

Moral Sensitivity as a Precondition of Moral Distress

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them to the view that there is nothing positive or redeeming about moral distress. But one could be excused for getting the impression that that is the stance that Campbell and colleagues take.

I want to suggest two things regarding the value—in particular the moral worth—of moral distress. The first concerns the disposition a health care worker might have to experience moral distress. And the point is that having such a disposition ought to be regarded as a virtue. It shows that one takes seriously the ethics of being a health care worker and that one cares about the values and principles governing one's care of patients. The second suggestion is that, for this very reason, if a health care worker responds with moral distress to a certain situation, and this is indeed an appropriate response to the circumstances, then that is a morally good and admirable response. Of course, it is bad that the circumstances call for such a response. And it is bad that the health care worker experiences the distress and discomfort involved in moral distress. But from a moral point of view, the health care worker is shown to have his or her heart in the right place, so to speak. And in itself, the moral value of that is positive, not negative.

An analogy might help here. If somebody we love dies, it is fitting to respond with grief. In being a fitting response, the grief has a positive moral value, even though the circumstances are bad. Or if a grave injustice is committed, it can seem appropriate to respond with righteous anger. This can be seen as a morally good response. The disposition to respond with grief at a loss, or with righteous anger at grave injustices, can be seen as a virtue. In much the same way, moral distress can be morally good in being an appropriate response to a troubling situation. And the disposition to respond in such a way can be regarded as a virtue.

Let me be clear: I am not suggesting that we should hope that situations arise that give health care worker reasons to display this kind of moral goodness. Rather,


we should try to make it the case that the kinds of situations that call for moral distress do not arise, so that health care workers do not have reason to respond with appropriate levels of moral distress. And when such tragic situations do arise, I am not suggesting that we should not offer any support for the health care workers who experience moral distress. The point is rather that if the choice is between trying to prevent situations causing moral distress or simply removing the moral distress (e.g., by giving health care workers mind-numbing drugs or whatever), then the choice ought in most cases to be the former.

For all they say in their article, I don't believe that Campbell and colleagues have committed themselves to a stance that conflicts with this point of view. But if they develop their broad analysis of moral distress in further work, this—namely, the exact normative and evaluative status of moral distress—would be a topic it would be interesting to hear them say more about.

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Moral Sensitivity as a Precondition of Moral Distress

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In their valuable contribution, Campbell and colleagues (2016) define moral distress (MD) as “one or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one

perceives to be morally undesirable.” When looking at this definition, one realizes that the term “perceive” appears twice, indicating a central precondition for experiencing MD, a perceptual ability, namely, the competence of moral

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sensitivity (MS). In our comment, we discuss the relevance of ongoing research on MS for the conception of MD with respect to two issues: First, would a lack of MD in situations where one would expect that this emotion is triggered indicate a lack of MS? Second, does the possibility of increasing MD in medical professionals pose a valid counterargument against training programs that aim to improve MS?

Moral sensitivity (also referred to as moral awareness or ethical sensitivity) is commonly defined as the ability to recognize moral issues when they arise in practice (for reviews on varying definitions of the construct see Rest 1986; Tanner and Christen 2013; Jordan 2007; Weaver 2007). According to our current understanding, MS is thought to incorporate both the ability to recognize moral issues in a morally ambiguous situation and the ascription of importance to these same issues (Jordan 2009).

Rest (1986) was one of the first to discuss the theoretical significance of moral sensitivity. He suggested MS to be a necessary precursor of moral decision making and moral action. In fact, lack of MS—also called moral blindness—is likely to have far-reaching implications. Without the initial recognition that a moral problem is at stake, no moral problem will exist for the individual and therefore also no need to enter into moral problem solving (Clarkeburn 2002). Furthermore, research and daily experience alike suggest that individuals largely differ in their capability of identifying the moral aspects of a situation (e.g., Gioia 1992; Jordan 2009; Reynolds 2006).

Given this body of research, the link of MS to Campbell and colleagues' definition of moral distress is obvious. Their definition points to two different areas of awareness: one referring to one's responsibilities in a given context and another referring to the moral salience of whatever happens in this context. We believe that perceiving oneself as involved in a situation already includes moral aspects—namely, the question of whether the context involves certain ethical responsibilities, for example, due to one's professional role. This is, by the way, an aspect that the current research on moral sensitivity may underestimate. Nevertheless, it seems to be a precondition that people have moral sensitivity in order to be able to experience MD—or, in short: Moral sensitivity implies the possibility (of experiencing) moral distress.

This assumption leads us to our first issue concerning the connection between moral distress and moral sensitivity: How might higher (lower) levels of MS correspond with higher (lower) levels of MD? We assume a complex relationship, which is mediated by contextual factors and other personal dispositions, and which would be worthy of empirical and theoretical investigation. For instance, some of the following considerations may be relevant:

First, assuming that someone frequently experiences MD: Does this imply a high level of MS, or perhaps even what one may call moral hypersensitivity? *Prima facie*, it seems implausible that a morally insensitive person could

experience MD. It seems logical that it will be morally sensitive people who generally experience moral distress most frequently and intensely. However, the question arises of when a person actually experiences moral distress, and how a person actually becomes aware of an unethical event. Parmar (2014) stresses that the emergence of moral issues may in fact arrive through interpersonal communication. A morally insensitive person may regularly be made aware of her contribution to undesirable situations by others (who are more sensitive than her), and then experience distress. Hence, a person could actually experience MD because of a lack of MS. Contrarily, a morally sensitive person might be able to avoid ethically undesirable outcomes through wise anticipation and adequate problem-solving strategies, and therefore experience less MD than others.

We find it particularly important to note that some roles and responsibilities (e.g., emergency physicians) and some living and working environments (e.g., unfair distribution of resources), may give rise to more morally undesirable outcomes than others. We assume that such conditions could lead people to become morally insensitive, perhaps as a coping mechanism to reduce moral distress. On the other hand, the suppression of MS needn't be the only means to reduce MD in such cases. Morally sensitive people could regularly experience moderate levels of MD, which they might be able to cope with due to their dedication to a greater cause, or because they judge the only alternatives as even worse.

Second, assuming that someone never or rarely experiences MD: Does this imply a low level of MS? It may well be that some people live and work in contexts where no morally problematic situations ever arise. In such a world, people wouldn't experience MD—whether they are morally sensitive or not. This seems very unlikely to us, though. Intuitively, it seems more likely for morally insensitive people to believe that they live and work in such a world, and therefore experience little or no MD.

However, as we have already shown in the preceding, we also expect that morally sensitive people would be far more likely to avoid ethically undesirable situations and outcomes, and to deal with them better than the morally blind: Distressful experiences from the past would probably motivate them to develop necessary skills (e.g., for negotiation) or to seek more acceptable working conditions. Therefore, a plausible relationship between MS and MD could be that people experience particularly high levels of MD shortly after they have become more morally sensitive. Over time, they would then develop appropriate (or inappropriate) strategies, skills, and attitudes to deal with the relevant situations, and thereby reduce the MD that they experience.

Our second issue concerns a possible objection to the moral sensitivity training of medical practitioners: the possibility that higher levels of MS could increase the MD that medical practitioners experience, and thereby deteriorate their motivation, well-being, and job satisfaction (with

negative consequences for the entire practice and patients in general).

As we have argued in the preceding, the relationship between MS and MD seems to be complicated. It seems plausible to assume that an enhancement of MS would—at least temporarily—lead to higher levels of MD. However, these negative emotions should ideally motivate people, such as medical practitioners, to change their own behaviors or to challenge how things are done in their contexts. After all, nobody would argue that a bad conscience is a bad thing—as long as we “deserve” to feel bad about something. The challenge here is to additionally equip medical practitioners with adequate attitudes, skills, and strategies to deal with the ethical features of their work in a constructive way—only promoting moral sensitivity may fall too short. Therefore, both trainings for and assessments of MS should also investigate other resources and outcomes, including moral distress.

CONCLUSION

For our discussion, the new definition of MD, which Campbell and colleagues have provided, has been very helpful. In particular, its openness in terms of including diverse types, sources, and intensities of distress is useful. The focus on what matters most, that is, a negative self-directed emotional reaction, which stems from one’s perceived (co-)responsibility for a morally undesirable situation, will help to further operationalize the concept and to enable studies, where MD is assessed alongside diverse other variables, including contextual factors and personal dispositions like moral sensitivity. ■

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A Misunderstanding of Moral Distress

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Campbell, Ulrich, and Grady (2016) should be commended for attempting to contribute to the discussion of what many believe is currently a messy concept. They propose that a broader definition of moral distress is desirable and offer up a new one. Sadly, despite their acknowledgment of caution from previous authors, their proposed definition is so broad that it is diagnostically and analytically meaningless. The authors’ vague definition, “one or more negative self-directed emotions or attitudes that arise in response to one’s perceived involvement in a situation that one perceives to be morally undesirable” (6), reduces the experience of moral distress to feeling bad because one is caught in a morally undesirable situation.

Moral distress is a feeling that has moral meaning. The sense that one has a responsibility to act is based on professional obligations. It is a feeling in response to a failed action in an ethically challenging situation. It is much more than feeling badly or simply being involved in a morally undesirable situation. The authors’ recommendation that when “the distress springs from obviously misguided moral views or unreasonable beliefs about one’s involvement” (8) it might be best to let individuals address the feelings on their own is misguided. This attitude implies disdain for an individual who may be developing his or her ethical sensitivity in practice. How is one to gain insight without seeking assistance in exploring the nature of one’s feelings?

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