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Moral Distress: An Instrumentalist Analysis of Conceptual and Empirical Literature

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Résumé

Ce mémoire explore le concept de la détresse morale dans le contexte de la prise de décision clinique. Plusieurs facteurs compliquent le processus de prise de décision dans le contexte clinique. Un tel facteur est la détresse morale. Selon sa conceptualisation originale, la détresse morale est ressentie lorsque la démarche à suivre est connue, mais sa réalisation est limitée ou empêchée par des contraintes, p.ex. institutionnelles, financières, organisationnelles. Une grande proportion de la recherche conceptuelle et empirique se penche sur cette conceptualisation qui aboutit à la recommandation de mieux conceptualiser ou comprendre la détresse morale. Ce mémoire présente une analyse de la fonction du concept, donc d'identifier ce que la littérature empirique et conceptuelle fournit comme définition pratique de la détresse morale. L'indentification de la définition fonctionnelle du concept servira donc comme point de départ pour mieux comprendre la richesse et la portée des connaissances sur la détresse morale.

Mots-clés : détresse morale; prise de decision; analyse conceptuelle; pragmatisme.

Abstract

This thesis explores the concept of moral distress in the context of decision-making. Several factors complicate the decision-making process in the clinical context. One such factor is moral distress. According to its original conceptualization, moral distress is experienced when the course of action is known, but its realization is limited or prevented by constraints, i.e., institutional, financial, or organizational. Much of the conceptual and empirical research on moral distress addresses this conceptualization, which leads to the recommendation to better conceptualize or understand moral distress. This thesis presents an analysis of the function of the concept, thus identifying what the empirical and conceptual literature provides as a working definition of moral distress. To this end, the identification of the function of the concept will serve as a starting point to better understand the variety and the richness of the concept of moral distress.

Keywords: Moral Distress; Decision-Making; Concept Analysis; Pragmatism

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Cont'd: continued

e.g.: exempli gratia

etc: et caetera

i.e.: id est

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

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Chapter 1 – Introduction

No two moral problems are exactly alike, and decision-making in the clinical context is seldom cut-and-dried. (Fins, 1998; Miller et al., 1997). When healthcare professionals navigate through difficult moral questions, decision-making often happens in a group setting to ensure that key stakeholders and perspectives are taken into consideration (Rangel, 2009). Such a process might involve discussions with healthcare professionals, a clinical ethicist, a legal expert and someone who represents the interests of the patient (Abdool et al., 2010; Doucet, 2014; Tarzian & Force, 2013). The added value of different stakeholders, however, does not guarantee that a morally troubling situation will be resolved, or that a solution can be easily found. In trying to weigh different options, shared decision-making is not always straightforward; navigating morally troubling situations requires carefully weighed thinking (Abdool et al., 2010; Bate et al., 2012; Cassell, 1976). Moral distress is but one example of a situation requiring particular thoughtfulness in the context of decision-making.

When he coined the term, Jameton (1984) described moral distress as what happens when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action". In other words, moral distress arises when a healthcare professional knows the correct action to take, yet barriers outside their control stand in the way of acting on that knowledge. Examples of these constraints or barriers include institutional policies, social norm conflicts, financial restrictions or even personal value conflicts. Moral distress may occur in situations of resource allocation or reasonable accommodation, where the outcome is undesirable because it does not reflect the values of the healthcare professionals or of the hospital.

The healthcare professional's values are an important consideration to keep in mind regardless of the constraint or morally troubling situation. There is literature on the subjective and experiential nature of moral distress, especially in the field of nursing (i.e., Corley, 1995; Jameton, 1993; McCarthy & Gastmans, 2015; Wilkinson, 1988; Wocial & Weaver, 2013). Researchers have since tried to understand moral distress in other healthcare contexts, precisely because according to the original conceptualization, its experience and effect are unwelcome (i.e., Astbury & Gallagher, 2017; Lützén & Kvist, 2012; Thomas & McCullough, 2015; Whitehead et al., 2015). Articulating the concept of moral distress provided all healthcare professionals beyond nurses with

a new vocabulary for their experiences. Despite agreeing on the unwelcome nature of moral distress experiences, authors tend to disagree on how to characterize or explain moral distress for various reasons.

In order to shed some light on this tension in the research on moral distress, Pauly et al. (2012) and Hamric (2012) outline how qualitative and quantitative research efforts have missed the mark, so to speak, on defining and characterizing moral distress. Though their findings are slightly dated, the bulk of the issues related to moral distress research still hold true even today. A first challenge they identify is that different studies generate varied understandings of moral distress and attach different terminology to their results (Hamric, 2012). Further, regardless of the type of analysis or methods, the majority of research on moral distress has focused on its negative consequences (Pauly et al., 2012). This limited perspective on moral distress effectively makes it difficult to build a robust understanding of the concept. The section that follows will address qualitative and quantitative research separately, outlining their contributions to the state of research on moral distress.

Qualitative studies on moral distress make it possible to develop information on contexts, and in which settings moral distress can be experienced (Hamric, 2012). A look to contexts helped identify the root causes of moral distress beyond those that Jameton (1984) had initially offered. For Pauly et al (2012), qualitative research highlighted the fact that important differences in understanding moral distress stemmed from identifying its main factors. It is implied that the variety of factors leading to or contributing to moral distress in early qualitative research made it more difficult to understand the concept and carry out effective follow-up research. The most prominent factor in moral distress is that of constraint.

Both authors disagree on whether or not the constraint stems from the individual, their workplace (environment) or professional responsibilities. Jameton (1984) originally emphasized how external or structural constraints can cause moral distress. These tangible constraints were the root of morally troubling scenarios in the lived experience of nurses. Accordingly, initial qualitative research focused on factors that could be explained in terms of workplace-related obstacles, like institutional policies and professional obligations. Such constraints were noticeable to the extent that a new vocabulary term, reactive distress, was coined to articulate what would happen when

one's initial distress or "frustration" with external constraints or obstacles went unaddressed (Jameton, 1993). This term remains prevalent in the literature.

Follow-up research studied reactive distress and shifted towards individual constraints. For example, Sporrong et al. (2004) looked at moral distress as a dichotomy between either following rules in the workplace or following one's conscience. Webster and Baylis (2000) focused on the individual constraints of morally troubling situations, which unlike external or workplace-related constraints, were perceived as more subjective. This research on individual constraints established the important link between reactive distress and healthcare practice (Pauly et al., 2012). For example, unhealthy work environments were found to exacerbate a lingering feeling of unease. As this feeling dragged on for a certain amount of time, a morally troubling situation could ensue (Epstein & Hamric, 2009). Possible resolutions for internal constraints included mainly the prospect of strengthening ethical components of practice (i.e., offering a more enriched ethics curriculum to healthcare professionals) and building "ethically healthy teams" (Whitehead et al., 2015).

But as Pauly et al. (2012) and Hamric (2012) point out, the majority of information on moral distress that emerged from qualitative studies amounted to indirect knowledge, since moral distress was a theme in the narrative data rather than a focus of the research. This means that more time and effort was spent on gathering indirect knowledge of moral distress (i.e., recounting the effects of moral distress through narratives) than on direct knowledge. As a result, there is a need to make sense of what healthcare providers actually refer to when they use the term instead of recounting the effects of their encounters with moral distress.

According to Pauly (2012), quantitative studies on moral distress made it clear that many healthcare professionals experience moral distress in various settings. While the term emerged from a nursing context, quantitative studies also evaluated moral distress in healthcare administrators, doctors, pharmacists, and, even beyond the healthcare setting, in students and physicians (Pauly et al., 2012). The measurement tools that were developed from quantitative studies pointed towards a variety of individual and structural factors. Such factors added a sense of conceptual ambiguity that many researchers set out to dispel through the development of measurement tools. Since measurement tools past and present tend not to propose structural

interventions, their added value is limited to the identification and measurement of moral distress only, which suggests that the research agenda on moral distress incomplete.

Hamric (2012) speculates that measurement tools avoid proposing strategies for mitigating moral distress, given the variety of the existing definitions and characteristics for the concept. Since the way a concept is understood affects how it is measured, it is particularly difficult to develop effective and reliable measurement tools when definitions and characteristics vary in the literature. In order to make sure that moral distress is being measured accurately, for Hamric (2012), researchers must specify the fact that they are measuring "different aspects of a complex domain or different concepts altogether." Otherwise, quantitative studies that claim to measure moral distress might, in fact, be measuring another concept, e.g., moral constraint (Fourie, 2015; Morley et al., 2017).

We contend this overall lack of conceptual clarity in moral distress literature, and qualitative and quantitative studies must first be addressed, in order to better prevent its occurrence and negative repercussions in practice. A consensus has yet to be reached on what moral distress actually refers to, if it should indeed refer to one type of experience. Given the subjective and experiential nature of the concept, arriving at a consensus in definitions of moral distress may not be a realistic endeavour, nor does it accurately represent what this research intends to convey. Varied characterizations of the concept have a particular trickle-down effect: since authors do not agree on how exactly to conceptualize moral distress, they accordingly do not agree on how it can best be measured, using a measurement tool for example. Beyond what Hamric (2012) and Pauly (2012) discuss in their appraisal of research on moral distress, the literature also seems to employ a rather one-dimensional or one-sided understanding of moral distress and to what it can refer practically speaking. As such, what this research intends to uncover is the function of the concept of moral distress.

Identifying the function of moral distress is made possible, in part, through an appraisal of descriptive elements like the definitions used for the concept. The variety of definitions and characteristics used to refer to the concept poses a problem in terms of how to intervene when moral distress arises. In other words, the problem with varied conceptualizations of the concept has made it equally difficult to agree on how to resolve, so to speak, experiences of moral distress. After all, the desire or need to respond to morally troubling situations that give rise to moral distress

seems altogether reasonable and "humane" (Tigard, 2019). For example, one study concluded that a narrow characterization of moral distress leads to underreporting its occurrence, whereas a broader characterization leads to more accurate self-reporting (Weber, 2016). Adopting a narrow characterization that views moral distress as only arising from specific tensions, contexts and morally troubling situations might even misconstrue coping strategies for not entirely corresponding to lived experiences of moral distress (Weber, 2016). Without establishing a functional definition of moral distress, a gap in the understanding of the concept persists in the literature.

In closing conceptual gaps such as those for moral distress, the instrumentalist analysis constitutes an appropriate way forward (Racine et al., 2019). Instrumentalist analyses tackle these aspects of ethics concepts in three steps: first, by analysing the gaps or consistencies in the given literature to show its more general and specific functions; next, by understanding what the experience of a concept reveals in particular context; and lastly by exploring methods that make it possible to validate that a concept fulfills its function (Racine et al., 2019).

The main objective of the master's thesis is to review literature on moral distress with a focus on the function of the concept. The function describes the main observable task or purpose of the concept of moral distress. Teasing out the function of moral distress will allow us to better understand its purpose and challenges in the context of healthcare. This work is based in part on a systematic content analysis (i.e., a literature review) of the concept of moral distress that will examine both conceptual and empirical literature.

Methodological approaches in empirical bioethics research are described in a second chapter, including the one chosen in our study, which features systematic sampling with qualitative data extraction. It also outlines the methods developed specifically for this thesis.

Next, the results of the literature review are presented in the third chapter in the form of a manuscript entitled "Moral Distress: An Instrumentalist and Functional Analysis of Conceptual and Empirical Literature."

A general discussion follows in a final chapter, with a focus on the ethical and pragmatic philosophical considerations for the proposed instrumentalist analysis. The hope for the reflections

and conclusions in this thesis is to inject new meaning into the understanding of the concept of moral distress, by overcoming the existing conflict of approaches which, we contend, ultimately prevents its practical understanding.

Chapter 2 – Methodology and Methods

This chapter will provide an overview of two main methodological approaches that have been used to describe or attempt to conceptualize similar concepts to moral distress. Building on their strengths and weaknesses, we suggest a third approach which aims at grasping the concept of moral distress in a new and, we believe, more practically relevant manner.

The first methodology considered is the systematic review of literature. Systematic reviews tend to address normative questions or problems through robust methods, which make them particularly relevant to reach sound and informed decision-making (Uman, 2011). The systematic review of reasons (Sofaer & Strech, 2012), for example, presents the issues, consequences and implications of a decision in a clear manner. In so doing, it provides a basis for policymakers to inform and nuance their decision-making. Similar methodologies such as scoping reviews and qualitative content analyses convey information meaningfully in that they draw original conclusions from wide nets of knowledge (Arksey & O'Malley, 2005; Elo & Kyngäs, 2007).

However, systematic reviews may fall short of providing a complete understanding of more experiential and subjective concepts like moral distress (Bartolucci & Hillegass, 2010; Mertz et al., 2016; Mertz et al., 2017; Wallace et al., 2012). Further considerations apart from those in systematic reviews of reasons should be acknowledged in order to meet the research objectives. As we will show below, moral distress has also been studied through an empirical lens, which leaves aside its conceptual nature. Both approaches present some loopholes to understanding the concept. On their own, conceptual and empirical studies miss the mark on concepts like moral distress because much of the existing research in bioethics uses empirical methodologies in order to articulate subjective and qualitative experiences (Brunnquell & Michaelson, 2016; Carnevale, 2009; Taylor, 2002).

Our literature review has revealed a conflict between the two main methodologies, and the need for a different and more appropriate approach to consider moral distress and, eventually, suggest practical solutions for healthcare. The methodology we propose below features a systematic sampling of information with a qualitative extraction and analysis of data. The first part

of this chapter will address the methodological decisions made for this research study. A detailed description of the methods used will follow.

Methodology

The understanding and analysis of the concept will be incomplete or lacking if solely based on a theoretical approach, as the conclusions drawn will not reflect the reality of those lived experiences. Similarly, only approaching the concept through an empirical lens does not sufficiently inform research on the concept and cannot lead to a satisfying definition. We first present an overview of the Systematic Review of Reasons methodology, highlighting its added value for qualitative research with a strong experiential component. We then use the same process to offer an overview of the framework for research on moral experience created by Hunt & Carnevale (2011). Finally, we will present our proposed methodology: the instrumentalist analysis.

Systematic Reviews of Reasons

Systematic Reviews of Reasons aim to provide an unbiased answer to a normative question, drawing from a wide net of conceptual studies (Sofaer & Strech, 2012). Standards for completing systematic reviews such as Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) ensure reproducibility, which in turn increases the reliability of the findings (Liberati et al., 2009). The unbiased nature of the results ideally provides an answer to a question that resonates, practically speaking, with policy and decision-making.

Systematic reviews have also expanded into qualitative research in bioethics, meaning that qualitative studies are identified in order to answer qualitative questions (Strech & Sofaer, 2012). This adaptation helps researchers evaluate the existing literature on a problem or topic so as to improve decision-making practices, for example (Sofaer & Strech, 2012). Part and parcel of bioethics empirical research is the notion that ethical implications influence decision-making. In that objective, systematic reviews of reasons identify "all the strong (and thus relevant) reasons and their implications" for a decision or ethical question (Strech & Sofaer 2013).

Contrary to informal reviews in bioethics and philosophy, which tend to be unsystematic, undocumented and unspecified in nature, especially given the interdisciplinary nature of bioethics literature, reviews of reasons bring a robust method which can help solve practical or ethical

questions (Strech & Sofaer 2013). Indeed, if the review of reasons is properly systematic, the risk of neglecting or forgetting certain relevant reasons, interpretations and implications is drastically reduced. Systematic reviews of reasons are then very likely to demonstrate a wider range of information than informal reviews and literature reviews more generally in bioethics (Strech & Sofaer 2013).

In the context of this research, however, it is difficult to see how systematic reviews of reasons would account for ethical implications easily or for more ethical dimensions of a concept. That is to say, quantitative and qualitative studies are needed to complement the different aspects of a particular research question. A Systematic Review of Reasons on the concept of moral distress would focus on the reasons why moral distress is forbidden or permissible in a healthcare context, for example. This thesis, instead, wants to investigate, uncover and understand what the functions of the concept of moral distress are, and how moral distress is operationalized in healthcare contexts. While the exhaustive approach to identifying relevant literature is desired for this research, the focus of the research questions applied to systematic reviews of reasons do not correspond to the information that we seek to obtain on the concept. An investigation into moral distress, a highly subjective and experiential concept, requires a methodology that can take into account ethics concepts easily and make sense of them.

Moral Experience Framework

A more appropriate methodology for the purpose of this research might lie in a completely different approach to that of the Systematic Review of Reasons. This contrasting approach might, for instance, be one that focus more on the more general concept of moral experience. Moral experience, however, has been made synonymous with morally troubling situations that are "challenging or distressing" (Hunt & Carnevale, 2011). Such a negative conceptualization leaves out the possibility that moral experiences are a common, and therefore can be positive or neutral, and not just negative (Tigard, 2019; Weber, 2016).

Beyond research on moral experiences in bioethics, empirical research has expanded the sense of morality through the social sciences. Detailed descriptions from anthropology (Schensul & Lecompte, 1999) and fine-grained classifications from phenomenology (Meijer, 2017) and hermeneutics (Allen, 1995) stress the importance of context and empirical approach in research.

The premise of these methodologies is that it is impossible to understand a person's life experience without first understanding their context (Hunt & Carnevale, 2011).

For example, anthropological methodologies bring forward the notion of "contextualized subjectivism" which stipulates that in order to understand why a moral experience is important in a person's life, it must first be known how that moral experience makes a difference in that person's life (Hunt & Carnevale, 2011). According to this perspective, it is impossible to divorce a person from their individual, social and moral context (Schensul & Lecompte, 1999). Therefore, one must analyze the person in relation to that context in order to understand the moral experience of interest.

To that end, the hermeneutical approach consists in interpreting a person's moral experience. That interpretation gives meaning or clarity to the experience of interest (Allen, 1995; Meijer, 2017). In this approach, morality is rooted in the person's implicit beliefs, and those implicit beliefs make up the context that guides the person's moral order (Hunt & Carnevale, 2011). A hermeneutical approach involves identifying the object to be clarified, isolating the moral experience from its context and naming the person or group for whom the exercise is relevant (Allen, 1995). We can imagine a hermeneutical approach to the concept of moral distress that would try to achieve the same in different healthcare contexts.

The contribution of the Moral Experience Framework for bioethics research is that it has aimed to expand the idea that moral experiences in healthcare can be anything other than negative. In one example, this framework has been applied to the context of doctors who do humanitarian work (Hunt, 2009). Through narrative retellings of their experiences, this framework uncovered the motivations and expectations of these doctors and described the impact of organizational and resource limitations on the practice of humanitarian medicine (Hunt, 2009). The highly detailed, contextualized and interpretive analysis of interactions with doctors made it possible to uncover the positive and neutral components of humanitarian medicine, without focusing solely on its negative aspects. Overall, the Moral Experience Framework provides a window into what the ethical stakes are for individuals and communities and can be adjusted to different practical settings and applications.

For the purpose of this research, the Moral Experience Framework only tells half the story we wish to develop on the concept of moral distress. While this framework embraces moral experience as inherently valuable, only a partial understanding of the experience can be obtained

because moral experiences are inherently subjective. We contend that a marriage of sorts between some components of the Systematic Review of Reasons and of the Moral Experience Framework is needed in the context of this research on moral distress. Combining elements from both these methodologies and using them as a source of inspiration will make it possible to properly address the problems with the conceptualization of moral distress. If these more conceptual problems do indeed affect the practice of healthcare professionals, the research methodology must address these issues with the objective to provide a way to close the conceptual gaps.

Instrumentalist Analysis

The methodology we propose, an Instrumentalist Analysis, combines elements of the Systematic Review of Reasons (i.e., systematic sampling) with a qualitative component (i.e., qualitative data extraction) that is informed by pragmatism, pragmatic approaches in bioethics research. For the purpose of this thesis, it is also partially informed by the Moral Experience Framework. The qualitative component of this methodology shows a sensitivity towards moral experience (Racine et al., 2019a) and provides a lengthy presentation of the Instrumentalist Analysis, including a rationale for its various components. We will outline some key elements of that rationale below before moving on to a description of the methods used in this research.

Phenomenology, hermeneutics, pragmatism and contextualized ethics theory are considered empirical bioethics methods (Racine et al., 2019a). Pragmatic approaches in bioethics research tend to view the basic premise or goal of ethics as growth (Dewey, 1941). What extends from this basic premise is the idea that solving ethical problems or getting to the bottom of morally troubling situations present us with an opportunity for growth (Pekarsky, 1990b). Pragmatic approaches to research focus on moral experiences and their interpretations. They tackle the interpretation of meaning with the goal of understanding human experience (James, 1975; Pierce, 1878). The Instrumentalist Analysis that will be carried out for this research will focus on identifying the function of the concept of moral distress. As such, the Instrumentalist Analysis will set a basis for understanding the concept, which will work towards human flourishing.

Experiences make it possible to grow and flourish; this is why pragmatism emphasizes research methods that focus on lived experiences, and experiential meaning that describe ethics concepts (Pekarsky, 1990a). Empirical research in ethics helps to enrich the understanding of the function or role of ethics concepts (Racine et al., 2019a).. This is because empirical research in

pragmatism is based on human experience. Concepts like moral distress are flexible, malleable instruments with respect to lived experience, outcomes and real-world implications (James, 1975). What matters most in lived situations is their experiential component; experience provides concepts with meaning. In this sense, concepts like moral distress articulate human realities, i.e., realities which question their meaning and purpose within the perspective of flourishing (Racine et al., 2019a). We need a methodological approach that accommodates this vision of ethics concepts.

Other empirical bioethics research methods have, in some ways, missed the mark in adopting a pragmatic approach to concepts that describe moral experiences. Weaver and Morse (2006) use "pragmatic utility" to examine definitions of moral awareness but do not look at the function of moral awareness in ethics, nor do they use empirical research to enrich the definition of the concept. Another study, this time on shared decision-making (Makoul & Clayman, 2006), proposes a concept that draws from several accounts but lacks empirical evidence and does not show a link between theory and experience. Dickert et al., (2017) use a function-based approach to informed consent. While their function-based approach allows for the contextualization of informed consent, the research does not involve empirical research in any way (Racine et al., 2019a).

The significance of a concept is related to its implications, and explanations for concepts are based on their implications (Capps, 2019). The Instrumentalist Analysis is based on the implications of a concept, making it insufficient to look at definitions of the concept alone (Capps, 2019). Practically speaking, looking at how researchers use or apply the concept empirically (i.e., what role it plays in real contexts), is an important exercise in understanding the function of the concept (Misak, 1998, 2007). The research carried out in this thesis accounts for a sub-set of the first step of the Instrumentalist Analysis. The first step of the Instrumentalist Analysis is. function identification, where the literature on a concept is reviewed to identify the function of the concept. The function of the concept refers to how moral distress is observable or operationalized in practice.

This first step of the Instrumentalist Analysis can be divided into the types of literature on moral distress, i.e., (1) conceptual or theoretical and (2) empirical. While empirical literature certainly illustrates how the concept is already being applied in practice, it is not as useful to us yet, for our purposes in this thesis. We need a more open-ended approach and stance towards the

possible functions of the concept in order to enrich our understanding of the concept. This research contends that not enough is yet known about the concept of moral distress in order to justifying having a closed approach to it. In considering both conceptual or theoretical and empirical literature on moral distress, we asked ourselves whether the definitions of moral distress are consistent with a more static or a more dynamic understanding of the concept.

In contrast to conceptual literature, empirical literature on moral distress is deductive, in that the concept is measured or quantified, and no conceptual or theoretical enrichment is provided. No questions are posed on the added practical value of using the term. There is a predetermined, set understanding of moral distress that underlies the empirical literature. This would require a more robust explanation and research.

An Instrumentalist Analysis, on the other hand, provides a definition of the concept more in terms of its function as opposed to a definition in a classic sense. A definition in a classic sense (i.e., identifying the necessary or sufficient components to it) represents a more closed approach which assumes that everything is already known about the concept. In this sense, a more classic definition of a concept would imply that the research on that concept is static, or otherwise saturated. Non-pragmatic approaches to understanding moral distress view the concept as more of a static concept than anything else. This approach present in the empirical literature is certainly of interest but amplifies the issues that researchers have raised on the information gaps and conceptual ambiguity that affect the state of knowledge on moral distress.

The more dynamic, pragmatic approaches view moral distress as more of a living, malleable concept that can adapt according to its context and according to lived experiences of it. Pragmatic approaches such as the Instrumentalist Analysis adopt a dynamic approach to moral distress. The underlying assumption of this approach is that lived moral experiences are dynamic (i.e., their contexts of application change, the circumstances leading to and following their use vary, and the effect of that experience on the person living it also changes), meaning that the definition of such a concept has to evolve as well, and cannot be itself static (Montreuil et al., 2020; Racine, 2016; Racine et al., 2019b).

The first step of function identification is a worthwhile endeavour even when it is carried out independently of the other steps in the Instrumentalist Analysis. Once the function of the concept is teased from the conceptual and empirical literature, more tailored and meaningful

research questions and methodologies can be developed in the function enrichment and function testing steps (Racine et al., 2019). But without identifying the function of the concept, the rest of the Instrumentalist Analysis cannot proceed.

We have surveyed two methodologies: The Systematic Review of Reasons and the Framework for Moral Experience. In the purpose of the proposed research, each methodology alone falls short because they only tell half the story that we want to tell. We thus adopted the Instrumentalist Analysis, as it brings together different elements of various methodologies to uncover the function of the concept of moral distress. We will now present in more detail the methods used in the proposed thesis.

Methods

In order to resolve the conflicts in methodologies surrounding the concept of moral distress, we carried out an Instrumentalist Analysis. The emphasis that the analysis places on the functions of the concept will make it possible to understand its uses and applications. The results of this analysis are presented in the manuscript entitled "*Moral Distress: An Instrumentalist Analysis of Conceptual and Empirical Literature*" (see Chapter 3).

The first step consisted in a systematic search for conceptual and empirical articles on moral distress. The second half of this chapter is dedicated to the methods adopted in the concept analysis and addresses the following points: (1) article selection; (2) data charting; (3) data analysis; and (4) methodological limitations.

Article Selection

We searched PubMed, Embase, CINAHL, and PsycInfo on 14/01/2019 using search equations (developed with the help of a specialised librarian) combining synonyms for moral distress with synonyms for clinical ethics and clinical decision-making. Keywords were selected in accordance with the controlled vocabulary of each database, as well as the use of their integrated search functions for keywords, titles or abstract terms resembling moral distress or clinical ethics. This initial search yielded 1019 results. Searches in all databases were saved, and weekly electronic updates requested from 01/2019 until 11/2019.

With duplicates removed, titles and abstracts were then screened based on their relevance to the research question and research aims. Initial inclusion criteria pertained to the language of the publication, the year of publication, the topic or focus of the article, and the context. Initial exclusion criteria followed suit, and was related to the article's context, main topic or content. Together, these two components comprised the initial screening.

Based on the reference lists of articles found in the initial screening, a secondary search followed on 20/02/2019. Articles were screened based on the relevance of the title and abstract, and the primary exclusion and inclusion criteria were applied to the secondary search, which yielded 63 articles. More robust exclusion criteria were applied at this stage. Articles such as *commentaries or replies* were excluded because they often addressed the concept of moral distress in a rather superficial way. *Unrelated topics* pertained to articles reporting specific narratives on situations that potentially lead to moral distress without offering a clear definition of moral distress to complement the description of relevant cases or events. Additional articles excluded from the sample discussed moral distress that resulted from a specific situation (i.e., abortion, critical care nursing, organ transplantation, paediatric intensive care unit). *Pointed scenarios or contexts within healthcare* did not provide nor discuss a definition of moral distress. Rather, such articles focused on the fact that a certain situation gave rise to moral distress and described or listed its negative effects on the healthcare professionals. In a similar vein, articles presenting the scope of research on moral distress were useful in mapping the trends and gaps in knowledge but left too much unsaid about moral distress on a conceptual or methodological level. For this reason, articles *about research on moral distress* were largely left out of the final sample.

A third and final author-name search based on reference lists of key articles found in initial and secondary screenings was carried out on 15/03/2019 to ensure that the final sample included any and all relevant publications from authors already included in the existing sample of articles. With duplicates removed, the same exclusion criteria did apply. This final search added 15 articles to the sample of articles. In total, 25 peer-reviewed articles were included in the final sample.

Data Charting

An Instrumentalist Analysis served as a basis for the questions and categories in the data charting spreadsheet (Racine et al., 2019a). Main charting categories included bibliographic data about the article; the definition, characteristics and functions of the concept; the context of application and

concrete illustrations of the concept in practice; justifications for its use and implications and results stemming from the application of the concept. The choice of data categories allows us to understand why the concept of moral distress is this good, useful or justified, The choice of charting categories, in our estimation, will best allow us to carry out the function identification step of the Instrumentalist Analysis. The charting categories are meant to show how complex, rich and varied the concept of moral distress is used and applied in the literature. As such, categories like descriptive data, context of application, justifications and implications (outlined below and in the next chapter) were selected and used.

A data charting spreadsheet was developed and adapted from an existing template used in another Instrumentalist Analysis in order to facilitate the identification and grouping of relevant information (Montreuil et al., 2020). In so doing, the charting categories were adapted to the concept of moral distress. The charting spreadsheet was piloted between the second and third article searches on a sample of ten articles. First, a review of articles was done in order to validate the data charting categories. The charting categories were then refined through a deliberative process and throughout a second reading of each article to ensure a meaningful Instrumentalist Analysis. Once the spreadsheet was validated on this sample, systematic data extraction followed.

Data Analysis

We first carried out a descriptive analysis of the charted data to thematically group the characteristics and functions of the concept and examine contextual or historical trends. This involved rephrasing and reorganizing the data to facilitate the analysis. Doing so helped to define the scope of the concept and its meaning, trace its evolution, and deduce its applicability to moral decision-making (Rodgers, 1999). Charted data was divided among four categories: (1) descriptive data (study type, definition of moral distress, characteristics of moral distress, function of the concept); (2) context of application (healthcare context, concrete examples of moral distress); (3) justifications (ethical justification, consistency with the original conceptualization); (4) implications (effects and implications, empirical results).

An inductive analysis of the categories of charted data followed. This second portion of the analysis made it possible to compare and contrast the charted definitions, characteristics, ethical justifications and other charted data. This inductive analysis of the charted data allowed for the function of the concept of moral distress to be gleaned from the entirety of the charted data. The

final themes were identified through a team review process consistent with an Instrumentalist Analysis (Racine et al., 2019a).Whereas most of the charted categories were directly reported in the reviewed articles, categories such as the function of the concept, the ethical justifications and the consistency with the original conceptualization were not as straightforward as the descriptive data categories. Accordingly, it was necessary to carry out an interpretive analysis of such categories in order to chart them in an accurate manner. Again, at any time, if there was a doubt as to the accuracy of the data charting technique or of the chosen themes, exchanges were had in a team review process.

Methodological Limitations

The Instrumentalist Analysis is a new methodology that requires further validation for other concepts like moral distress and assent (Montreuil et al., 2020) that have clinical and ethical implications in bioethics research. The qualitative data extraction process that is part and parcel of the Instrumentalist Analysis is inherently partly subjective. In order to address this limitation and therefore increase the level of objective data extraction, two researchers were involved in a rigorous process of results validation. Beyond using a sample of ten articles to validate the data charting categories, the results validation involved extended discussion over several weeks to ensure that the charted data reflected the information available in the articles. A second and related limitation involves the choice of electronic databases and descriptors (or controlled vocabulary). The concept of moral distress is not consistently indexed, if at all, in electronic databases, meaning that the keyword searches had to combine several different synonyms for moral distress, with the hope that doing so would capture all the relevant articles. To this end, a specialised librarian affiliated to the *École de santé publique de l'Université de Montréal* (ESPUM) was closely involved in the development of the keyword searches for each database. These two limitations of data charting categories and electronic database keywords can be addressed as research on the concept of moral distress develops and expands.

Accordingly, a more robust study on a more commonly known moral experience in healthcare (i.e., moral awareness) would involve a larger sample of articles and more people involved in data extraction and analysis. This would eventually lead to different data categorizations and therefore, to defining different functions of the same concept. In the same way, if and when the Instrumentalist Analysis was to be repeated on moral distress, the resulting

functions, ethical justifications and other more interpretive data charting categories would be different from the ones identified in the following chapter.

Original Contribution of the Methodology

The proposed research on moral distress is more qualitative, experiential and subjective in nature, a hybrid or altogether new methodology is needed in order to capture and reflect the function of the concept. To this end, the proposed methodology combines a systematic sampling with a qualitative data extraction of both conceptual and empirical literature. The Instrumentalist Analysis allows for a review of the theoretical and empirical literature on the concept of moral distress, bringing together different perspectives on moral distress. This combination of conceptual and empirical articles provides as vast an understanding of the function of the concept on more philosophical (abstract) terms and in practical terms as well.

Chapter Synthesis

We reviewed a methodology that informs strong normative research in bioethics, the Systematic Review of Reasons. This methodology is known for its goal of providing unbiased information from a wide net of data. We then looked at a framework that allows moral experiences to be articulated in bioethics, a crucial consideration for the concept of moral distress, although the understanding of that moral experience that results from the use of the framework does not provide an appreciation of moral experience that quite catches what we seek to uncover about the concept of moral distress. Beyond presenting the specificities of each methodology, we aimed at exposing their shortcomings to address our research question when applied on their own. These considerations led us to adopt an Instrumentalist Analysis, which combines systematic sampling and qualitative data extraction in order to identify the functions of a given concept (e.g., moral distress). What follows in the next chapter are the results of the proposed research in the form of a manuscript entitled, “Moral Distress: An Instrumentalist Analysis of Conceptual and Empirical Literature.”

Chapter 3 – Results: "Moral Distress: An Instrumentalist and Functional Analysis of Conceptual and Empirical Literature"

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The results chapter will be published in an article format. For this reason, what follows is a manuscript in its most recent form. It will be submitted in the coming weeks in a bioethics journal that we deem appropriate, considering the topic and the scope of the research. EM produced the first complete and extensive draft of the manuscript: this includes having carried out the database searches, the data extraction and charting as well as the presentation of the results (both as a narrative and in table form) and the analysis and conclusion sections. ER contributed to establishing the inclusion and exclusion criteria in terms of the article selection and was actively involved in adapting the data charting technique to moral distress. Apart from providing general direction on the form and content of the overall manuscript, ER also reviewed the complete first draft and added precisions to the abstract, the conclusion and the analysis.

Abstract

Background: Moral distress occurs when challenges make it difficult to act ethically or as one deems ideal in the face of a morally troubling situation. Conceptual and empirical research on the concept show great variety in the definitions and characteristics of moral distress. Importantly, the actual function of the concept and the context in which it moral distress is triggered remains unclear. Does moral distress point to inherently problematic moral experiences or is it rather the sign of a healthy moral sense? The aim of this research is to review literature on moral distress with a focus on the function of the concept.

Methods: Literature searches yielded a total of 25 articles.

We performed an instrumentalist concept analysis to identify the functions in specific contexts of the concept of moral distress. Content extraction categories were modeled on previous applications of the Instrumentalist Analysis and refined through a team review process. Content was extracted with respect to (1) definitions of the concept; (2) characteristics and functions of the concept; (3) the context of application of the concept; (4) justifications of the concept; and implications and results generated by the application of the concept.

Results: Two key functions of moral distress were present in the literature: moral distress was found to envisioned as the source (e.g., the trigger, the cause) or the outcome (e.g., the result, the upshot) of a difficult and morally compromising decision.

Conclusions: The richness and diversity of available information on moral distress are a testament to the complexity of interactions that underlie the experiences and effects of moral distress. The ethical justifications for applying the concept are a potential avenue for further research.

Keywords: Moral Distress; Decision-Making; Concept Analysis; Pragmatism

Introduction

Moral distress, following Jameton's landmark definition, occurs when difficulties stand in the way of carrying out pre-identified correct courses of action (1984). Moral distress is what occurs when "one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" Jameton (1984). Such difficulties might originate in a value conflict, a financial restriction or a restrictive institutional policy. Regardless of the nature and origins of the difficulty, they consist of elements that delay or impede moral action and thus generate a morally troubling situation.

Because the experience and effects of moral distress are unwelcomed and unsettling, there is a rather extensive conceptual and empirical literature exists on moral distress.. Since the late 1980s, nurses and other healthcare professionals have recounted their experiences of moral distress. Recounting and documenting experiences of moral distress as they happen in context is a key exercise in understanding an ethics concept. because ethics concepts are best studied within their context (Racine et al., 2019). Adding a layer of information on lived experiences of essentially provides a more context-specific understanding that completes and rounds out its purely theoretical components.

The literature on lived experiences of moral distress evolved to accommodate situations ranging from awareness to discomfort, and beyond to burnout (i.e. (Corley et al., 2001; Sporrong et al., 2004; Wilkinson, 1988). Early research on moral distress (Jameton, 1984, 1993; Wilkinson, 1988) described pointed examples of moral distress in terms of workplace-related constraints that left nurses feeling unease and upset with their lack of agency. This early research was but the beginning of investigations into the characteristics and effects of moral distress in healthcare. Later, the introduction of moral distress measurement tools in the United States (Corley, 1995; Corley et al., 2001) and in Europe (Sporrong et al., 2006) focused on moral distress as an occupational hazard or otherwise the result of an unfavourable job environment. As other healthcare professionals noticed that they, too, had similar experiences as those described in nursing. What followed in the late 2000s and 2010s was a string of publications aimed at adapting moral distress to different healthcare contexts (see e.g., (Barth et al., 2018; Lamiani et al., 2017; Pergert et al., 2019; Sharif Nia et al., 2017; Soleimani et al., 2016). This influx of this recent research added to the differing types of moral distress scenarios and characteristics, notably by brining greater attention to internal

moral life such as conflicts with personal moral values. Thus, there has been a significant evolution in the moral distress literature but theoretical coherence within therein remains an issue.

According to a recent systematic review of moral distress literature (Sanderson et al., 2019), the state of knowledge on the concept remains heterogeneous and incohesive. Despite decades of research, no new-and-improved measurement tool, no call to action for awareness and institutional policies, nor any mitigation strategies have had a lasting effect on the understanding of the concept, i.e. (Hamric, 2012; Hanna, 2004; McCarthy & Deady, 2008; Pauly et al., 2012; Sanderson et al., 2019)In addition, the richness of moral distress scenarios coupled with the varied descriptions of lived experiences suggests the need for a richer and more cohesive understanding of the concept. Without a clear basis or understanding of moral distress, people who are confronted with or exposed to such situations may find it difficult to solve or even approach them. This is problematic if the goal of ethics is flourishment or growth (Pekarsky, 1990) since unclear language, or worse language that alienates from experience, can have the reverse effect (Fiester, 2015).

To address concerns related to the conceptual confusion around moral distress and especially the need for rich and thick understandings (Williams, 1985) of moral distress, we undertook an instrumentalist conceptual analysis (Racine et al., 2019). This kind of analysis envisions concepts as tools and the role of ethics theory to provide useful tools for moral agents to grow as moral agents. Positioning the concept of moral distress as a tool in the hands of users brings a perspective focused on the function of that concept, its purpose, as well as its justifications and its concrete implications. Ultimately results from an ethical inquiry are enhanced awareness, reflections, sensitivity and an increased understanding of the situations that lead to moral distress, for example (Racine, 2016).

Objectives

The aim of the research reported in this paper was to review literature on moral distress with a focus on the function of the concept. To achieve this objective, we conducted an instrumentalist analysis of the concept of moral distress. This analysis was based on a literature review of conceptual and empirical articles. Empirical articles include systematic reviews of literature on moral distress; however, this category focuses mainly on tools that measure moral distress in a healthcare context. Our secondary objective was to critically review the findings as they relate to moral decision-making in healthcare.

Method

We used an instrumentalist concept analysis approach (Racine et al., 2019). Instrumentalist concept analyses involve three main steps: (1) identifying the functions that a particular concept serves; (2) enriching the functions with input from key stakeholders; (3) testing the usefulness of those functions within a given context (Racine et al., 2019). In this article we report our efforts towards completing the first step of an instrumentalist concept analysis, that is, to identify the function of the concept of moral distress in the context of healthcare.

The term *function* refers to the use of the concept in practice, i.e., how moral distress is recognizable or observable in real-world contexts. Following insights of philosophical pragmatism, the elements of a function include not only the definition or characteristics of a concept (Pierce, 1878), but also why that concept is used within a particular context, and to what end (Racine et al., 2019). To identify the function, we considered the main message the author wanted to communicate when they used this concept.

To carry out this initial step of the instrumentalist concept analysis, we systematically reviewed the concept of moral distress in healthcare literature. We focused on two main types of articles within the context of healthcare: articles on the nature of the concept itself, which we refer to as conceptual articles; and articles that present a method to describe or quantify moral distress, which we have dubbed empirical articles. According to its initial definition by Jameton, a person experiences moral distress when constraints limit the ability to act on what they identify as the right course of action (Jameton, 1984) We also analysed the ethical implications of the concept of moral distress in healthcare in decision-making.

Article Sampling

We searched CINAHL, Embase, PsycInfo and PubMed using search equations that combined synonyms for moral distress, clinical ethics and decision-making (See **Table 1**). Keywords were selected in accordance with the controlled vocabulary of each database, as well as the use of their integrated search functions for keywords, titles or abstract terms resembling moral distress or clinical ethics. To provide a rich understanding of moral distress and accordingly include publications that our initial search did not capture, we carried out two additional searches following a 'snowballing' approach: a manual search through the reference lists of the screened articles and

an author-name search for additional references. Any database alerts from the search equations were added into the same during this latter search stage.

Table 1. – Database Search Queries

Database	Search Query	Yield (articles)
CINAHL	((TI moral N3 distress OR AB moral N3 distress OR SU moral N3 distress) AND ((AB clinical N3 ethics OR TI clinical N3 ethics OR SU clinical N3 ethics) OR (MH Ethics OR MH Decision Making, Ethical)))	226
Embase	((ETHICS, CLINICAL/ or ETHICS CONSULTATION/ or ETHICS COMMITTEES, CLINICAL/) or ((clinical adj3 ethics).ab,kw,od,ti)) and ((moral adj3 distress).ab,kw,od,ti.)))	52
PsycInfo	((((title: (clinical NEAR/3 ethics))) OR ((abstract: (clinical NEAR/3 ethics))) OR ((Keywords: (clinical NEAR/3 ethics)))) OR (((IndexTermsFilt: ("Bioethics")))))) AND ((title: (moral NEAR/3 distress)) OR (abstract: (moral NEAR/3 distress)) OR (Keywords: (moral NEAR/3 distress)))	54
PubMed	(((((("Ethics, Clinical"[Mesh]) OR (("clinical ethics"[Title/Abstract]) OR "clinical ethics"[Other Term]))) AND ((("Moral distress"[Title/Abstract]) OR ((("Morals"[Mesh:noexp])) OR "Stress, Psychological"[Mesh])))))) AND (((((("Decision Making"[Mesh:noexp] OR "Clinical Decision-Making"[Mesh]) OR "decision making"[Other Term]) OR "decision making"[Title/Abstract])))	758

Article Screening

With duplicates removed from the retrieved articles, the titles and abstracts were then screened based on their relevance to the research objectives. At this stage, primary inclusion and exclusion criteria were applied. Initial inclusion criteria (See **Table 2**) pertained to the language of the publication, the year of publication, the topic or focus of the article, and the context. Initial exclusion criteria followed suit, and were related to the article's context, main topic or content. Together, these two steps concluded the initial screening.

Upon completing the initial screening of the database searches, a secondary screening of the retrieved articles was undertaken. A more robust list of exclusion criteria was applied at this stage. Articles such as *commentaries or replies* were excluded because they did not exhibit the desired level of rigorous research methodology. *Unrelated topics* pertained to articles reporting specific narratives on situations that potentially lead to moral distress without offering a clear

definition of moral distress to complement the description of relevant cases or events. Additional articles excluded from the sample discussed moral distress that resulted from a specific situation (i.e., abortion, critical care nursing, organ transplantation, paediatric intensive care unit). Articles that described how moral distress resulted from a specific case of organ transplantation, for example, focused on the negative effects of experiencing moral, without a discussion on how to avoid repeat situations. These *pointed scenarios or contexts within healthcare* did not provide nor discuss a definition of moral distress. Rather, such articles focused on the fact that a certain situation gave rise to moral distress and described or listed its negative effects on the healthcare professionals. In other words, for these articles the definition and very existence of moral distress were implied, meaning that the focus was not on the definition itself but rather an experience of moral distress. Other articles presenting the scope of research on moral distress were useful in mapping the trends and gaps in knowledge but left too unsaid much about moral distress on a conceptual or methodological level. When the sole focus of the article was mapping trends on moral distress research without a look to the concept itself and its foundations, the article was excluded. For this reason, articles *about research on moral distress* were left out of the final sample.

Table 2. – Primary Inclusion and Exclusion Criteria

A. Inclusion Criteria		
Guiding Questions	**Description**	**Justification**
In what language was the article published?	Written in English, French, Italian or Spanish	Either EM or ER can read and understand these languages
In what context is the discussion of moral distress situated? On which aspect of the concept of moral distress do the authors focus?	Moral distress is the main subject of the publication such that (a) a conceptual analysis of moral distress ensues; (b) authors present an instrument that measures moral distress in a healthcare setting	Studying conceptual articles as well as (empirical) articles that present an instrument for measuring moral distress provides a wider picture of the function of moral distress in literature
In what year was the article published?	1984 or later.	The concept of moral distress was first introduced in 1984
B. Exclusion Criteria		
Does the article address moral distress in the context of medical/nursing students, or in medical/nursing curriculum?	Expresses the need for ethics-based residency programs or ethics grand rounds	Usually explores hypothetical or fictitious scenarios with students lacking advanced ethics training. Does not discuss the concept of moral distress to the desired depth.
Does the article solely focus on deliberation in clinical ethics?	Presents a conceptual analysis or a case study of deliberation in clinical ethics	Without directly addressing moral distress in the article, the link between deliberation and moral distress remains too implicit
Does the article solely focus on decision-making in healthcare?	Presents a conceptual analysis or a case study or a tool on decision-making in healthcare	Without directly addressing moral distress in the article, the link between decision-making and moral distress remains too implicit
Does the article present an analysis of close terms to moral distress but that are not moral distress?	Presents a conceptual analysis or a case study on terms that resemble moral distress	Confuses moral distress with related terms which do not apply in this analysis

Data Charting

An instrumentalist analysis served as a basis for the questions and categories in the data charting spreadsheet (Racine et al., 2019). Main charting categories included bibliographic data about the article, the definition and characteristics of the concept, ethical justifications for its use, the context of application and concrete illustrations of the concept in practice (See **Table 3**). A data charting spreadsheet was developed and adapted from an existing template used in other studies in order to facilitate the identification and grouping of relevant information (Montreuil et al., 2020). It was piloted between the second and third article searches on a sample of ten articles. The charting categories were then refined through a deliberative process to ensure a meaningful instrumentalist analysis. Once the charting spreadsheet was validated on this sample, systematic data extraction followed.

Table 3. – Data Charting Categories*

A. Basic Descriptive Data		
Guiding Questions	**Definitions**	**Instructions**
In what year was the article published?	Refers to the year when the article has been published.	Based on the year of the printed version of the article, mentioned directly in the reference.
In what country are the authors based?	Refers to the country where the authors affiliations are.	Based on the country mentioned next to the department affiliation directly in the article for the corresponding author
What are the authors' disciplinary affiliations?	Refers to the department where the author(s) is(are) working or affiliated.	Based on the department affiliations for the authors mentioned directly in the article.
What are the aims and objectives of the article?	What the article/study plans to achieve	Aims or objectives explicitly reported by the authors.

*Data extraction strategy adapted from Montreuil et al (2020).

Table 3. – Data Charting Categories (cont'd)*

B. Functional Analysis		
Guiding Questions	**Definitions**	**Instructions**
Definition of the Concept: What is the definition of moral distress? What references do the authors use to define the concept of moral distress?	A statement of the meaning of a word, what it designates or describes.	Charted when the authors defined moral distress as 1) an emotion or a response to a troubling situation; (2) a workplace-related ethical issue; (3) a feeling of unease.
Characteristics and Functions: a) What are the characteristics of this concept?	a) The characteristics of the concept of moral distress are the qualities or features that belong to it and make it recognizable.	a) Characteristics mentioned explicitly in the article. Main categories of characteristics include: (1) internal and external constraints on moral action; (2) perception of constraint and perception of involvement in an action; (3) negative reactions.
b) What are the functions aimed at?	b) The functions (of the concept of moral distress), which can be operationalized, observed and appreciated	b) Functions were charted as either the source of a difficult decision or the outcome of a difficult decision. If the functions were not explicitly mentioned, they were interpreted based on the entirety of the article.
Context of Application of the Concept: In which situations is this concept used or applied? Does the meaning of this concept differ or not based on context?	Description of how and where the concept of moral distress is applied in the context of care.	Content that lists, describes or elaborates how moral distress manifests itself in the healthcare context, or how moral distress affects healthcare professionals in their interventions and interactions.
Justifications of the Concept: Why is this concept proposed? Why is it important to pay attention to the concept? Why are the proposed functions important?	Ethical principles that point to the importance of paying attention to moral distress. This refers to conceptual (i.e. philosophical / qualitative) justifications for the importance of moral distress.	Ethical principles of (1) integrity, autonomy or agency and (2) responsibility or duty are either explicitly mentioned or interpreted based on the fundamental elements mentioned in the article.
b) How consistent is the author's view of the concept of moral distress with the original conceptualization?	b) Statement that relays the extent to which the article aligns with the original conceptualization of moral distress (i.e. in Jameton, 1984 and Jameton, 1993).	b) When authors describe the concept along the same lines as when it was initially introduced in the literature, the stance is labelled "consistent." If the authors propose a different conceptualization, the stance is "inconsistent." The term "mitigated" designates authors who do not take a clear position or present arguments in both directions.
Implications and Results of the Concept: a) What are the reported benefits or challenges of the use of this concept in clinical care?	a) The benefits (positive effects/implications) or challenges (negative effects/implications) of the use and understanding of moral distress.	a) Content that identifies, describes or explains the positive or negative consequences of the application of the concept in the healthcare context.
b) What happens as a result of applying this concept? What are some of the clinical and ethical implications of its application?	b) The results of empirical studies that examine (1) the integration of moral distress measurement tools in healthcare practice or (2) the added value of the empirical research to the understanding of moral distress	b) All reported results regarding the impact of application/integration of moral distress in healthcare.

*Data extraction strategy adapted from Montreuil et al (2020).

Data Analysis

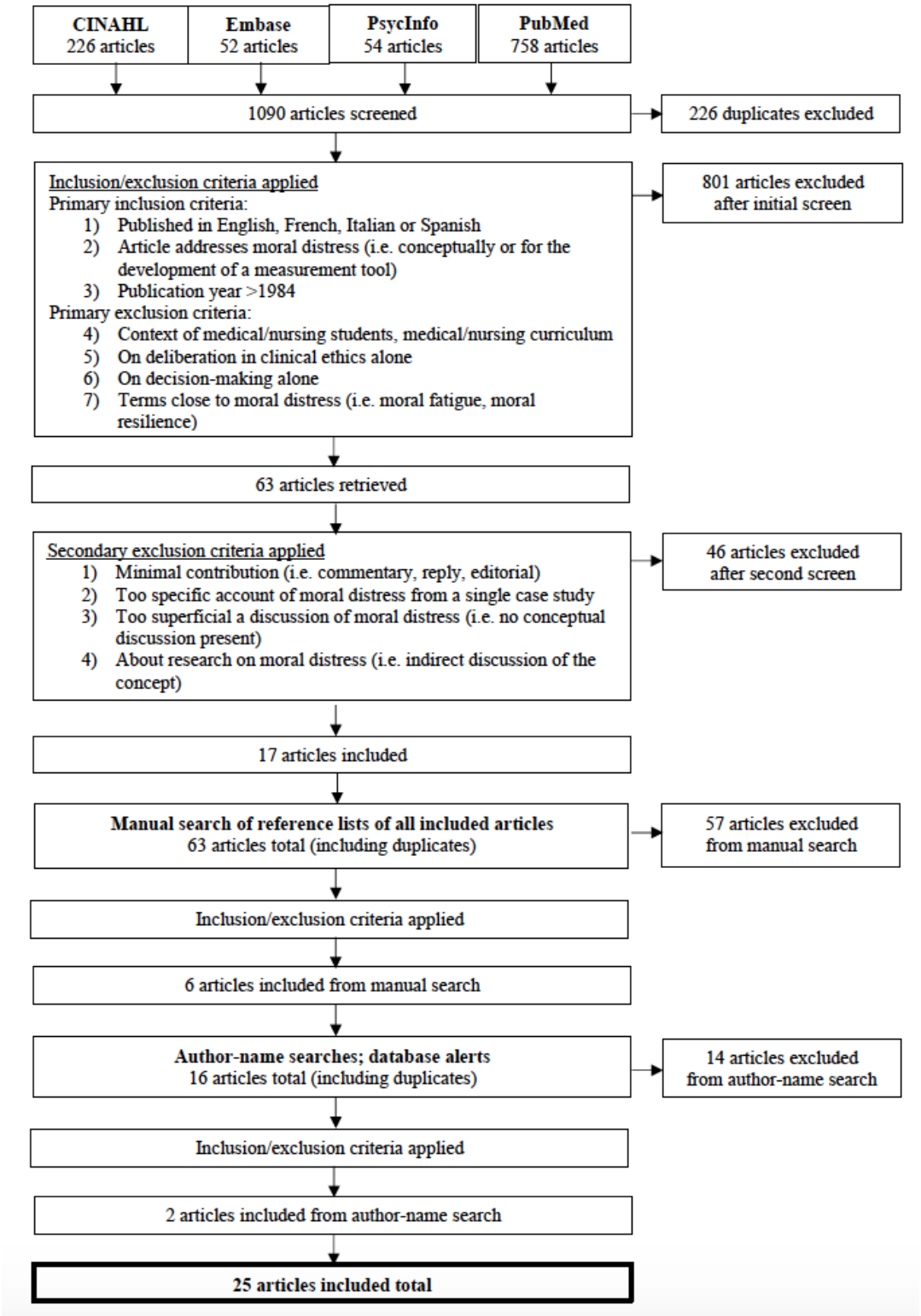
We analyzed the charted data to thematically group the characteristics and functions of the concept and examined contextual or historical trends. This involved rephrasing and reorganizing the data to facilitate the analysis. Charted data was divided among four categories: (1) descriptive data (study type, definition of moral distress, characteristics of moral distress, function of the concept); (2) justifications (ethical justification, consistency with the original conceptualization); (3) context of application (healthcare context, concrete examples of moral distress); (4) implications (effects and implications, empirical results, recommendations). Data charting categories were adapted from an instrumentalist analysis on the concept of assent from Montreuil et al., (2020). The final themes were identified through a team review process consistent with an instrumentalist concept analysis (Racine et al., 2019).

Results

As a result of the search and screening process, twenty-five articles were retained. Of this sample, 15 articles addressed moral distress at a conceptual level. This segment included articles that were written as a narrative or discussed moral distress in qualitative terms. The ten remaining articles presented the results of an empirical study or presented a novel tool to measure moral distress in a given healthcare setting. Two of the included articles did not present explicit characteristics or features of moral distress; and four other articles did not give a specific definition nor referred to an existing definition of moral distress. These articles provided other relevant information (i.e., concrete examples of moral distress situations or a description of how moral distress is understood in practice) and were therefore included in the review.

Please refer to **Appendix 1** for a full list of the articles and an overview of the charted data.

Image 1. – Inclusion and Exclusion Flow Chart



Overview

Nearly half of the articles (12 out of 25) came from countries in North America, with 11 from the United States and one from Canada. The same proportion of articles were from other parts of the world: 12 articles came from European countries, and one from Latin America. When specified, authors' affiliations included fields such as nursing (3), medicine (2), health or public health (2), and philosophy, ethics or bioethics (5).

Definition of Moral Distress

Definitions of moral distress fell into three main categories: (1) moral distress as an emotion or a response to a troubling situation; (2) moral distress as a workplace-related ethical issue; (3) moral distress as a feeling of unease when faced with professional obligations or in terms of one's personal moral framework. For some articles, no definition was identified (Fourie, 2017; Jameton, 1993; Lützén & Kvist, 2012; Tigard, 2019).

Eight articles defined moral distress as an emotion or a response to moral situations. Definitions included: a negative moral emotion linked to conflict (Dudzinski, 2016), a psychological response to morally troubling situations (Fourie, 2015); a form of distress that arises from personal or professional obstacles and circumstances (Tigard, 2018) and ethical dilemmas (Sporrong et al., 2006). Other articles used general or broad terms to define moral distress as a negative emotion directed towards the self (Campbell et al., 2016), an experience of a moral event (McCarthy & Deady, 2008; Morley et al., 2017) or a problem that threatens the integrity of healthcare workers (Hamric et al., 2012). These definitions emphasized on more general aspects of the experience of moral distress, rather than focusing on the context in which moral distress may arise.

Four articles defined moral distress as a workplace-related ethical issue. Moral distress was seen as distress with respect to patient care quality (Jameton, 1984); a feeling of compromise in the workplace (Varcoe et al., 2012); and what happens when the workplace makes it difficult for appropriate steps to be taken in a morally troubling situation (Corley et al., 2001). Other definitions emphasized that workplace demands come into tension with the healthcare provider's personal moral values (Astbury & Gallagher, 2017; McCarthy & Monteverde, 2018).

Eight more articles defined moral distress as a feeling of unease with professional obligations or in terms of one's personal moral framework. These definitions included, for example: being unable to act on ethical obligations (Wocial & Weaver, 2013); what happens when internal or external constraints lead a person to act against their professional judgment (Jameton, 1984; Lamiani et al., 2015) or a judgment that results from being unable to act on one's moral knowledge (Thomas & McCullough, 2015). Similar language was used to convey dissatisfaction at not being able to act against a sense of better judgment (Barlem & Ramos, 2015; Sanderson et al., 2019; Sporrong et al., 2004; Wilkinson, 1988).

Characteristics of Moral Distress

Moral distress was characterized in three main ways: in terms of (1) internal and external constraints on moral action; (2) perception of constraint and perception of involvement in an action; (3) negative reactions.

Constraint was a key characteristic for several articles. Internal constraints refer to the fact that personal moral values or moral knowledge (i.e., the healthcare professional's sense of right and wrong) get in the way of acting in a morally troubling situation (Jameton, 1984; McCarthy & Deady, 2008; McCarthy & Monteverde, 2018; Wilkinson, 1988). External constraints concern either workplace policies, institutional demands, professional responsibilities or power relations (Barlem & Ramos, 2015; McCarthy & Gastmans, 2015; Varcoe et al., 2012). Internal and external constraints on moral action are the elements of a moral situation that produce a sense of difficulty or unease for the healthcare professional. Healthcare professionals report internal constraints when their personal moral values make it difficult for them to take action in a moral situation. The healthcare professional's own personal moral values or professional moral values stop them from taking action. External constraints refer to any consideration that is outside of the control of the healthcare professional, i.e., financial/budgetary considerations, resource limitations, institutional policies, professional guidelines or federal regulations. When external constraints contributed to the experience of moral distress, it is because a strict institutional policy, for example, intensified the pressure that the healthcare professional felt in the moral situation, which made it difficult to take action.

The perception of constraint (i.e., feeling obliged to act against one's sense of right or wrong) was considered a key characteristic of moral distress, notably in Barlem & Ramos (2015).

The perception of involvement in action or inaction (i.e., how active a role the healthcare professional thinks they have in a moral situation) was also featured as a key characteristic of moral distress, especially when the action or inaction goes against one's sense of right and wrong (Jameton, 1993; Sporrong et al., 2006). Both these characteristics emerged as a matter of the way the healthcare provider interpreted the moral situation, or the impression they had. This meant, for example, that as soon as the healthcare provider would detect an internal or external constraint at hand in the moral situation, this would contribute to their experience of moral distress. When healthcare professionals had the impression that they were directly or indirectly involved in taking action in a moral situation, that perceived involvement alone was a central feature of moral distress.

Some, though not all articles, stressed the importance of temporality or timeliness of moral distress (Jameton, 1993; McCarthy & Monteverde, 2018; Tigard, 2018). For these authors, moral distress was time sensitive. Taking action quickly, within a reasonable delay of time or not taking action at all affected how much moral distress the healthcare provider experienced, even once the moral situation was addressed.

Seven articles mentioned the specific negative emotional and psychological reactions to moral distress as characteristics of the concept. These authors saw the negative emotional (i.e., sadness, discomfort, anger) and psychological (i.e., compassion fatigue, burnout) reactions to moral distress as important characteristics (Astbury & Gallagher, 2017; Campbell et al., 2016; Dudzinski, 2016; Hamric et al., 2012; Lützén & Kvist, 2012; McCarthy & Monteverde, 2018; Thomas & McCullough, 2015).

Articles also drew distinctions between moral distress and related terms (i.e., moral dilemma, moral uncertainty, moral constraint) as a way of describing the characteristics of moral distress (Barlem & Ramos, 2015; Fourie, 2015, 2017; Jameton, 1984; Sporrong et al., 2006). Related terms were used to illustrate how moral distress is different or distinct from those terms, but not addressed with the same level of detail as moral distress. Only two articles did not mention any characteristics of moral distress (Corley et al., 2001; Wocial & Weaver, 2013).

Function of the Concept of Moral Distress

The function of the concept of moral distress was defined as either the source or the outcome of moral situations in healthcare decision-making. For example, some articles described moral

distress as enabling the identification of the external constraints that infringe on what the healthcare professional considers as the right thing to do. Moral distress is thus a source of moral situations. Other articles referred to moral distress as a way of identifying the emotional or psychological effects of making difficult decisions. Any mention of such effects or the experience of having to make a difficult decision was considered as the outcome of a difficult decision. Functions were identifiable in 19 of the 25 articles included in the final sample (See **Table 4**).

Moral Distress as the Source of a Difficult Decision

Eleven articles defined the function of moral distress as the source of morally troubling situations. In these articles, moral distress itself generated the circumstances of a difficult decision. Together, these articles presented moral distress as a difficulty encountered in the workplace (i.e., value conflicts, either between decision-makers or along personal-professional value differences) that made it challenging to take action or make a decision in a situation.

Moral Distress as the Outcome of a Difficult Decision

Eight articles defined the function of the concept of moral distress in terms of the outcomes of making difficult decisions. In this category of articles, the experience of moral distress was characterized by some form of suffering, whether intellectual, psychological or emotional. These types of suffering stemmed directly from the ability or inability to make a difficult decision or dealing with a morally troubling situation (i.e., effects of providing less than ideal quality of care to patients). Two articles in this segment highlighted positive or neutral effects of moral distress, instead of focusing on negative outcomes of making a difficult decision (Sanderson et al., 2019; Tigard, 2019). For these authors, moral distress presented an opportunity for growth or maturity in the face of difficult circumstances.

Table 4. – Functions of the Concept of Moral Distress

Moral Distress as the Source of a Difficult Decision (n = 11)	
Author (Year)	**Function of the Concept of Moral Distress**
Wilkinson (1988)	In the context of nursing, the function of moral distress is to describe the experience and effect of providing less than ideal quality of care to patients.
Corley et al., (2001)	In the context of nursing, the function of moral distress is to identify institutional constraints in a hospital setting that involve the experience of: (1) a disproportionately high amount of individual responsibility (vis-à-vis other health care professionals); (2) acting in ways not consistent with the patient's best interests; (3) being deceptive.
McCarthy & Deady (2008)	The function of moral distress is to identify the positive, negative, neutral emotional and psychological effects of moral constraints that nurses experience.
Hamric et al. (2012).	The function of the concept of moral distress is to identify a threat to the integrity of healthcare providers, particularly when faced with a constraint.
Wocial & Weaver (2013)	The function of the concept of moral distress is to identify external constraints that act upon what the nurse considers as the ethically right thing to do.
Barlem & Ramos (2015)	The function of the concept of moral distress is to identify the ill-at-ease feeling towards a moral situation that puts healthcare provider and patient at odds with one another.
Fourie (2015)	The function of the concept is to identify the psychological effects of morally challenging situations in healthcare.
Lamiani et al., (2015)	The function of the concept of moral distress is to identify the culmination of a variety of workplace-related difficulties.
Dudzinski (2016)	In the context of healthcare, the function of the concept of moral distress is to identify the underlying source of moral conflict.
Astbury & Gallagher (2017)	The function of the concept of moral distress is to identify the occupational constraints that pharmacists experience.
Fourie (2017)	The function of the concept of moral distress is to identify troubling situations in decision-making (like constraint and uncertainty) that make it necessary to consider the well-being of patients and medical professionals.
Tigard (2019)	The function of the concept of moral distress is to describe an opportunity for "moral maturity," where an enhanced awareness of one's deeply held personal values, and personal identity are revealed.

Table 4. – Functions of the Concept of Moral Distress (cont'd)

Moral Distress as the Outcome of a Difficult Decision (n = 8)	
Author (Year)	**Function of the Concept of Moral Distress**
Jameton (1984)	The function of moral distress is to identify the negative effects of occupational hazards in nursing.
Jameton (1993)	In the context of nursing, the function of moral distress is to identify job dissatisfaction and an unfavourable job environment.
Sporrong et al. (2006)	In the context of health care professionals, the function of moral distress is to identify the experience of moral dilemmas, even in mundane situations that happen on a normal workday.
Lützén & Kvist (2012)	The function of the concept of moral distress is to identify moral situations that either lead to negative outcomes or that elicit negative reactions from healthcare providers.
McCarthy and Gastmans (2015)	In the context of nursing, the function of the concept of moral distress is to describe the suffering that happens when healthcare professionals act contrary to their deeply held "ethical values, principles or commitments."
Thomas and McCullough (2015)	In the context of healthcare, the function of the concept of moral distress is to describe the intellectual experience of making a judgment involving a certain degree of compromise that undermines either individual or professional integrity.
Sanderson et al. (2019)	The function of the concept of moral distress is to identify the moral responsibility that medical professionals have towards their patients and medical community (in particular when medical professionals perceive a potential for harm).
Tigard (2019)	The function of the concept of moral distress is to describe an opportunity for "moral maturity," where an enhanced awareness of one's deeply held personal values, and personal identity are revealed.

Context of Application

Concrete Illustrations of Moral Distress Scenarios in Context

Sixteen articles mentioned moral scenarios and of those 16, three articles had implicit or anecdotal scenarios. These descriptions took various forms. **(**See **Table 5).**

Conceptual articles presented illustrations of moral distress as brief case examples. These were featured as implicit or anecdotal situations (Campbell et al., 2016; Fourie, 2015, 2017; Jameton, 1993; Thomas & McCullough, 2015; Tigard, 2018, 2019).

Among the empirical articles, moral distress measurement tools (Astbury & Gallagher, 2017; Hamric et al., 2012; Sporrong et al., 2006; Wilkinson, 1988) presented concrete examples of moral distress in general terms (i.e., truth-telling or lying to patients, providing futile care to a dying patient, feeling unable to provide adequate care to patients due to time constraints), with some (McCarthy & Gastmans, 2015; Sporrong et al., 2004) organized according to categories (i.e. resource limitations, lack of support structures, clinical situations). One article that showed the research and development process associated with the Moral Distress Thermometer did not provide any concrete examples of moral distress (Wocial & Weaver, 2013). Eleven articles did not mention any illustration or concrete example of moral distress. Some used implicit examples, usually mentioned in passing as a sentence fragment (Dudzinski, 2016; Jameton, 1984; Varcoe et al., 2012), or none at all (Barlem & Ramos, 2015; Fourie, 2017; Lamiani et al., 2015; Lützén & Kvist, 2012; McCarthy & Deady, 2008; McCarthy & Monteverde, 2018; Morley et al., 2017; Sanderson et al., 2019; Wocial & Weaver, 2013).

Table 5. – Examples of Moral Distress in Context

Conceptual Articles (n= 15)

Author (Year)	Concrete Examples of Moral Distress
Jameton (1984)	Example: Carrying out a standard battery of blood tests for newly admitted patients is costly, poses unnecessary risks & therefore is unethical. Difficult for nurses to change this practice, especially when it provides financial benefits for the hospital.
Jameton (1993)	(1) **Postoperative Exercise**: Patient refuses to do post-operative exercises. Nurse unable to motivate patient, approaching wit's end (how much more energy to invest?) (2) **Inadequate Consent**: Nurse unable to provide patient with important information on complications before consenting to a cesarean-section. (3) **Overtreatment**: Premature baby has important neurological and physical problems. Parents, not having received a lot of information, opt for aggressive treatment, which is painful for baby. Nurse has no say in treatment plan.
Sporrong et al., (2004)	(1) **Resources/Resource limitations** Time management/scheduling issues. Has an impact on the quality of care provided to patients; Impression that as time runs on, the quality of care and interpersonal abilities of the healthcare provider decrease; Difficulty dividing attention between patients and administrative tasks; Burden of administrative duties (very time consuming); Negative feelings, guilt and not pulling one's own weight; Distress at having to allocate limited resources; Lack of economic resources: staff is expensive, but so are (1) medical equipment and tools, (2) technology (admin and medical). Focus is often on maintaining budget (at mid-level and upper management), with little/minimal discussion on other expenses. Lack of financial resources as a source of distress for doctors and healthcare provider. (2) **Rules vs Praxis** Difficult or impossible to act according to regulations/guidelines (i.e. illegally treating patients in bathrooms or corridors, using age as a reason for refusing medical care/treatments); Breaking a rule because of moral conviction is not legally admitted (where there is a conflict between the regulation and what the healthcare provider saw as best for the patient); An action is perceived as morally right, but is difficult or impossible because of administrative routines. (3) **Conflicts of Interest** Referring to patient's integrity: difficulty of respecting professional secrecy or of being sensitive to patient's needs in terms of how well healthcare provider perceive of their ability to relate to patients (i.e. when delivering a diagnosis); Due to hierarchies, professional relations, moral values: carrying out orders (i.e. filling a prescription knowing that the dosage or choice of medication isn't ideal for that patient) against their conviction; work-life balance is difficult to achieve given the urgency of paging HCP in a large team when many types of expertise are needed; Relations between patients and colleagues. (4) **Lack of Support Structures** Informal discussion of ethical issues – no formal, organized, systematic discussion of support for ethical issues; Discussions or debriefings reserved for "serious incidents," for which "official discussions" take place.
McCarthy & Deady (2008)	None provided (alternatively, scenarios are named in passing and contain no details)

Table 5. – Examples of Moral Distress in Context (cont'd)

Conceptual Articles (n= 15)

Author (Year)	Concrete Examples of Moral Distress
Lützén & Kvist (2012)	None provided (alternatively, scenarios are named in passing and contain no details)
Varcoe et al., (2012)	None provided (alternatively, scenarios are named in passing and contain no details)
Barlem & Ramos (2015)	None provided (alternatively, scenarios are named in passing and contain no details)
Fourie (2015)	Revisits Jameton 1993's moral situations, **Postoperative Exercise** and **Overtreatment**. See corresponding presentation of these moral situations above.
Thomas & McCullough (2015)	Example: **A nurse cares for a dying patient in intensive care unit who gets cardiopulmonary resuscitation (CPR)**. When a resident enlists interns to take turns practicing CPR on the dying patient, the nurse becomes uneasy (challenge to professional integrity). With the family's wishes unknown, nurse doesn't have authority to stop resident/interns from continuing CPR (threat to professional integrity). At the resident's call, CPR continues further despite not knowing family or patient's wishes; nurse threatens to leave clinical duties (violation of professional integrity). Example: **Residents make a pact to rotate 3-hour shifts to assist with overloaded emergency room admissions**. One member asks to switch so he can attend his daughter's birthday (challenge to individual integrity). He suggests compromises to suit him and other residents, who refuse to bend (threat to individual integrity). Others present him with an ultimatum - stick with the schedule or you're out permanently (violation to individual integrity). He stays.
Dudzinski (2016)	(1) End-of-life analgesic care: making patient comfortable versus administering a lethal dosage; (2) Providing futile medical care for a dying patient.
Campbell et al., (2016)	(1) **Moral Uncertainty**: A general surgeon who just finished his residency, is assigned to a cohort of patients whose complex medical problems make him doubt his ability to treat them adequately. He fears that his colleagues might not respect his decision to seek advice or hand off some cases to more experienced staff. (2) **Mild Distress**: A surgeon is known to have outbursts in the operating room, often targeting other healthcare professionals. A scrub nurse who is in the surgeon's good graces feels discomfort at protesting when he witnesses an outburst, as this might jeopardize the quality of care (3) **Delayed Distress**: An experienced emergency room doctor takes aggressive resuscitative measures on a patient in critical condition following an accident. Hours later, when he reflects on the patient's expected quality of life, he doubts the appropriateness of his care. (4) **Moral Dilemma**: A 13 year-old cancer patient's prognosis is precarious. A bioethicist is called in to help the care team decide how much information to disclose to the patient. Parents oppose to any information being disclosed because it will cause him distress. (5) **Bad Moral Luck**: A psychiatrist describes some much-needed antidepressants to his patient, who later overdoses on the medication and dies by suicide. The psychiatrist is greatly distressed at this morally undesirable outcome. (6) **Distress by Association**: A terminally ill patient agrees to participate in a research study, believing that it will have a direct benefit on their health. A nurse sees that the patient did not understand the potential risks of participating. She tries to convince the patient to back out, approaches the research team with her concerns for the patient's wellbeing, to no avail. Nurse feels guilty, distressed at her unsuccessful involvement.

Table 5. – Examples of Moral Distress in Context (cont'd)

Conceptual Articles (n= 15)

Author (Year)	Concrete Examples of Moral Distress
Fourie (2017)	None provided (alternatively, scenarios are named in passing and contain no details)
McCarthy & Monteverde (2018)	None provided (alternatively, scenarios are named in passing and contain no details)
Tigard (2018)	**Gene's Decision**: Gene, a nurse, must decide whether or not to administer methadone to Patient 1 experiencing opioid withdrawals and high levels of pain. Gene and her fellow nurses are authorized to give Patient 1 methadone but decide on giving other painkillers first. When the patient dies, Gene feels guilt and blame for this death. This leads her through a series of events, including burnout, and leaving her job. **Unnecessary Blood Testing**: A nurse must run blood tests on all newly admitted patients, as per hospital policy. For cases where the testing is unnecessary or can pose a risk to the patient, the nurse feels a sense of responsibility in wrongdoing to patients. **No-kill Care**: A doctor has a conscientious objection to medical aid in dying and cannot bring herself to administer a lethal dosage to a very ill patient. Though she realized that she must put her personal convictions aside in order to help reduce her patient's suffering, she had a lingering feeling that she was doing something morally wrong. **Gene's Indecision**: Patient 1 is experiencing opioid withdrawals and high levels of pain. Gene, a nurse, is authorized to give Patient 1 methadone and several other painkillers. She cannot reasonably predict how Patient 1 will react to either of the available painkillers (i.e. improvement and detox, coma, death). Gene feels entirely unable to decide (1) whether or not to administer painkillers at all, and (2) which painkiller to try first.
Tigard (2019)	Example: A competent patient with a terminal illness requests medical aid in dying. His palliative care physician cannot administer the dosage (assumption is that it's because of an institutional policy). The physician learns that "she cares too much about patients' dignity to let certain laws govern the duration of their lives. (...) Despite the pain of her morally distressing experience, the physician undergoes a crucial life of uncovering and affirming her most deeply held values."

Table 5. – Examples of Moral Distress in Context (cont'd)

Empirical Articles (n= 10)

Author (Year)	Concrete Examples of Moral Distress
Wilkinson (1988)	(1) Difficulties related to end-of-life care (i.e. obtaining a do-not-resuscitate order) (2) Futile care, especially for terminally ill patients (3) Truth-telling/lying to patients (4) Incompetent or inadequate care from physician
Corley et al., (2001)	(1) Work in a situation where the number of staff is so low that care is inadequate. (2) Carry out the physician's orders for unnecessary tests and treatments for terminally ill patients. (3) Assist the physician who in your opinion is providing incompetent care. (4) Work with 'unsafe' levels of nurse staffing. (5) Initiate extensive life-saving actions when I think it only prolongs death. (6) Follow the family's request not to discuss death with a dying patient who asks about dying. (7) Follow the physician's request not to discuss death with a dying patient who asks about dying. (8) Carry out the physician's order for unnecessary tests and treatment. (9) Follow the physician's order not to tell the patient the truth when he/she asks for it. (10) Follow the physician's request not to discuss Code status with the family when the patient becomes incompetent. (11) Observe without intervening when health care personnel do not respect the patient's dignity. (12) Participating in care for a hopelessly injured person … sustained on a respirator when no one will make a decision to 'pull the plug'. (13) Follow the family's wishes to continue life support even though it is not in the best interest of the patient. (14) Let medical students perform painful procedures on patients solely to increase their skill. (15) Assist physicians who are practicing procedures on a patient after CPR has been unsuccessful. (16) Prepare a terminally ill elderly patient on a respirator for surgery to have a mass removed. (17) Carry out a work assignment in which I do not feel professionally competent. (18) Provide better care for those who can afford to pay than those who cannot. (19) Ignore situations of suspected patient abuse by care givers. (20) Ignore situations in which I suspect that patients have not been given adequate information to insure informed consent. (21) Discharge a patient when he has reached the maximum length of stay based on diagnostic related grouping although he has many needs. (22) Perform a procedure when the patient is not adequately informed about procedures which he/she is about to undergo. (23) Carry out orders or institutional policies to discontinue treatment because the patient can no longer pay. (24) Avoid taking any action when I learn that a nurse colleague has made a medication error and does not report it. (25) Assist the physician who performs a test or treatment without informed consent. (26) Give only haemodynamic stabilizing medication intravenously during a Code with no compression or intubation. (27) Follow the physician's request not to discuss Code status with patient. (28) Prepare an elderly man who is severely demented and a `No Code' for surgery to have a gastrostomy tube put in. (29) Follow the family's wishes for the patient care when I do not agree with them. (30) Give medication intravenously to a patient who has refused to take the medication orally.

Table 5. – Examples of Moral Distress in Context (cont'd)

Empirical Articles (n= 10)

Author (Year)	Concrete Examples of Moral Distress
Sporrong et al., (2004)	**Level of Moral Distress** (1) The integrity of the patient/customer relative to other patients/customers is disregarded (2) It is difficult to adjust information to the needs of the patient/customer (3) The patient/customer who 'cries out loud' gets more or faster help than others (4) Patients/customers have to wait for a long time to have their treatments/prescriptions made up (5) The care of patients/customers is deficient owing to pressure of time (6) I am sometimes forced to act against my conscience **Tolerance/Openness** (7) My colleagues have an understanding of my reasoning about difficult decisions (8) At my place of work different opinions and values are tolerated (9) At my place of work we talk about moral problems
Hamric et al., (2012)	(1) Follow the family's wishes to continue life support even though I believe it is not in the best interest of the patient; (2) Initiate extensive lifesaving actions when I think they only prolong death; (3) Continue to participate in care for a hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to withdraw support; (4) Witness healthcare providers giving "false hope" to a patient or family; (5) Witness diminished patient care quality due to poor team communication; (6) Watch patient care suffer because of a lack of provider continuity.
Wocial & Weaver (2013)	None provided (alternatively, scenarios are named in passing and contain no details)
Lamiani et al., (2015)	None provided (alternatively, scenarios are named in passing and contain no details)
McCarthy & Gastmans (2015)	(1) **Clinical situations** (involving harm to patients): aggressive and futile treatment, carrying out unnecessary tests, lack of treatment, poor pain management, incompetent or inadequate care, deception and inadequate consent for treatment. (2) **Difficult working conditions and limited resources**: increased corporatization of healthcare, administrative, organizational and legal policies, lack of policies and guidelines, the shift in focus from patients and families to organizations, poor staffing, cost cuts, economic efficiencies, increased workloads. (3) **Structural conditions** (asymmetries of power and authority): lack of authority and support, imbalances of power, inability to advocate, lack of recognition of nursing expertise and devaluation of nursing perspectives, lack of opportunity to voice concerns, poor teamwork and team support, professional and inter-professional conflicts especially nurse-physician conflicts. (4) **Moral sources**: moral sensitivity, value conflicts, unhealthy ethical climates, morally uninhabitable workplaces, gap between normative expectations attached to a professional role and the 'personal moral compass'; lack of resolve, lack of moral competency, lack of knowledge, lack of courage and self-doubt.

Table 5. – Examples of Moral Distress in Context (cont'd)

Empirical Articles (n= 10)

Author (Year)	Concrete Examples of Moral Distress
Astbury & Gallagher (2017)	(1) Supply of controlled drugs in the best interest of a patient when legal requirements are unmet (2) Wasting National Health Service (NHS) resources to elicit patient compliance (3) Actively challenging prescribers regarding prescriptions that contained medicines or doses thought to be inappropriate (4) Feeling unable to provide an adequate level of service due to time constraints (5) Professional judgment conflicts with the preferences and wishes of the customer (6) Commercial values and a pressure to link sell to generate additional sales (7) Emergency supply of prescription-only medications when procedural requirements are unmet (8) Request from patients for medication for use outside of their licensed indications (9) Supply of emergency hormonal contraception in conflict with religious or moral beliefs (10) Professional requirement to engage in whistleblowing though this may be to the detriment of one's career (11) Compulsion to release confidential patient data under non-healthcare-related legislation (12) Commercial incentives that are in opposition to best clinical practice (13) The sale of unregulated or unproven products
Morley et al., (2017)	None provided (alternatively, scenarios are named in passing and contain no details)
Sanderson et al., (2019)	None provided (alternatively, scenarios are named in passing and contain no details)

Justifications

Ethical Justifications

Very few articles explicitly mentioned ethical principles as ethical justifications for moral distress, if at all. (See **Table 6**). Based on the groupings of ethical principles listed in the articles, two main perspectives emerged: (1) moral distress as being related to integrity, autonomy or agency and (2) moral distress as being related to responsibility or duty.

Understanding the concept of moral distress was often linked to integrity, autonomy or agency. In an early article, the experience and effect of moral distress was reported in light of its negative outcomes with respect to the nurse's "wholeness" and the quality of patient care, her autonomy and integrity (Wilkinson, 1988). In another article, the importance of understanding moral distress was directly related to its causes, i.e., issues in integrity, autonomy and powerlessness (Hamric et al., 2012). Autonomy was also listed on its own as an ethical justification for needing to better understand moral distress, with a mention of empowerment and self-reflection as important values to build and foster (Lamiani et al., 2015). Individual and professional integrity were also found to be ethical justifications for understanding ethically significant moral distress (Thomas & McCullough, 2015). Another article linked moral distress to the role of the healthcare provider, specifically the level of autonomy associated with that role: power relationships are particularly important in moral distress, especially when the relationship or dynamic varies between healthcare professionals (Barlem & Ramos, 2015; McCarthy & Deady, 2008). For these authors, moral distress plagues nurses precisely because power imbalances work against the favour of nurses, while underestimating their power undermines their level of responsibility in the decision-making process.

The second type of ethical justifications pertained to responsibility and duty. The personal moral convictions of health care providers are not necessarily the same as the moral convictions of other groups (i.e., community, colleagues, employers/hospital, patients), so moral distress is therefore important as it relates to their responsibilities and duties (Corley et al., 2001; Sporrong et al., 2006; Sporrong et al., 2004).

A few articles drew elements of both justifications, mentioning a combination of integrity, autonomy and agency as well as responsibility and duty to mention a broader list of ethical justifications (Astbury & Gallagher, 2017; McCarthy & Monteverde, 2018; Morley et al., 2017; Varcoe et al., 2012).

Table 6. – Ethical Justifications for Understanding Moral Distress

Author (Year)	Ethical Justifications
Jameton (1984)	No ethical justifications mentioned explicitly. Moral distress is important because the experience of it describes how the role of nurses relates to other healthcare professionals. Moral distress relates to the nurse's autonomy, responsibility, awareness, integrity.
Wilkinson (1988)	The author mentions autonomy and integrity. Moral distress experiences and effects have negative outcomes with respect to (1) the nurse's "wholeness" and (2) the quality of patient care that nurse can provide.
Jameton (1993)	No ethical justifications mentioned explicitly. The author alludes to (1) the nurse's sense of duty and/or responsibility and (2) their autonomy.
Corley et al. (2001)	Duty and/or responsibility are mentioned foremost. Integrity and autonomy are addressed in passing.
Sporrong et al. (2004)	Duty and/or responsibility is mentioned in the text.
Sporrong et al. (2006)	No ethical justifications mentioned explicitly. Duty and/or responsibility are alluded to in the text: the personal moral convictions of healthcare providers are not necessarily the same as the moral convictions of others.
McCarthy & Deady (2008)	The authors mention duty and/or responsibility and integrity in the text.
Lützén et al (2012)	No ethical justifications are mentioned explicitly. Authors allude to moral awareness in the text.
Hamric et al. (2012).	Authors mention integrity, autonomy and power or powerlessness as ethical justifications.
Varcoe et al. (2012)	Authors discuss integrity and autonomy as an ethical justification. This text also mentions power or powerlessness.
Wocial & Weaver (2013)	No ethical justifications mentioned explicitly or alluded to in the text.
Barlem & Ramos (2015)	Authors discuss autonomy: the experience of moral distress is linked to the role of the healthcare professional and the level of autonomy associated with that role.
Fourie (2015)	No ethical justifications mentioned explicitly or alluded to in the text.
Lamiani et al. (2015)	Authors mention autonomy in the text, referring specifically to empowerment, self-reflection.
McCarthy & Gastmans (2015)	Autonomy and integrity (personal and professional) are alluded to, not mentioned directly in the text.
Thomas & McCullough (2015)	Integrity is mentioned in the text (personal and professional integrity).
Dudzinski (2016)	Authors allude to integrity or agency in the text without mentioning it directly. They address agency and compromise as they relate to moral distress.
Campbell et al. (2016)	Authors allude to autonomy in the text without mentioning it directly.
Astbury & Gallagher (2017)	Authors do not provide a clear ethical justification in the text. They allude to autonomy and integrity, stating that moral distress is problematic because it happens when the professional regulations and legal requirements for pharmacists come into tension with the pharmacist's moral framework.
Fourie (2017)	In the text, Fourie mentions moral awareness as an ethical justification for understanding moral distress.
Morley et al. (2017)	Authors mention (moral) agency and the importance of good moral judgment.
McCarthy & Monteverde (2018)	Authors mention integrity, agency, constraint, compromise in the text.
Tigard (2018)	No ethical justifications mentioned explicitly or alluded to in the text.
Tigard (2019)	The author alludes to autonomy and "moral maturity" in the text without mentioning it directly.
Sanderson et al. (2019)	Authors do not provide a clear ethical justification in the text. They mention duty and/or responsibility, integrity and moral awareness.

Stance on Original Conceptualization of Moral Distress

Both of Jameton's accounts of moral distress are considered as the basis for comparison in this section. As a result, they were omitted from the sample of 25 articles. Of the remaining 23 articles, 16 were deemed in favour or consistent with Jameton, while 4 articles were mitigated and 3 were inconsistent with the original conceptualization (see **Table 7**).

All ten of the empirical articles (i.e., systematic review of argument-based literature, development of measurement tools, etc.) were consistent with Jameton's conceptualization of moral distress. Conceptual articles were divided in their stance on Jameton's conceptualization: eight articles were deemed consistent with Jameton because their presentation of the concept was based on either reactive distress or described moral distress as a negative experience (Lamiani et al., 2015; McCarthy & Gastmans, 2015; Sporrong et al., 2004; Varcoe et al., 2012; Wilkinson, 1988).

Four conceptual articles were deemed mitigated with respect to Jameton, meaning that they contained elements both consistent with and opposed to the original conceptualization. Reported reasons were: (1) presents major concerns for the narrow scope of existing research but provides a definition and resulting function that are consistent with Jameton (McCarthy & Deady, 2008); (2) claims that moral distress is a possibility for growth instead of a barrier or constraint, but focuses on negative experiences and effects (Lützén & Kvist, 2012); (3) presents major concerns on the integrity of existing conceptual and empirical research on moral distress but does not take issue with Jameton's definition in order to rectify the problems in research (Fourie, 2015); (4) moves away from Jameton's definition, makes key clarifications, draws key distinctions, but ultimately perceives of moral distress in negative terms (Thomas & McCullough, 2015).

Finally, three articles presented the concept of moral distress in opposition from Jameton, explaining moral distress as a possibility for growth instead of a barrier or constraint (Barlem & Ramos, 2015; Tigard, 2018). Another perspective presented moral distress as the mark of positive character traits (Tigard, 2019). As a result, these three accounts were deemed inconsistent with and overall, against Jameton's conceptualization.

Table 7. – Stance on Original Conceptualization

Empirical Articles (n = 10)	
Consistent with Jameton 1984/1993 (n = 10)	
Author (Year)	**Stance on Original Conceptualization**
Wilkinson (1988)	Based on Jameton's conceptualization of moral distress. Findings corroborate Jameton. Moral distress cast in a negative light: negative experience, negative effects.
Corley et al., (2001)	Based on reactive distress, as presented by Jameton.
Sporrong et al. (2006)	Conceptualization of moral distress is overall consistent with Jameton, and findings focus on the causes and effects of moral distress.
Hamric et al. (2012).	Based on and inspired by Jameton's conceptualization of moral distress.
Wocial & Weaver (2013)	Based on reactive distress, as presented by Jameton.
Lamiani et al., (2015)	Conceptualization of moral distress is overall consistent with Jameton, and findings focus on the causes and effects of moral distress.
McCarthy & Gastmans (2015)	Overall consistent with Jameton's conceptualization.
Astbury & Gallagher (2017)	Based on constraint, especially occupational constraint.
Morley et al., (2017)	Based on and inspired by Jameton's conceptualization of moral distress, i.e., focus on constraint.
Sanderson et al., (2019)	Overall consistent with Jameton's conceptualization.

Table 7. - Stance on Original Conceptualization (cont'd)

Conceptual Articles (n = 15)	
Consistent with Jameton 1984/1993 (n = 6)	
Author (Year)	**Stance on Original Conceptualization**
Sporrong et al. (2004)	Based on and inspired by Jameton's conceptualization of moral distress.
Varcoe et al., (2012)	Based on and inspired by Jameton's conceptualization of moral distress.
Dudzinski (2016)	Based on and inspired by Jameton's conceptualization of moral distress.
Campbell et al., (2016)	Based on and inspired by Jameton's conceptualization of moral distress.
Fourie (2017)	Tries to overcome Jameton's conceptual ambiguity but ultimately ends with a definition that is overall consistent with Jameton, i.e., focus on constraint.
McCarthy & Monteverde (2018)	Based on Jameton's conceptualization. Explicitly sets out to defend this view.
Mitigated with Jameton 1984/1993 (n = 4)	
McCarthy & Deady (2008)	Presents major concerns for the narrow scope of existing research but provides a definition and resulting function that are consistent with Jameton.
Lützén & Kvist (2012)	Claims that moral distress is a possibility for growth instead of a barrier or constraint but focuses on negative experiences and effects.
Fourie (2015)	Presents major concerns on the integrity of existing conceptual and empirical moral distress research, but ultimately proposes maintaining Jameton's narrow definition of moral distress.
Thomas & McCullough (2015)	Moves away from the specific definition that Jameton provides. Makes key clarifications, draws key distinctions from Jameton but ultimately perceives of moral distress in negative terms.
Inconsistent with Jameton 1984/1993 (n = 3)	
Barlem & Ramos (2015)	Claims that moral distress is a possibility for growth instead of a barrier or constraint.
Tigard (2018)	Claims that moral distress is a possibility for growth instead of a barrier or constraint.
Tigard (2019)	Views moral distress as an experience that points to positive character traits. Deviates overall from Jameton's conceptualization.

Implications and Results

Obstacles and Benefits of Moral Distress Research (Conceptual and Empirical Articles)

Eight articles named conceptual ambiguity as a major difficulty in understanding and applying moral distress in healthcare contexts. A few articles mentioned the need to widen the scope of the healthcare contexts (Corley et al., 2001; Fourie, 2017; McCarthy & Deady, 2008; McCarthy & Monteverde, 2018; Sporrong et al., 2006) or narrow the scope of the concept in future research efforts because conceptual ambiguity leaves moral distress studies at a standstill. Other authors claimed that moral distress gets confused with related terms such that moral distress studies do not measure what they set out to do (Fourie, 2015). Two studies specifically emerged from a need to remedy the conceptual ambiguity surrounding moral distress: one to provide a checklist for further research (Tigard, 2018), the other to propose an all-encompassing definition of moral distress (Morley et al., 2017).

Other articles associated the results of their research as beneficial, positive or constructive when they made links between the experience and effect of moral distress. Reasons included: (1) distinguishing the experience from the effect (Jameton, 1984; Wilkinson, 1988); (2) links moral distress to ethical climate and workplace satisfaction (Hamric et al., 2012); (3) allows healthcare providers to articulate their perceived moral distress in a meaningful way (Campbell et al., 2016; Jameton, 1984; Wocial & Weaver, 2013), and also because having a vocabulary for moral distress means that healthcare providers have ethical "competencies" (Barlem & Ramos, 2015).

Empirical Results (Empirical Articles Only)

Two general results overlapped in empirical articles. The first was the need for further research efforts on interventions or strategies to alleviate moral distress. Research efforts mentioned had to do with ethics training for nurses (Wilkinson, 1988); workplace-related interventions that reduce moral distress (Corley et al., 2001) in both frequency and intensity (Astbury & Gallagher, 2017); and identifying vulnerable workplaces (Sporrong et al., 2006).

The second type of empirical results had to do with establishing advancements in understanding moral distress, especially in different workplace settings. This perspective was present in all empirical articles to varying degrees.

Discussion

Our main objective was to identify the function of the concept of moral distress in healthcare, analyze how it has been applied to clinical practice and its effects. The clinical application of the concept of assent has been discussed in the literature since the late 1980s, with no consensus emerging on its definition and use in practice. A majority of articles show consistency with Jameton's conceptualization (Jameton, 1984, 1993). There was relative lack of clarity on the definition, characteristics, moral situations and ethical justifications. We will focus this discussion on the descriptive content on definitions and characteristics as well as ethical justifications in this section. We discuss our findings with respect to the (1) ethical relevance of moral distress and (2) moral distress in clinical decision-making.

Ethical Relevance of Moral Distress

In terms of the descriptive data for the definitions and characteristics of moral distress, there was great variability. Variability matters for understanding the concept of moral distress because not having a body of literature holding together conceptually speaking makes it more difficult to identify the concept when faced with morally troubling situations. In the context of an instrumentalist analysis, variety in descriptive data means that there is much richness that may not have been understood as of yet. Next, the functions of moral distress in conceptual and empirical literature generally focused on negative causes and effects of moral situations.

As for the ethical justifications of the concept, the fact that ethical justifications were mostly implicit means that they are open to interpretation, notably with respect to why moral distress matters in the healthcare context. The danger with open interpretations is that the onus remains on the person doing the analysis to interpret the information, and their interpretation might not correspond with the intended meaning of those who were involved in the research to begin with. Finally, the lack of moral situations or concrete examples of moral distress in practice allows for a margin of interpretation and richness in the application of moral distress in decision-making in healthcare that would respect, in a sense, the variety of intellectual, psychological and emotional effects of moral distress.

Moral Distress in Clinical Decision-Making

Our secondary objective was to critically review the findings as they relate to moral decision-making in healthcare. Overall, there was an overwhelmingly negative view of moral distress; reflecting a utilitarian use and understanding of moral distress. Moral distress was overwhelmingly viewed as an obstacle or barrier to decision-making, with only a few exceptions. However, more recent research (Tigard, 2018, 2019) shows a novel approach to moral distress as a form of critical awareness and introspection towards one's values.

A pragmatic approach to moral distress literature helps to bridge the conceptual gaps in the literature by emphasizing the experiential nature of moral problems, but also because it views moral problem-solving as an opportunity for growth and development (Pekarsky, 1990). Literature on pragmatism places great importance on carrying out deliberation in a practical context. This deliberation typically follows a democratic process model of inquiry and problem-solving (Fins et al., 1997).

Context is the cornerstone of a pragmatic approach (Altman, 1983). Pragmatism proposes a process of inquiry that featured reasoned and negotiated decisions for acceptable courses of action that reflect the reality of particular lived situation (Fins, 1998; Jansen, 1998). Accordingly, each situation of moral distress thus has a unique quality that affects the possible outcomes. But moving from situations to outcomes needs to be guided by ethical principles. Ethical principles inspire actions, whose consequences are then weighed and justified in accordance with the context and the relevant chosen principles (Fins et al., 1997). This deliberative, context-specific process is democratic in that it includes all the relevant stakeholders affected by the moral distress scenario in a shared decision-making process (Fins et al., 1997).

Additional features of a pragmatic approach to ethical deliberation are that pragmatic approaches to moral problem-solving embody (1) non-linear and logical and (2) integrative and cyclical processes (Fins et al., 1997). The unique context of each situation of moral distress requires undertaking certain interconnected tasks (e.g., understanding the situated nature of a given moral problem; engaging in open-ended deliberation) in order to reach the most ethically acceptable course of action (Racine, 2016). Pragmatic moral problem-solving allows situations of moral distress to evolve from a static (i.e. resolution relying on fixed understandings of moral distress) to a dynamic (i.e. moral development) end goal, derived from the resolution and its underlying

process (Racine, 2016). Applied to the context of moral distress, this implies that moral distress is a cue about the problematic nature of the situation. It is an invitation to stop and reflect upon the situation but is no panacea.

There remain important challenges to overcome regarding the concept of moral distress and its practical implications. Practical standards to assess moral distress are largely missing and evidence supporting the many claims made in the literature would require further investigation in actual real-world situations. Conceptual and empirical literature on moral distress helps to identify and quantify its existence, but it typically is not connected to strategies to overcoming moral distress. Agreeing upon the definition and characteristics of the concept could help generate meaningful resolution strategies, especially since, healthcare providers long for a proper methodology to mitigate the effects of moral distress, if and when mitigation is possible and desirable. The strategies needed would include practical systems-level standards in healthcare institutions as well as for healthcare associations, and national and international-level standards. Pragmatism and its approaches to moral problem-solving offer opportunities for solutions, interventions and other avenues for attenuating the negative effects of moral distress.

Limitations

The findings reported in this paper bear several limitations. The empirical studies reviewed are conducted on moral distress in healthcare and most of the reported implications were inferred. We included conceptual articles and empirical studies but did not use a quality appraisal tool for this review. Given that the data charting technique (which involved rephrasing and reorganizing the data) and the instrumentalist analysis are new, these methods require some fine-tuning. This can be done as additional instrumentalist analyses are carried out on other concepts.

Conclusion

Moral distress represents an important lived experience in healthcare settings. It was first put to light in the context of nursing but is now considered a pervasive phenomenon in the healthcare professions. Given its importance and its detrimental implications for healthcare professionals, moral distress has been intensely investigated. However, the purpose of this concept remains

unclear as well as some of its key characteristics and implications. Better defining the goals of a describing situations as situations of moral distress (e.g., to indicate a personal dilemma, to indicate an institutional problem) could help increase the functionality of this concept. This is largely the purpose of the instrumentalist concept analysis we undertook. Despite some limitations in charting content for certain categories, the results of our review show the extent of conceptual ambiguity in the literature. For example, the function of moral distress is limited to indicating the sources or consequences of distressing situations, but it is not situated within an ecology of morality where difficult experiences would be a source of meaning. In a similar sense, while empirical articles are consistent with the original conceptualization of moral distress, the conceptual articles are divided, showing accounts that are at times contrasting yet other times consistent with Jameton. Definitions, characteristics and concrete illustrations of moral distress also conveys a rather heterogeneous body of literature. The next critical step for research is to engage closely with healthcare professionals in order to arrive at a conceptualization of moral distress that conveys the richness of its meanings.

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Chapter 4 – General Discussion and Conclusion

This project set out to identify the function of moral distress in empirical and conceptual bioethics literature. To do so, we adapted a methodology that would allow for a systematic sampling and qualitative selection of articles. The methodology included a detailed content extraction strategy, focusing on elements such as how authors defined, characterized and applied the concept in practice. These elements allowed us to identify two functions for the concept: moral distress was employed to express either the source or the outcome of a difficult decision.

In their discussions of the concept, authors rarely linked moral distress with ethical principles or values. Without tying moral distress to ethical principles makes it difficult to understand why moral distress matters (i.e., why we should care about it) in the first place. A variety of definitions, characteristics and concrete illustrations of moral distress were identified, which suggests that the existing research on the concept could benefit from some revision. This final chapter presents (1) ethical and then (2) pragmatic philosophical considerations that stem from the results presented in the previous chapter.

Ethical Considerations

This section will discuss some of the results from the previous chapter, specifically on the ethical justifications for research on moral distress. In addition, this section will discuss how the articles show consistency with the original understanding of moral distress by Jameton (1984, 1993), and the impact that Jameton's understanding of the concept has on identifying its functions.

Ethical justifications are crucial aspects of the Instrumentalist Analysis because they show how and why authors use ethical principles or ethical concepts in their discussion of moral distress. Looking at ethical justifications is useful because it provides important clues as to the relevance of understanding the concept and its effects in context. Since it first appeared in nursing literature, scholars, researchers, and healthcare professionals have come to place a great emphasis on the concept of moral distress; highlighting its varied symptoms, causes and effects through retellings of experiences. Beyond the practical bearings (i.e., how moral distress might affect the clinical environment or healthcare institution and its operations), making clear sense of the ethical basis for understanding moral distress explains why stakeholders should care enough about it – enough

to carry out more research, develop methodological tools to quantify the frequency and intensity of moral distress experiences.

Even when articles mentioned an ethical principle or some kind of ethical reasoning for the importance of understanding the role of moral distress in decision-making, the discussion was minimal or anecdotal at best. Comments linking the concept to ethical principles or on reasons for understanding moral distress in ethical terms were made only in passing. Likewise, Lützén & Kvist (2012) assert that not enough research is done on the ethical aspects of moral distress, and that is problematic for the state of knowledge on the concept. Similarly, we found that authors did not provide an explicit and robust account of what existence of moral distress entails on an ethical basis. At the outset, the lack of an encompassing ethical justification seems ironic, given that the experience of moral distress bears an impact on the person experiencing it, whether that experience is positive, negative or neutral (Weber, 2016).

Articulating an ethical justification for the concept is needed in both the conceptual and empirical literature. Not being able to explain why it is important to investigate and understand moral distress in ethical terms means that authors are unable to explain what makes the experience of moral distress worth researching. A minority of authors explained, for example, that moral distress needs to be researched more closely because such experiences affect the healthcare professional's level of autonomy or responsibility, which often negatively affects their behaviour and practices (Corley et al., 2001; Lamiani et al., 2015; Sporrong et al., 2006; Thomas & McCullough, 2015). Most authors instead stated that research on moral distress is important simply because the experience of it involves negative emotions which are unwanted and must be avoided at all costs (Astbury & Gallagher, 2017; McCarthy & Monteverde, 2018; Morley et al., 2017; Varcoe, Colleen et al., 2012). More general justifications (i.e., that moral distress is bad and must therefore be avoided) come into contrast with justifications that relate the experience of moral distress to an ethical principle, value or concept (i.e., moral distress is bad because it makes healthcare professionals feel like they have less autonomy than they normally would as individuals and as professionals). This contrast between general and more detailed justifications makes it difficult to generate a cohesive understanding of moral distress, especially when so much importance is placed on the concept. Lacking a straightforward explanation of why moral distress matters on an ethical basis also makes it challenging to move forward in research on the concept.

As such, it is possible to consider that not knowing why the experience and effect of moral distress matters in ethical terms can render much of the research redundant.

Overall, this observation can support the claim from Sanderson et al., (2019) that research on moral distress has plateaued. Claiming, as Sanderson et al., (2019) do, that research on moral distress has changed very little over time can be seen as presumptuous, not to mention that doing so also discounts the added value of much of the conceptual and empirical research that was published since the concept first appeared in the literature. Such a stance is much too provocative to adopt in the context of this thesis. It is, however, possible to consider that the uniform nature of research on moral distress that Sanderson et al., (2019) speak of has more to do with the fact that a lot of the research remains consistent with the original conceptualization offered by Jameton. We can speculate as to why this is the case.

A first hypothesis is, following Fourie (2017), that the conceptual literature and empirical studies on moral distress in nursing ethics make a category error, often confusing conflict for distress. This is mostly based on the fact that Jameton provides ambiguous, unclear distinctions between conflict, dilemma and distress, which are bound to perpetuate themselves in the literature. For Fourie (2017), often what researchers measure or explore is conflict based on Jameton's (1993) narrow definition, not dilemma. If we confuse moral distress with conflict, then there is substantial research missing on the origins of constraint and on outlining ethically significant constraint. This, in turn, makes it much more difficult to understand what exactly moral distress looks like in the context of nursing; what we think we know about moral distress needs to be labelled appropriately so that it can be studied and understood. Sporrong et al., (2004) made a similar observation. Not only did all interviewees experience moral distress in their study on healthcare professionals in Sweden, but all of them also mentioned a lack of consensus among providers as to what consists of an ethical dilemma or an ethical issue. In contrast, interviewees were able to clearly identify a legal issue. These two concurrent observations from Fourie (2017) and Sporrong et al., (2004) that are over a decade apart show that despite methodological advancements in research on the experiential components of ethical issues in healthcare, the theoretical or conceptual understandings of moral distress have not advanced much.

Another hypothesis is that factors apart from the category errors identified in Sporrong et al., (2004) and Fourie (2017) perpetuate problems in understanding the concept of moral distress.

For example, the lack of moral situations or concrete examples in practice allows for a margin of interpretation and richness in the application of moral distress in decision-making in healthcare that would correspond to the variety of intellectual, psychological and emotional effects of moral distress. But this is problematic because research on moral distress focuses solely on negative outcomes or precursors, without properly reflecting on the gamut of origins, causes and effects of moral situations. Essentially for Sporrong et al., (2004) and Fourie (2017), the research on moral distress is stuck in a one-dimensional, short-sighted conceptualisation of moral distress which does not benefit the healthcare professionals who may experience it. Decision-making situations in healthcare are already loaded with meaning and involve their own baggage and risks that would make focusing on a negative set of outcomes unhealthy in a workplace environment. This shift from an exclusively or overwhelmingly negative view of moral distress requires openness in conceptual and empirical research.

The focus on negative effects is a major issue for understanding when healthcare professionals experience moral distress. Both functions identified in the results (i.e., that moral distress is either the source or the outcome of a difficult moral decision) refer to the psychological or emotional effects or experience of moral distress as being exclusively negative. A focus on negative effects of moral distress might give the impression that preventing moral distress in the first place (i.e., fixing the healthcare system, promoting ethics education) is the correct solution to seek out (Tigard, 2018). But such an analysis focuses too much on its negative effects. For any situation in which a healthcare professional experiences moral distress, it can also spark a reflection on what really matters to the professional. In other words, healthcare professionals can use their experience of moral distress as an opportunity to question their personal, interpersonal and professional values. Accordingly, the frequently-encountered recommendation to avoid addressing moral distress in the first place is problematic; avoiding moral distress altogether would in some ways remove the possibility of reflecting on what matters to the healthcare professional.

Sanderson et al., (2019) build on the hypotheses raised in the previous paragraphs when they address the fact that despite the variety of research and critical approaches to moral distress, researchers have not reached a consensus as of yet that replaces Jameton, or at least challenges Jameton sufficiently enough for moral distress researchers to advocate for a new conceptualization. One article in particular (Tigard, 2019) mentions feedback from anonymous reviewers which

suggests that moral distress experts provide pushback when moral distress is the main topic of discussion. We can speculate as to why this might be because: (1) vying away from Jameton's conceptualization might be perceived as the willingness to discount the experiences of healthcare professionals (particularly nurses) as the catalyst for this area of research; (2) there is some other underlying reason for keeping moral distress within the context of nursing or within the vocabulary of conflict and constraint; (3) conservatism dictates that there would be too many implications associated with a big shift in understanding and conceptualizing moral distress.

Part of the answer could be provided by Jameton himself. When he revisited his concept in 1993, Jameton listed the "inefficient, morally problematic and ultimately burdensome" differences between doctors and nurses in the US healthcare system as follows: (1) doctors have too much decision-making power over nurses; (2) hospital bureaucracy is such that the nurse-patient relationship cannot be optimally relational or supportive; and (3) "a considerable salary and status gap exists between doctors and nurses" (Jameton 1993). This led Jameton (1993) to state that "what nurses sometimes report as dilemmas actually indicate distress about the nature of the health care system and the roles of nurses." This particular explanation from Jameton shows why the moral distress of nurses had since been attributed to job dissatisfaction and dissatisfaction with their job environment. Knowing that Jameton provided the distinction of reactive distress (i.e., that not addressing initial moral distress promptly has adverse effects on the person experiencing it) points to this as well. Jameton draws attention to the experience of nurses and how their position in the healthcare setting becomes more fragile with the addition of moral distress.

Further expanding on the analysis proposed by Jameton, Hanna (2004), discusses a concept called role morality. For Hanna (2004), role morality implies that a healthcare professional is capable of distinguishing between their personal and professional values. When a healthcare professional – or any other kind of professional that deals with morally troubling situations – cannot readily separate their professional values from their personal values, they may likely (1) experience professional blunting or burnout, (2) dedicate inordinate amounts of energy to advocating for the interests of their patients; and (3) engage in whistleblowing because they let these preoccupations, which correspond to their personal values, transfer into their professional values. In other words, nurses tend to sympathize with their patients as human beings and also in a professional capacity, based on their professional roles. Acting in ways that promote the interests of patients requires

institutional or organizational support, which is often lacking for nurses, on account of the status differences between doctors and nurses. Sundin-Huard & Fahy (1999) explain that the lack of institutional support for nurses intensifies their experience of moral distress to the extent that they have a burnout. Hanna (2004) and Sundin-Huard & Fahy (1999) agree that a nurse's advocacy attempts, when met with moral distress, lead to burnout. Together, these two accounts reinforce Jameton's assertion above that a nurse's experience of moral distress is overwhelmingly negative and burdensome, and efforts must be made to eliminate it completely, otherwise the healthcare system will suffer greatly.

Reacting to such explanations by Hanna and Jameton, one of the concerns that McCarthy & Deady (2008) raise on moral distress research is that it "perpetuates the dominant or meta-narratives about the professional identity of nursing that … ought to be challenged." These authors see Jameton's conceptualization as problematic because it sends the wrong message about nursing and the role of nurses. Researchers must pay attention to situations of moral distress and first-person nursing accounts that display more constructive or positive outcomes, rather than blaming hospital bureaucracy or organizational culture as factors that make it hard to be a nurse with a conscience.

Building on these disparities between Jameton's definition of moral distress and nurses' explanation of lived moral distress, Hanna (2004) outlines some of the related implications. On the one hand, there is a lack of clear communication of the definition of moral distress to nurses who might be experiencing it. This misunderstanding and misinterpretation of the definition gets perpetuated when inaccurate examples are used to explain the concept. For example, Wilkinson (1988) uses truth-telling or lying to patients as a concrete illustration of moral distress, and one of the examples from Hamric et al., (2012) involves the notion that making a complaint to one's medical team makes it possible to receive more help or help in a timely manner. While these examples might align themselves with the lived experiences of nurses and show consistency with what Jameton wants to convey in his explanation of moral distress, these examples focus on negative aspects of nursing (i.e. hospital bureaucracy or organizational culture mentioned above), they do not represent the full gamut of experiences a nurse can live in their daily practice. Hanna points out that the mislabelling of moral distress as a negative experience in general (Varcoe, C. et al., 2012) or as a negative self-directed emotion (Campbell et al., 2016) is problematic because the

moral prefix carries a lot of weight, especially when the healthcare context involves many connotations to take into consideration. Finally, healthcare professionals might lack extensive training in philosophy and so would not have similar approaches to qualifying the concept of moral distress as well as the function of the concept. Ultimately, without a clear definition, the concept remains difficult to identify. In turn, it becomes more challenging to assess the qualities and characteristics of moral distress, making it more difficult to quantify or evaluate extent of moral distress, or even to trace the limits of its applicability in a given healthcare context.

Further, the traditional conceptualisation of moral distress that is based on and inspired by Jameton has led to many authors claiming that efforts must be made in order to eradicate it from the healthcare setting altogether. For Tigard (2018), these research efforts are "problematic" because they perpetuate an understanding of moral distress that is mistaken or misunderstood. When a person experiences emotional discomfort in the healthcare context, Tigard views this as the sign of a person's character as being "honourable" (2019) because the degree of one's emotional response to a moral situation reveals how much they care about it. This perspective offers a novel way of approaching the existing empirical research on moral distress. Instead of viewing moral distress as something overwhelmingly negative, Tigard (2019) suggests that researchers should reframe their attitude towards the concept to view the experience of moral distress itself as something beneficial to the person experiencing it. This diverts the focus from repeating information on the causes or effects of moral distress to elucidate what the experience of moral distress tells us about the person experiencing it. Hanna (2004) starts to articulate this when she cautions that moral distress does not 'equal' psychological distress (as implied in Jameton 1984, 1993), but can be expressed in psychological and emotional terms. McCarthy and Deady (2008) build on this when they say that despite the fact that moral distress has emotional and psychological effects, it cannot be reduced to them. Initial and reactive distress (à la (Jameton) places too much emphasis on the negative emotional and psychological effects of moral distress experiences. For Sanderson et al., (2019) Jameton's terminology of 'knowing the right thing to do' has a polarising effect, that is, it generates a right/wrong dichotomy as the underlying principle driving moral distress. These three statements suggest attempts to reconsider the concept of moral distress in a way that deviates from Jameton. Instead, they tend to suggest the emphasis should be put on its experiential and thus impossibly 'black or white' nature.

Making the ethical relevance of moral distress clear and being opened to reconsidering the original conceptualization is needed because of the nature of the experience of moral distress. The experience of moral distress is a significant one – it indelibly leaves a mark on those who encounter it (McCarthy & Deady, 2008; Sporrong et al., 2004; Sundin-Huard & Fahy, 1999; Tigard, 2018, 2019; Whitehead et al., 2015; Wilkinson, 1988). Research that tries to articulate and otherwise dispute various components of the concept points to the fact that moral distress is so unsettling an experience that researchers cannot agree on what the concept refers. As of yet, only a minority of accounts acknowledge the possibility of positive or neutral aspects of moral distress, with most focusing on negative experiences. Despite the valuation accorded to these experiences, the persistent effort to refine the concept means that it presents an opportunity for maturation or growth (Tigard, 2018, 2019). This is desirable for a pragmatic endeavour because the goal of ethical inquiry is growth (Pekarsky, 1990).

Inspired by pragmatism and its commitment to growth, an Instrumentalist Analysis provides a definition of the concept in terms of its function as opposed to a definition in a classic sense. A definition in a classic sense (i.e., identifying the necessary or sufficient components to it) represents a more closed approach which assumes that everything is already known about the concept. Accordingly, researchers who define moral distress along the same lines as Jameton, or otherwise identify gaps in information (such as, e.g., on some elements of conceptual ambiguity on moral distress) without challenging the components of Jameton's definition and conceptualization embark on a hair-splitting endeavour that does not advance knowledge on moral distress. Defining moral distress in terms of internal or external constraint, or on moral judgement makes it more difficult to understand what purpose the concept serves.

Switching the focus to the function of the concept of moral distress (i.e., what the concept actually refers to concretely within a certain context), makes it possible to escape the original negative view of moral distress that Jameton has perpetuated. This more dynamic point of view, a pragmatic approach, conceives of moral distress as more of a living, malleable concept that can adapt according to its context and according to lived experiences of it.

Pragmatic Philosophical Considerations

This section will address more general pragmatic philosophical considerations. We will address some basic elements of the pragmatic theory of truth or correspondence theory of truth to supplement and frame how the pragmatic approach can help us to arrive at a heightened understanding of a given concept.

Classic pragmatic theories of truth do not look at what make a concept a concept but rather focus on what people do or say when they describe a concept (Capps, 2019). This means they look at the practical use or function of the concept, instead of focusing on arriving at a definition in a classic sense (i.e., the corresponding description for a word in the dictionary). Pragmatic theories of truth consider the practical characteristics of a given concept as essential to understanding that concept (Pierce, 1878). A look to the definitions and characteristics that authors use to describe a concept, as well as concrete illustrations of the concept and ethical justifications make it possible to step back and piece together the function of the concept. This explains, in a sense, the choice of data charting categories (i.e., concrete illustrations, context of application, reported definition and characteristics, function of the concept).

This pragmatic approach moves away from classic definitions, opting instead for a "pragmatic elucidation of truth" that provides "an account of the role the concept plays in practical endeavours" (Misak, 2007). The Instrumentalist Analysis proposed in this research represents a pragmatic approach which aligns itself with the objectives for this project: the function of a concept, which the Instrumentalist Analysis focuses on, identifies the practical difference of using and having that concept (Capps, 2019). Pragmatic theories are not about finding a word or concept that can substitute for truth but that they are, rather, focused on tracing the implications of using this concept in practical contexts. This is what Misak (1998, 2007); calls a "pragmatic elucidation." Noting that it is "pointless" to offer a definition of truth, she concludes that "we ought to attempt to get leverage on the concept, or a fix on it, by exploring its connections with practice" (Misak, 2007). Similarly, this proposed research tries to gain some pull on the concept of moral distress, in both conceptual and empirical terms.

The classic objections of pragmatic theories of truth highlight the fact that such theories "do a poor job if viewed as providing a strict definition of truth" (Capps, 2019). For this precise reason,

the Instrumentalist Analysis does not claim to provide strict definitions of the concepts they study. Rather, it sheds light on the practical uses of the concept. A focus on the concept's practical uses (i.e., its functions) opens up the possibility to observe and draw on any discrepancies between the concept's intended use and how it is understood in practice instead of developing a robust theory of the concept (Rorty, 1998, 2000). This does not necessarily imply that such a discrepancy exists. Both the recurring appearance and effect of the concept over time and throughout research points to the likelihood that some aspects of that concepts are not yet understood. To the extent that some facets of moral distress may not already appear in research, or that some of the richness of the experience of moral distress has not yet been articulated in research, the Instrumentalist Analysis serves a purpose.

One way to unpack the purpose of an Instrumentalist Analysis is to use a "practical starting point" (Hildebrand, 2003). This research adopts a starting point which runs along these same lines. That is to say, the conceptual basis of moral distress comes from Jameton's original definition. This choice befits the analysis based on the fact that much of the research, both empirical and conceptual, uses Jameton's conceptualization as a starting point as well. The proposed research aims to align itself with this baseline understanding of moral distress in order to ensure that it remains consistent with the rest of the literature, at least in terms of its starting point. Adopting a similar baseline understanding of the concept will ensure that the analysis will base itself on a typical understanding of the concept. The Instrumentalist Analysis will, in turn, inject new meaning into the baseline understanding of moral distress (i.e., in terms of ethical justification and consistency with the original conceptualization, etc).

In contrast to this proposal, a non-pragmatic approach to the concept of moral distress can be found in Wocial & Weaver's presentation of the Moral Distress Thermometer (2013). The Moral Distress Thermometer is a visual scale of 11 points, from 0-10, with verbal descriptions, on the perceived level of moral distress that the healthcare professional experiences. Wocial and Weaver (2013) explain that visual and numeric scales like the Moral Distress Thermometer are suitable to measure experiences like moral distress that are "completely subjective; not directly observable, nor constant." This tool quantifies the healthcare professional's perceived amount of moral distress at a given point in time, within a given context, asking them 'Do you have it?' and 'How bad is it?' A brief, rather reductive definition of moral distress is provided on the tool itself, and no further

elaboration on the concept, nor any more qualifying information for the 0-10 verbal descriptions (i.e., additional layers of information such as social, personal, institutional, behavioural impacts that would describe to what the different numerical values might correspond). Further, the Moral Distress Thermometer is not a standalone tool: it needs corroboration from the Moral Distress Scale (Corley et al., 2001) or another more substantial instrument that demonstrates a more comprehensive understanding of that healthcare professional's experience of moral distress. Quantitatively measuring the intensity of a healthcare professional's experience of moral distress decontextualizes that experience from the circumstances that precede and surround it. Given that experiences of moral distress are subjective and linked to their context, ascribing a numerical value to that experience actually makes the concept more difficult to understand.

In opposition with proposals like the Moral Distress Thermometer, the Instrumentalist Analysis approach does not view moral distress as an end in and of itself (Racine et al., 2019). Rather, it is both the end and the means. The concept has to be placed in a larger ethical ecosystem and then recontextualized (Montreuil et al., 2020; Racine et al., 2019). Doing so helps us to stay critical with regards to how the concept is understood and applied. It is necessary to re-contextualise and adopt a more reflective approach on the concept and the functions that emerge from the literature in specific contexts. This allows us to be more reflective as well. Epistemological reflection (i.e., *how we know what we know about moral distress*) that stems from an Instrumentalist Analysis ensures that the focus of the experience remains dynamic and not stuck on its negative psychological effects in nurses, for example.

To further illustrate instrumental analyses, it may prove useful to survey considerations from clinical pragmatism in order to reinforce the link between the concept of moral distress and clinical decision-making (Fins, 1998; Fins et al., 1997; Miller et al., 1997). Clinical pragmatism views moral principles as 'working hypotheses' that serve as guides for resolve morally problematic situations in their context (Fins et al., 1997). Moral principles are not immutable; they must adapt to their evolving contexts. When moral principles no longer "provide satisfactory guidance" for resolving morally problematic situations, they must be reconstructed (Fins et al., 1997). Fixed, permanent and immutable rules do not provide adequate (i.e., reliable and satisfactory) guidance for dynamic and complex problems like those encountered in healthcare. This is because unique, contextually rich scenarios like the morally troubling situations identified

in the literature on moral distress do not correspond well with rigid moral principles. Whereas moral principles are static, morally problematic situations are dynamic and require dynamism, flexibility and adaptability from moral principles for them to be useful (Fins et al., 1997; Racine, 2016; Rangel, 2009).

In this light, the conceptual ambiguity that researchers have associated with moral distress should be interpreted as a signal that the concept should be reconstructed. This particular orientation from clinical pragmatism represents why the conceptualization of moral distress that emerges from the results (in the previous chapter) would benefit from a more dynamic, open approach to the concept in order for it to be identified and addressed meaningfully for healthcare professionals today. Contextually situated ethical reflection (i.e., in the face of a specific moral problem) keeps moral judgement and clinical practice separate, without one taking precedence over the other, and makes ethical reflection possible (Fins et al., 1997). Ethical analysis therefore has to be anchored in specific clinical situations. Clinical thinking must involve some ethical reflection, and clinical practice must be open to change, in light of that ethical reflection (Fins et al., 1997; Miller et al., 1997). Pragmatic approaches to clinical situations apply similar methods of inquiry of clinical problem-solving to moral problem-solving (Miller et al., 1997); (Jansen, 1998). This is because, just like in the clinical world, moral problems emanate from a particular set of circumstances within the context of healthcare (Rangel, 2009).

Limitations and Future Considerations

The challenge of the Instrumentalist Analysis is, in part, to make sense of experiences of moral distress without discounting their validity. The resulting functions of moral distress that were identified may not end up being drastically different (i.e., may not fundamentally challenge or disrupt) from what already appears in the current conceptual and empirical literature. What matters just as much, though, are the ethical justification and the effects and implications of each account of moral distress. These components ultimately influence the function of the concept, so the Instrumentalist Analysis is not a closed-loop endeavour. As the literature continues to develop, more Instrumentalist analyses will need to be carried out again, and compared, contrasted and

placed in dialogue with other analyses. These repeated efforts will act as a litmus test for the added value of the Instrumentalist Analysis on the scope of research on moral distress.

The Instrumentalist Analysis is still more constructive than what exists in the conceptual and empirical research because it is less focused on theoretical or conceptual aspects of moral distress alone. Neither does it try to quantify an experience that is yet misunderstood. Since this kind of analysis is new, it does not yet provide a means to appraise the level of accuracy of the resulting function of the concept. Adopting a pragmatic approach to the concept of moral distress does not, however, guarantee a tangible change in attitudes towards morally troubling situations. Follow-up research that extends the Instrumentalist Analysis into more direct contact with stakeholders coupled with engagement with researchers and stakeholders will help drive that message forward. Until more investigation into pragmatic approaches to moral distress is carried out, research on the concept will remain, in a sense, stagnant.

The scope of this thesis is limited in that it focuses primarily on conceptual or theoretical articles that provide, logically, a more theoretical understanding of moral distress in healthcare. It is true that the addition of more practical texts outlining the clinical-organizational nature of moral distress experiences would provide an enhanced understanding of the concept. Doing so (i.e., using the functional understanding of moral distress resulting from this thesis to make sense of more practical or applied experiences) would account for an altogether logical next step forward in the Instrumentalist Analysis. In an effort to keep the scope of this research more modest, more conceptual or theoretical articles were retained and sought out.

One important consideration remains to be addressed moving forward. Moral distress seems to remain studied between medical professionals and patients (Sanderson et al., 2019). This is a problem, because even within the context of moral distress in end-of-life care, for example, there exists the potential for moral distress between medical professionals, and between medical professionals or patients and the healthcare institution. Even methodological tools like the Moral Distress Thermometer (Wocial & Weaver, 2013) report the importance and effect of expanding the interactions that lead to moral distress in future research. This tool, like others, looks at moral distress in interactions between healthcare providers and their patients. It completely disregards the possibility of moral distress in other interactions, i.e., between professionals (nurse-doctor, between doctors), or between healthcare providers and healthcare institutions. These are key

interactions to consider moving forward, especially where shared decision-making in the clinical context is concerned.

Conclusion

This project set out to understand the functions of the concept of moral distress and has led to what we have attempted to describe as a problematic gap in its understanding, with repercussions on the practice. Without trying to give the reason to any of the methodologies that have so far been used to try and apprehend the concept, we suggested a novel approach. The main objective was to identify the function of the concept of moral distress in empirical and conceptual bioethics literature. To this end, we adapted a methodology that would allow for a systematic sampling and qualitative selection of articles.

The proposed Instrumentalist Analysis revealed many possible interpretations of the concept of moral distress. Hamric et al., (2012) suggests that the case may be so because knowledge on moral distress is often acquired indirectly or through learning from the experiences of others. Those experiences, in turn, get filtered through the methodological and conceptual lenses of the researchers who study them. Subjective and hermeneutical processes go on in this manner such that new meanings or interpretations can be gleaned from the literature. Yet, many researchers cited in the previous chapters claim that the scholarship on moral distress is saturated. A shift in perspective may help the research overcome this stalemate between conceptual ambiguity and the need to accurately define and characterize experiences of moral distress.

One important aspect that stands to benefit from a mindset shift is the burden of conceptual ambiguity associated with the concept of moral distress. This factor alone continues to act as the impetus for more research on moral distress. Healthcare professional should try to understand what makes these experiences so unpleasant. Rather than perceiving of the variety of possible definitions, characteristics and functions of the concept as a sign of ambiguity, this can be reframed more constructively as richness in moral experience. Viewing the multiple characterizations of moral distress as displaying richness serves two purposes: on the one hand, it is a testament to the methodological and conceptual thoroughness of the existing research, and on the other hand speaks

to the depth of the lived experiences of healthcare professionals. In this sense, the richness of the concept of moral distress makes it more of a universal, relatable experience.

The tendency to dissect the definition and characteristics of moral distress presents another aspect that stands to benefit from a mindset shift. For Tigard (2019), the simple fact of identifying moral distress validates its presence. In other words, the mere ability to be aware or perceive of moral distress signals that a person is experiencing it. This stands in opposition with research that categorizes moral distress along highly specific and exclusive sets of definitions and characteristics. These components are certainly significant and pertinent factors to consider at a more hands-on level. Rather than dissecting these aspects of moral distress, identifying it should take precedence over any such details. A more generous conceptualization of moral distress would be more appropriate to that end than would a restrictive understanding (i.e., along the lines of Jameton).

Accordingly, a broader conceptualization of the concept of moral distress must be outlined. Further research efforts to develop understanding of the concept of moral distress must make strides to avoid the problems mentioned above. The proposed Instrumentalist Analysis in this master's project represents a first step of three. A logical continuation of this analysis would involve two additional research activities: (1) function enrichment, which collects the perspective of stakeholders so as to enrich the understanding of the concept's functions identified here and (2) function testing, an observation-based evaluation of the function in a given context (Racine et al., 2019). These follow-up research activities would develop a stronger relationship between the concept of moral distress as it is understood in theory and in practice. It follows that more in-depth Instrumentalist analyses would allow for a stronger link to be established between the definition and characteristics of moral distress in both the conceptual literature and in empirical studies that measure or quantify a healthcare professional's perceived moral distress in practice.

Beyond more research on the function of the concept, awareness is needed in healthcare for the simple purpose of identifying an experience of moral distress firsthand, before attaching a negative or positive value to it. Shifting the focus towards education and awareness does not discount the importance of uncovering the meaning of the concept and its function. Rather, doing so acknowledges that moral distress exists and that healthcare professionals are not immune to it, regardless of the specific characteristics in the literature. Perhaps what is needed most, then, is a

shift in attitude towards moral distress. Ultimately, a renewed attitude towards moral distress will provide healthcare professionals with a sense of validation when they perceive their own moral distress. That validation will, in turn, allow healthcare professionals to move along more confidently in the decision-making process.

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Appendix 1 – Overview of Charted Data

The following table presents the charted data categories for the literature review, organized according to the function of moral distress:

Appendix 1: Functional Analysis of Conceptual and Empirical Literature on Moral Distress

Moral Distress as the Source of a Difficult Decision (n = 11)							
Reference	**Basic Descriptive Data about the article**		**Functional Analysis (Overview)**				
Authors (date)	**Country**	**Affiliation**	**Definition of Moral Distress**	**Characteristics, Meaning and Function (when available)**	**Justifications/Effects and Implications (Overview)**		
					Benefits	**Challenges**	**Results of its application**
Wilkinson (1988)	United States	X	Multi-dimensional distress (emotions, actions, situations, cognition) associated with the quality of patient care.	There are two types of constraints that lead to moral distress: internal constraints (linked to the role of the nurse) and external constraints (having to do with the hospital as an organization). The perception of a constraint is a key factor in the experience and the effect of moral distress. In the context of nursing, the function of the concept of moral distress is to describe the experience and effect of providing a less than ideal quality of care to patients.	Draws a distinction between the experience and the effect of moral distress. Distinguishes between internal and external constraints.	Need a clearer explanation or distinction between experience and effect of moral distress. Unclear how moral situations and moral distress characteristics are distributed amongst experience and effect components: need specific examples in order to make more sense of them.	First research of its kind: multi-faceted analysis of experience and effect in nurses. Discusses moral outrage (briefly at the conceptual level, and with nurses on a practical level) as a consequence of the effect of moral distress. Highlights the importance of ethics training for nurses.
Corley et al (2001)	United States	Hospital	Moral distress happens when factors in the healthcare environment make it difficult or infeasible to take ethically appropriate steps	The function of the concept of moral distress is to identify institutional constraints in a hospital setting that involve the experience of: (1) a disproportionately high amount of individual responsibility (vis-à-vis other health care professionals); (2) acting in ways not consistent with the patient's best interests; (3) being deceptive.	"The instrument is an appropriate measure of moral distress among nurses caring for adults in hospitals; instruments are needed for nurses working in other settings."	"The Moral Distress Scale may have to be modified for other types of work settings - for example, occupational health, nurse practitioners in primary care, and neonatal nurses. However, further testing with a larger sample of nurses is recommended to enhance the instrument's reliability and validity."	"Identifying the nurse's level of moral distress in the work setting that led to [a] resignation would clarify the relationship between moral distress and resignation of a position. The factors identified should guide research on interventions to reduce moral distress."
McCarthy and Deady (2008)	Ireland	Not specified	Moral distress is "an umbrella concept" that points to positive, negative and neutral experiences of moral constraint.	Nurses hold moral values, and moral distress happens when these values are somehow threatened. In the context of nursing, the function of the concept of moral distress is to identify the positive, negative, and neutral emotional and psychological effects of moral constraints.	Stresses the importance of widening the focus of moral distress experiences in nursing.	Asserts that there is a conceptual ambiguity that forces moral distress studies into a self-defeating trap/rut, which needs to be overcome.	X
Hamric et al (2012).	United States	Nursing	A problem that threatens the integrity of healthcare providers and healthcare systems.	Not addressing moral distress leads to a crescendo of moral residue. This has an overall negative psychological, emotional, behavioural effect on healthcare provider's moral integrity The function of the concept of moral distress is to identify a threat to the integrity of healthcare providers, particularly when faced with a constraint.	Ranking of 21 constraints (moral situations) on a 5-pt Likert scale for frequency and intensity. Research cited in the article shows the link between moral distress, ethical climate of healthcare environments and job retention.	Measures moral distress interventions even though it's built to measure frequency and intensity of moral distress.	Builds on Moral Distress Scale (Corley 2001, in this sample) in these ways: (1) Includes more causes of moral distress; (2) Is a shorter questionnaire so is more accessible to healthcare providers; (3) Has a broader relevance: ICU and non-ICU settings & nursing and other healthcare providers

Appendix 1: Functional Analysis of Conceptual and Empirical Literature on Moral Distress (cont'd)

Moral Distress as the Source of a Difficult Decision (n = 11)							
Reference	**Basic Descriptive Data about the article**		**Functional Analysis (Overview)**				
Authors (date)	**Country**	**Affiliation**	**Definition of Moral Distress**	**Characteristics, Meaning and Function (when available)**	**Justifications/Effects and Implications (Overview)**		
					Benefits	**Challenges**	**Results of its application**
Wocial and Weaver (2013)	United States	Nursing; Medical Ethics	When one knows the ethically correct thing to do, but is prevented from acting on that perceived obligation	In the context of nursing, the function of the concept of moral distress is to identify external constraints that act upon what the nurse considers as the ethically right thing to do.	Provides critical care nurses with a way of identifying and communicating their experiences of moral distress. Quantifies/assigns a numerical value to the perceived amount of moral distress at a given point in time, within a given context.	X	"The Moral Distress Thermometer has great potential as a screening tool for use in research, evaluating the effectiveness of interventions designed to decrease a nurse's level of moral distress. It intentionally measures moral distress 'within the past 2 weeks' (acute moral distress). It provides a standard definition of the concept and then asks a respondent 'Do you have it?' and 'How bad is it?'"
Barlem & Ramos (2015)	Brazil	X	Disarming awareness of one's lacking agency while weighing limited actions in a limited environment.	"The construction of the conception of moral distress is based on the assumption that there is an irregularity between what nurses think is the right thing to do and some (inner or outer) restriction that prevent (sic) them from taking the appropriate measures according to their perceptions." It is not always easy to pinpoint moral distress because it is an emotional and therefore subjective experience. The function of the concept of moral distress is to identify the ill-at-ease feeling towards a situation that puts healthcare provider and patient at odds with one another, BUT that can be addressed and resolved through moral deliberation	"In this model, moral distress is highlighted as something positive, since the possibility to visualize everyday problems in their ethical dimension requires of the individuals the ethical-moral competencies that are able to mobilise resistances against the phenomenon of moral distress." Ask not why certain situations lead to moral distress. Rather, ask why nurses don't "ethically resist" the situations that lead to moral distress	X	X
Fourie (2015)	Switzerland	Biomedical Ethics	"A psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both"	The function of the concept is to identify the psychological effects of morally challenging situations in healthcare.	Conceptual literature and empirical studies on moral distress in nursing ethics makes a category error, often confusing conflict for distress. This is because Jameton provides unclear distinctions between conflict, dilemma and distress, which are bound to perpetuate themselves in the literature. Often what researchers measure or explore is conflict, not dilemma, based on Jameton's narrow definition.	X	X

Appendix 1: Functional Analysis of Conceptual and Empirical Literature on Moral Distress (cont'd)

Moral Distress as the Source of a Difficult Decision (n = 11)							
Reference	**Basic Descriptive Data about the article**		**Functional Analysis (Overview)**				
Authors (date)	**Country**	**Affiliation**	**Definition of Moral Distress**	**Characteristics, Meaning and Function (when available)**	**Justifications/Effects and Implications (Overview)**		
					Benefits	**Challenges**	**Results of its application**
Lamiani et al (2015)	Italy	Not specified	"A specific distressing experience" in which internal constraints lead a person to acts against their professional judgment.	Moral distress predictors include lack of support in dealing with difficult patients, lack of respect towards colleagues, lack of involvement in the decision-making process, lack of ethical reflection and debate; poor intra-professional collaboration; lack of support from colleagues, and disappointment when it does happen. The function of the concept of moral distress is to identify the culmination of a variety of workplace-related difficulties.	The results (on the effects and causes of moral distress and other related terms in the workplace) stress the importance of preventive measures such as team collaboration, ethical climate reflections/exercises.	X	X
Dudzinski (2016)	United States	Bioethics	A moral emotion, insofar as it is founded in moral angst or conflict.	Distinguishing features of the experience of moral distress: (1) heightened moral responsibility; (2) directly related to patient well-being; (3) perceived powerlessness; (4) underlying blame; (5) A conflict between a minimum of 2 obligations/responsibilities, minimum 1 being a professional responsibility. The function of the concept of moral distress is to identify the underlying source of moral conflict.	The Moral Distress Map assists clinicians in identifying the precise moral sources of their distress. This is important because moral sources point towards the possible actions that can be taken.	The Moral Distress Map is not a standalone tool: authors suggest the use of another tool (the Moral Distress Scale, for example) to identify appropriate actions.	X
Astbury and Gallagher (2017)	United Kingdom	Medical Sciences	Authors view moral distress as a tension between regulatory demands and the individual provider's moral framework. (Definition cited directly from Nathaniel 2006, "Moral Reckoning in Nursing")	The unique context of pharmacy work poses limits on acting according to one's moral judgment, which leads to enduring negative psychological and behavioural consequences. Major factors in the moral distress of pharmacists include: (1) legislative constraints; (2) challenges to professionalism; (3) commercialism; (4) risk-taking & resilience. In the context of pharmacy, the function of the concept of moral distress is to identify the occupational constraints that pharmacists experience.	Using a moral distress instrument adapted for pharmacists shapes priorities for professional guidelines and provides a basis for guidelines for reducing the frequency and intensity of moral distress	Use of 7-pt Likert scale: frequency never-always; intensity none-overwhelming. The fixed descriptions for each point do not allow for flexibility, especially when responses fall between two values. In this sense, the use of the Likert scale fails in accurately recording or scoring individual experiences.	"The results will be used to develop general strategies to reduce the frequency and intensity of moral distress in pharmacists working for the [public healthcare system in the United Kingdom]."
Fourie (2017)	United States	Philosophy; Bioethics	Moral distress is the combination of "constraint-distress," "uncertainty-distress," and 3 relevant and independent moral values in the healthcare context.	Jameton's definition should be seen as a sub-category of a wider definition of moral distress. Fourie calls his definition "moral-constraint-distress," or simply "constraint-distress." But "constraint-distress" is not the only morally significant form of moral distress. In light of this, Fourie recommends a broader definition of moral distress. This includes the fact that (a) constraint is not a necessary condition of moral distress; (b) moral distress arises from other troubling situations aside from moral constraint. Fourie calls this "moral-uncertainty-distress," or "simply uncertainty-distress."	Fourie acknowledges the fact that patients experience moral distress, and not just medical professionals amongst themselves. These moral values might be able to be adapted to reflect the moral distress that patients experience.	X	X

Appendix 1: Functional Analysis of Conceptual and Empirical Literature on Moral Distress (cont'd)

Moral Distress as the Outcome of a Difficult Decision (n = 8)							
Reference	**Basic Descriptive Data about the article**		**Functional Analysis (Overview)**				
Authors (date)	**Country**	**Affiliation**	**Definition of Moral Distress**	**Characteristics, Meaning and Function (when available)**	**Justifications/Effects and Implications (Overview)**		
					Benefits	**Challenges**	**Results of its application**
Jameton (1984)	United States	X	When institutional constraints get in the way of what the nurse recognizes as the right course of action.	Moral distress has 2 components: (A) Moral knowledge of correct action; (B) Institutional constraints that make it impossible to act on A. The function of moral distress is to identify the negative effects of occupational hazards in nursing.	Articulates a reality affecting nurses in their professional practice (hospital setting).	X	X
Jameton (1993)	United States	Preventive and Social Medicine	X	Moral distress has 2 components: (1) Initial distress: "feelings of frustration, anger, and anxiety" in reaction to institutional constraints and value conflicts with others; (2) Reactive distress: distress from not having acted on initial distress (a buildup of initial distress over time). A central feature to moral distress is inaction or not taking action In the context of nursing, the function of the concept of moral distress is to identify job dissatisfaction and an unfavourable job environment.	The addition of the sub-components of initial and reactive distress allows nurses to further understand the quality of the moral distress that they may experience: (1) They will be able to take the whole scenario into account, not just the underlying ethical principles in the dilemma/distress. (2) This involves weighing the principles against one another and, potentially, finding a resolution to the scenario.	X	X
Sporrong et al (2006)	Sweden	X	Stress related to ethical dilemmas.	Moral dilemmas lead directly to moral distress. Healthcare providers can deal with dilemmas by weighing autonomy, non-maleficence, beneficence and justice against one another (i.e. a principlist approach). Research on moral uncertainty shows that health care providers (1) struggle to identify moral dilemmas and (2) have an insufficient knowledge of ethical principles. In the context of health care professionals, the function of moral distress is to identify the experience of moral dilemmas, even in mundane situations that happen on a normal work day.	(1) Authors claim "good" overall internal validity and consistency for both factors (level of moral distress; tolerance/openness). (2) Focusing on more general moral distress situations in health care makes it possible to compare different settings and professions and make more sweeping statements on levels of moral distress and tolerance/openness. (3) This tool can be used in tandem with other moral distress measurement tools in order to provide valid comparisons between different groups of health care providers. It therefore allows for comparisons to be made between groups of healthcare professionals.	X	Goal: develop an instrument of moral distress measurement that focuses on "everyday ethical dilemmas" for a variety of health settings. Ultimately, this tool would be used to identify workplace settings that are burdened by moral distress.

Appendix 1: Functional Analysis of Conceptual and Empirical Literature on Moral Distress (cont'd)

Moral Distress as the Outcome of a Difficult Decision (n = 8)							
Reference	**Basic Descriptive Data about the article**		**Functional Analysis (Overview)**				
Authors (date)	**Country**	**Affiliation**	**Definition of Moral Distress**	**Characteristics, Meaning and Function (when available)**	**Justifications/Effects and Implications (Overview)**		
					Benefits	**Challenges**	**Results of its application**
Lützén & Kvist (2012)	Switzerland	Psychology	X	Moral distress can be understood in (1) psychological terms as negative emotional and psychological reactions in response to an external constraint which makes that person unable to take action based on their moral knowledge; (2) in physiological terms as an arousal of the sympathetic and parasympathetic nervous systems; (3) in theological terms: conscience is an intellectual faculty that distinguishes between right, wrong, good and bad actions. The function of the concept of moral distress is to identify moral situations that either have negative outcomes or elicit negative reactions from healthcare providers.	Moral stress allows room for positive consequences, i.e. "preventing moral blindness". Authors propose that moral stress and moral distress are two different concepts because they refer to opposing reactions and experiences: moral distress being negative outcomes and moral stress producing positive actions.	Identifies shortcomings in Jameton's research, which according to the authors have not been overcome yet: (1) moral distress definition was initially a hypothesis that was then used as the theoretical basis for research and studies (2) No consideration of a discussion on the relational aspects of moral distress (3) Too much focus on the psychological reactions to external constraints.	X
McCarthy and Gastmans (2015)	Ireland	Nursing	"the psychological-emotional-physiological suffering that nurses experience when, constrained by circumstances, they participate in perceived wrongdoing by action or omission."	The normative meaning of moral distress involves: (1) Making a moral judgment; (2) Personal and professional identity and integrity; (3) A range of moral competencies; (4) The scope of moral responsibility of a nurse In the context of nursing, the function of the concept of moral distress is to describe the suffering that happens when healthcare professionals act contrary to their deeply held "ethical values, principles or commitments."	Surveys and synthesizes a wide variety of argument-based literature on moral distress in healthcare.	X	X
Thomas and McCullough (2015)	United States	Medicine	Ethically significant moral distress (ESMD) is the intellectual experience of making a judgment that leaves a person unable to act on their moral knowledge.	ESMD weakens, threatens or violates one's capacity to act with integrity, on either an individual or professional level. Individual integrity refers to the moral character of the health care professional in general. Professional integrity refers to the professional character of the health care professional. In the context of healthcare, the function of the concept of moral distress is to describe the intellectual experience of making a judgment involving a certain degree of compromise that undermines either individual or professional integrity.	Raises the idea that moral distress or ESMD should be categorized along a "continuum of ethical significance," from situations that are concerning, to dangerous to corrosive.	X	X

Appendix 1: Functional Analysis of Conceptual and Empirical Literature on Moral Distress (cont'd)

Moral Distress as the Outcome of a Difficult Decision (n = 8)							
Reference	**Basic Descriptive Data about the article**		**Functional Analysis (Overview)**				
Authors (date)	**Country**	**Affiliation**	**Definition of Moral Distress**	**Characteristics, Meaning and Function (when available)**	**Justifications/Effects and Implications (Overview)**		
					Benefits	**Challenges**	**Results of its application**
Tigard (2019)	Germany	X	X	Emotional responses to given situations provide important clues/insights as to what and how we care about. If we do not experience outrage when people or things are harmed, it indicates that we do not care. The experience of emotional discomfort makes us appreciate psychological equilibrium/positive emotional responses more. Each moral distress experience presents an opportunity for us to understand ourselves better. The function of the concept of moral distress is to describe an opportunity for "moral maturity," where an enhanced awareness of one's deeply held personal values, and personal identity are revealed.	Focuses on moral distress between patients and healthcare professionals.	X	X
Sanderson et al (2019)	Australia	Health	"Ethical unease or disquiet resulting from a situation where a clinician believes they are contributing to avoidable patient or community harm through their involvement in an action, inaction or decision that conflicts with their own values."	The function of the concept of moral distress is to identify the moral responsibility that medical professionals have towards their patients and medical community (in particular when medical professionals perceive a potential for harm).	Novel use of a quality appraisal tool for moral distress literature reviewed in sample. No evidence of a similar type of approach used in other more empirical approaches to conceptul moral distress literature in this sample of articles.	X	X

Appendix 1: Functional Analysis of Conceptual and Empirical Literature on Moral Distress (cont'd)

No Function Detected (n = 6)							
Reference	**Basic Descriptive Data about the article**		**Functional Analysis (Overview)**				
Authors (date)	**Country**	**Affiliation**	**Definition of Moral Distress**	**Characteristics, Meaning and Function (when available)**	**Justifications/Effects and Implications (Overview)**		
					Benefits	**Challenges**	**Results of its application**
Sporrong et al (2004)	Sweden	Public Health	"traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the health care provider feels she/he is not able to preserve all interests and values at stake."	X	Tallies concrete moral distress situations derived from interviews with healthcare providers.	X	X
Varcoe et al (2012)	Canada	Nursing	A negative experience which leaves the moral agent feeling compromised in their workplace environment.	Moral distress has these features : (1) Relational concept; (2) Involves a serious moral compromise; (3) A solitary or communal experience for any person working in a health care organization; (4) layered and complex; (5) emotional, psychological and/or physical manifestations; (6) Time-sensitive, as it may lead to moral residue; (7) Often originates in broader systemic organizational practices and routines.	Stresses the importance of understanding the sociopolitical context of moral distress situations.	X	X
Campbell et al (2016)	United States	X	Negative self-directed emotions resulting from one's perceived participation in a morally undesirable situation.	Three main characteristics of moral distress and morally distressing situations: (1) Negative self-directed attitude – bad feelings directed at oneself (i.e. guilt, shame, rumination) (2) Perceived involvement – level of action or inaction in a situation (3) Perceived moral undesirability – level of agreement or disagreement re actual vs ideal outcome	Claims that a new, broader definition and taxonomy of moral distress will support more inclusive research: "different responses for different situations." With the 6 moral scenarios in mind, healthcare providers can better articulate their experiences of moral distress. Moral distress doesn't only refer to overwhelmingly negative situations: "mild forms of negative emotions" also supported in this approach.	X	X

Appendix 1: Functional Analysis of Conceptual and Empirical Literature on Moral Distress (cont'd)

No Function Detected (n = 6)							
Reference	**Basic Descriptive Data about the article**		**Functional Analysis (Overview)**				
Authors (date)	**Country**	**Affiliation**	**Definition of Moral Distress**	**Characteristics, Meaning and Function (when available)**	**Justifications/Effects and Implications (Overview)**		
					Benefits	**Challenges**	**Results of its application**
Morley et al (2017)	United Kingdom	Social and Community Medicine	Moral distress is (1) the experience of a moral event that leads to or causes (2) the experience of psychological distress	The following were discussed as conditions of moral distress definitions: Constraint is a sufficient condition for definition; Moral integrity is ambiguous so it can't be a sufficient component of the definition. The use of the term moral judgements was not uniform throughout the sample, making it more difficult for the authors to understand what moral distress refers to in the first place. Lack of agreement on its significance makes it neither a necessary nor a sufficient condition. "Moral uncertainty and experiencing dilemmas" are sufficient conditions for moral distress definitions.	Consolidates the features of 34 articles that discuss the definition of moral distress to some extent; compares the components of moral distress definitions amongst the sample in order to make sense of a meaningful definition of moral distress.	X	X
McCarthy and Monteverde (2018)	Ireland	Nursing; Medicine	Negative emotional responses to (1) clinical scenarios involving a loss of moral integrity; (2) work environments that decrease one's perceived level of moral agency.	The clinical context/environment gives rise to moral distress. Internal or external constraints motivate or discourage "morally appropriate actions."	The authors make claims and provide distinctions which are either implicit or not directly mentioned in previous literature: (1) Keep moral distress definition narrow (i.e. context-specific) in order to make it more measurable/possible to mitigate. If moral distress is too broadly defined, that will complicate the process of making a decision or coming to a solution. (2) Moral uncertainty and moral dilemmas are stressful but manifest themselves differently than moral distress and thus require their own adapted practical tools and approaches.	X	X
Tigard (2018)	United States	Philosophy	Moral distress results from varied obstacles, and circumstances that do not necessarily involve the presence of an obstacle.	4 characteristics of moral distress: (1) involves causal circumstances; (2) the person experiencing it has certain paradigmatic features; (3) development over time (reasons for subsidence, dissipation, persistence); (4) involves a commitment to a moral norm to a varying extent.	Calls to question the added value of moral distress scholarship since Jameton (especially research that claims to reframe Jameton's account). Provides detailed reasons or explanations why Jameton 1984/1993, Wilkinson 1988 and Corley 2001 fall short of enriching the literature. Offers a checklist of moral distress characteristics for researchers. Together they consist of meaningful contributions to the existing literature. Justifies the choice of the characteristics with reference to Jameton, Wilkinson and Corley ('standard' accounts of moral distress) through the use of concrete examples.	X	X