

Moral Distress and Constraints (Tied Together)

Abstract

Moral distress was (on one prominent reading) originally proposed as a phenomenon wherein nurses knew the right thing to do but were constrained from doing it. Since then, the concept has evolved to include a broader array of phenomena, notably including those where the nurse does not know the right thing to do. In this article I argue that this purported evolution has actually been a step in the wrong direction, and that we would do well to return to (one reading of) the original understanding of the concept. There are both negative and positive reasons for this return. The negative reason is that the original arguments in favor of broadening the concept were undermotivated. The more practical reason is that removing the centrality of institutional barriers to the concept of **moral distress** also shifts the onus of ameliorating that distress away from the institution. Concepts have power, and how we think about a problem shapes what solutions we are likely to consider.

What is original about this work?

This work brings novel counterarguments against the expansion of moral distress to include cases such as those of moral indecision. I also articulate how (one reading of) the more traditional definition is not susceptible to dangerous educational practices relating to empowerment and distress transference.

What impact is the work likely to have on care practice, leadership, research and/or education?

I believe this work has the potential to change how people think and teach about moral distress. This can effect positive change in practice, as people return to focusing on institutional constraints rather than sending the message that nurses need to adjust their internal states. Despite being (on one reading) an older view, I argue that it is consistent with more recent insights on the importance of moral resiliency. I also hope it will redirect much of the conceptual research on moral distress generally—both theoretical and empirical.

Keywords:

Moral Distress, Moral Dilemmas, Conceptual Analysis, Constraint Distress, Uncertainty Distress, Philosophy of Science

Introduction

A nurse working overnight at the hospital is only two hours into his shift, but he is already behind schedule. His unit is short-staffed tonight, with no aides on the floor and several call lights blinking around the hall. The patient in room sixteen is post-op and asking for already overdue pain medication. The patient in room twelve is feeling short of breath. The patient in room eight just can't get comfortable in her bed. The patient in room nine's daughter just arrived and requested an update. The nurse knows how to help each patient, but he does not have enough time to provide good care. He also knows that—at least on some idealized level—he *should* be providing more time to each patient. However, he simply cannot do so. The nurse in this situation is suffering on multiple levels. He is

overtaxed, psychologically spent, and perhaps feeling guilty. However, it has also been suggested that, in such cases, there is potentially another *sui generis* harm he is experiencing specifically as a product of knowing the right action but being prevented from taking it. This harm has traditionally been identified as moral distress. While there is much agreement regarding the existence of this harm, there has been a perhaps surprising degree of dissonance regarding what precisely the harm amounts to and how to limn the concept of **moral distress**¹ that picks it out from among the menagerie of other harms a nurse might experience. I will argue presently that even when there are other morally relevant issues at play, the **moral distress** will generally be a distinct feature.

Moral distress was (on one reading to be discussed) originally defined as an emotional, physical, and psychological discomfort that occurs when an individual knows the ethically correct action but is prevented from doing so by external barriers (1, p. 6). However, the question has since been raised whether that is all that there is to moral distress, or whether a better understanding of the concept should include a broader array of cases.

Consider the following scenarios:

Scenario A:

¹ I use bold terms to denote concept names; while this paper is mostly conceptual exploration, at some points it makes sense to refer to the phenomenon itself.

A nurse is working in an emergency department and is treating several victims of a motor vehicle accident. They are preparing a mother in critical condition for emergency surgery while she repeatedly asks them about the condition of her daughter. They have been informed that her daughter was killed in the crash, and they must decide how to respond to the mother. They cannot decide whether veracity and autonomy override the clear and present danger her being agitated before emergency surgery could cause.

Scenario B:

A nurse in an intensive care unit is treating an elderly man with a terminal prognosis and intense pain. They are an experienced employee who has seen similar cases, and they know it is time to stop aggressive measures and transition to palliative care. The patient's spouse, who has power of attorney, insists on trying aggressive measures.

In the first scenario, the nurse is unsure what the correct action to take is, and an ethical argument could be made for any of multiple decisions. Scenario B is an example of the what some (2) have taken to be the original definition of **moral distress**. The nurse knows the right action is to institute comfort measures, but they are unable to act on this due to an external constraint (specifically, the legal constraints that result from the power of attorney disagreeing).

To be clear, this is not an exegetical paper. I am not committed to the claim that this is in fact the “original” definition as presented in its first appearance (1) or a version created subsequently by Jameton interpreters—a matter to which I will return presently, but which is not of central importance. The major thesis of this paper is the normative claim that this understanding of **moral distress**—wherever and whenever it might be from—should be taken seriously as a worthwhile articulation of the **moral distress** concept.

Recently, this definition of moral distress has faced scrutiny. It has been proposed that the definition should be expanded to include the sort of dilemmas shown in Scenario A (i.e., a situation where an individual feels discomfort but does not know the correct action to take). Swimming somewhat against the tide, in this article I argue that this purported evolution has actually been a step in the wrong direction, and that we would do well to return to (one reading of) the original understanding of the concept. There are both negative and positive reasons for this return. The negative reason is that the original arguments in favor of broadening the concept were undermotivated. The positive reason is that removing the centrality of institutional barriers to the concept of **moral distress** also shifts the onus of ameliorating that distress away from the institution. Concepts have power, and how we think about a problem shapes what solutions we are likely to consider.

The Evolution of Moral Distress

The original characterization of moral distress was that “...moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (1, p. 6). There is some dispute over whether on Jameton’s account that which arises (the moral distress itself) is a psychological state (as it is read by Corley(3)) or rather an ethically fraught situation itself that could (but might not) induce such a psychological state (as it is read by Paley(4)). Corley grounds her reading in the terminology itself, whereas Paley grounds his in some elements of the surrounding context. This paper is not an attempt at Jameton exegesis, so we need not commit to which reading is correct. The view I will be defending is the normative claim that the best way to understand **moral distress** is as picking out the psychological state where one knows the right thing to do but is prevented from doing it. I take this to be the view of Jameton as defined by Corley (and thus henceforth refer to it as “JDC”)—whether this view is properly attributed to Jameton, Corley, or someone else is somewhat beside the point.²

Moral distress initially was taken to focus on clinical decision-making and a feeling of powerlessness in nursing staff. Since then, the concept has expanded to include a

² One philosophical precedent for the approach of producing what one takes to be a good reading of a classic text without knowing where that reading originated is Kripke’s rendition of Wittgenstein on rule following (5); since it was unclear whether either Wittgenstein or Kripke was committed to the account presented, philosophers have taken to calling it “Kripkenstein”.

variety of professions where moral judgment is constrained, such as physicians, social workers, and military personnel (6).

In the past two decades, debate has continued regarding what causes moral distress and how moral distress affects those experiencing it (7). A cumulative review of studies evaluating moral distress found that the top reported causes of moral distress in healthcare workers included end-of-life decisions and futile care, a disconnect between an organization's efficiency and quality of care, and staffing issues (8).

We see an example of moral distress in end-of-life decision-making in Scenario B above, showing a situation that healthcare workers face regularly. Arends et al (9) give an account of interviews with a group of intensive care nurses who reported experiencing moral distress at work; the main themes from these interviews were a sense of powerlessness due to feeling unheard or overruled, as well as feelings of frustration from their values not being reflected in the decision for the treatment. These themes reflect the JDC interpretation; the nurses' moral knowledge is not being represented in treatment decisions due to external constraints.

The putative advance on the traditional definition most relevant for present purposes is Fourie's contention that ethically difficult demands should be included in the definition of **moral distress** (10), even in the absence of constraints. She frames this as a response to Jameton, seeming to assume Corley's interpretation.³ The central argument is

³ While Paley (4) contends that this is the best reading of Jameton's original work, he seems to acknowledge that it would come as a surprise to most people in the interim.

that the conceptual separation of **ethical dilemma** and **moral distress** is unhelpful at best and foundationally confused at worst. Fourie proposes that moral distress should be defined more broadly as a “psychological response to morally challenging situations such as those of moral constraints of moral conflict, or both” (p. 91). In this sense, **moral distress** would be used as an umbrella concept, encompassing both what Fourie labels “constraint distress” and “uncertainty distress” (p. 92). Returning to our original scenarios, Scenario B was presented as an example of moral distress and Scenario A as a dilemma. Fourie argues that both are examples of **moral distress**, one due to a constraint and one not, but both united in having a negative impact on the individual.

Fourie also points out that it is difficult to pull apart these two kinds of moral discomfort. She writes, “although Jameton does not state this explicitly, he seems to be claiming that situations of moral distress and moral dilemma are mutually exclusive.” (p. 92) Let us consider scenario B from above using the viewpoint of Fourie’s article. The original definition (per Fourie) categorizes this scenario as an instance of constraint rather than dilemma. The nurse knows his patient should not have aggressive treatment, but he must administer the care anyway. Fourie argues that the nurse here may be experiencing some level of uncertainty distress along with constraint distress, which would not fall under Fourie’s reading of Jameton’s original implied stipulation of mutual exclusivity (10).⁴ With this in mind, her revised definition for moral distress is as follows:

⁴ There might be a bit of bookkeeping required in determining whose version of **moral distress** is being responded to at which point. In this case, since the response is aimed at Fourie, the target is her

Moral distress is a psychological response to morally challenging situations such as those of moral constraint or moral conflict, or both. (p. 97)

We will expand further on her claims concerning the mutual exclusivity of constraint and uncertainty distress later in this paper.

There are other accounts of **moral distress**. In one prominent review, Morley et al (7) define **moral distress** by saying that “the combination of (1) the experience of a moral event, (2) the experience of ‘psychological distress’ and (3) a direct causal relation between (1) and (2) necessary and sufficient conditions for MD” (660). Saying that moral distress can encompass any psychological distress that is caused by a moral event seems to have reached a very inclusive expansion of the original definition. VanderWeele et al (11) cite generalization as an explicit advantage of more recent definitions.⁵ However, it is not immediately clear why generalization per se should be considered a good thing, much less what the limits of that generalization should be.

Let us take stock. While there are innumerable axes of variation for accounts of **moral distress**, we have focused primarily on two—whether or not it should involve a psychological state or the situation that precipitates it, and whether or not it should require

interpretation of Jameton. Thankfully Fourie’s reading seems to be the same as my normative account which, as far as I can tell, is effectively the same as Corley’s interpretation of Jameton.

⁵ This work is better known for its treatment of **moral injury**, which is the prolonged effect of moral distress. Whether their definition of moral distress is necessary to maintain their account of moral injury is a question to be pursued elsewhere; since it is certainly possible that one state (moral injury) could be caused by different kinds of things this does not prejudice the question of the proper extent of **moral distress**.

a constraint rather than other causes of moral consternation. The resulting space looks like this:

	Does not Require Constraints	Requires Constraints
Psychological State	Fourie	Corley's Jameton
Situation	Possibly unoccupied?	Paley's Jameton

The columns are clearly mutually exclusive and exhaustive. Since the major question of this paper will be the decision between columns, the properties of the rows are less important. That said, while they are likely mutually exclusive (while psychological states can be components of situations, it would be odd to claim that they were situations themselves), they are certainly not exhaustive—it is an open possibility that there is still a more nuanced state that composes moral distress yet to be proposed. The table is not supposed to argue for the viability of any particular position, but rather simply to map out conceptual space.

The argument here is that taking a leftward step from the upper right corner is a mistake. The main contention is that arguments Fourie (10) makes for moving from the right column to the left—presented explicitly by Fourie and evaluated here as philosophical conceptual analysis—are somewhat flawed.

Against Arguments for Removing Constraints

The move to abandon the requirement that **moral distress** only refer to distress caused by the knowing the right thing but being constrained generally trace their citations back to Fourie’s seminal 2015 paper (10). Fourie explicitly invokes the language of philosophical analysis (p. 92), a methodology that has largely fallen out of favor but with which I have a great deal of sympathy. As such, her arguments are open to philosophical dissection, analysis, and rejection, which is precisely what I aim to do.

By my count, Fourie makes three separate arguments against the original JDC. It is possible of course that there are points in the article intended to be independent that I have missed, but I will at least have taken the burden to be shifted to those that claim a sound argument can be reformulated that does not fall prey to the objections raised to the three found.

Fourie’s First Argument: JDC’s Examples Involve Moral Conflict

One of Fourie’s arguments is that Jameton’s own example that purports to show that the experience of moral distress is different from the experience of a moral dilemma is confusing because it also involves a dilemma. This argument fails in several ways, some of which yield philosophical insight into the nature of **moral distress**.

At this point it makes sense to quote in full Jameton's original case and Fourie's response to it, as both will figure into all three of Fourie's arguments.

Here then is Jameton's original case, as cited in Fourie (10):

Overtreatment (Moral distress): In this case, a severely ill infant is in neonatal intensive care 'and has poor prospects for a normal life . . . [and] is most likely to be severely retarded, bedridden and in chronic pain.' In some similar cases, infants have been taken off the respirator and allowed to die. However, in this case the parents 'do not seem to understand the situation' and the physicians pursue aggressive treatment. The nurse has to perform treatments which are very painful to the infant, and which he would not perform if it were up to him. Jameton maintains that this is a case of moral distress and not moral dilemma, because the nurse has made a moral judgement – these painful treatments should not be performed. (p. 92)

Here in turn is Fourie's response to the case (10):

Consider that in this case it seems feasible that the physicians or parents, or both groups, believe that pursuing treatment and trying to keep the infant alive is the morally correct action. Or perhaps they are not sure which action is morally correct but see value in keeping the infant alive. Or perhaps they are conflicted between moral values – keeping the child alive on the one hand, and reducing its suffering,

on the other. If any of these claims are true, then it seems we could have a case of moral conflict. (p. 94)

Fourie believes that the presence of moral conflict undermines the notion that distress is always a result of constraints because “It would be inaccurate to say that the nurse is unable to perform what he regards to be the morally correct action *merely* because of a co-worker or an institutional barrier (such as the hierarchy in place which stipulates that it is the physician who makes final decisions about treatment).” (p. 95, emphasis in original.)

Here is my best reconstruction of a valid version of Fourie’s argument:

P₁) If there is moral conflict in a situation, the inability of a nurse to perform the correct action is not merely due to institutional constraints.

P₂) If the inability to perform the correct action is not merely due to institutional constraints, then the example is not one that meets JDC’s criteria of moral distress.

P₃) If the example is not one that meets JDC’s criteria of moral distress, then JDC’s account of moral distress is inadequate.

P₄) There is moral conflict in the “Overtreatment” scenario presented in JDC.

C) JDC’s account of moral distress is inadequate.

There are three problems with this argument, specifically in that—while P₁ seems acceptable—P₂, P₃, and P₄ are all false.

P_3 is the most obviously problematic. Even if one were to grant that the example has moral conflict (P_4), and further grant that the presence of moral conflict undermines whether a case is one of moral distress (P_2), one bad example does not a theory unmake. Unless it is impossible for there to be examples of JDC moral distress that lack moral conflict, no inconsistency (or even inconvenience) has been demonstrated. Fourie acknowledges this possibility on p. 95, but argues that confusion in the literature somehow indicates that the examples were the best that could be chosen after all. I do not follow the reasoning between subsequent disagreement and the impossibility of finding examples, so we will turn to issues with other premises.

To the question of whether they were incautiously chosen examples, it is not clear that they are; P_4 is at least potentially false on a reading Fourie herself presents to us. Note that in Fourie's own articulation she acknowledges that this (only) *could* be a case where moral conflict is present. She draws attention to this modal operator in fn. 12, where she says that if the other parties are acting from clearly unethical motives, then there is no case of moral conflict. However, that further concedes that there *is* a reading of the case which meets JDC's criteria of **moral distress**, which proves that it is *possible* for there to be such cases. Fourie thus actually constructs a case in fn. 12 which would not be possible to construct if JDC were inherently inconsistent or even confused.

One might still maintain that even if JDC's account is not inconsistent or even confused, it at least does not apply as broadly as is thought, based on its failure to be applicable on the more standard reading of Overtreatment. This brings us to the most

subtle but the most important issue with this argument, which is that P_2 is false as well.

JDC's account does not demand that the *only* causal factor involved be institutional constraints, as that would clearly be absurd. Every phenomenon, event, and experience has an innumerable web of causal factors, up to and including the Big Bang. Even if this is a case where moral conflict was involved somewhere along the way, that does not mean that the moral conflict is what is preventing the nurse's action at the point of moral distress.

The point can be made clearer with an articulation of where different barriers appear in the causal nexus of an event such as Jameton's example of moral distress. What JDC requires is that institutional barriers rather than moral conflicts be at least partially constitutive of the phenomenon, which Overtreatment bears out. Fourie's argument does not just fail to demonstrate that moral conflict is constitutive of the phenomenon, but it does not even show that it is the proximate⁶ cause. Instead, all that has been argued is that moral conflict exists as a distal cause somewhere on the chain, which says nothing about the nature of the phenomenon. This is not the place to spell out a full theory of the relation between causes and conceptual content, but it has been established for some time that even fairly reliable causes do not gain immediate entry into the content of the concepts they lead to—otherwise one gets strange results such as misrepresentation becoming

⁶ I will note below that it is not clear causes determine content at all; however, even if they did, presumably not all distal causes could do so (for fear of the Big Bang objection).

impossible, and blows to the head that reliably cause the same hallucination of dogs becoming part of the meaning of **dog** (12).

Aside from the general point that moral conflict can cause moral distress without necessarily being part of the content of **moral distress**, it is also worth flagging that in Fourie's case there is a potential equivocation regarding what it means for there to be moral conflict present. Notice that Fourie cites views that diverge from the nurse's as held by the "physicians or parents", which points to a manner of interpersonal conflict. Internal conflict of the sort traditionally associated with dilemmas is nowhere to be found even on Fourie's own objection.

Fourie's Second Argument: Equivocation on "Moral Dilemma"

At one point Fourie questions whether Jameton's distinction between **moral distress** and **moral dilemma** can be maintained once she points out that it is not even clear whether JDC has in mind what philosophers call "genuine dilemmas" as opposed to "moral conflict". A case is a genuine dilemma when there is literally no resolution whereby one can avoid any impermissible behavior. (This situation could be referred to colloquially—and even, on some religious views, quite literally—as "damned if you do, damned if you don't.") Fourie characterizes moral conflicts as situations where there appear to be *prima facie* clashing principles, but where there is an all-considered morally permissible action. The allegation is then made that Jameton's distinction between moral distress and moral

dilemma equivocates between these two notions of the philosophers' genuine dilemmas and the more common cases of moral conflict.

When one accuses an author of equivocation, there are two possible (potentially complementary) charges being levied—one could be arguing that the exposition is unclear, or one could be arguing that regardless of what is actually said that there is no unequivocal reading that makes the argument valid. Since my goal is the normative construction and defense of the JDC view, the question of the clarity of Jameton's exposition is not of immediate concern. I argue instead that the arguments supporting JDC can be rendered valid in terms of a single reading of the operative terms. Specifically, everything he says in defense of the distinction between constraint and uncertainty can be understood in terms of what Fourie calls "moral conflict" without needing to consider genuine philosophers' dilemmas. The principle of charity likely dictates that if this is the best interpretation (as I will argue below) then it is the one we should utilize, but that is a separate point.

Fourie first argues that JDC cannot really mean a philosopher's dilemma, as the ultimate impossibility of the situation is no part of his explicit characterization of dilemmas, nor his choice of examples. As noted, I agree that JDC is not best understood as commenting on philosophers' dilemmas at all. For one thing, some philosophers deny their very existence (13) and—even if they are real—one would have no epistemic access to whether or not one was in one. If we can make sense of Jameton's arguments without invoking genuine dilemmas, that would be for the best.

However, no harm is done to JDC's position by saying that the distinction is best understood as between moral distress on the one hand and (mere) moral conflict on the other. Fourie cites two reasons for the supposed tension introduced by a shift from dilemma-talk to conflict-talk. The first is that JDC says that moral conflict and moral distress are supposed to be mutually exclusive, and the second is that all of JDC's cases of moral distress also involve moral conflict. Our answer to both points is the same, which is that while JDC holds that a particular experience cannot be one of both distress and conflict, that does not entail that the two cannot occur in the same example at different times and in different characters. Fourie continually points to the conflict involved in deciding what to do for a patient in "Overtreatment", but this is irrelevant to the content of the nurse's moral distress. Other people—e.g., the physician—engaged in conflict at other times. That says nothing about the content of the nurse's experience right now, which is, indeed, incompatible with *his* having moral conflict *now*. The reason is exactly the one to which JDC points—if he did not know what to do, that would be a very different experience from having his moral integrity thwarted.

There is a recurring theme to Fourie's concerns, to the effect that the presence of moral conflict in particular scenarios allegedly undermines the claim that moral conflict and moral distress are mutually exclusive. However, lots of mutually exclusive things can appear in the same scenario—any scenario where a patient dies invokes concepts of both "alive" and "dead", but that should not be taken to undermine their mutual exclusivity. This is particularly true when one of the things is incidental to the scenario, such that we can imagine cases with one but not the other. For example, we can readily imagine cases

where a nurse's moral distress is caused by a rigid hospital policy that no one would have supported had they foreseen this particular context—here there is no moral conflict, but there might well be moral distress.

One could argue that the finer-grained deconstruction of Overtreatment into earlier moral conflict and later moral distress is ad hoc, and that we should accept at face value that the moral conflict and moral distress are inherently intertwined in this case. That would, however, be an unjustified move at this stage in the dialectic. On the JDC account of **moral distress**, moral distress and moral conflict will be separable in any imagined case. Requests to consider cases where they cannot be torn apart would be like a response to a theory of justice as fairness that asks one to consider an unspecified hypothetical case where something unfair is happening that is nevertheless just—on the account under consideration there will be no such cases. This is a feature of JDC rather than a bug, as it builds some measure of falsifiability into the account. If one can find an example where the content of the moral distress indisputably includes moral conflict, then JDC cannot be capturing what **moral distress** really is.

Moral Distress and Etiology

The final argument one might take away from Fourie is that it is generally a mistake to conflate a psychological state with its cause. How one feels when one experiences moral distress is independent of what causes it, and therefore the cause cannot be part of what constitutes the moral distress itself.

If this argument is in fact being made, it is clearly at odds with perfectly legitimate common practice. Psychological states are frequently fixed not just by their phenomenological content, but by their etiology as well. To take a clear example, one cannot have Post-Traumatic Stress Disorder (PTSD) if one is not post-trauma. Even if one were to somehow get into a qualitatively identical state, it would simply be wrong to call it PTSD. Common practice here seems quite sensible—whether or not one has actually experienced trauma could be very relevant to the state one is in, even if it feels identical to some other state. This is not to claim that all psychological states are characterized etiologically; generalized anxiety is generalized anxiety regardless of what (if anything?) its causes are (at any level of causation). However, the example of PTSD does show that it is not in any way indicative of a mistake to include etiological components as necessary constituents of psychological states.

This does not argue in favor of including any particular cause in the content of **moral distress**, but shifts the burden against the argument that doing so would be fundamentally confused. Even with this burden shift, the operative question becomes what concept of **moral distress** we should employ.

Positive Advantage of JDC

So far, I have argued that the reasons for altering the JDC definition of moral distress are not properly motivated. One might consider the situation a draw, and argue that there is no reason to favor one characterization over the other. How should we decide?

There are many possible desiderata when engaging in a project of concept choice, though none is wholly uncontroversial.⁷ Sally Haslanger (18), in addressing the high-stakes and (at least philosophically) disputed concepts of **race** and **gender**, discusses several ways one might answer “questions of the form, ‘What is X?’” (p. 32). The main two approaches she highlights are⁸:

- 1) The naturalistic approach of determining what (natural?)⁹ kind our concept term tracks (Plato’s (20) famed carving of nature at its joints, 265e), and
- 2) The practical approach of figuring out what the concept is for and what its content would need to be to fulfill that function well.

Putting aside a host of metatheoretical issues (see fn. 7), these seem to be the two most operative questions—what (if anything) is there in the world that can answer to the concept **moral distress**, and what sort of concept do we want **moral distress** to be?

The naturalistic question exists at the crossroads of empirical work and philosophy of science. I have argued elsewhere¹⁰ that our best theories of kinds (e.g., homeostatic property clusters) support an ontological difference between cases with and without

⁷ Carnap famously gave criteria for explicating a concept, but they typically involve re-engineering a folk or settled previous concept (14); they are less explicitly useful in the early stages of concept development, though many of their guiding lights can still apply. Burgess & Plunkett (15) argue that this project is vital to philosophy, with Plunkett (16) going on to say that much of philosophy occurs in this process of metalinguistic determination of how concepts should be used. However, in neither location can be found an account of the reasons that should be employed to adjudicate such a debate. Queloz (17) argues that reasons for employing some concepts over others is needs-based, but as his project is primarily geared towards solving a metatheoretical problem with the authority of concepts it does not really answer the ground-level normative question of how to choose between them either.

⁸ She also mentions an *a priori* approach, but it does not apply well to this case.

⁹ Khalidi (19) makes a fascinating observation here that the term “natural kind” seems to have originated in Venn misquoting Mill on “kinds”, which has potentially biased philosophers against cognitive and psychological kinds ever since.

¹⁰ Currently only in presentation form, though in development for publication.

external constraints, both based on differences in their causes (as built into the definitions) and in at least some of their crucial effects (as different sorts of solutions would make sense for the two cases). For purposes of nursing ethics (and *Nursing Ethics*), the question of practical needs is, however, likely more salient.

What then is the end at which we can or should aim by having a concept of **moral distress**, and what construction of **moral distress** would serve that end best? At least within the context of nursing, one possible answer would be to pick out the problem nurses actually have. However, no one is disputing the claim that nurses struggle both with dilemmas and with constraints. The dispute is regarding whether those are the same *kind* of struggle; the kindhood question, however, returns us to the ontological inquiry already briefly discussed above. An alternative possible end would be to group situations in such a way so as to maximize our ability to ameliorate those struggles.

This brings us to the crux of the matter, which is what version of the concept of **moral distress** would be the most helpful? (Pragmatists might well wonder why we did not just skip to this question at the start.) I argue that a concept that keeps distinct dilemmas from constraints is more likely to ameliorate nurses' struggles for a number of reasons. These reasons are admittedly speculative; if a randomized controlled trial could be done wherein one society used one moral distress concept and a different society of randomly chosen individuals used another, it could turn out as a matter of fact that I am wrong about which would be more helpful. In the absence of the availability of such an experiment though, we can still try to think through what would be likely to be of help.

If dilemmas and constraints require largely different remedies, then it would be helpful to keep them conceptually separate. There is certainly overlap, as both are forms of psychological stress that might benefit from mental health treatment (21). There is however a straightforward practical difference with respect to how best to handle suffering caused by dilemmas versus suffering caused by constraints, in that the former can be ameliorated by increasing confidence in ethical reasoning whereas in the latter case there would be a very good chance that increasing confidence would make matters worse.

When one is wracked by uncertainty, gaining confidence in the correct answer can be helpful. If I am torn with respect to which car to buy and then some decisive piece of evidence arrives that favors one over the other, that comes as a relief. It's a simple point, but if the problem is that I do not know what I should do, then coming to know what I should do eliminates at least one very important aspect of the problem. This is, perhaps, one important role of education in normative ethics, and one role (among many) of ethics committees. By contrast, if the problem is generated by the fact that I already know what to do, then reinforcement of that belief will have no positive effect. Butler et al (21) explicitly deny a role for ethicists in alleviating moral distress for reasons broadly along these lines, and Prentice et al (22) even tout the benefits of belief in moral subjectivism (which, presumably, would at a minimum lower one's credence that one has *the* correct answer). I would not go so far as to agree with the possible implication that trying to decrease one's credence would be a good thing, but increasing one's credence in cases of constraint distress would certainly seem unhelpful at best and dangerous at worst.

There is a long history in medicine of confusion among concepts, in the semi-technical sense articulated by Camp (23) of treating two separate things as if they were really one.¹¹ This history clearly demonstrates the dangers of such a mistake. To illustrate the operative notion of **confusion**, philosophers often point to mundane examples such as the way the word “jade” runs together two different stones (jadeite and nephrite). The historian’s significantly less mundane example could be how “female hysteria” runs together both diverse real conditions (such as PTSD and depression) as well as entirely fictional conditions (such as wandering uteruses and general assertiveness). The fact that treatment for this latter condition was inconsistent and incoherent (for example, both more and less sexual activity were prescribed) is evidence both of the separateness of the underlying elements as well as the harm inherent in ignoring that separateness. Admittedly it has sometimes been thought to be beneficial to take two seemingly distinct things and treat them as one, as for example when Asperger’s was folded into Autism Spectrum Disorder—though it is noteworthy that in that case and many like it there are those who question the benefit of the amalgamation (26).

Another crucial pragmatic argument for utilizing the JDC definition was made by Deschenes et al (27), though they (as far as I know) did not intend their arguments to do so.

Deschenes et al (27) present a fairly damning indictment of the view of **moral distress** that they inherited from the Fourie tradition. They point out that when we take the focus off

¹¹ While Camp utilized the concept of **confusion** at least as early as 1988 (24), he was still well behind Kelley’s description of the “jingle fallacy” in the 1920s (25).

of institutional constraints and begin to consider internal factors, this has the practical effect of shifting the burden for alleviating moral distress at least partially from the institution to the individual nurse. Their response “is to propose an alteration to ‘internal characteristics’ that will assume less responsibility of change from the individual to place a heavier onus on systemic and institutional constraints.” (p. 1145) Shifting verbiage from talk of the internal barriers from “constraints” to “characteristics” might help somewhat in deemphasizing that the nurse is constraining themselves, but it still finds the locus of the problem as internal to the nurse.

JDC is at the same time both more conceptually conservative and more rhetorically powerful. It is more conservative because simply running the clock back a few years to a view that is broadly coextensive with Corley’s interpretation of Jameton would align current usage more with the traditional. It is more powerful because if **moral distress** is always characterized by external constraints, the question of how to finesse whether to characterize the internal components as “constraints” or “characteristics” can be sidestepped entirely.

One could argue that perhaps it should be decisive that moral distress ontologically comprises both constraint and uncertainty varieties, even if it would more appropriately place more burden on institutions rather than individual nurses to ameliorate the problem by focusing primarily on the former. Such an argument would be to favor ontology over pragmatics, which is not absurd. However, this is the point at which the negative arguments against Fourie and the positive arguments work in concordance; if there were

well motivated ontological reasons for favoring a disjunctive account, we could accept such an account while as a practical matter making a conscious choice only to worry about the constraint-centric disjunct. Conversely, if there were no reason to focus on external factors as loci of responsibility and interventions, then there perhaps would be no reason to favor a more unified account over a disjunctive one.¹² However, if a more unified account would focus our attention in the right direction, and a more disjunctive account has no independent conceptual motivation, then the proper conceptual choice seems relatively straightforward.

It is worth being explicit that when I say that the burden should be on institutions, I mean precisely that—not that the burden should be on individual nurses to effect institutional change. I thus agree with Prentice et al (22) that encouraging nurses' empowerment absent other remedies runs various risks, including disillusionment in the face of failure or offloading one's problems onto someone else (what they dub "transference of moral distress") in the face of success. However, where they contend that a shift away from empowerment thinking (which remedy is *arguably* suggested in (28)) requires a conceptual shift from JDC, I maintain that a proper understanding of JDC would equally suggest such remedies as moral resilience.

One might perhaps grant that uncertainty and constraint should be kept conceptually distinct and still wonder which has the best claim to the term "moral

¹² Though even in this case, one could wonder about considerations of parsimony. I plan to make arguments elsewhere to this effect.

distress”. The main target of this paper is conceptual clarification rather than terminological regimentation; if we are clear that the two concepts are distinct, we can choose to associate either with any term/symbol we choose. To the extent that Corley’s exegetical project does bear weight, then reserving the term “moral distress” for the constraint-based concept seems a sensible move.

Conclusion

Part of the appeal of the JDC account of **moral distress** is its accordance with common experience. Returning to the opening of this paper, the example where a nurse knows how to provide care to all of his patients but does not have time to deliver it properly is familiar to those working in the healthcare field, and aligns with the JDC account of the term. Through this paper, I have reviewed one reading of the original concept of **moral distress** and the recent evolution of the concept. I raise several objections, in the spirit of arguing that not all conceptual change constitutes conceptual progress. In this case specifically, removing the requirement for an external constraint is based on undermotivated arguments. To the extent that Corley’s exegesis was correct, the original concept was good all along; to the extent that it was not in line with Jameton’s original meaning, so much the better for Corley’s philosophy.

I see four directions for future research. First, one could approach the conceptual questions from the perspective of philosophy of science, seeking to determine when a more generalized concept is appropriate. Second, the choice of the use of **knowledge** as a key conceptual constituent of **moral distress** brings with it a host of epistemological

questions, which proved beyond the scope of this paper to explore. Third, one could investigate what Prentice et al (22) consider to be the subjectivity of moral dilemmas in the ICU, which would bring one into the intersection of epistemology and metaethics. Finally, perhaps the most useful contribution would be further empirical research into the practical effects of employing and/or teaching different definitions of **moral distress**.

Clearly, further research into moral distress is warranted. I argue that in doing so we would do well to work in the JDC framework for a variety of reasons. Perhaps the most important of these reasons is that other accounts risk placing much of the conceptual (and likely some of the practical) burden onto the shoulders of individual nurses, whose shoulders clearly carry quite enough burden already.

References

1. Jameton, A. *Nursing Practice: The Ethical Issues*. Prentice-Hall; 1984.
2. Corley MC. Moral distress of critical care nurses. *Am J Crit Care*. 1995;4(4):280–5.
3. Corley MC. Nurse Moral Distress: a proposed theory and research agenda. *Nurs Ethics*. 2002 Nov;9(6):636–50. doi:10.1191/0969733002ne557oa
4. Paley J. *Concept analysis in nursing: a new approach*. London ; New York: Routledge, Taylor & Francis Group; 2021. (Routledge advances in research methods).
5. Kripke SA. *Wittgenstein on rules and private language: An elementary exposition*. John Wiley & Sons; 1982.
6. Fourie C. Who Is Experiencing What Kind of Moral Distress? Distinctions for Moving from a Narrow to a Broad Definition of Moral Distress. *AMA J Ethics*. 2017 Jun 1;19(6):578–84. doi:10.1001/journalofethics.2017.19.6.nlit1-1706 PubMed PMID: 28644787.
7. Morley G, Ives J, Bradbury-Jones C, Irvine F. What is “moral distress”? A narrative synthesis of the literature. *Nurs Ethics*. 2019 May;26(3):646–62. doi:10.1177/0969733017724354 PubMed PMID: 28990446; PubMed Central PMCID: PMC6506903.

8. Beheshtaeen F, Torabizadeh C, Khaki S, Abshorshori N, Vizeshfir F. Moral distress among critical care nurses before and during the COVID-19 pandemic: A systematic review. *Nurs Ethics*. 2024 Jun;31(4):613–34. doi:10.1177/09697330231221196 PubMed PMID: 38116787.
9. Arends SAM, Steenbergen M, Thodé M, Francke AL, Jongerden IP. Moral distress among nurses involved in life-prolonging treatments in patients with a short life expectancy: A qualitative interview study. *Patient Educ Couns*. 2022 Jul;105(7):2531–6. doi:10.1016/j.pec.2022.01.017
10. Fourie C. Moral distress and moral conflict in clinical ethics. *Bioethics*. 2015 Feb;29(2):91–7. doi:10.1111/bioe.12064 PubMed PMID: 24602097.
11. VanderWeele TJ, Wortham JS, Carey LB, Case BW, Cowden RG, Duffee C, et al. Moral trauma, moral distress, moral injury, and moral injury disorder: definitions and assessments. *Front Psychol*. 2025 Mar 5;16:1422441. doi:10.3389/fpsyg.2025.1422441
12. Fodor JA. Semantics, Wisconsin Style. In: Silvers S, editor. *Rerepresentation* [Internet]. Dordrecht: Springer Netherlands; 1989 [cited 2026 Oct 8]. p. 1–18. Available from: http://link.springer.com/10.1007/978-94-009-2649-3_1 doi:10.1007/978-94-009-2649-3_1
13. Johnson R, Cureton A. Kant's Moral Philosophy. In: Zalta EN, Nodelman U, editors. *The Stanford Encyclopedia of Philosophy* [Internet]. Winter 2025. Metaphysics Research Lab, Stanford University; 2025 [cited 2026 May 12]. Available from: <https://plato.stanford.edu/archives/win2025/entries/kant-moral/>
14. Brun G. Explication as a method of conceptual re-engineering. *Erkenntnis*. 2016;81(6):1211–41.
15. Burgess A, Plunkett D. Conceptual Ethics I. *Philos Compass*. 2013 Dec;8(12):1091–101. doi:10.1111/phc3.12086
16. Plunkett D. Which Concepts Should We Use?: Metalinguistic Negotiations and The Methodology of Philosophy. *Inquiry*. 2015 Nov 17;58(7–8):828–74. doi:10.1080/0020174X.2015.1080184
17. Queloz M. The ethics of conceptualization: Tailoring thought and language to need [Internet]. Oxford University Press; 2025 [cited 2026 Oct 2]. Available from: <https://library.oapen.org/handle/20.500.12657/99227>
18. Haslanger S. Gender and race: (What) are they? (What) do we want them to be? *Noûs*. 2000;34(1):31–55.
19. Khalidi MA. Cognitive ontology [Internet]. Cambridge University Press; 2024 [cited 2026 Oct 2]. Available from: <https://www.cambridge.org/rs/universitypress/subjects/philosophy/philosophy-mind-and-language/cognitive-ontology-taxonomic-practices-mind-brain-sciences>

20. Plato. *Phaedrus*.
21. Butler J, Langlois D, Loughheed K. The Scope of Clinical Ethics: Letting Go of Moral Distress. *Am J Bioeth*. 2026 Apr 27;1–13. doi:10.1080/15265161.2026.2657873
22. Prentice TM, Gillam L, Davis PG, Janvier A. The use and misuse of moral distress in neonatology. *Semin Fetal Neonatal Med*. 2018;23(1):39–43
23. Camp JL. *Confusion: A study in the theory of knowledge* [Internet]. Harvard University Press; 2002 [cited 2026 Oct 2].
24. Camp JL. Why attributions of aboutness report soft facts. *Philos Top*. 1988;16(1):5–30.
25. Kelley TL. *Interpretation of educational measurements* [Internet]. World Book Company; 1927 [cited 2026 Oct 2].
26. Baron-Cohen S. *Autism and Asperger syndrome* [Internet]. Oxford University Press; 2008 [cited 2026 Oct 2].
27. Deschenes S, Gagnon M, Park T, Kunyk D. Moral distress: A concept clarification. *Nurs Ethics*. 2020 Jun;27(4):1127–46. doi:10.1177/0969733020909523
28. Epstein EG, Delgado S. Understanding and addressing moral distress. *Online J Issues Nurs*. 2010;15(3).