Morality, normativity and measuring moral distress

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DOI:
10.1111/nup.12319

Nursing Philosophy

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Journal:	*Nursing Philosophy*
Manuscript ID	NUP-2020-0006.R2
Manuscript Type:	Original Article
Keywords:	Moral Distress, Moral Normativity, Psychological Distress, Definition

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Abstract

It is known that people have been getting distressed for a long time and healthcare workers, like the military, seem to fit criteria for being at particular risk. Fairly recently a term of art, moral distress, has been added to types of distress at work, though not restricted to work, they can suffer. There are recognised scales that measure psychological distress such as the General Health Questionnaire and the Kessler scales but moral distress it is claimed is different warranting its own scale. This seems to be because of both the intensity and nature of moral problems encountered at work that is so powerful and so destructive of moral agency and integrity. This paper will focus on how, if at all, moral distress is different by examining the idea of moral normativity.

Moral normativity is understood as roughly the sort of thing that all rational persons would endorse regardless of his interests, having an 'automatic reason giving force' and is likely to also require an overriding force. Specifically, it will examine how this force of moral claims seems to be needed for moral distress to be so destructive of healthcare professional's moral agency and integrity. This is related to the idea of warrantedness of the reaction of distress. Even if morality had such a strong normativity one can still ask is distress the correct or warranted reaction? It seems plausible that if distress is a correct response for it to be both moral and warranted it needs a strong account of moral normativity. The idea of a distinct form of distress as moral distress may be true in theory but is too contested both ontologically and epistemologically for a useful practice of measurement at present.

Key words: Moral Normativity, Moral Distress, Psychological Distress, Definition

> Unless it is said, implausibly, that all 'should' or 'ought' statements give reasons for acting, which leaves the old problem of assigning a special categorical status to moral judgement, we must be told what it is that makes the moral 'should' relevantly different from the 'shoulds' appearing in normative statements of other kinds (Foot, 1972, p. 309).

> Similar to that of qualitative studies, this problem of different definitions compounds the difficulty of developing adequate measures, since how a concept is defined matters greatly in measurement (Hamric, 2012, p. 44).

Introduction

It is known that people have been getting distressed for a long time and healthcare workers, like the military, seem to fit criteria for being at particular risk. Fairly recently a term of art, moral distress, has been added to types of distress at work, though not restricted to work, they can suffer. An example of how moral distress can arise is within the practice of palliative care (Maffoni et al, 2019). This nicely brings out causes to do with the practice itself such as repeated exposure to dying and death and complex decision making and causes that in a sense are not necessary or at least of a different nature such as large workloads due to financial constraints. Both may ultimately adversely affect patient care but have quite different causes. There are recognised scales that measure psychological distress such as the General Health Questionnaire and the Kessler scales, but moral distress is claimed to be different thus requiring its own scale (McCarthy and Gastmans, 2015). This seems to be because of the nature of moral problems encountered at work that is so powerful and so *destructive of moral agency and integrity* (Hamric, 2012, p.47 emphasis is mine). This paper will focus on how, if at all, moral distress is different (Dudzinski, 2016) by examining the idea of moral normativity.

For now, moral normativity is understood as more than the following of rules about what is correct or allowed such as the rules of etiquette or codes (Parfitt, 2011). Such reasons may or may not be categorical (Foot, 1972) in nature as being authoritative and inescapable for all rational persons

regardless of interests, having an 'automatic reason giving force' (Foot, 1972, p. 309; Luco, 2016). Moral normativity is to be understood in a strong sense and is taken to be that moral reasons because they are moral always 'override' non moral reasons (Hurley, 2017). Such strong moral normativity is difficult to justify (Baker, 2018; Dorsey, 2016a) but it may be what is needed if moral distress is to be sufficiently distinct from other types of distress and for it to be so destructive of healthcare professional's moral agency and integrity and also for the reaction of distress to the moral event to be appropriate . Questions then arise as to what sort of thing moral properties could be to have such normative force and how we can know about them.

In a way, this paper is a supplement to the moral distress map of Dudzinski, 2016. It will use three necessary and sufficient conditions for moral distress (Morley et al 2017) to structure the essay and suggest that a fourth condition is needed if we want to reach a single definition. It is proposed, but not discussed in any depth that we should stop trying to provide the definition of moral distress. Instead, we should measure psychological distress to detect individuals scoring highly with the aim of discussing with them the presumed causes of and consequent responses to this issue. After all distress, but not necessarily stress, ought to be prevented or at least minimised. It perhaps even creates a duty to prevent or minimise it.

In the present landscape, it may require further qualitative research exploring the understanding of professional roles and their relationship to morality, moral theory, moral epistemology, and especially moral compromise. Reflections in and on practice to help manage distress are also suggested. The idea of a distinct form of distress as moral distress may be true in theory but is too contested both ontologically and epistemologically for a useful practice of measurement at present.

The need for a definition of moral distress

The need for a definition of moral distress as a distinct type of distress has been raised in the nursing and applied ethical literature (Dudzinski, 2016; Morley et al, 2017) broadly because it highlights the moral labour of nursing and its often morally problematic relationship to organisational concerns

(Fourie, 2016; McCarthy and Gastmans, 2015).This need has been extended to other healthcare professions and occupations (McCarthy and Monteverde, 2018) as well as other professions and occupations such as business (De Tienne et al, 2012). The underlying concern seems to be related to the fact that moral problems encountered at work may negatively affect a person's identity or the sense of self and because of the moral aspect do so in a devastating way or at least a particularly important way that encounters with non-moral problems do not. However, it is worth pointing out that one's identity or sense of self can be grounded in non-moral values based on self-interest (Taylor, 1992). There is also some reason to be a little wary of some accounts of identity and its results (Breakey, 2016) so identity per se may not be the concern but perhaps appropriate identity. Also, we do not fail to be a self if there is some dissonance in our integrity so the concern about moral distress must be about its destructiveness (Hamric, 2012) of one's identity that is grounded in moral concerns. This leaves open the question about what identity is and how do different aspects of one's life relate to identity such as for example moral concerns and self-interested or prudential concerns and probably involves accounts of normativity.

The focus on healthcare professions seems to be based on a claim that the work is directly moral work or that what a healthcare professional does, and is, may be moral or at least strongly morally infused (Pellegrino and Thomasma,1981; Lazenby, 2020). Just to note, one potential cause of moral distress can be conflict between the person and his professional role (Cribb, 2011; Thomas and McCullough, 2015). Within nursing it is often held that they as a profession suffer especially from moral distress because of their extensive accountability with limited authority (Davis and Aroskar, 1978; Morley et al 2019). This is tricky to understand. Apart from definitional concerns as to whether one can be accountable without authority it can only be non-moral authority the nurse may lack not moral authority. So, perhaps a nurse does not have the authority in law or in his employment to act against the reasons of a doctor *ceteris paribus* or a more senior nurse. But moral authority is not something that comes from one's professional, legal or employment status (Foot, 1972; McDowell, 1978; Crisp, 2006) and its authority has to do with its normativity; its reason giving force (Dorsey,

2016a). However, the idea of limited authority of nurses may relate to the idea of being constrained in their actions. They can always do what they think is right or good, but there are pressures or reasons not to do so. This point is related to the scope of the definition of moral distress, whether it should be 'narrow' or 'broad' (Morley et al, 2019; McCarthy and Monteverde, 2018).

Definitions of moral distress are largely contested (Ulrich and Grady, 2018). Many researchers advocate for a broader account than Jameton's original 'narrow' account as constrained moral judgement (Fourie, 2017; Campbell et al, 2016; Morely et al, 2019). 'Account' rather than definition is used because it is not clear that Jameton (1984) intended to provide a definition of moral distress (John Paley in conversation). Since Wilkinson, (1987), definitions of moral distress have been given that include as well as constraint, uncertainty and (moral) dilemmas (Fourie, 2017; Campbell et al, 2016). The differing definitions of moral distress given in the literature may mean that one is measuring different things (Morley et al, 2017). This hinders attempts to help practitioners via the use of empirical research.

Morley et al (2017) provide what is perhaps the broadest definition of moral distress via three necessary and jointly sufficient conditions:

1. Experience of a moral event

2. Experience of psychological distress

3. A direct causal relation between 1 and 2.

On this account moral distress cannot occur without conditions 1, 2 and 3 and nothing else is needed for moral distress to occur. All the definitions of moral distress given in the literature, narrow and broad, fall under these three conditions. The three conditions are meant to give an account of what moral distress is. However, as Morley et al, (2017) point out the breadth of the definition means that it is not of practical use. This calls into question the attempt to give the definition of moral distress as opposed to exploring the many senses it can have and although this point is not the

explicit focus of this paper what follows gives, I think, similar reasons. To help practitioners, empirical work much of which will rely on measurement of moral distress, there needs be agreement on what sort of event a moral event is and its relationship to psychological distress (Morley et al, 2017). This is what much work on moral distress has been attempting to do resulting in the narrow and broad definitions above, and it is likely that a number of distinct moral distress scales will be necessary to cover the phenomena if it exists (Hamric, 2012); a practical problem in itself but also one that again questions attempts to provide the definition of moral distress.

However, all seem to assume that it is clear what counts as a moral event so that moral distress can be distinguished from other types or causes of psychological distress (Dudzinski, 2016; Morley et al 2017). Even if this can be done, and there are doubts that it can at least without substantive moral enquiry (Dorsey, 2016a), the claim that moral distress is especially problematic needs justification (Hamric, 2012). Relatedly and perhaps especially because of the practical need to relieve moral distress suffered by professionals and others as much as possible the definition may require a fourth necessary condition; 4. The distress is warranted or fitting or correct (Gert, 2017). Of course it is very contested what is to count as fitting (Gert, 2017).

A moral event

Moral distress, assuming it exists, (though there is no doubt some or many people are becoming distressed at work), is a very complex phenomenon. Thus, the attempt to operationalise and measure this issue is difficult: morality is contested in part because of its normativity (Foot, 1972; McDowell, 1978; Crisp, 2006; McPherson, 2018). Dorsey, 2016a give a list of five conditions that might make morality a distinct domain and on which it is contested: content, ground, reactive attitudes, motivation, and normativity.

Normativity can be divided into the evaluative (good, cruel etc.) and the deontic (right, ought) (Skorupski, 2011). The virtue ethics literature may dispute the language of ought but not reasons and rationality so normative force remains e.g. McDowell, 1978; Armstrong, 2006. Normativity

appears in many domains such as epistemology, and aesthetics as well as morality and is applied to or is a part of many things including evaluations, reasons, and attitudes such as belief and desire. It is usually contrasted with description. Moral normativity is thought by many to have a different sense from other types of normativity being more than the fact that morality has moral authority and prudence has prudential authority and etiquette has etiquette authority (Foot, 1972; Crisp, 2006; Dorsey, 2016b). The extra something is its overridingness because it is moral; its normative force (Dorsey 2016b). It is worth noting that the distinctiveness of morality or moral properties with or without the overriding force is contested and thus what counts as a moral event is contested (Dorsey, 2016b and 2016a).

The moral distress literature whilst attempting to claim that moral distress is a distinct entity in fact only highlights the difficulties of distinguishing moral from other events. The claims made are very similar that although experience of moral distress may involve emotions and psychological states, it is not reducible to them or it is distinct from them or that moral distress should not be conflated with psychological distress (McCarthy and Deady, 2018; Hanna, 2004). Psychological distress of necessity has a cause, so it is hard to know what it means for something to be reducible to or the same as or conflated with just psychological distress (McCarthy and Deady, 2008; Hanna, 2004). Whatever and crucially assuming (possibly implausibly (Lazarus, 1999, 2006)) some one thing can be singled out as the cause of the psychological distress, say X, then the distress is labelled X-distress. An example from the literature illustrates this.

> Psychiatric nurses may, for example, be emotionally distressed while restraining a patient, but they are likely to become morally distressed only if they believe that restraining the patient is morally wrong (McCarthy and Deady, 2008, p. 256).

Emotions themselves do not just happen, at least emotions that can in any sense be connected with some form of cognition or appraisal rather than a knee jerk reaction, there is a cause or at least a reason for them, especially some cognition of an event. So, it is not clear how emotional distress can

be a distinct thing rather than a result or effect of some other thing. One needs to ask why the nurses experience emotional distress when restraining a patient. It is very plausible to think that it is because of moral reasons or at least reasons that are associated with morality such as loss of autonomy or freedom, or perhaps risk of physical harm or loss of dignity or even perhaps it affects the nurses' and patient's wellbeing understood as moral. Or perhaps the reason for the emotional distress is caused by something else such as tiredness. Perhaps there is no reason for it at all. So, it is possible to hold that the psychiatric nurses' experience of emotional distress can fall under conditions 1-3 and is a type of moral distress. Similarly, when trying to differentiate the need for an account of moral distress from other types of distress Morley et al (2017) use the general example of life events. But without stipulation that life events are not to include moral events this will not do. Other more specific examples are family, or occupation. But again, without some explanation as to when a family event or occupational event is not also a moral event this is problematic.

This issue is about the boundary of the moral and whilst this is contested in philosophy (Sinnott-Armstrong and Wheatley, 2014; Dorsey, 2016b) it is important to know what is to count as a moral event that makes X-distress moral distress. It is very important when moral distress is being applied to healthcare because it is perhaps easier to make some connection of every action or event to morality and thus claim to be a moral event. Some nurses, physicians and philosophers seem to assume this at least for healthcare professional roles (Pellegrino and Thomasma, 1981; Lazenby 2020). This I think is reflected in difficulties of delimiting the items used within moral distress scales as being all and only causes of moral distress. On such accounts it seems everything could be a potential cause of moral distress thus there is nothing to be distinct and no need for a moral distress scale. One could perhaps replace condition 1 above with 1a. Experience of an event; covering anything that directly causes psychological distress which would then by definition be moral distress. But unless the boundary problem can be resolved condition 1 is itself not helpful because, like 1a. it could cover anything at all dependent upon what one takes a moral event to be. On such an account condition 1 is equivalent to 1a.

A reason for the ease of moralising professional roles within healthcare has to do with the content of morality as well as normativity. It seems plausible that morality is at least concerned with other regarding content and to be distinct as morality and not for example etiquette has to do with the others well-being (Dorsey, 2016a) although some accounts of virtue ethics it is directly about one's own well-being or (enlightened) self-interest (Hursthouse, 1999). But here we get into details within normative moral theory and it is not clear how for example some accounts of moral duty is concerned with wellbeing. But within healthcare there seems to be a plausible connection between what it as an institution does and morality. This is because either facts are equated or entangled with values with a direct connection with ought (reasons) and the ought is to be understood as a moral ought.

Healthcare can be an especially difficult area to disentangle description from values and the normative because it has directly to do with living human beings where facts that are usually understood as descriptions can easily become teleological evaluations based on biological function which in turn is used to ground a should or ought but it need not be a moral should or ought or at least it is contested (McDowell, 1998; Woodcock, 2006). A malfunctioning heart is bad and should be repaired. If you want to be healthy then you should have your heart repaired. But it is one thing for there to be such evaluative facts and another for there to be prescriptions of ought and should, that follow from them and especially in a sense of normative force needed for morality to be distinct from the non-moral. Neo-Aristotelian virtue ethics relies on this idea using examples of animals such as owls claiming there is something wrong with an owl with poor sight then making an analogy with the functioning of human beings and then stretching it include our rationality, note not morality (Hursthouse, 1999; Foot, 2000). The point is made that there is a rational connection between what is good for us and reasons for action though it is unlikely to be an overriding reason. It may be claimed that the point of the institution of healthcare is this functional approach and thus it is its main reason for practical decision making. But again, and nursing brings this out very well, it need not be its overriding reason for action. There is often some tension between the role of healthcare

workers and the institution and ideas of autonomy and ultimate reason (Pellegrino and Thomasma, 1981).

Though it seems plausible that morality does have or could have a distinct content (but there is at present no agreement on what it is) and thus there could be moral distress requiring a distinct scale to measure it what it needs in addition is an account of its distinct normative force. The account of good for above can be understood as a 'generic normativity' (Copp, 2004) that evaluative terms in general possess. It may or may not also be understood as a hypothetical ought about well-being that need not be understood as a moral notion or moral reason if moral reasons are taken to be categorical reasons (which still may not distinguish moral reasons from reasons of etiquette). Taking this medicine is, very probably, good for you so you ought to take it or have reason to take it if you want to increase the probability of getting better (*ceteris paribus*). Science can provide the probabilities about biological function and moral psychology can provide correlations between virtues as traits that provide a good or a best bet for 'happiness' (Peterson and Seligman, 2004; Kristjánsson, 2012; Risjord, 2005; but see Tiberius and Hall, 2010 for concern over psychology's lack of concern over objective wellbeing). But on some accounts of morality and it's normativity being good for is not sufficient or even necessary for its deontic force; what is needed is something like a categorical ought or reason that is applicable to all rational beings irrespective of outcome. On other accounts, morality as good for understood as the virtuous person's reasons, override, or silence other reasons in practice (McDowell,1979; Vigani, 2019).

There is a stronger and weaker version. The weaker version being where the non-moral reasons remain as reasons, but moral reasons always override them. On the stronger version where the moral reasons are such that other reasons simply do not count as reasons. Moral normativity as silencing would at least seem to warrant the idea of distress though it would need to explain how the constraints were even taken to be reasons and why if moral reasons were silencing of all else how there could be distress at all. Morality in this strong sense of normativity (Vogelstein, 2013) may

make moral distress a distinct type of psychological distress by clearly demarcating the moral from the non-moral though it does so by blurring (many of) the very moral/non-moral differences. Anything weaker makes it more difficult to justifiably distinguish a moral event from a non-moral event or moral reasons from other reasons as well as the response that is distress. This is directly related to condition 2 about causing psychological distress which seems to be a particularly devastating type of distress and that only a very strong notion of normativity would seem to make this appropriate. But now questions of meta-ethics are relevant about what sort of thing morality can be to have such force especially where on some accounts it is independent from an agent's psychology. It also raises issues about moral epistemology.

This sense of morality as 'strong moral rationalism' (Dorsey, 2016b) that is perhaps *suis generis* in nature is hard to reconcile with a naturalistic morality (Majors, 2007), and thus hard to make use of empirically when explaining the relationship between conditions 1, 2 and 3 or creating a scale to measure it. Such a strong account of normativity would make actions or inactions cited in the moral distress literature irrational. Though we can for practical purposes perhaps distinguish between a rational person and a real person (Crisp, 2015a), strong moral rationalism reminds one of the need for caution as to the role of emotions in morality; even Nussbaum (2003) claims they can be unreliable. It is reason that seems to matter most (Crisp, 2006; Parfit, 2011) and it is unclear why or how psychological distress is related to such a moral event at least for the practically wise. And even on a weaker account of morality there is a problem of moral epistemology.

Even if a nurse, doctor, patient and relative agreed on all the facts they may still disagree as to what evaluation to place on them. But even if they agreed on the facts and evaluation or agreed on the 'evaluative-facts' they may still disagree as to what ought to be done or what they have reason to do because they may put different emphasis or weight on the same reasons. The normative force may be felt quite differently, and this is regardless of the possibility that there could be a correct account. In other words, there may be good reasons that differ in normative force about what should be done

held by people who care about the patient's well-being and for its own sake, not just because it is part of their job or profession. Additionally, apart from the fact of moral disagreement which alone should give one pause for thought about one's moral beliefs and judgement, on some accounts within moral philosophy knowledge of these demands or the truth of moral reasons and its reason giving force is intuitive (Crisp, 2015b) and justification *a priori* adding a further difficulty for empirical work and it raises issues about condition 3 'causation' (Majors, 2007; Crisp, 2006).

Causation

Causation like morality is a contested concept whether it is cause between material objects or between mental events and physical properties (Davidson, 1980). Lazarus' (1999) writing about psychology and the emotions notes that in psychology a stimulus-response model was displaced by stimulus- organism- response where organism included the mind in relation to behaviour/action part of the relation being causal. He is wary of reductive analysis as all that is important for explanation or even causation in psychology and a similar concern is related to the nature of moral properties to natural ones. There is a large literature that attempts to 'naturalise' moral properties whilst retaining its force so that instead of moral properties being decidedly odd (Mackie, 1977) , they are just like any other properties that we think are not odd. Or else a naturalist account may deny morality has a 'strong normativity' or an 'authoritative force' (Copp, 2004) but this leaves space for the weight of reasons as to what to do could fall to prudence and not morality and this may affect the idea of becoming distressed by not being able to act as one thinks one morally ought.

Even supervenience of the moral on the factual does not imply normative properties are caused by the factual, the actual relationship is very contested (Hattiangadi, 2018), and condition 3 is contested. Even the common term 'in virtue of' or 'response to' complicates the relation. If causation is covered by natural laws, then the normative seems to disappear. The 'in virtue of what?' did X cause Y question seems especially problematic for naturalistic moral explanations (Sayre-McCord, 1988; Majors, 2003). Non-naturalistic moral realism seems to avoid the question of

causality (Majors, 2003) and in any case, if true, would make empirical work on moral distress particularly difficult. Reductive moral realism removes any distinction needed for there to be moral distress rather than psychological distress. Appeal to moral facts or properties to explain condition 3, to causally affect us, is mysterious or at least highly contested. Crucially the mysteriousness is in the main due to the need to accommodate the normativity of morality (*ibid*.). This difficulty for causal explanations between a moral event and an effect that is psychological distress holds (I think) for reasons understood as causes.

Reasons are normative and may be causes via an agent's beliefs and desires (Davidson, 1980; Risjord, 2005). Plausibly there are moral reasons and so these it would seem can have a causal effect. However psychological states are not reasons. For some accounts of morality this necessitates 'agreement' by a community to constitute the beliefs and desires of the agent as norms (or not) and thus reasons for an individual agent's beliefs and desires. However, as Risjord (2005) explains, action explanations are not causal explanations, and this is important for understanding the difficulty for condition 3. Beliefs and desires as causes are psychological facts about an agent and the social status provided by the community is not part of the causal event:

> X causally explains Y only if X is an event…in the causal history of Y (Risjord, 2005, p. 300).

One account that tries to give explanations for how belief and desire can be causes but not a causal explanation is an erotetic model of explanation (Risjord, 2005). But the erotetic model of explanation based as it is on both the ability to describe norms without thereby endorsing them and community agreement on what reasons count as norms makes it problematic to meet condition 1, which is the condition that distinguishes moral distress from non-moral psychological distress. This can be illustrated using the relevance criteria used in the erotetic model. In intentional action explanation the explananda accounts for the reason for the action based on the agent's pro attitude (desires) and this is the relevance condition and it 'presupposes a normative relationship' (Risjord, 2005, 303 emphasis mine). What is the relevance criterion for condition 2 and how does it relate to

condition 1? Whilst it may seem plausible to account for intentional action by asking 'why?' and presupposing some normative relationship it is less clear how this transfers or accounts for the relationship between conditions 1 and 2 where the result or effect is psychological distress. The point made in the previous paragraph as to how condition 3 holds remains.

Moral normativity and *distress*

There are psychological accounts of distress that include the evaluative as appraisal (Lazarus, 1999; Moors, 2009) but such accounts blur or at least are unclear about any distinction between moral and non-moral; psychology can include the evaluative but does not and should not extend to the prescriptive where moral theory must (Crisp, 2006) and there is no agreement on what this is. A gap in the form of a relationship remains between conditions 1, 2 and 3.

A brief note about constraint is warranted here because this is much discussed in the literature on moral distress in relation to condition 3. I think McCarthy and Monteverde (2018) are correct that constraint is relevantly different to moral dilemma and moral uncertainty as causes of condition 3 though presumably one could become psychologically distressed because of dilemma and uncertainty and hence morally distressed. However, my guess is that we would be surprised if this were the case; it just would not seem warranted. Moral authority as constraint is relevant here. Even if one holds to the categorical force of morality as overriding morality is ultimately in the same boat as that of the authority of law or of a profession; one can still go against it. But a strong categorical account of moral normativity as overriding seems to warrant some strong response on the part of the agent if he does not do as he thinks he morally should. This is assuming this can be the case and the agent still does know the moral thing to do. 'Moral' in the weaker sense that equates with any event causing distress can easily allow for balancing or weighing reasons with the reasons given by people in authority. From a normative as general reasons approach it may be that the nurse (or phronimos?) has judged that the reasons for acting or refraining from acting has he did are stronger than or better than the 'moral' reasons. Relatedly if the cause of the distress is not constraint but for

example a dilemma or, differently, uncertainty the appropriateness of the distress as well as responses to it and responsibility for the response will or should be different for epistemological concerns connected with the ontological as appropriateness of response.

An idea in epistemology of 'pragmatic encroachment' (Fantl and McGrath, 2007) where roughly whether a subject knows that p can vary due to differences in practical states such as the importance or risk involved so that for example withdrawing life support from a patient with the high probability of very quick death requires a greater strength of evidence than does thinking a colleagues clinical competence is poor. It is of note that the literature on moral distress has raised a similar concern changing the definition from knowing the right thing to do to something epistemically weaker such as perceiving or believing or confusingly make clear moral judgements. Even if this should not be the theoretical standard for knowledge it seems to have some practical weight again related to the warrantedness or otherwise of the resulting distress.

Relatedly, Morley et al (2017) have usefully tabulated the many epistemological terms in use in the literature on moral distress such as judgement, belief, knowledge, uncertainty and rightly suggests that either they are all been used to mean judgement or they are taken to be different. This matters for empirical work on moral distress because of the connection with reasons for action or not acting and the associated psychological response. For instance, being certain or knowing that doing some action is wrong and bad or vicious seems to have a different epistemological status to believing which in turn differs from uncertainty. These different epistemological stances intuitively at least require different psychological responses and different measurement scales.

Understanding the normative force of morality as categorical and overriding because of its special normative prescriptive force, seems to justify the extreme emotional response that is distress, not simply stress, when one does not do as it requires. The qualification seems to is important. Knowledge of any objective thing, and for moral realism and more contentiously anti-anti realist stances or response depend accounts, morality is objective, the epistemic and the ontological can

come apart such that it is (just) the construal by a nurse of the situation that causes his distress. Although the distress is 'real', the nurse is suffering what we will call for now mental anguish and probably physiological symptoms; it is not moral distress because it is not caused by a moral event. Either because the nurse is mistaken in what he construes to be a moral event, or he is correct in his construal but is mistaken in his reaction as response. Even response dependent accounts of morality, where roughly the nature of moral properties is in a sense dependent on human being's responses, attempt to provide critical distance between having the response and the response being merited (warranted or appropriate) (D'Arms and Jacobson, 2000). It may be the correct or warranted response should not be one of not distress but something else perhaps anger at oneself for cowardice or anger at others for something, perhaps not agreeing with their own moral judgement.

In relation to objectivity of the moral there is also a further concern that a nurse may not recognise a moral event and its warranting a certain response and thus will not lead to psychological distress on his part even if it should do so. Literature suggests that this non-recognition of a moral event by third persons is major cause of moral distress for individual nurses and is reflected in some of the items in the moral distress scales. But there seems to be a double count on behalf of the agent first person account suffering moral distress who must first recognise a moral event and know the correct response and then know that the other agent as work colleague third person account either can or differently should recognise what needs be the same moral event and respond appropriately perhaps understood as the same as the first person. But some of the literature about moral particularism especially on the holism of reasons (Hooker and Little, 2000) strongly suggests that for example simply being a different person may itself change the moral valence of the situation, in effect making the moral situation relevantly different. Even if the valence cannot change the agent's reasons might. In fact, the issue is compounded because in the moral distress literature what is taken to be problematic is the colleague's incompetence and so this must be in some sense moral incompetence for it to be moral distress. Yet morality unlike say geology or anatomy has no epistemological experts and thus it is much more difficult to judge a standard for competence.

Finally, it may be objected that even if distress is the wrong or inappropriate moral response it seems that warranted or not the individual still experiences distress. An event or an action that at least is perceived or, better, construed by the agent herself that causes distress directly perhaps also indirectly is practically significant. Distress is an evaluative term with no positive valence perhaps equivalent in sense to the latter end of Lazarus' (1999) notion of a continuum of stress through to trauma. This plausible account of the nature of distress as normative as evaluative, dependent upon not only input (cause) and output (response) but also mediating appraisal by the agent is important. The point here is that there is reason to relieve suffering however it is caused and thus reason to relieve distress.

This weaker account of normativity of evaluative reasons results in two things. First condition 1 needs replacing with 1a Experiencing an event. We may think that a completely irrational person has no reason that we can understand to feel distress even though the sheer fact that it is distress being felt warrants helping. This account of warranted helping may be labelled moral but if so then it is simply a placeholder for anything that causes distress and thus condition 1 can be replaced with 1a unless a clear distinction can be made. Second the evaluative is still normative and thus condition 4 is still necessary especially so since the point of this classificatory project is practical; to do something about healthcare workers (and others) psychological distress.

The warranted unwarranted distinction together with the current condition of moral epistemology has implications for responsibility for alleviation of the distress which may be institutional, professional, or individual. Constraint and its connection with moral responsibility is quite complex and has been discussed in moral philosophy for thousands of years. More recently perhaps, the issue of appropriate emotions and other psychological responses are once more to the fore (Nussbaum, 2003; Crisp, 2006). The strongest account of constraint would be something akin to being certain that X is the right thing to do but being physically prevented from doing so one cannot do it. Constraint in practice is always much weaker; the nurse can act or refrain from acting but there will

be well known potential or real costs in doing so; one might say reasons against doing so. It may be the 'constraint' is actually or ultimately the nurse's cowardness; or the nurse has decided there are better reasons not to act; or perhaps the nurse has, like almost all of us, not quite reached the mark of the *phronimos* and is mistaken in his situational appreciation.

These points then raise an interesting question about the role of emotions for moral knowledge and in this case for moral distress. Emotions can be recalcitrant remaining even when the nurse knows that X or knows there are better reasons and yet still feels certain emotions of certain strength that he now justifiably believes to be inappropriate. The nurse may initially feel distress but very quickly realises that he should not. The distress as emotional response remains, and he knows it should not.

Conclusion

The need for a distinct account of moral distress is mainly practical and so some of this paper may seem to miss the mark entirely. For some metaethical concerns need not have any relation to real life practice but I doubt this is true. But even normative theories differ in accounts of what makes something right or good some of which blur distinctions between moral and other events.

There is a need develop robust research studies that can be compared and where possible aggregated. The idea is that they all use a similar or the same robust tool. These reasons are related to the objective of remedying moral distress including being able to measure their effects (if any). However, measurement scales for moral distress make the assumption that there is agreement on what a moral event is and perhaps that it can be known *a posteriori*. The previous sections have at least problematized this assumption of there being one thing that is moral distress, and which can be clearly demarcated and thus problematizes the psychometrics of current moral distress scales. All attempts to measure moral distress comes undone if no account of a moral event can be given that ensures it is objective and statistically (at least) causes psychological distress. But more than statistics is required and that something is normativity.

Relatedly a relational approach to understanding what stress (distress) is emphasises the interrelationships of family and work stress as well as the importance of individual personality variables for their effect. What causes stress reaction and what counts as a stressor is the significance as appraised by the person encountering it (which may be subconscious). What is a 'daily hassle' (Kanner, et al 1981) for some is a very stressful perhaps even distressing event for others. Better to take condition 1 a. and understand condition 2 as necessarily requiring an appraisal by the individual, measure levels of perceived distress and then ask individuals about what it is they think is causing their distress. I think a plausible summary will be unjustified suffering of patients. Condition 4. Is necessary both because of its theoretical importance in defining a moral event but also because of the practical need for doing so. Perhaps much of the remedy for moral distress will be about the appropriateness or otherwise of the response to the event.

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Morality, Normativity and Measuring Moral Distress

Abstract

It is known that people have been getting distressed for a long time and healthcare workers, like the military, seem to fit criteria for being at particular risk. Fairly recently a term of art, moral distress, has been added to types of distress at work, though not restricted to work, they can suffer. There are recognised scales that measure psychological distress such as the General Health Questionnaire and the Kessler scales but moral distress it is claimed is different warranting its own scale. This seems to be because of both the intensity and nature of moral problems encountered at work that is so powerful and so destructive of moral agency and integrity. This paper will focus on how, if at all, moral distress is different by examining the idea of moral normativity.

Moral normativity is understood as roughly the sort of thing that all rational persons would endorse regardless of his interests, having an 'automatic reason giving force' and is likely to also require an overriding force. Specifically, it will examine how this force of moral claims seems to be needed for moral distress to be so destructive of healthcare professional's moral agency and integrity. This is related to the idea of warrantedness of the reaction of distress. Even if morality had such a strong normativity one can still ask is distress the correct or warranted reaction? It seems plausible that if distress is a correct response for it to be both moral and warranted it needs a strong account of moral normativity. The idea of a distinct form of distress as moral distress may be true in theory but is too contested both ontologically and epistemologically for a useful practice of measurement at present.

Key words: Moral Normativity, Moral Distress, Psychological Distress, Definition

> Unless it is said, implausibly, that all 'should' or 'ought' statements give reasons for acting, which leaves the old problem of assigning a special categorical status to moral judgement, we must be told what it is that makes the moral 'should' relevantly different from the 'shoulds' appearing in normative statements of other kinds (Foot, 1972, p. 309).

> Similar to that of qualitative studies, this problem of different definitions compounds the difficulty of developing adequate measures, since how a concept is defined matters greatly in measurement (Hamric, 2012, p. 44).

Introduction

It is known that people have been getting distressed for a long time and healthcare workers, like the military, seem to fit criteria for being at particular risk. Fairly recently a term of art, moral distress, has been added to types of distress at work, though not restricted to work, they can suffer. An example of how moral distress can arise is within the practice of palliative care (Maffoni et al, 2019). This nicely brings out causes to do with the practice itself such as repeated exposure to dying and death and complex decision making and causes that in a sense are not necessary or at least of a different nature such as large workloads due to financial constraints. Both may ultimately adversely affect patient care but have quite different causes. There are recognised scales that measure psychological distress such as the General Health Questionnaire and the Kessler scales, but moral distress is claimed to be different thus requiring its own scale (McCarthy and Gastmans, 2015). This seems to be because of the nature of moral problems encountered at work that is so powerful and so *destructive of moral agency and integrity* (Hamric, 2012, p.47 emphasis is mine). This paper will focus on how, if at all, moral distress is different (Dudzinski, 2016) by examining the idea of moral normativity.

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For now, moral normativity is understood as more than the following of rules about what is correct or allowed such as the rules of etiquette or codes (Parfitt, 2011). Such reasons may or may not be categorical (Foot, 1972) in nature as being authoritative and inescapable for all rational persons

regardless of interests, having an 'automatic reason giving force' (Foot, 1972, p. 309; Luco, 2016). Moral normativity is to be understood in a strong sense and is taken to be that moral reasons because they are moral always 'override' non moral reasons (Hurley, 2017). Such strong moral normativity is difficult to justify (Baker, 2018; Dorsey, 2016a) but it may be what is needed if moral distress is to be sufficiently distinct from other types of distress and for it to be so destructive of healthcare professional's moral agency and integrity and also for the reaction of distress to the moral event to be appropriate . Questions then arise as to what sort of thing moral properties could be to have such normative force and how we can know about them.

In a way, this paper is a supplement to the moral distress map of Dudzinski, 2016. It will use three necessary and sufficient conditions for moral distress (Morley et al 2017) to structure the essay and suggest that a fourth condition is needed if we want to reach a single definition. It is proposed, but not discussed in any depth that we should stop trying to provide the definition of moral distress. Instead, we should measure psychological distress to detect individuals scoring highly with the aim of discussing with them the presumed causes of and consequent responses to this issue. After all distress, but not necessarily stress, ought to be prevented or at least minimised. It perhaps even creates a duty to prevent or minimise it.

In the present landscape, it may require further qualitative research exploring the understanding of professional roles and their relationship to morality, moral theory, moral epistemology, and especially moral compromise. Reflections in and on practice to help manage distress are also suggested. The idea of a distinct form of distress as moral distress may be true in theory but is too contested both ontologically and epistemologically for a useful practice of measurement at present.

The need for a definition of moral distress

The need for a definition of moral distress as a distinct type of distress has been raised in the nursing and applied ethical literature (Dudzinski, 2016; Morley et al, 2017) broadly because it highlights the moral labour of nursing and its often morally problematic relationship to organisational concerns

(Fourie, 2016; McCarthy and Gastmans, 2015).This need has been extended to other healthcare professions and occupations (McCarthy and Monteverde, 2018) as well as other professions and occupations such as business (De Tienne et al, 2012). The underlying concern seems to be related to the fact that moral problems encountered at work may negatively affect a person's identity or the sense of self and because of the moral aspect do so in a devastating way or at least a particularly important way that encounters with non-moral problems do not. However, it is worth pointing out that one's identity or sense of self can be grounded in non-moral values based on self-interest (Taylor, 1992). There is also some reason to be a little wary of some accounts of identity and its results (Breakey, 2016) so identity per se may not be the concern but perhaps appropriate identity. Also, we do not fail to be a self if there is some dissonance in our integrity so the concern about moral distress must be about its destructiveness (Hamric, 2012) of one's identity that is grounded in moral concerns. This leaves open the question about what identity is and how do different aspects of one's life relate to identity such as for example moral concerns and self-interested or prudential concerns and probably involves accounts of normativity.

The focus on healthcare professions seems to be based on a claim that the work is directly moral work or that what a healthcare professional does, and is, may be moral or at least strongly morally infused (Pellegrino and Thomasma,1981; Lazenby, 2020). Just to note, one potential cause of moral distress can be conflict between the person and his professional role (Cribb, 2011; Thomas and McCullough, 2015). Within nursing it is often held that they as a profession suffer especially from moral distress because of their extensive accountability with limited authority (Davis and Aroskar, 1978; Morley et al 2019). This is tricky to understand. Apart from definitional concerns as to whether one can be accountable without authority it can only be non-moral authority the nurse may lack not moral authority. So, perhaps a nurse does not have the authority in law or in his employment to act against the reasons of a doctor *ceteris paribus* or a more senior nurse. But moral authority is not something that comes from one's professional, legal or employment status (Foot, 1972; McDowell, 1978; Crisp, 2006) and its authority has to do with its normativity; its reason giving force (Dorsey,

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2016a). However, the idea of limited authority of nurses may relate to the idea of being constrained in their actions. They can always do what they think is right or good, but there are pressures or reasons not to do so. This point is related to the scope of the definition of moral distress, whether it should be 'narrow' or 'broad' (Morley et al, 2019; McCarthy and Monteverde, 2018).

Definitions of moral distress are largely contested (Ulrich and Grady, 2018). Many researchers advocate for a broader account than Jameton's original 'narrow' account as constrained moral judgement (Fourie, 2017; Campbell et al, 2016; Morely et al, 2019). 'Account' rather than definition is used because it is not clear that Jameton (1984) intended to provide a definition of moral distress (John Paley in conversation). Since Wilkinson, (1987), definitions of moral distress have been given that include as well as constraint, uncertainty and (moral) dilemmas (Fourie, 2017; Campbell et al, 2016). The differing definitions of moral distress given in the literature may mean that one is measuring different things (Morley et al, 2017). This hinders attempts to help practitioners via the use of empirical research.

Morley et al (2017) provide what is perhaps the broadest definition of moral distress via three necessary and jointly sufficient conditions:

1. Experience of a moral event
2. Experience of psychological distress
3. A direct causal relation between 1 and 2.

On this account moral distress cannot occur without conditions 1, 2 and 3 and nothing else is needed for moral distress to occur. All the definitions of moral distress given in the literature, narrow and broad, fall under these three conditions. The three conditions are meant to give an account of what moral distress is. However, as Morley et al, (2017) point out the breadth of the definition means that it is not of practical use. This calls into question the attempt to give the definition of moral distress as opposed to exploring the many senses it can have and although this point is not the

explicit focus of this paper what follows gives, I think, similar reasons. To help practitioners, empirical work much of which will rely on measurement of moral distress, there needs be agreement on what sort of event a moral event is and its relationship to psychological distress (Morley et al, 2017). This is what much work on moral distress has been attempting to do resulting in the narrow and broad definitions above, and it is likely that a number of distinct moral distress scales will be necessary to cover the phenomena if it exists (Hamric, 2012); a practical problem in itself but also one that again questions attempts to provide the definition of moral distress.

However, all seem to assume that it is clear what counts as a moral event so that moral distress can be distinguished from other types or causes of psychological distress (Dudzinski, 2016; Morley et al 2017). Even if this can be done, and there are doubts that it can at least without substantive moral enquiry (Dorsey, 2016a), the claim that moral distress is especially problematic needs justification (Hamric, 2012). Relatedly and perhaps especially because of the practical need to relieve moral distress suffered by professionals and others as much as possible the definition may require a fourth necessary condition; 4. The distress is warranted or fitting or correct (Gert, 2017). Of course it is very contested what is to count as fitting (Gert, 2017).

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A moral event

Moral distress, assuming it exists, (though there is no doubt some or many people are becoming distressed at work), is a very complex phenomenon. Thus, the attempt to operationalise and measure this issue is difficult: morality is contested in part because of its normativity (Foot, 1972; McDowell, 1978; Crisp, 2006; McPherson, 2018). Dorsey, 2016a give a list of five conditions that might make morality a distinct domain and on which it is contested: content, ground, reactive attitudes, motivation, and normativity.

Normativity can be divided into the evaluative (good, cruel etc.) and the deontic (right, ought) (Skorupski, 2011). The virtue ethics literature may dispute the language of ought but not reasons and rationality so normative force remains e.g. McDowell, 1978; Armstrong, 2006. Normativity

appears in many domains such as epistemology, and aesthetics as well as morality and is applied to or is a part of many things including evaluations, reasons, and attitudes such as belief and desire. It is usually contrasted with description. Moral normativity is thought by many to have a different sense from other types of normativity being more than the fact that morality has moral authority and prudence has prudential authority and etiquette has etiquette authority (Foot, 1972; Crisp, 2006; Dorsey, 2016b). The extra something is its overridingness because it is moral; its normative force (Dorsey 2016b). It is worth noting that the distinctiveness of morality or moral properties with or without the overriding force is contested and thus what counts as a moral event is contested (Dorsey, 2016b and 2016a).

The moral distress literature whilst attempting to claim that moral distress is a distinct entity in fact only highlights the difficulties of distinguishing moral from other events. The claims made are very similar that although experience of moral distress may involve emotions and psychological states, it is not reducible to them or it is distinct from them or that moral distress should not be conflated with psychological distress (McCarthy and Deady, 2018; Hanna, 2004). Psychological distress of necessity has a cause, so it is hard to know what it means for something to be reducible to or the same as or conflated with just psychological distress (McCarthy and Deady, 2008; Hanna, 2004). Whatever and crucially assuming (possibly implausibly (Lazarus, 1999, 2006)) some one thing can be singled out as the cause of the psychological distress, say X, then the distress is labelled X-distress. An example from the literature illustrates this.

> Psychiatric nurses may, for example, be emotionally distressed while restraining a patient, but they are likely to become morally distressed only if they believe that restraining the patient is morally wrong (McCarthy and Deady, 2008, p. 256).

Emotions themselves do not just happen, at least emotions that can in any sense be connected with some form of cognition or appraisal rather than a knee jerk reaction, there is a cause or at least a reason for them, especially some cognition of an event. So, it is not clear how emotional distress can

be a distinct thing rather than a result or effect of some other thing. One needs to ask why the nurses experience emotional distress when restraining a patient. It is very plausible to think that it is because of moral reasons or at least reasons that are associated with morality such as loss of autonomy or freedom, or perhaps risk of physical harm or loss of dignity or even perhaps it affects the nurses' and patient's wellbeing understood as moral. Or perhaps the reason for the emotional distress is caused by something else such as tiredness. Perhaps there is no reason for it at all. So, it is possible to hold that the psychiatric nurses' experience of emotional distress can fall under conditions 1-3 and is a type of moral distress. Similarly, when trying to differentiate the need for an account of moral distress from other types of distress Morley et al (2017) use the general example of life events. But without stipulation that life events are not to include moral events this will not do. Other more specific examples are family, or occupation. But again, without some explanation as to when a family event or occupational event is not also a moral event this is problematic.

This issue is about the boundary of the moral and whilst this is contested in philosophy (Sinnott-Armstrong and Wheatley, 2014; Dorsey, 2016b) it is important to know what is to count as a moral event that makes X-distress moral distress. It is very important when moral distress is being applied to healthcare because it is perhaps easier to make some connection of every action or event to morality and thus claim to be a moral event. Some nurses, physicians and philosophers seem to assume this at least for healthcare professional roles (Pellegrino and Thomasma, 1981; Lazenby 2020). This I think is reflected in difficulties of delimiting the items used within moral distress scales as being all and only causes of moral distress. On such accounts it seems everything could be a potential cause of moral distress thus there is nothing to be distinct and no need for a moral distress scale. One could perhaps replace condition 1 above with 1a. Experience of an event; covering anything that directly causes psychological distress which would then by definition be moral distress. But unless the boundary problem can be resolved condition 1 is itself not helpful because, like 1a. it could cover anything at all dependent upon what one takes a moral event to be. On such an account condition 1 is equivalent to 1a.

A reason for the ease of moralising professional roles within healthcare has to do with the content of morality as well as normativity. It seems plausible that morality is at least concerned with other regarding content and to be distinct as morality and not for example etiquette has to do with the others well-being (Dorsey, 2016a) although some accounts of virtue ethics it is directly about one's own well-being or (enlightened) self-interest (Hursthouse, 1999). But here we get into details within normative moral theory and it is not clear how for example some accounts of moral duty is concerned with wellbeing. But within healthcare there seems to be a plausible connection between what it as an institution does and morality. This is because either facts are equated or entangled with values with a direct connection with ought (reasons) and the ought is to be understood as a moral ought.

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Healthcare can be an especially difficult area to disentangle description from values and the normative because it has directly to do with living human beings where facts that are usually understood as descriptions can easily become teleological evaluations based on biological function which in turn is used to ground a should or ought but it need not be a moral should or ought or at least it is contested (McDowell, 1998; Woodcock, 2006). A malfunctioning heart is bad and should be repaired. If you want to be healthy then you should have your heart repaired. But it is one thing for there to be such evaluative facts and another for there to be prescriptions of ought and should, that follow from them and especially in a sense of normative force needed for morality to be distinct from the non-moral. Neo-Aristotelian virtue ethics relies on this idea using examples of animals such as owls claiming there is something wrong with an owl with poor sight then making an analogy with the functioning of human beings and then stretching it include our rationality, note not morality (Hursthouse, 1999; Foot, 2000). The point is made that there is a rational connection between what is good for us and reasons for action though it is unlikely to be an overriding reason. It may be claimed that the point of the institution of healthcare is this functional approach and thus it is its main reason for practical decision making. But again, and nursing brings this out very well, it need not be its overriding reason for action. There is often some tension between the role of healthcare

workers and the institution and ideas of autonomy and ultimate reason (Pellegrino and Thomasma, 1981).

Though it seems plausible that morality does have or could have a distinct content (but there is at present no agreement on what it is) and thus there could be moral distress requiring a distinct scale to measure it what it needs in addition is an account of its distinct normative force. The account of good for above can be understood as a 'generic normativity' (Copp, 2004) that evaluative terms in general possess. It may or may not also be understood as a hypothetical ought about well-being that need not be understood as a moral notion or moral reason if moral reasons are taken to be categorical reasons (which still may not distinguish moral reasons from reasons of etiquette). Taking this medicine is, very probably, good for you so you ought to take it or have reason to take it if you want to increase the probability of getting better (*ceteris paribus*). Science can provide the probabilities about biological function and moral psychology can provide correlations between virtues as traits that provide a good or a best bet for 'happiness' (Peterson and Seligman, 2004; Kristjánsson, 2012; Risjord, 2005; but see Tiberius and Hall, 2010 for concern over psychology's lack of concern over objective wellbeing). But on some accounts of morality and it's normativity being good for is not sufficient or even necessary for its deontic force; what is needed is something like a categorical ought or reason that is applicable to all rational beings irrespective of outcome. On other accounts, morality as good for understood as the virtuous person's reasons, override, or silence other reasons in practice (McDowell,1979; Vigani, 2019).

There is a stronger and weaker version. The weaker version being where the non-moral reasons remain as reasons, but moral reasons always override them. On the stronger version where the moral reasons are such that other reasons simply do not count as reasons. Moral normativity as silencing would at least seem to warrant the idea of distress though it would need to explain how the constraints were even taken to be reasons and why if moral reasons were silencing of all else how there could be distress at all. Morality in this strong sense of normativity (Vogelstein, 2013) may

make moral distress a distinct type of psychological distress by clearly demarcating the moral from the non-moral though it does so by blurring (many of) the very moral/non-moral differences. Anything weaker makes it more difficult to justifiably distinguish a moral event from a non-moral event or moral reasons from other reasons as well as the response that is distress. This is directly related to condition 2 about causing psychological distress which seems to be a particularly devastating type of distress and that only a very strong notion of normativity would seem to make this appropriate. But now questions of meta-ethics are relevant about what sort of thing morality can be to have such force especially where on some accounts it is independent from an agent's psychology. It also raises issues about moral epistemology.

This sense of morality as 'strong moral rationalism' (Dorsey, 2016b) that is perhaps *suis generis* in nature is hard to reconcile with a naturalistic morality (Majors, 2007), and thus hard to make use of empirically when explaining the relationship between conditions 1, 2 and 3 or creating a scale to measure it. Such a strong account of normativity would make actions or inactions cited in the moral distress literature irrational. Though we can for practical purposes perhaps distinguish between a rational person and a real person (Crisp, 2015a), strong moral rationalism reminds one of the need for caution as to the role of emotions in morality; even Nussbaum (2003) claims they can be unreliable. It is reason that seems to matter most (Crisp, 2006; Parfit, 2011) and it is unclear why or how psychological distress is related to such a moral event at least for the practically wise. And even on a weaker account of morality there is a problem of moral epistemology.

Even if a nurse, doctor, patient and relative agreed on all the facts they may still disagree as to what evaluation to place on them. But even if they agreed on the facts and evaluation or agreed on the 'evaluative-facts' they may still disagree as to what ought to be done or what they have reason to do because they may put different emphasis or weight on the same reasons. The normative force may be felt quite differently, and this is regardless of the possibility that there could be a correct account. In other words, there may be good reasons that differ in normative force about what should be done

held by people who care about the patient's well-being and for its own sake, not just because it is part of their job or profession. Additionally, apart from the fact of moral disagreement which alone should give one pause for thought about one's moral beliefs and judgement, on some accounts within moral philosophy knowledge of these demands or the truth of moral reasons and its reason giving force is intuitive (Crisp, 2015b) and justification *a priori* adding a further difficulty for empirical work and it raises issues about condition 3 'causation' (Majors, 2007; Crisp, 2006).

Causation

Causation like morality is a contested concept whether it is cause between material objects or between mental events and physical properties (Davidson, 1980). Lazarus' (1999) writing about psychology and the emotions notes that in psychology a stimulus-response model was displaced by stimulus- organism- response where organism included the mind in relation to behaviour/action part of the relation being causal. He is wary of reductive analysis as all that is important for explanation or even causation in psychology and a similar concern is related to the nature of moral properties to natural ones. There is a large literature that attempts to 'naturalise' moral properties whilst retaining its force so that instead of moral properties being decidedly odd (Mackie, 1977) , they are just like any other properties that we think are not odd. Or else a naturalist account may deny morality has a 'strong normativity' or an 'authoritative force' (Copp, 2004) but this leaves space for the weight of reasons as to what to do could fall to prudence and not morality and this may affect the idea of becoming distressed by not being able to act as one thinks one morally ought.

Even supervenience of the moral on the factual does not imply normative properties are caused by the factual, the actual relationship is very contested (Hattiangadi, 2018), and condition 3 is contested. Even the common term 'in virtue of' or 'response to' complicates the relation. If causation is covered by natural laws, then the normative seems to disappear. The 'in virtue of what?' did X cause Y question seems especially problematic for naturalistic moral explanations (Sayre-McCord, 1988; Majors, 2003). Non-naturalistic moral realism seems to avoid the question of

causality (Majors, 2003) and in any case, if true, would make empirical work on moral distress particularly difficult. Reductive moral realism removes any distinction needed for there to be moral distress rather than psychological distress. Appeal to moral facts or properties to explain condition 3, to causally affect us, is mysterious or at least highly contested. Crucially the mysteriousness is in the main due to the need to accommodate the normativity of morality (*ibid*.). This difficulty for causal explanations between a moral event and an effect that is psychological distress holds (I think) for reasons understood as causes.

Reasons are normative and may be causes via an agent's beliefs and desires (Davidson, 1980; Risjord, 2005). Plausibly there are moral reasons and so these it would seem can have a causal effect. However psychological states are not reasons. For some accounts of morality this necessitates 'agreement' by a community to constitute the beliefs and desires of the agent as norms (or not) and thus reasons for an individual agent's beliefs and desires. However, as Risjord (2005) explains, action explanations are not causal explanations, and this is important for understanding the difficulty for condition 3. Beliefs and desires as causes are psychological facts about an agent and the social status provided by the community is not part of the causal event:

> X causally explains Y only if X is an event…in the causal history of Y (Risjord, 2005, p. 300).

One account that tries to give explanations for how belief and desire can be causes but not a causal explanation is an erotetic model of explanation (Risjord, 2005). But the erotetic model of explanation based as it is on both the ability to describe norms without thereby endorsing them and community agreement on what reasons count as norms makes it problematic to meet condition 1, which is the condition that distinguishes moral distress from non-moral psychological distress. This can be illustrated using the relevance criteria used in the erotetic model. In intentional action explanation the explananda accounts for the reason for the action based on the agent's pro attitude (desires) and this is the relevance condition and it 'presupposes a normative relationship' (Risjord, 2005, 303 emphasis mine). What is the relevance criterion for condition 2 and how does it relate to

condition 1? Whilst it may seem plausible to account for intentional action by asking 'why?' and presupposing some normative relationship it is less clear how this transfers or accounts for the relationship between conditions 1 and 2 where the result or effect is psychological distress. The point made in the previous paragraph as to how condition 3 holds remains.

Moral normativity and *distress*

There are psychological accounts of distress that include the evaluative as appraisal (Lazarus, 1999; Moors, 2009) but such accounts blur or at least are unclear about any distinction between moral and non-moral; psychology can include the evaluative but does not and should not extend to the prescriptive where moral theory must (Crisp, 2006) and there is no agreement on what this is. A gap in the form of a relationship remains between conditions 1, 2 and 3.

A brief note about constraint is warranted here because this is much discussed in the literature on moral distress in relation to condition 3. I think McCarthy and Monteverde (2018) are correct that constraint is relevantly different to moral dilemma and moral uncertainty as causes of condition 3 though presumably one could become psychologically distressed because of dilemma and uncertainty and hence morally distressed. However, my guess is that we would be surprised if this were the case; it just would not seem warranted. Moral authority as constraint is relevant here. Even if one holds to the categorical force of morality as overriding morality is ultimately in the same boat as that of the authority of law or of a profession; one can still go against it. But a strong categorical account of moral normativity as overriding seems to warrant some strong response on the part of the agent if he does not do as he thinks he morally should. This is assuming this can be the case and the agent still does know the moral thing to do. 'Moral' in the weaker sense that equates with any event causing distress can easily allow for balancing or weighing reasons with the reasons given by people in authority. From a normative as general reasons approach it may be that the nurse (or phronimos?) has judged that the reasons for acting or refraining from acting has he did are stronger than or better than the 'moral' reasons. Relatedly if the cause of the distress is not constraint but for

example a dilemma or, differently, uncertainty the appropriateness of the distress as well as responses to it and responsibility for the response will or should be different for epistemological concerns connected with the ontological as appropriateness of response.

An idea in epistemology of 'pragmatic encroachment' (Fantl and McGrath, 2007) where roughly whether a subject knows that p can vary due to differences in practical states such as the importance or risk involved so that for example withdrawing life support from a patient with the high probability of very quick death requires a greater strength of evidence than does thinking a colleagues clinical competence is poor. It is of note that the literature on moral distress has raised a similar concern changing the definition from knowing the right thing to do to something epistemically weaker such as perceiving or believing or confusingly make clear moral judgements. Even if this should not be the theoretical standard for knowledge it seems to have some practical weight again related to the warrantedness or otherwise of the resulting distress.

Relatedly, Morley et al (2017) have usefully tabulated the many epistemological terms in use in the literature on moral distress such as judgement, belief, knowledge, uncertainty and rightly suggests that either they are all been used to mean judgement or they are taken to be different. This matters for empirical work on moral distress because of the connection with reasons for action or not acting and the associated psychological response. For instance, being certain or knowing that doing some action is wrong and bad or vicious seems to have a different epistemological status to believing which in turn differs from uncertainty. These different epistemological stances intuitively at least require different psychological responses and different measurement scales.

Understanding the normative force of morality as categorical and overriding because of its special normative prescriptive force, seems to justify the extreme emotional response that is distress, not simply stress, when one does not do as it requires. The qualification seems to is important. Knowledge of any objective thing, and for moral realism and more contentiously anti-anti realist stances or response depend accounts, morality is objective, the epistemic and the ontological can

come apart such that it is (just) the construal by a nurse of the situation that causes his distress. Although the distress is 'real', the nurse is suffering what we will call for now mental anguish and probably physiological symptoms; it is not moral distress because it is not caused by a moral event. Either because the nurse is mistaken in what he construes to be a moral event, or he is correct in his construal but is mistaken in his reaction as response. Even response dependent accounts of morality, where roughly the nature of moral properties is in a sense dependent on human being's responses, attempt to provide critical distance between having the response and the response being merited (warranted or appropriate) (D'Arms and Jacobson, 2000). It may be the correct or warranted response should not be one of not distress but something else perhaps anger at oneself for cowardice or anger at others for something, perhaps not agreeing with their own moral judgement.

In relation to objectivity of the moral there is also a further concern that a nurse may not recognise a moral event and its warranting a certain response and thus will not lead to psychological distress on his part even if it should do so. Literature suggests that this non-recognition of a moral event by third persons is major cause of moral distress for individual nurses and is reflected in some of the items in the moral distress scales. But there seems to be a double count on behalf of the agent first person account suffering moral distress who must first recognise a moral event and know the correct response and then know that the other agent as work colleague third person account either can or differently should recognise what needs be the same moral event and respond appropriately perhaps understood as the same as the first person. But some of the literature about moral particularism especially on the holism of reasons (Hooker and Little, 2000) strongly suggests that for example simply being a different person may itself change the moral valence of the situation, in effect making the moral situation relevantly different. Even if the valence cannot change the agent's reasons might. In fact, the issue is compounded because in the moral distress literature what is taken to be problematic is the colleague's incompetence and so this must be in some sense moral incompetence for it to be moral distress. Yet morality unlike say geology or anatomy has no epistemological experts and thus it is much more difficult to judge a standard for competence.

Finally, it may be objected that even if distress is the wrong or inappropriate moral response it seems that warranted or not the individual still experiences distress. An event or an action that at least is perceived or, better, construed by the agent herself that causes distress directly perhaps also indirectly is practically significant. Distress is an evaluative term with no positive valence perhaps equivalent in sense to the latter end of Lazarus' (1999) notion of a continuum of stress through to trauma. This plausible account of the nature of distress as normative as evaluative, dependent upon not only input (cause) and output (response) but also mediating appraisal by the agent is important. The point here is that there is reason to relieve suffering however it is caused and thus reason to relieve distress.

This weaker account of normativity of evaluative reasons results in two things. First condition 1 needs replacing with 1a Experiencing an event. We may think that a completely irrational person has no reason that we can understand to feel distress even though the sheer fact that it is distress being felt warrants helping. This account of warranted helping may be labelled moral but if so then it is simply a placeholder for anything that causes distress and thus condition 1 can be replaced with 1a unless a clear distinction can be made. Second the evaluative is still normative and thus condition 4 is still necessary especially so since the point of this classificatory project is practical; to do something about healthcare workers (and others) psychological distress.

The warranted unwarranted distinction together with the current condition of moral epistemology has implications for responsibility for alleviation of the distress which may be institutional, professional, or individual. Constraint and its connection with moral responsibility is quite complex and has been discussed in moral philosophy for thousands of years. More recently perhaps, the issue of appropriate emotions and other psychological responses are once more to the fore (Nussbaum, 2003; Crisp, 2006). The strongest account of constraint would be something akin to being certain that X is the right thing to do but being physically prevented from doing so one cannot do it. Constraint in practice is always much weaker; the nurse can act or refrain from acting but there will

be well known potential or real costs in doing so; one might say reasons against doing so. It may be the 'constraint' is actually or ultimately the nurse's cowardness; or the nurse has decided there are better reasons not to act; or perhaps the nurse has, like almost all of us, not quite reached the mark of the *phronimos* and is mistaken in his situational appreciation.

These points then raise an interesting question about the role of emotions for moral knowledge and in this case for moral distress. Emotions can be recalcitrant remaining even when the nurse knows that X or knows there are better reasons and yet still feels certain emotions of certain strength that he now justifiably believes to be inappropriate. The nurse may initially feel distress but very quickly realises that he should not. The distress as emotional response remains, and he knows it should not.

Conclusion

The need for a distinct account of moral distress is mainly practical and so some of this paper may seem to miss the mark entirely. For some metaethical concerns need not have any relation to real life practice but I doubt this is true. But even normative theories differ in accounts of what makes something right or good some of which blur distinctions between moral and other events.

There is a need develop robust research studies that can be compared and where possible aggregated. The idea is that they all use a similar or the same robust tool. These reasons are related to the objective of remedying moral distress including being able to measure their effects (if any). However, measurement scales for moral distress make the assumption that there is agreement on what a moral event is and perhaps that it can be known *a posteriori*. The previous sections have at least problematized this assumption of there being one thing that is moral distress, and which can be clearly demarcated and thus problematizes the psychometrics of current moral distress scales. All attempts to measure moral distress comes undone if no account of a moral event can be given that ensures it is objective and statistically (at least) causes psychological distress. But more than statistics is required and that something is normativity.

Relatedly a relational approach to understanding what stress (distress) is emphasises the interrelationships of family and work stress as well as the importance of individual personality variables for their effect. What causes stress reaction and what counts as a stressor is the significance as appraised by the person encountering it (which may be subconscious). What is a 'daily hassle' (Kanner, et al 1981) for some is a very stressful perhaps even distressing event for others. Better to take condition 1 a. and understand condition 2 as necessarily requiring an appraisal by the individual, measure levels of perceived distress and then ask individuals about what it is they think is causing their distress. I think a plausible summary will be unjustified suffering of patients. Condition 4. Is necessary both because of its theoretical importance in defining a moral event but also because of the practical need for doing so. Perhaps much of the remedy for moral distress will be about the appropriateness or otherwise of the response to the event.

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