and her team (2005) and Olson (1998), also found nurses reporting their intent to leave current positions, or nursing itself, because of moral distress. They found moral

distress to be a complex phenomenon; ethical climates were significantly correlated with individual moral distress. This may mean that "moral distress should not be framed or located as an individual concern … rather, further investigation of the ways in which organizational factors contribute to moral distress is needed" (Pauly et al. 2009: 569).

Based on findings reported elsewhere, we believe that moral distress does exist among managers in the context of priority setting and resource allocation (Mitton et al. 2010). Two key examples of moral distress were identified in this work: (1) managers having to "sell" a direction or decision that they themselves do not believe in and (2) managers breaking obligations to staff or colleagues. That is, on the basis of the evidence we collected, we were able to identify for these cases strongly held ethical/moral principles that the respondents felt they were being forced to violate. It is the presence of such a clear ethical dimension that distinguishes moral distress from the other demands of fast-paced and highly contentious healthcare workplace decision-making. These arguments are made in greater detail elsewhere (Mitton et al. 2010).

The current paper describes some of the organizational conditions under which moral distress occurs, or which might be thought to accentuate the experience. We show that the presence of moral distress, and how managers respond to it, has negative consequences for healthcare organizations. Finally, we consider possible organizational responses to the problem, including whether formal training in priority setting methods – such as the widely implemented program budgeting and marginal analysis (PBMA) framework (Mitton and Donaldson 2001; Peacock et al. 2006; Mitton et al. 2003) – might have beneficial impacts in terms of preventing or mitigating moral distress.

Methods

Given that this research was an early attempt to investigate a new topic, and in order to consider whether a particular concept could be usefully employed, thematic content analysis, guided by constructivist principles – the qualitative approach that we used – was appropriate (Green and Thorogood 2004). We conducted three focus groups (n=12 participants) and individual interviews (n=6) with mid-level managers and senior executives in two health authorities in British Columbia between June and December 2008. Participants' descriptive data were not systematically collected; however, their recorded comments and researchers' observations allowed us to assess certain key characteristics. Fourteen of 18 were female. Most had substantial years of administrative experience, either with their current employer or elsewhere in the public sector, and could best be described as in their middle to late careers.

Interviews and focus groups enable participants to give answers in their own words to researchers' questions; they allow respondents to describe situations and experiences in rich detail. When not enough is known about a topic to pose questions that can be addressed quantitatively using validated response options, qualitative

methods are better suited to addressing research objectives. While individual interviews were our preferred method, we employed focus groups pragmatically owing to time and resource constraints. That is, we were prepared to attach our data collection sessions to previously scheduled meetings when participants – very busy managers – would be available in the same location. The same interview guide was used with both one-on-one and group sessions. More detailed discussion of the methodological questions this approach might raise is available elsewhere (Mitton et al. 2010).

We purposively sought informants who had previous exposure to formal priority setting processes – in this case, with the PBMA framework, which has been used widely by decision-makers in British Columbia and elsewhere (Dionne et al. 2008; Teng et al. 2007; Urquhart et al. 2008; Patten et al. 2006; Halma et al. 2004) – and those who had not had such exposure. Decision-maker partners in the two health authorities helped us identify and approach potential participants. In one case, a senior member of the executive team recruited colleagues in comparable decision-making positions on our behalf. In the other authority, a senior executive member e-mailed all mid-level managers within the region, described the research, noting that it had endorsement by the health region, and invited any interested managers to contact the research team directly.

All the focus group discussions and the interviews were audio-recorded with permission and subsequently transcribed. Respondents were asked to think of situations in which they had experienced moral distress (according to the definition provided, in general and in relation to priority setting specifically), to describe what (if any) personal consequences resulted from these experiences and to identify personal or organizational characteristics that they thought might be related to moral distress in management. Respondents were also asked if there were steps that they thought their organization could take to alleviate or prevent the kinds of experiences that they considered to be morally distressing. The complete interview schedule is available elsewhere (Mitton et al. 2010).

Two of the authors independently analyzed subsets of the transcripts. We began with a template based on our research questions and interview guide. For example, we compared respondents' descriptions of their experiences to our given definition of moral distress, to see if they were consistent with that construct. As a second example, we isolated all mentions of PBMA to determine if they did or did not include mention of the alleviation of distress. Other themes were developed inductively. Analysis proceeded through constant comparison (Parry 2004). Conceptual labels developed through reading of the earliest transcripts were assigned to emerging thematic categories (open coding). Respondents' comments in subsequent transcripts were assigned to existing or new categories. Disagreements among authors were resolved by discussion. Categories were compared against one another and refined until the data were internally coherent and each category was distinct from the others. The study was approved

by the Behavioural Research Ethics Board at the University of British Columbia and the Human Research Ethics Board at the University of Victoria; it was also reviewed and approved by an internal ethics board as required at one of the health authorities.

Results

The first set of results reported here pertains to *organizational conditions* within which moral distress is likely to occur. We then turn to identified *negative consequences* of moral distress for respondents' personal well-being. Finally, *potential individual and organizational responses* are reported, including whether experience with a formal approach to priority setting and resource allocation was mentioned in regard to individual managers' experience of moral distress. The number of transcripts within which each theme is identified is noted; we do believe, however, that with qualitative research the frequency of a theme does not necessarily indicate its importance.

Organizational conditions

Respondents spoke of different aspects of priority setting situations that they found most difficult. Three interrelated themes arose: resource-constrained environments, inequities in budgets and misalignment of values. We do not suggest that these are exhaustive of the situations in which distress might arise.

Managers felt distressed when they had to make choices about what to do with limited funding (five of nine transcripts), including how to organize required care in circumstances when they were well aware of both human resource limitations and time constraints.

> I think that is one of the things that as managers we sometimes struggle with – actually having enough time to actually do a full analysis of the decisions that we are making. … sometimes when you are pushed to make some decisions where you don't feel that you have had enough time to actually walk it through properly, sometimes you end up with a decision that could have been a little bit better, which is a hard thing to swallow. (Int-1, p. 11)

The challenges of making decisions in these environments were compounded when managers felt that resources or opportunities were unfairly or inequitably distributed within their organizations. Respondents in five of nine transcripts explicitly described cases in which their clinical areas had, over time, become responsible for performing functions that other sectors of the organization had divested (e.g., purchasing, maintenance, housekeeping). These new responsibilities were not accompanied by any redistribution of budgets. Nor were they necessarily within the skill set of

these managers. In short, some departments achieved savings by leaving others to pick up, uncompensated, the performance of tasks that – from an organization-wide or system perspective – could not be abandoned.

Respondents also experienced distress in attempting to carry out management roles when they felt that the organization's overall or main priorities differed from those they personally held (seven of nine transcripts). They felt that they would be unable to follow through if they tried to pursue what they felt to be the best, most ethical, policy. They also felt that they had to position or frame their choices in a way that accorded with the organization's established directions. Among several examples, one that clearly stood out was a tension between patient care and risk management:

> We carry that moral distress of "Are we using our resources to mitigate those situations where we've actually got the highest need?" No, we use our resources to situations where we have the highest risk organizationally, which is a different template in a different sort of construction than the actual client risk. (Nov. FG, p. 7)

> When it becomes a risk management or when someone gets hurt, then that seems to be a trigger. Basically, anything I have sort of gone ahead with, I have had to appeal to the "risk" perspective. Like "politically this would not be popular," or "you're at risk," or "liability" … that seems to get the administrators' attention as compared to "hey, let's do this so we actually are looking after the health of our staff and of our patients." (Int-2, p. 3)

Negative consequences experienced by these managers

A number of potentially serious personal health consequences that respondents attributed, at least in part, to moral distress were described. These included high blood pressure, ulcers, loss of sleep, exhaustion/fatigue, poor diet and lack of energy. Of course, there are no data in this qualitative study to assess whether such claims are objectively justified. One key difference from the clinical literature on moral distress was the repeated claim (appearing in four of nine transcripts) that distress did not manifest in increased sick time claims, because managers "don't take time off." Decreased productivity (i.e., "presenteeism"), however, was noted.

In terms of emotional well-being, at various points in the interviews our respondents used the following words or phrases to describe their experiences of moral distress: discouragement, annoyance, sense of failure, sadness, anger, frustration, hopelessness, disappointment, angst, guilt, powerlessness, burnout, loss of idealism, loss of self-esteem, cynicism, apathy, bitterness and aloneness. Further consequences of moral distress identified by the respondents included impaired workplace relationships,

diminished staff morale and impaired family and interpersonal relationships (e.g., "I take it out on my family"). These managers noted that the moral distress of their workplace responsibilities could not be left behind at quitting time; one described how, during personal time, s/he was "always thinking about it."

Personal responses

Respondents mentioned a number of means by which they coped with or managed their experience of moral distress. The one to which we draw attention here, because of its implication for organizational as well as personal health, is what we may call the "exit option." That is, some managers may cope with distress by contemplating or planning to leave positions, organizations or the healthcare sector itself.

> I know for me personally, one of the things that I have been thinking of because I am one of the "future leaders" in healthcare, is "do I want to stay in healthcare?" I look at what is potentially happening for 15 years down the road and I don't know if I want to be [a] senior leader in healthcare at that point. (Dec. FG, p. 20)

> I am out in a position where I need to move something faster than I am ready with my teams and then I get into that huge piece of suffering. That is where I almost have a real problem personally and at that point wonder if I can stay in the system, because I don't believe in it and so then that gets me to the point where I question "am I really in the place where I need to be?" (June FG, p. 5)

Exiting might also take the form of detaching one's self, as much as possible, from organizational commitment and routine. That appears to have both an organizational behavioural component (e.g., ceasing to attend meetings) as well as an affective one (trying not to take things too much to heart).

> Sometimes you actually do some self-preservation by disengaging from some of the regional work, the committee meetings where you get frustrated, it doesn't really matter what you say. So therefore I will just put my head down and disengage from the system and just try to look after my own circle of influence. (Int-1, p. 14)

> I can only go so far and push so far and then I have to say, "I am not personally responsible for this, it is an organizational and institutional decision-making process and I can't fix it all." (Int-2, p. 7)

This theme was present in seven of nine transcripts.

Organizational responses

In addition to their personal choices, our respondents described ways in which the employer might usefully react. They felt that an important aspect of the problem was the failure of the organization to acknowledge the existence of moral distress as an issue in management (explicitly claimed in four of nine transcripts).

> It is validation – that is, the name of what you are trying to achieve – is to validate that this is a real experience and that it is not abnormal human beings that are having these reactions. (Nov. FG, p. 38)

> Being upfront about acknowledging the problem. Saying "Hey, we can under-stand that we have brought some issues here that are causing moral distress. Everything is not perfect, so let's start to look at creative ways to work on this." I am not going to tell you I have the answer. I wish I did. But at least acknowl-edging that the whole world isn't wonderful and special. (Int-3, p. 17)

Conversely, managers (in three of nine transcripts) described situations in which they clearly felt that the experience of moral distress was being dismissed, and that they were expected to slough it off or otherwise keep quiet about their feelings or concerns.

> We do get messages coming down the hierarchy that are quite distressing – including messages about "Don't let that distress you – that's your job." … And if you are contaminating the performance of your job with all of these feelings that you really shouldn't have, that is actually a performance issue. (Nov. FG, p. 14)

Finally, we looked in our data to see whether those managers with experience of PBMA – which included only the participants in the November and December focus groups – suggested that in any way this formal training with a systematic approach to priority setting and resource allocation had an effect on their experi-ence of moral distress. We must note that PBMA had not been implemented, in either health authority, with an explicit intention to mitigate moral distress. There appears to be no strong evidence in these cases that respondents associated PBMA with reductions in their experience of moral distress. However, there did seem to be some possibility that it may have made things more difficult for managers by drawing their attention to differences between their values and desires for how organizations should set priorities and what actually occurs. In particular, they are made aware of how little evidence for good decision-making exists, or is used, and how often choices

made through an agreed-upon, transparent and formal process might be trumped by politics or other external influences.

The use of PBMA appeared to highlight, for some respondents, the lack of evidence-based decision-making within their organizations:

> That is the greatest moral distress for me, are we making decisions based on evidence, and the answer is a resounding "no" for the most part. (Dec. FG, p. 10)

> I had some unallocated dollars in my budget, so it got reallocated and I did my own PBMA, but I tell you the guilt I felt about giving this program more than this program … it was "I really shouldn't be giving these guys more." … I don't know. (Nov. FG, p. 10)

Respondents also found it distressing that priorities developed through formal resource allocation protocols were subsequently challenged and often superseded by choices based on other factors, such as politics or interest group pressures. Yet, as loyal members of the organization, they were expected to adopt and implement these new priorities.

> We did a resource allocation process three or four years ago, if you recall. … [Program A] was supposed to get the funding and then we ended up cancelling that out and funding [Program B] even though that showed less evidence in terms of its success and effectiveness. … That is a good case of moral distress, [when] you try to make program decisions based on what is most effective and then that gets cancelled. (Dec. FG, p. 10)

> [Consider] last year's PBMA process, which we went through and tried to honour all of the process. … In the end when the agreement was that the allocation should go to [Programs A and B], that those were the top two priorities, the response was, "Well, there must be something wrong with the tools," or "People didn't really understand what they were making a decision about." (Nov. FG, pp. 18–19)

Based on the data collected, we found no evidence that moral distress might be mitigated by experience with a formal priority setting framework (that is, no one spontaneously mentioned any beneficial effects), while conversely, we identified several examples of how a formal framework could result in increased moral distress. Given our qualitative design, these findings are suggestive but not conclusive and not necessarily generalizable to other settings.

Discussion

Prior to this study, we are not aware of research that has attempted to delineate the concept of moral distress in a broad range of mid- and senior-level healthcare managers. Our results suggest that moral distress is a relevant managerial concept not unique to clinical staff (Mitton et al. 2010). As reported here, we were able to identify conditions or circumstances in which moral distress occurs, examples of negative consequences of moral distress and some potential individual and organizational responses to the problem. We also had thought *a priori* that having experience with a formal priority setting framework might have some unintended benefit in mitigating instances of moral distress, but none of our respondents voluntarily offered any comments that supported this idea.

Respondents reported that moral distress plays a role in both personal and organizational consequences, including negative physical and emotional impacts upon employees. In this sense, our data confirm what has previously been reported in the clinical literature (Rodney and Starzomski 1993; Gaudine and Thorne 2000; Gaudine and Beaton 2002; Decker 1997; Corley et al. 2001; Millette 1994; Pauly et al. 2009). We must note, of course, that any links between moral distress and what was described as ill health or burnout are not causally proven here; we are reporting the managers' perceptions that there is such a relationship in their own cases.

Respondents felt that a key organizational response to moral distress should be to honour and validate the issue (i.e., name it). This response, too, has been found in the clinical literature, where recommendations to address the problem often revolve around creating opportunities for reflective dialogue and sharing of stories (Sporrong et al. 2006; Storch et al. 2009; Pauly et al. 2009; Austin et al. 2005). We note that in each focus group we conducted, the members expressed thanks for the opportunity to discuss issues of moral distress with colleagues, describing the research process itself as having almost therapeutic value. This finding occurs in other studies of moral distress as well (MacRae 2008; Storch et al. 2009). Clearly, many healthcare workers desire a forum in which they can build trust in one another and identify and discuss ethical concerns, including moral distress. Differences among perceptions, and questions as to whether individual judgments in fact ought to be shared by the organization as a whole, can also be considered, though not necessarily resolved, in such spaces.

Use of the formal priority setting approach known as PBMA has been shown in other contexts to make decision-makers more aware of the ethical issues involved in allocating scarce resources (e.g., see Gibson et al. 2006). In some cases, as shown in our findings, this awareness may lead to moral distress. It should be incumbent upon proponents of resource allocation methods and tools to consider such potential impacts. Such consideration has not always been explicitly applied, as these frameworks have tended to be seen in the past as primarily economic rather than ethical devices. That said, many of the things that respondents suggested would help them

cope, or would ease situations of distress, are among the principles and techniques contained by PBMA, such as a consensual approach, open and transparent decision-making, increased use of evidence and mitigation of political interference. Others have also speculated that for healthcare professionals to experience moral distress (as long as they are self-aware and reflective about it) may not be entirely bad, as it demonstrates that they are ethically sensitive to the moral and value conflicts inherent in the provision of care (Austin et al. 2005). Further research on these impacts is warranted.

Limitations

Some limitations exist with the current study. First, the study is restricted to two health authorities and 18 mid- and senior-level managers with participants purposively selected. Although people in a range of managerial roles were in fact included in the invitation, it may be that only those who had experienced moral distress agreed to participate. While this factor does not negate their own unique experiences, we cannot suggest how widespread the reported experiences are, nor can we suggest that they are necessarily representative. We did not set out to identify causal links between moral distress and any negative impacts on well-being.

Second, there may be some potential bias from the fact that many (though not all) of the participating managers knew members of the research team through working with them on previous projects.

Third, in our consideration of whether experience of moral distress was affected by the use of a formal priority setting framework, it should be noted that we did not directly ask respondents during the course of the focus groups about their experience with PBMA. Rather, we knew which respondents had used the PBMA framework and we specifically looked in their comment for any spontaneous, voluntary reference to it. These participants were nonetheless fully informed prior to the focus groups that the role of formal priority setting was a subject of the research and we would be interested in their comments on it. This design avoided leading the respondents to a spot where they may have sought to identify benefits of PBMA in order to please the researchers. It may, however, have failed to elicit positive instances. In other words, these findings can only be suggestive pending future, more focused, qualitative or quantitative study.

Conclusion

In the research reported here and elsewhere, we found that the concept of moral distress is relevant to healthcare managers as well as practitioners. We observed that, in this sample of mid- and senior-level managers, many of the perceived negative consequences and individual or organizational responses that were expected potentially to alleviate the problem seem to be similar to those reported in the clinical literature (e.g.,

Pauly et al. 2009; Storch et al. 2009). The added value of this study is the implication in identifying key conditions and potential consequences so that organizations can work towards developing appropriate responses. Future research should focus on outlining the relative importance of moral distress on the negative consequences identified vis-à-vis other potential contributing factors, as well as examining the merits of various organizational responses.

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