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***Moral Distress,
Moral Equilibrium and
the Moral Equilibrium Framework:
Health Professionals' Well-being in the Face of Daily
Challenges to Moral Values and Integrity.***

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Abstract

The impact of moral distress on health professionals, patient care, healthcare teams, organisations and the healthcare sector itself, is at this time significant and increasing. Most research into moral distress has focussed on nurses in acute care settings, and largely in the United States. This combined ethnographic and interpretive phenomenological research investigated gaps in the moral distress literature including the experiences of health professionals' moral distress (1) in the Australian context, (2) in a multidisciplinary specialist palliative care team, and (3) in a community setting. My research began with the question: "how do community specialist palliative care health professionals experience and respond to moral distress?"

This study makes three significant contributions to the contemporary exploration of moral distress. The first is the concept of moral equilibrium-disequilibrium that offers a new way of understanding and responding to moral challenges in palliative care. This new concept emerged from the iterative analysis of the experiences of participants in this setting. Moral *disequilibrium* results when health professionals, faced with challenges to their values and moral integrity, are unable to adapt to maintain their moral integrity. Moral disequilibrium is part of the everyday experience of being a health professional, and like all experiences will vary from person to person and in intensity, from mild (e.g. moral discomfort) to severe (e.g. moral distress, moral injury). The moral equilibrium-disequilibrium concept provides a positive perspective to moral challenges, and also considers the psychological, spiritual and physical well-being of health professionals. The concept is of practical value to clinicians as it names the dynamic involved in their experiences without the associations of varied current definitions of moral distress. If moral disequilibrium can be identified and addressed early, it may mitigate the progression into further disequilibrium.

The second significant contribution is the development of the novel Moral Equilibrium Framework (MEF). The framework comprises three dynamic phases: identification of moral disequilibrium and the moral values involved; its resolution in attaining a "good enough" moral equilibrium; and the evolution phase of growth in moral understanding including the building of moral resilience. Whilst the framework was derived from the experiences of health professionals who were part of this study, I argue that its phases and processes are consistent with various recommendations in the moral distress literature, adding to its strength. The moral distress literature also emphasised the importance of organisational responsibilities in mitigating moral distress. Similarly,

whilst the MEF focusses on individual and team processes, its use does not negate the organisation's role in helping to minimise moral disequilibrium.

The third important finding of this research is that the team as an entity can experience moral disequilibrium. This is in contrast to previous studies that name moral distress as individual experiences occurring within the team. This revelation of team moral disequilibrium highlights the importance of being attentive to and addressing the state of moral disequilibrium not only at the individual level but also at the team level.

In answer to my research question, I conclude that experiencing daily moral challenges, community specialist palliative care health professionals often choose to respond in ways that help to regain a "good enough" moral equilibrium, both as individuals and members of a team.

The thesis will be of interest to health professionals who experience daily moral challenges in an ever growing, stress-filled environment of caring for patients, and who seek to find ways of regaining and sustaining "good enough" moral equilibrium and integrity.

Declaration

This is to certify that

- (i) the thesis comprises only my original work towards the PhD,
- (ii) due acknowledgement has been made in the text to all other materials used,
- (iii) the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Caroline Gaik-Gim Ong

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Style Notes

For this thesis I have used a modified version of the APA 7th style.

Pseudonyms

The names of the participants in this study have been de-identified and pseudonyms used to maintain the confidentiality of the participants. To increase the participants' confidentiality, I have grouped and named participants of similar palliative care experience and age but address them as one individual. For instance, Group Rhonda, or G Rhonda, comprise three senior nurses in middle management positions, aged in their thirties and forties. However, as I relate their experiences I do so as though G Rhonda was an individual. Group Andrea, or G Andrea was a group of three senior allied health professionals aged in their forties and fifties.

Names beginning with "A" were individual allied health professionals, for example Alex. Similarly, names beginning with "R" were registered nurses, for example Riley. For these individuals I identify them as senior or junior depending on their years of experience. Junior health professionals were those with less than four years' experience, and senior, more than four years. This arbitrary criterion was based on some of the participants' description of themselves as junior or senior professionals.

Doctors are those who have a medical degree and had names beginning with "D". Registrars are doctors who are in the palliative care physician training program and have names beginning with "D" as well. Physicians in this thesis are doctors trained in a medical specialty such as palliative care and are sometimes known as consultants—their names also begin with "D". Marin was the name given to the manager, however, where comments were made not pertaining to her role as manager, she was included in the G Rhonda group. In general, I also used names not attributable to a particular gender to maintain the confidentiality of the participants as there were three male participants.

Spelling

I use the British English spelling of words, unless the word appears in a quote in which case the original spelling is used.

Acronyms

| | |
|------------|-----------------------------|
| CNC | Clinical Nurse Consultant |
| GP | General Practitioner |
| ME | Moral Equilibrium |
| MEF | Moral Equilibrium Framework |

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Chapter 1: Introduction

I first encountered the term “moral distress” during my Masters study in Bioethics and Health Policy several years ago. One of the earlier definitions of moral distress was given by nurse ethicist Andrew Jameton (1984): “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” (p. 6). Whilst it caught my attention then, my interest in researching moral distress grew after I personally experienced such significant moral distress that I resigned from the community health centre where I had been working at as a GP. I wrote to a friend:

I quit! I have had enough! After 25 years I resigned and moved next door! Patients who attended the clinic at the community health centre were predominantly elderly with multiple chronic problems, non-English speaking migrants and of low socio-economic background. All was good. The staff at the clinic worked well together. We were a community. We all pitched in and went the extra mile for patients. Then the Board decided to get rid of the executive team and put a new one in.... The rumour was that there were changes in funding and so we had to be profit-making.... The new executive it seemed brought a different philosophy and had values which were very different to that of the organisation. It was no longer about excellent and compassionate care for those who were poor and vulnerable. We had meetings after meetings with the executive in charge of the medical clinic and the chief executive officer, we even gave the medical clinic executive suggestions of how to increase our income, but they wouldn't listen. We were expected to see more patients and work significant unpaid overtime. The GPs [General Practitioners] and I felt we were unable to provide adequate care to our patients who had very complex needs and we felt pressured into dangerous practice. We even kept putting reports into Riskman [a quality and risk software that reported cases of misadventure, injury and risk of injury] of risks in managing patients because of the workload. I felt that I couldn't live my values and the way I believe medicine should be practiced. We were putting patients' lives at risk. I couldn't do that. Bullying practices were also at play. The whole medical team comprising GPs, nurses and receptionists, experienced significant stress and moral distress. Three of us GPs left at varying times in the course of a few months. It was not good. (Caroline, senior GP)

It was an experience of team moral distress that I had not previously encountered, and I was intrigued as to how each health professional responded to this situation, as individuals and how we responded as a team. I was unsure if my vocation as a religious sister made any difference to the experience of moral distress. Thus, began my interest in researching moral distress in community care.

In this chapter I further explore this interest in moral distress and the significance of this research. I describe the gaps in moral distress knowledge on which this project focussed. I then give a brief account of the Australian context relevant to this research. I conclude with the research aim and the thesis overview.

As I began my research project, I became even more curious about health professionals' responses to moral distress in community care. I was also unclear if health professionals considered all moral challenges as moral distress regardless of the literature definition, or even if they were aware of the moral distress concept. In February 2018 during my recruitment presentation to staff at the community-based specialist palliative care service where I did my fieldwork, I posed my research question. It was: "*How is moral distress experienced by community palliative care health professionals and how do they respond to it?*" The participants did not recognise the term "moral distress" but seemed familiar with the experience.

Soon after the presentation G Andrea, a very experienced and caring allied health professional, offered to be interviewed. She became a key participant with whom I had a number of informal conversations and two further in-depth interviews. Her descriptions of the impact of moral challenges in her work characterised the moral struggles that many health professionals in this community palliative care service were experiencing.

I've been in palliative care now for a very long time and I've never heard of moral distress before this. I realised then that there is a lot of stuff we deal with that is moral distress, but you sort of don't recognise it as such. So now we are able to label it a bit more, now that we know what it is. I think we were acknowledging it but not labelling it and it helps to label it....

For me there are a few things that could be thought of as moral distress.... Work is a lot more fast paced now... my struggle is how to leave the ones [patients] I think are okay... but there is no time to check on them again... we

don't have the capacity to follow through and I find that hard... challenging. Is this moral distress? I guess it really doesn't matter, to me it is.

Then there is the patient who on the first visit said she supported euthanasia. [G Andrea went on to describe the patient and the patient's medical condition and social situation.] She asked me what I thought. I felt uncomfortable but replied that it was really up to her and that it's nothing about whether I agree with it or disagree, and we can't at the moment anyway. She knew that the Bill [Victorian Assisted Dying Act 2017] won't come into play in time for her. I said to her that it is not about me and that I was there to support her, but I also wanted her to be well informed before making any decisions.... I did take it to supervision.... I'm more confident now in helping her. (G Andrea, senior allied health professional)

Whilst G Andrea was pleased to be able to label her experience, I noted that she was not concerned about meeting the stated definition of moral distress—to her it was moral distress. This was an awareness that became significant—the bringing to consciousness of what was happening for G Andrea and the naming of it was more important than the accuracy of labelling the experience in line with definitions in the current literature.

Another key participant was G Rhonda, a senior nurse within this service, who gave accounts of her experiences of moral distress as a specialist palliative care nurse.

I think it's hard to grasp what moral distress is. You talked about constraints... but what are the constraints? Lack of funding, so you are caught pushing staff to do more work and take on more shifts? How is that fair? Is that moral distress or just stress? Does it matter? The stress or distress is still there! And I don't think it's as simple as all that. I think it also depends on what else you have going on in your life. Some days you can handle anything, other days it's a struggle and you are not as confident if it's the right thing to do....

There was a patient who was on a syringe driver for a lot longer than usual... the family kept asking for more [medications], even threatened to complain to the health commissioner. We knew it wasn't right, but we also weren't there all the time with the patient, short of having a hidden camera we couldn't tell if that was what the patient needed. The patient was drowsy all the time so we couldn't quite ask her either. Everyone was involved—allied health, the consultant [palliative care doctor], management, the priest, the GP.... She did

die in the end of course but it kept you wondering if you did the right thing....
(G Rhonda, senior nurse)

There were many more examples that G Andrea, G Rhonda and their colleagues gave of the moral challenges they faced daily which they named as moral distress. Many of the examples that were shared did not meet with the definition of moral distress that authors such as Jameton (1984, p.6) and Epstein et al. (2019, p. 114) describe. The participants' broad classification of these experiences as moral distress was similar to Hamric's (2000) experiences of nurses. Hamric noted, "nurses are unfamiliar with the terminology of moral distress and how to recognise it... they cannot distinguish moral distress from uncertainty of a moral dilemma" (p. 200). Like G Andrea, the nurses Hamric discussed found great relief in "giving the painful feelings a name and seeing how others have experienced them..." (p.200). Hence whilst the term moral distress might not quite capture the experience, as for G Rhonda and G Andrea, it was nonetheless important to name and share the experience. This motivated me to explore and understand the dynamics and issues involved in the health professionals' experiences that distinguished these experiences from moral distress.

Significance of This Research

Most research aims to define moral distress as a problem that needs fixing, taking the approach of cause and effect. There is very little empirical research that explores moral distress from where it sits in the web of the lived experiences of health professionals. This research sets out to do just that. My research contributes an empirical-based understanding of another dimension in the exploration of moral distress—the actual clinical experiences of health professionals as they navigate the daily moral challenges that could easily lead to moral distress.

I wondered if one of the many reasons moral distress has taken prominence in recent times was because it can give expression to the growing moral struggles and challenges that health professionals face daily, as it did for G Andrea and G Rhonda. Yet the complexities inherent in the lived experience of health professionals, such as other stresses and relationships, also contribute to the experiences of these moral struggles and challenges, as G Rhonda explained. Moral distress as defined by Jameton (1984, p. 6) and Epstein et al. (2019, p. 114) may not be adequate in capturing all experiences of moral struggles and challenges, and I suspect neither is it intended to do so. As I delved further into fieldwork, I wondered if there was another concept that better captured their experiences.

Most research on moral distress has been conducted in the United States and in the acute care setting. In the community setting there is only one Australian study which explored nurse moral distress in residential aged care (Burston et al., 2016). This research brings to attention the lived experiences of a group of specialist palliative care health professionals in Victoria, Australia, as they faced the daily moral challenges of caring for patients in the community. It gives voice not only to these health professionals' experiences but also to the practical ways they chose to resolve them and grow from the experiences.

My focus is on the evolving field of specialist palliative care, in community health and in the relational dynamics that can happen in multidisciplinary care teams. I now briefly describe these three areas in the Australian context, naming a few possible moral challenges that may arise within these contexts, possibly leading to moral distress.

Palliative Care in Australia

Palliative care is a relatively new specialty in medicine and continues to evolve (Australian Government Department of Health, 2018, p. 7; Currow & Phillips, 2013). As palliative care broadens its scope of practice and establishes itself as a specialty equal to other specialties, new moral challenges could arise.

Palliative care's history can be traced back to when hospice care first began. Care was focussed on ill and dying patients when no further curative treatment was available (National Hospice and Palliative Care Organisation. 2016). The birth of modern holistic palliative care can be attributed to Dame Cecily Saunders who introduced the concept of "total pain"; this was defined in 1964 as including the management of not only physical symptoms but also mental distress and social or spiritual problems (Saunders, 2001, p.430). Holistic palliative care in Australia was initially only provided to those diagnosed with cancer. From 1989 onwards, its scope of practice extended to patients with any life-limiting diseases (Currow & Phillips, 2013, p.40). In 2019, Palliative Care Australia described palliative care or palliative medicine as "person and family-centred care, provided for a person with an active, progressive, advanced..." and life-limiting disease, "and for whom the primary goal is to optimise the quality of life" (Palliative Care Australia, 2019). Its scope broadened further to bereavement care for the family and loved ones.

Palliative care is a relatively new medical specialty. The world's first sub-specialist training program in palliative medicine was offered by the Royal Australian College of Physicians (RACP) in 1988. In 2000, a Chapter of Palliative Medicine was formed by the RACP (Currow & Phillips, 2013). Its status as one of the youngest specialties in medicine contributes to the moral challenges palliative care health professionals face (Chapter Four: Moral Challenges).

Palliative care can be arbitrarily categorised into general and specialist palliative care (Palliative Care Australia, 2018b). General palliative care is often given by medical and allied health teams in relatively uncomplicated end of life care, such as when symptom control is managed well by appropriate medications and patients and family are accepting of the patients' dying and death. However, when end of life care becomes complicated, specialist palliative care services may be more appropriate, whether they are provided intermittently or continuously, to people who are inpatients or outpatients of hospitals, or in the community setting.

An example of intermittent care might be when a patient's symptoms become difficult to manage and a more complicated regime of medication might be needed. The general practitioner (GP) might call upon the community specialist palliative care team to assist with assessment and advice or refer the patient to a hospital as an outpatient. Once the symptoms are under control the GP would continue the care of the patient knowing that she could call upon the community specialist team or the hospital should the need arise again. Good relationships between GPs and specialist palliative care teams as well as open communication encourage good patient care.

In contrast to intermittent care, continuous care would be provided when the patients' care needs are complex and require ongoing monitoring by the specialist team, such as frequent visits to change syringe driver medications. Continuous care might also be needed in situations of complex family dynamics requiring ongoing counselling and support from the allied health team—psychological distress may complicate the patient's pain control. An alternative to home care would be for the patient to receive inpatient care (Better Health Channel, 2017).

The context of a broadening scope of practice as well as the gradual establishment of palliative care as a speciality may result in increasing moral challenges. The holistic approach helps determine the priorities of care based on the patient's wishes, and physical, spiritual and psychosocial considerations. Theoretically moral challenges and distress would be minimised as all aspects of care are taken into consideration (Bishop

& Scudder, 1997). Conversely, with more health professionals involved in care there could be more differences of opinions, values and goals, possibly resulting in further moral challenges (McEvoy & Duffy, 2008).

A broader scope of practice involving patients still receiving active treatment also implies a greater patient load unless a proportionate increase in resources is also available. Where there are limited resources, ethical issues of justice and equity of care become more challenging. The jurisdiction between general and specialist palliative care can be challenging and becomes morally challenging when there are differences of opinions and values as to what constitutes good patient care. Different goals of care, for example prolongation of life where the burden is greater than the benefit, between hospital specialists and palliative care health professionals may result in further moral challenges. In the community setting, if the specialist palliative care service is a consultative service, GPs are the primary care coordinators. Hubris and miscommunication between GPs and specialist palliative care teams can also result in further moral challenges.

Australian Community-based Healthcare

Community-based healthcare is healthcare provision outside of hospital and other acute care settings (Department of Health & Human Services, n.d.). Patients are treated in community healthcare centres, general practices, private healthcare practices, and in patients' own homes. Other community settings include correctional facilities, specialist housing for people with disability and mental illness, residential aged care facilities and places where the homeless gather. It may involve a variety of services often coordinated by a general practitioner—medical, dental, nursing, and allied health which includes physiotherapy, occupational therapy, audiology, podiatry, exercise physiology, counselling and other support services.

Moral distress for health professionals working in community settings is under researched. I considered three elements relevant to this research project. Firstly, the pace of caring for patients in community settings is often slower and the need less urgent than in the acute setting. Secondly, health professionals tend to work autonomously compared to their hospital counterparts. Thirdly, with increasing complexities in community care structure there may be increasing communication difficulties in community care.

In general, the urgency of care in the community setting is less than in the acute setting. If care is urgently needed patients are often referred to hospitals by various means including: after being assessed by healthcare professionals such as the specialist palliative care team; after telephone consults; via the ambulance service; or by patients self-presenting to the hospital emergency department. For the most part health professionals in the community setting would set their own pace in seeing patients. The assumption would be that this would likely result in the capacity to provide good quality care according to best-practice and thus minimise moral challenges of care provision. A contrary argument could be that as demand grows, and funding is dependent on the number of patients seen, moral distress may result as health professionals are constrained from fulfilling their value of excellence in care provision. So, whilst the pace may be slower and the urgency of care not as significant, the increasing demand for service may be a source of health professional moral distress.

Healthcare professionals in the community setting often work alone and with greater autonomy than those in acute care settings. Some may have their reference points or professional support from colleagues at a main office site such as a community health centre or the palliative care services' main office. These colleagues may or may not know the patients. In the acute care setting members of a multidisciplinary team are more often in communication with each other about a particular patient. This greater autonomy of health professionals in the community setting may mean that there are less occasions when their moral values are being challenged. On the other hand, there may be fewer opportunities for health professionals to resolve, with assistance from their colleagues, any moral distress or moral challenges that arise.

Communication with others involved in the care of patients is key in good patient management and particularly so in community care (Gardiner et al., 2012).

Unfortunately, this can be problematic in community care. Income is dependent on patient load. The higher the patient load the less time there is for administration which often includes corresponding with GPs who are regarded as the primary healthcare providers in Australia. In the same way GPs' heavy patient loads may mean they are not easily contactable or that they may not return calls when specialist palliative care health professionals leave messages requesting return calls. It is also not uncommon for patients to have more than one GP. Moral challenges may then arise as to how to fulfil obligations of care to patients because of uncertainty about which GP is central to the patient's care and the lack of time to communicate adequately to all the patients' GPs.

In the setting of community care, GPs coordinating patients' care may not realise that their patients see particular healthcare professionals such as physiotherapists or chiropractors, as patients may have self-referred. This may pose a challenge for GPs in the provision of good healthcare to their patients, especially where there may be apparent conflicting management strategies and goals between GPs and other health providers including specialist palliative care health professionals.

The Multidisciplinary Team in Healthcare

As community palliative care services evolved in Australia, so did the composition of the team who provide the services. This is important to note as different disciplines may have different approaches to patient care, which may in turn contribute to moral conflict or moral distress. In Australia, community-based specialist palliative care services vary in the composition of healthcare professionals from service to service. Some are nurse-only services working with other care providers in the community, including GPs and allied health professionals. However, as the demand for healthcare increases and its provision becomes more complex and specialised, the advantages of having multidisciplinary teams becomes evident. Most services now have allied health professionals such as counsellors, social workers and pastoral carers, as part of their teams. When there are multiple health professionals with their own expertise and approaches to healthcare, there needs to be an understanding of how they can work together to achieve the common goal of good patient care (Crawford & Price, 2003).

Terminology

Three approaches of health professionals from different disciplines working together as a team are named in the literature: multidisciplinary, interdisciplinarity and transdisciplinarity (Choi & Pak, 2006). I mention this as the approaches taken by the different health professionals in this project vary according to the situation and these differences may contribute to the varied moral challenges. An excellent explanation of the differences is given by Choi and Pak (2006) in their literature review. They concluded that “the three terms... refer to the involvement of multiple disciplines to varying degrees on the same continuum” (p. 359). Multidisciplinary, according to them, by nature is “additive” like “a mixed salad, in which the ingredients remain intact and clearly distinguishable”; interdisciplinarity by nature is “interactive” like a “stew, in which the ingredients are only partially distinguishable”; and transdisciplinarity by nature is “holistic” like “a cake (in which the ingredients are no longer distinguishable,

and the final product is of a different kind from the initial ingredients” (Choi & Pak, 2006, pp. 359-360).

An example of a multidisciplinary approach might be individual team members assessing the need of the patient according to their own disciplines. Their individually-derived patient goals may or may not be similar between the disciplines. This can be a challenge, especially if each discipline believes they know what is best for the patient. These challenges may be moral in nature especially if the health professionals experience them as challenges to their moral integrity in not being able to provide exemplary care.

An example of an interdisciplinary approach might be that the different professionals meet together with the patient, asking the necessary questions and developing a management plan which incorporates the different aspects of the patient's needs. The challenge here could be an inability to reach a consensus, with each discipline emphasising the greater importance of their specific approach, and the patient caught in the middle and feeling vulnerable. Again, these challenges may be experienced by the health professionals as challenges to their moral integrity.

An intermediate approach between multidisciplinary and interdisciplinary approaches along Choi's and Pak's continuum, might be that individual health professionals assess the patient separately then meet together to share information and reach a consensus on ongoing management for the patient.

A transdisciplinary approach sees the members of the team sharing a common goal of care with the patient. Here disciplinary boundaries are blurred within a scope of practice—there is “an overlap of responsibilities and functions amongst the various disciplines.... [E]ach team member takes responsibility for the patient as a whole and the specific intervention is not the sole responsibility of a particular discipline” (Gordon et al., 2014, p. 428). In this approach, moral challenges may result in the team, as an entity, experiencing moral distress.

Where the interactions of team members of multiple disciplines are along the multidisciplinary-interdisciplinary-transdisciplinary continuum, may be dependent on the complexities of the patient's needs, unless specified by a particular service. This was evident in my observations in this research project.

In Australian healthcare, the term “multidisciplinary team” is used for any approach along this continuum, despite the Victorian Health Department making a distinction

between the interdisciplinary and multidisciplinary approaches (Department of Health and Human Services, 2018). For these reasons, for the purposes of this research, I use the term “multidisciplinary” as the overarching term for any approach taken that involves multiple disciplines working together.

Benefits of Multidisciplinary Teams

Multidisciplinary teams comprise members from two or more disciplines, for example, nurses, doctors, allied health professionals. The benefits of multidisciplinary teams are evident. Instead of multi-tasking, nurses for instance could focus on nursing care, and when longer-term psychosocial care is needed, the patients and/or families can be referred to counsellors or social workers. This allows nurses, for example to see more patients needing nursing care. It does not preclude nurses from providing a supportive ear when patients or family members are in immediate distress. A difficulty might arise if the patients or families are given different information by different health professionals, leading to confusion. It becomes a moral challenge when one health professional witnesses a colleague behaving unethically or when the different health professionals continue to give differing advice to patients.

Another positive effect of multidisciplinary is that decisions made regarding patient care may be more comprehensive as they incorporate a variety of professional perspectives and expertise. The referral process to the various disciplines could be expedited and corridor conversations or phone calls to a colleague about patients in relation to the referrals may be more comprehensive than written forms. Whilst it may be possible that multidisciplinary team meetings involve further time commitment it could also be argued that in the long run it saves time as information that might have taken longer to obtain is shared easily. A difficulty that may arise here is if there exists a hierarchical model of relationships and authority, leaving some health professionals feeling powerless to do anything.

Learning from other disciplines regarding their perspectives, approaches and roles may also help members appreciate each other, make more appropriate referrals and share this knowledge with patients and families. This may avoid misunderstandings and misguided expectations regarding other team members from different disciplines. However, how these multidisciplinary approaches and interactions influence the experiences of moral challenges and moral distress remains to be fully understood. This research explores some of the aspects described above.

Research Question and Aims

My research question was: “how is moral distress experienced by community specialist palliative care health professionals?” I had two aims associated with this question.

Firstly, to explore how community specialist health professionals experience moral distress but also to note the influences that contribute to their experience of this distress. In other words, why did one health professional experience significant moral distress whereas another did not, when both were exposed to the same moral challenge.

The second aim was to explore how the health professionals, having experienced moral distress, responded to these experiences. I was interested in the strategies they employed and what for them constituted a satisfactory outcome.

The lived experiences of this group of specialist palliative care health professionals add to understandings of moral distress and moral challenges in the Australian community setting. This may assist other health professionals in similar settings to navigate their own moral challenges.

Thesis Overview

In this thesis I focus on community specialist palliative care health professionals' experiences of moral distress. I argue that they often chose to respond in ways to help regain a good enough moral equilibrium with their personal and professional core values, both as individuals and members of a team. I introduce the new concept of moral equilibrium, based on participants' experiences, and I offer the novel Moral Equilibrium Framework based on their attempts to resolve their moral disequilibrium.

In this chapter I described my interest in exploring moral distress, not just in terms of cause-and-effect, but in the more complex lived experience of health professionals. I also described the significance of this research in the underexplored area of community specialist palliative care health professionals. I gave an overview of the palliative care specialty, community-based healthcare, and the multidisciplinary team in the Australian context. In doing so I named a number of moral challenges I foresaw in these areas. I then posed my research question and aims.

In Chapter Two, I critically review the moral distress literature and identify gaps in moral distress research. I explain the significance of the moral distress phenomenon in terms of its impact on individuals, the team and organisation if left unaddressed. I also describe the evolving healthcare sector and changing palliative care specialty as

exemplified by the specific service within which I did my fieldwork, beyond the broad overview I gave in Chapter One.

Chapter Three outlines the methodology and methods used to gain insight into this phenomenon of moral distress. I explain its inductive, empirical, combined ethnographic and interpretive phenomenological research design. I also describe in further detail the service within which I conducted the fieldwork, including the participants.

Chapter Four describes the moral challenges that the participants named as causing moral distress and feelings of dis-ease. This rich data led to the concept of moral equilibrium-disequilibrium which I explain in the next chapter.

In Chapter Five I introduce, define and describe the concept of moral equilibrium based on the data. I relate this to core values, and name some of the contributions to a state of equilibrium. I also introduce the concept of “good enough” moral equilibrium.

Chapter Six summarises the participants’ responses to moral disequilibrium which formed the bases for the development of the Moral Equilibrium Framework (MEF).

Chapter Seven describes in detail the Moral Equilibrium Framework including the three processes of: (1) identifying individuals’ or the team’s moral values and the presence of moral disequilibrium; (2) resolving the moral disequilibrium; and (3) evolving from the experience and building moral resilience.¹

Chapter Eight concludes the thesis with a summary of the findings of this research. It suggests further recommendations for the development and applications of the MEF; the contributions of both individual health professionals and the organisation towards minimising moral disequilibrium; the significance of the findings of this research; and its limitations and prospects for further research.

In answer to the thesis question, I conclude that experiencing daily moral challenges, community specialist palliative care health professionals often choose to respond in ways to regain a “good enough” moral equilibrium in line with their core values, both as individuals and members of a team.

¹ Cynda Rushton (2016b) defines moral resilience as “the capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, distress, or setbacks... minimize one’s own suffering, and allow one to serve with highest purpose” (p. 112).

Chapter 2: Moral Distress

We hadn't heard of moral distress before. I think we [group of allied health professionals in the service] realised that we probably experience it all the time. We are still not sure what it is fully... but it seems familiar. (Ange, junior allied health professional)

It's really hard to know what's moral distress. You almost can't define it.
(Reska, senior nurse)

Both Ange and Reska, like G Andrea and G Ronda quoted in Chapter One, named two of the many difficulties encountered in moral distress research. One is the observation that whilst the literature on moral distress has grown significantly in the last few years, the term “moral distress” is still not known amongst many health professionals (Hamric et al., 2006, p. 18; Ritchie et al., 2018). However, once explained to health professionals, they easily recognised the discomfort or distress associated with moral challenges as a common experience (Hamric, 2014, p. 462; Hanna, 2004, p. 74; Jameton, 1993, p. 543). The second observation is the difficulty in definitively grasping the concept of moral distress, as Reska remarked. This is understandable given the lack of agreement in the definition of moral distress in the literature.

This chapter is a critique of the moral distress literature, focussing on the lack of consensus in the definition of moral distress, and the emergence of two general categories of definitions—the specific and the broad. I also highlight the importance of identifying and addressing moral distress by describing the significant impact of moral distress on individual health professionals, on the team and on the organisation. Additionally, I name recommendations in the literature that address moral distress as a context for those described by the participants in Chapter Six: Responding to Moral Challenges. Finally, in naming the gaps in moral distress literature, I identify the need for this research specifically exploring moral distress in community specialist palliative care health professionals.

Why it is Important to Define Moral Distress

I first describe the importance of defining the moral distress concept so as to emphasise why the lack of definition is problematic. The importance of defining moral distress is three-fold. Firstly, to avoid misunderstandings and ensure that the concept being discussed is conceived as the same for all involved in the discussion. Secondly, it helps direct in-depth moral distress research based on specific properties within its

definition. Thirdly, it helps direct actions needed to address it, such as policies and procedures and education.

Bickenbach (1997) notes “the value of a definition is that it clarifies our ideas so that we know if statements in which those ideas appear are true or false, likely or unlikely” (p. 102). Hence a good definition of moral distress possesses all the properties that are essential for an experience to be called moral distress (Bickenbach, 1997, p. 101). Once a definition is known it can then be researched both qualitatively and quantitatively. In the case of moral distress: the concept can then be explored through:

- empirical research, resulting in its validation, or further development;
- the extent and degree of can be determined through quantitative or qualitative research;
- the causes can be determined and addressed or minimised; and
- approaches to resolve it can also be determined.

Hence, a good definition of moral distress provides direction in researching moral distress, including finding solutions for it, based on the properties of moral distress named.

Another example of the importance of definition is in determining the direction of policies and education. For instance, if moral distress is defined as distress caused by being unable to pursue the right course of action because of institutional constraints (Jameton, 1984, p. 6), then addressing the constraints would be important in resolving or minimising moral distress. If the definition of moral distress includes moral conflicts and moral constraints (Fourie, 2015, p. 91) then the solution might focus more on ethics education to resolve conflicts and constraints.

Definitions of Moral Distress

There is no consensus in the moral distress literature on the definition of moral distress. In this section I argue that the elusiveness of the definition of moral distress may be due to two different perspectives: moral distress as a specific, well-defined concept; and moral distress seen more broadly as moral challenges resulting in distress. Further, the roles of emotions, constraints, and subjective and objective moral values vary across the different definitions of moral distress.

The concept of moral distress, and descriptions akin to it, has been present in the literature since the late 1800s and early 1900s and was introduced into nursing ethics

in the 1970s (Jameton, 2013, pp. 298-299). Jameton's (1984) description of moral distress is often quoted as the original definition: 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" (p. 6). It was a general statement that named moral judgement and institutional constraints as key components of the moral distress experience, based on Jameton's conversations with nurses. Jameton (1984) was also quick to distinguish it from moral uncertainty and moral dilemmas, as did others (Epstein et al., 2016). *Moral uncertainty* happens when there is uncertainty regarding the morally right action for a given situation, whilst in *moral dilemma* "two conflicting principles apply, but they support mutually inconsistent courses of action" (Jameton, 1984, p. 6). For Jameton (1984) moral distress was a concept—a theoretical or abstract construct (Charmaz, 2014, p. 342) based on observations, yet to be fully researched.

Empirical studies however emphasise the emotional aspect of the moral distress experience. Wilkinson (1987/1988) was one of the first to research moral distress empirically. She named moral distress as a phenomenon in her study of nurses, recognising moral distress as common to the lived experiences of her participants (Wilkinson 1987/1988, p.17) and not just a concept.

Wilkinson (1987/1988) also emphasised the emotional aspect of the experience in her definition of moral distress as the "psychological disequilibrium and negative feeling state when a person makes a moral decision but does not follow through by performing the moral behavior indicated by that decision" (Wilkinson 1987/1988, p.16). This is an important contribution as psychological disequilibrium manifested by emotions plays three significant roles in moral distress: (1) as a herald to the presence of moral distress as Wilkinson (1987/1988, 1989) points out; (2) in the reflection on the experience (Gillam et al., 2014; Molewijk et al., 2011) and (3) in its impact on the individuals' capacities to function (American Association of Critical Care Nurses, 2004, 2008).

Wilkinson's (1987/1988) research of nurses also observed that constraints can be both external and personal (p.21). External constraints were named as authorities of doctors, legal issues, nursing and hospital administration decisions, and policy issues, whilst personal constraints included "nurses being socialised to follow orders..., fear of losing jobs, self-doubt and lack of courage" (Wilkinson 1987/1988, p.21). These personal constraints are personal characteristics that limit the capacities of health professionals to follow through on their decisions (Deschenes et al., 2020). The presence of personal and external constraints is another significant condition for moral distress in both its specific and broad definitions.

The important concept of “good enough” in the descriptive experience of moral distress was also raised by Webster and Bayliss (2000), but not highlighted in subsequent definitions of moral distress. Following Wilkinson’s (1987/1988) research, Webster and Bayliss (2000) suggested broadening the definition to include not just failing to pursue a right course of action, but also “failing to do so to one’s satisfaction... because of an error in judgement, or some personal failing” (p. 217). Again, this is another important distinction as “failing to do so to one’s satisfaction” may imply a threshold beyond which it is unacceptable not to act. In other words, one must take the right course of action, otherwise moral distress ensues. However, up to that threshold, it may be good enough and acceptable not to act, given the circumstances. This distinction is important as it illustrates a flexibility in the interpretation of what constitutes moral distress. Health professionals might, for instance, find that the constraints in taking a morally right action are due to a lack of resources, which may lead them to reassess their moral judgement. The health professionals might accept that given the circumstances, what they can morally do, is good enough.

The question as to whether the moral values on which moral judgements are made should be objective or subjective, is another point of contention. Hanna’s (2004) critique of Jameton’s philosophical description of moral distress which she contends is based on moral relativism (p.75), is an example of this subjective/objective dilemma. She argues that there is a “normative” aspect that is critical but not taken into consideration, that of conscience and natural law (Hanna, 2004, p. 75-76). Hanna proposes that conscience is born of a non-manipulative innate knowing of moral “ends” or “goods” which are supernaturally determined, and therefore more significant than the human-determined moral end which is subject to manipulation (p. 75-77). Whilst Hanna’s point of view itself is subject to further criticism in that conscience itself can be manipulated (Rushton, 2018, pp. 88-89), Hanna raises an important point—are there non-manipulative reference points that hold true in all situations? I suggest that the presence of varied ethical theories and approaches to what constitutes an ethically right action or decision could indicate that the notion of non-manipulative reference points of moral truths is still evolving (Clouser & Gert, 1990). In the interim, it is important to recognise and constantly reshape personal values based on professional values and other relevant normative ethical approaches and theories. Rushton (2018) sees this constant reshaping of values as an important part of the dynamic of maintaining moral integrity (p.79).

Perhaps it was Jameton's use of the words "moral" and "distress," affirmed by Wilkinson's inclusion of emotions in the definition of moral distress, that resulted in subsequent calls to broaden the definition of moral distress to include any moral situation causing distress. These distress-causing moral states include moral dilemmas, moral conflicts, moral outrage, moral confusion and so forth (Campbell et al., 2016; Fourie, 2015; Morley et al., 2020). Others named the lack of Jameton's conceptual clarity and definitions of moral judgements (Hanna, 2004; Morley et al., 2020) as resulting in the lack of consensus on its definition.

Nonetheless it seems that a continuous "tug-of-war" between the specific concept and definition, and the broad phenomenon or lived experiences, continues to plague the moral distress debate. This "tug-of-war" results in the lack of consensus and the continual propositions of moral distress definitions and concepts (Deschenes et al., 2020; Hanna, 2004; Kälve mark et al., 2004, pp. 1082-1083; McCarthy & Deady, 2008; Morley et al., 2019; Nathaniel, 2006; Pauly et al., 2012; Webster & Bayliss, 2000, p. 217). This "tug-of-war" between the specific and broad definitions of moral distress is exemplified and explored next, before I describe the definition used in this thesis.

Specific Definition of Moral Distress

Jameton (1993) eventually expanded his concept of moral distress to include in its definition emotions and personal constraints in the categories of initial and reactive distress. He describes initial moral distress as occurring "when the nurse makes a moral judgment about a case in which he or she is involved and the institution or co-workers make it difficult or impossible for the nurse to act on that judgment" (Jameton, 1993, p. 544). One possible cause of constraint for the nurse, Jameton (2013) later proposed, is the conflict of values between the nurse and the institution or co-workers (p, 298).

According to Jameton (1993), this inability to act according to the health professionals' values and moral judgement then leaves them in a moral dilemma as to what to do next. He calls this reactive distress and relates this to health professionals' sense of moral responsibility, personal attributes such as self-confidence and lack of knowledge, as well as the context and circumstances within which the health professionals are experiencing the reactive distress (Jameton, 1993, p. 544).

Jameton's (1993) concept of moral distress is illuminating as it names important components evident in most definitions in the literature: moral judgements based on

values; conflict of values resulting in emotional responses; the inability to live out those values because of conflict or obstruction by those in authority (initial distress); and uncertainties or dilemmas as to the further action necessary to resolve the conflict (reactive distress). Jameton's (1993) moral distress concept also considers the health professionals' personal characteristics, capacity and circumstances, and I suggest moral resilience, in dealing with their inability to act on their moral judgements. This dynamic in some ways is consistent with the experiences of the participants in this research.

However, the assumption that moral judgements are a *fait accompli* can be troublesome. It implies that no other considerations would make a difference and reactive distress is inevitable given the external constraints. I contend that whilst this may be true for some health professionals, other health professionals who are more open to other points of view or contextual considerations may reconsider both their moral values and the consequent judgements and actions. Repenshek (2009) for instance suggests that moral distress may well be a consequence of conflicting subjective moral values. If moral subjectivity is the issue, then health professionals' openness to re-evaluating their moral judgements when reflecting on the different moral views put forward by others, may result in less moral distress—there is less conflict of values (Prentice et al., 2020, p. F1). If, in this re-evaluation, another moral judgement is made that is more aligned with the institution's or co-workers' values, there would be no reactive distress. The proposition that the moral judgement is not necessarily a *fait accompli* is yet another challenge to Jameton's definition.

Another possibility is that, knowing that the issue may be based on moral subjectivity, health professionals may be less likely to impose their own values on others and more accepting of differences. The goal of being able to work together in the care of patients may be another consideration in health professionals' moral judgement, thus maintaining what Holtz, Heinze and Rushton (2018) call relational integrity (pp. e490-e491). Relational integrity is maintained when the health professionals' integrity is preserved whilst remaining open and flexible "to others' values and beliefs" (Holtz et al., 2018, p. e491).

Despite Jameton's (1993) further elucidation of his concept, the call for a broader definition continued (Hanna, 2004; McCarthy, 2008; Pauly, 2012). However, Epstein et al. (2016, p. 17) are right in insisting on a more specific definition of moral distress when it comes to quantitative research as parameters and limitations are necessary to accurately compare and determine causes and effects, and resolutions (Smith, 2019

#10010). In a recent article, based on definitions proposed by Jameton (1993) and others (Bruce et al., 2015; Hamric, 2014; McCarthy & Monteverde, 2018; Penny et al., 2014; Varcoe et al., 2012), Epstein et al. (2019, p. 114) name more definitively what they believe are five key components of a moral distress experience:

- Complicity in wrongdoing—there is an external “pressure to act unethically.”
- Lack of voice.
- Wrongdoing associated with professional (not personal) values.
- Repeated experiences—moral residue with or without the crescendo effect.²
- Three levels of root causes (patient, unit, system). (p. 114)

These key components of moral distress are clear and succinct, enabling more consistent and quantifiable moral distress research such as the Measure of Moral Distress for Healthcare Professionals instrument (Epstein et al., 2019). Other instruments such as the Moral Distress Scale (Corley et al., 2001) and its multiple context-related revisions (Lamiani et al., 2017; Penny et al., 2014; Vaziri et al., 2015) are examples of quantifiable measurements of moral distress elucidating the scope of moral distress in various practice and cultural contexts (Dodek et al., 2016; Whitehead et al., 2015).

Broad Definition

The calls to broaden the definition of moral distress arise from authors who believed that Jameton’s (1984, 1993) description of moral distress was too narrow (Campbell et al., 2016; Fourie, 2015; Webster & Bayliss, 2000). Fourie (2015) initially suggests that constraints be removed from the definition. However, in a subsequent article Fourie suggests two categories of moral distress: “constraint distress” and “conflict distress” (Fourie, 2016, p. 24) and goes on to justify the importance of subcategorising moral distress based on circumstances. This distinction is relevant in that Fourie (2016) acknowledges that whilst there is a theoretical academic definition for moral distress there is also a more common understanding of moral distress in the day-to-day practice of healthcare (p. 24). I raise this as foreground to the new dimension in moral distress understanding this research has uncovered. The question at this point in the literature review for me was whether there is a pragmatic concept that explains what health professionals commonly call moral distress. This new pragmatic concept may answer

² “moral residue” is the cumulative experiences of compromised moral integrity (Webster & Bayliss, 2000, p. 218) and “crescendo effect” is the build-up effect of unresolved moral residue resulting in stronger emotions (Epstein & Hamric, 2009).

Fourie's intuition that constraints should not be the only criteria for moral distress (Fourie, 2015; 2016, p. 24). It may also affirm Fourie's (2015) preliminary definition that "moral distress is a psychological response to morally challenging situations such as [but not limited to] those of moral constraint or moral conflict, or both" (Fourie, 2015, p. 97, my inclusion).

Other authors felt that moral dilemmas, moral conflicts, moral uncertainty and moral outrage also cause distress and so should be defined as moral distress (Campbell et al., 2016; Fourie, 2015; McCarthy & Deady, 2008). As mentioned, I believe this argument perceives moral distress in its literal sense of distress caused by moral issues or challenges. It is akin to what Fourie (2016) calls the common understanding of "moral distress in health care practice" when distinguishing this from moral distress due to constraints (p. 24). It is this broad definition of moral distress that the participants in this research adopted, naming the moral challenges that caused distress as moral distress.

Despite the lack of consensus on the definition of moral distress, in general there are two conditions that are common across both the specific and broad definitions thus far. These two conditions are: **moral judgements**—in accordance with the health professionals' personal and professional values, hence moral integrity; and the **constraints** on acting on those judgements.

Moral Judgement

Any moral judgement individuals make is dependent on a number of factors. Primary to these are the individuals' personal and professional values formed by their upbringing, relationships, past experiences and professional development (Schwartz, 2012). Alongside moral values are also the influences of past experiences, including consequences of past moral decisions, moral residue, the socio-economic and political contexts, and their relationships—especially with significant others from whom they seek affirmation (Killen & Dahl, 2018). The individuals' personality, openness to differences and change, and capacity for reflection, and ethical reasoning also contribute to their capacity to make informed and rational moral judgements (Rushton & Penticuff, 2007, pp. 325-326).

Making moral judgements based on moral values maintains individuals' moral integrity. Moral integrity has been included in a few definitions of moral distress (American Association of Critical Care Nurses, 2008; Hamric, 2014 p. 457), and in one

taxonomy of moral distress (Thomas & McCullough, 2015, p. 104). Hamric (2014) for instance describes moral distress as occurring “when an individual’s moral integrity is seriously compromised, either because one feels unable to act in accordance with core values and obligations, or attempted actions fail to achieve the desired outcome” (p. 457). Here Hamric (2004) equates acting “in accordance with core values and obligations” (p. 129) as maintaining one’s moral integrity. Hardingham (2004) adds that integrity means “wholeness in the relationship between our actions and our values and beliefs” (p. 129). Moral values are thus core to moral integrity and moral judgements.

What constitutes professional integrity however is somewhat dictated by the professional body to which health professionals belong and its values. Corley et al. (2001, p. 251) alluded to this in naming “professional role conflict” as another external constraint. Here Corley et al. describe the nurse as not being able to fulfill their professional role as advocate and carer because of a sense of powerlessness in the hierarchical management structure in acute care.

When our personal and professional integrity is challenged or violated, our identity, meaning and purpose, and probably our sense of belonging, are also challenged, or violated (Miller, 2013). We become vulnerable in the uncertainty of who we are and what we stand for and its impact on our relationships. A sense of powerlessness, self-doubt, loss of meaning (Lützén & Ewalds-Kvist, 2013), can come into play. Thus, there is much invested in making moral judgements that maintain our moral integrity.

Past experiences might influence individuals’ awareness of moral challenges and the impact of their moral decisions—their moral sensitivity. Moral sensitivity is described by Lutzen et al., (2006) as “an ‘attention’ to the moral values involved in a conflict-laden situation and a self-awareness of one’s own role and responsibility in the situation” (p. 189). If there is significant reactive distress or moral residue, it is very likely that the individuals’ moral sensitivities might be heightened. Thus, not only are moral judgements based on the facts of the moral situation but also the presumed consequences of the judgements or decisions on others.

Moral judgement may be influenced by moral residue in other ways (Epstein & Hamric, 2009). Memories of unresolved moral distress might cause individuals to relive the negative emotions. This may cause individuals to react more strongly than if this was the first experience of moral distress—the crescendo effect observed by Epstein and Hamric (2009). It may also reinforce any negative sense of self such as poor self-

esteem, guilt, self-blame and powerlessness (Epstein & Hamric, 2009, p. 331; McCarthy & Deady, 2008, p. 256), as well as impact on individuals' perspectives and capacities to respond to the current situation and make moral judgements.

Contributing to these is the social, economic and political context that may impact on individuals—either directly or indirectly. This aspect of moral decision making is rightly emphasised by Varcoe et al. (2012):

moral distress must be seen as a phenomenon that is experienced by individuals, but shaped not only by the characteristics of each individual (e.g., moral character, values, beliefs), but also by the multiple contexts within which the individual is operating, including the immediate interpersonal context, the health care environment and the wider socio-political and cultural context. (p. 56)

Individuals do not live in isolation but in constant relationship with everyone around them. It would make sense then that individuals would be continually influenced by each relationship in varying degrees. These relationships in turn influence individuals' sense of moral agency (Musto et al., 2015) and judgement.

Thus, moral judgements are often based on moral values and maybe dependent on individuals' past experiences, moral sensitivity, moral residue, context and relationships. How individuals make moral judgements varies from person to person and is likely to be contingent on individuals' personalities, capacities for reflection, openness to differences and change, and ethical reasoning skills (Killen & Dahl, 2018).

Constraints

Although Jameton's (1984, p. 6) initial definition highlighted the importance of institutional constraints, it soon became apparent that constraints can be both personal and external, including institutional, (Wilkinson, 1987/1988, p. 21), or an interplay of the two.

Personal constraints are aspects that block individuals from acting according to their moral understandings and include lack of self-confidence, doubts about self-knowledge, various fears, personality, a lack of courage to speak out or a fear of conflict and a sense of powerlessness (American Association of Critical Care Nurses, 2004; Hamric et al., 2012, p. 2; Wilkinson, 1987/1988). Whilst the literature names such characteristics as internal constraints, Deschenes et al. (2020) argue that what the

literature vaguely considered personal/internal constraints is more complex, and involves values, identity, agency, and relationships. They argue that these personal/internal constraints are in fact personal/internal characteristics of individual health professionals. They go on to suggest that it is inappropriate to emphasise changing personal/internal characteristics, including identity, in addressing moral distress. Deschenes et al. (2020) argue that the onus of addressing moral distress needs to be on the system and organisations causing the external constraints (p. 1127). I concur with their argument. I believe that the contribution to constraints or limited moral agency is an interplay of personal characteristics and “systemic and institutional constraints” (Duchenes et al., 2020, p. 1127). However, whilst personal characteristics such as the capacity to be open to other perspectives can change, it is inappropriate to expect health professionals to change other personal characteristics associated with identity and core values. Hence the onus is more on systems and organisations to evaluate their contributions to health professionals moral distress. This is especially so when organisations lack capacity to cater for differences of approaches, values and perspectives (Duchenes et al., 2020, p. 1143). I agree with Deschenes et al.’s (2020) proposal of targeting strategies towards improving “the moral environment, barriers to ethical practice, and support for moral learning and value sharing” in addressing moral distress (p. 1144).

External constraints include organisational policies, legal prohibitions, inadequate communication, inadequate staffing or inadequate administrative support (Corley et al., 2001; Hamric, 2012; Harrison et al., 2016; Mealer & Moss, 2016a). The external constraints Corley et al. (2005, pp. 382-383) describe include objectifying patients to meet institutional requirements and excluding nurses from patient management decision making.

Whilst there is extensive research on the constraints seen in the acute care and emergency care settings (Kilcoyne & Dowling, 2007; Langley et al., 2015; Prentice et al., 2017; Vincent et al., 2020), little is known about the constraints present in other situations such as community care (Brazil et al., 2010). Filling these gaps would contribute significantly to understanding both the moral distress phenomenon as well as the precedent moral challenges.

Another gap in moral distress literature is the exploration of the role of particular professional disciplines, if any, in the health professionals’ experience of moral distress. There are only a few studies that have noted experiences of constraints in different health professionals within a particular unit, and two that surveyed health

professionals from various disciplines (Houston et al., 2013; Whitehead et al., 2015). It is not surprising that different health professionals experience moral distress differently (Whitehead et al., 2015). An assumption could be made that the significance of the different roles within the healthcare team could account for this difference, but this has not been supported empirically. It has been suggested that nurses are more likely to experience moral distress than physicians, which is attributed to nurses' perceived lack of capacity to act and feeling voiceless in moral conversations (Mealer & Moss, 2016b) or to their being socialised into "following orders" (Wilkinson, 1987/1988, p. 21).

Others, such as Barlem and Ramos (2014/2015) describe moral distress as an outcome of power play between the voiceless nurse and more powerful physician and/or the institution (p. 611). Whilst it may be useful to categorise contributing causes of moral distress as personal characteristics or external constraints, again the reality is that it is an interplay of both personal characteristics and external constraints as Deschenes et al. (2020) determine.

Having made moral judgements the decision whether to act on that decision would likely depend on the health professionals' sense of moral agency, and with that, a sense of moral responsibility. This in turn also tends to be conditioned by personal and professional values, personality or character, motivation and commitment (Rushton & Penticuff, 2007, pp. 326-327). Beauchamp and Childress (2009) defined a moral agent as one who satisfies two conditions: "(1) the individual is capable of making moral judgements about the rightness and wrongness of actions, and (2) the individual has motives that can be judged morally," (p. 74) regardless of whether the moral judgement or motives are right or wrong.

Varcoe et al. (2012, p.59) introduced the concept of compromised moral agency into the moral distress debate. They defined moral distress as "the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards." If all seriously compromised moral agency results in moral distress, then it would be important to explore the situations or conditions that would compromise this agency—the constraints that impedes the capacity to take the morally right action.

Thesis Definition of Moral Distress

For the purposes of this thesis, I modify Nathaniel's (2003) definition of moral distress, which is:

Moral distress is the pain or anguish affecting the mind, body, or relationships resulting from a patient care situation in which the nurse is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner perceived by the nurse to be morally wrong. (p. 22)

I define moral distress as the psychological stress “affecting the mind, body, or relationships resulting from a... situation in which the [individual] is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner perceived by the [individual] to be morally wrong” (Nathaniel, 2003, p. 22, my changes in square brackets).

Whilst Nathaniel's definition correctly identified the psychological stress as “pain or anguish,” as “distress” would imply, I incorporate the situations whereby the conditions of moral distress—moral judgement and constraints—are present but the resulting emotions are not necessarily pain or anguish but might be for some an annoying discomfort or dis-ease. This would be in keeping with some of the definitions that do not emphasise the degree of emotions attached to moral distress (Hamric, 2000, p. 199). I also removed the situation of “patient care” so as to be broad enough to incorporate other situations that are morally challenging but not necessarily involving patient care, for example in organisational re-structure. In keeping with this intention, I also substitute “nurse” with “individual”. Nathaniel's definition I believe captures the elements common to most definitions of moral distress in the literature.

As well as perceiving moral distress as an event, the exploration of this phenomenon has also brought to light the secondary impact of the initial event. Moral distress is recognised as an experience that can accumulate over time. This was noted by Webster and Baylis (2000) who defined *moral residue* as “...that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised” (p. 218).

Epstein and Hamric (2009) took it further to posit that the build-up of distress over time can happen for both initial and reactive distress; they describe it as initial cumulative residue, with the eventual crescendo effect resulting in very strong emotions. Whilst there does not appear to be a gap in this aspect of moral distress research, the cumulative effect of moral distress is worth noting. It is similar to other types of psychological distress not related to morality—akin to the idiom of “the straw that broke the camel’s back.” Unresolved distress from whatever cause, including moral distress, has far-reaching consequences for the whole person: physically, socially, spiritually and even financially.

This is significant as it reminds us to see moral distress not just as a phenomenon to be explored and analysed but as part of a person’s history/experience—it is the person or health professional that is the focus of my exploration, not moral distress per se. Moral distress is happening to an individual with a history. The person carries with them the memory of past experiences which in turn influences the perception and experience of this current event and in time, future events of moral distress and their consequences.

Why Moral Distress is Important—Effects and Consequences

In this section I explore the impact of moral distress as reported in the body of empirical research on moral distress. The research on moral distress, once predominantly in nurses in the acute care setting in the United States (Altaker et al., 2018; Corley, 1995; Hefferman & Heilig, 1999; Wilkinson, 1987/1988), now includes other disciplines and countries, with each noting its importance in the functioning of individuals. Other disciplines include pharmacy practice (Astbury et al., 2015; Crnjanski et al., 2012), occupational therapy (Penny et al., 2014); physiotherapy (Carpenter, 2010); drone warfare (Christen et al., 2014); psychology (Austin et al., 2005) and podiatry (Losa Iglesias et al., 2010). Research in moral distress has also expanded to countries such as Saudi Arabia (Almutairi et al., 2019); Iran (Asgari et al., 2019; Borhani et al., 2017); Turkey (Atabay et al., 2015); Brazil (Barlem et al., 2013); Italy (Lamiani et al., 2020); Spain (Losa Iglesias et al., 2010); Australia (Burston et al., 2016) and Korea (Choe et al., 2015). This body of research suggests that moral distress is prevalent across all disciplines and has an impact on the individual, the team, and the organisation, all of which can have ramifications on patient care.

Impact on Individual Health Professionals

At the individual level, the symptoms and signs of moral distress are similar to the suffering of any other kind of distress—anxiety, panic attacks, fatigue, exhaustion, sleeplessness, headaches, gastrointestinal symptoms and epigastric pain, poor cognitive function, paranoia, guilt, purposelessness, social withdrawal, burnout and many others (American Association of Critical Care Nurses, 2004; Neumann et al., 2018; Rushton et al., 2015; Wilkinson, 1987/1988). It affects the individual’s physical, psycho-social and spiritual well-being such that Wilkinson (1989) appropriately named it an “effect on wholeness” (p. 517). The difference in this context in comparison to others causes of distress is that the cause is morally related.

This personal impact on health professionals also impacts on patient care—avoidance of patients, lack of sensitivity to patient needs, negative attitudes towards patients and not fulfilling duties of care (Burston & Tuckett, 2013, p. 319; Rushton, 2017b; Wilkinson, 1989, p. 16).

Rushton’s (2018) conceptual map captures what can happen to health professionals if moral distress is left unaddressed (p. 54). Rushton begins by describing the presence of moral adversity as challenging individuals’ integrity. Integrity manifests as “a commitment to uphold core ethical values, principles and commitments... and to speak up about violations of these values and principles” (p.57). This “imperilled integrity” then leads to moral stress, which in turn can lead to further moral suffering such as moral distress or moral outrage. If moral suffering is not addressed it can lead to moral injury which Rushton (2018) notes occurs when there is “an actual violation that erodes our moral core” (p. 66). Rushton continues to explain that unresolved moral injury can then lead to moral decline—state of “decline in moral perception... discernment... competence, character, or function... even taking pride in misdeeds” (p. 68). It is interesting to consider if this state of moral decline or moral dysfunction would be akin to moral disintegration. Hence, moral distress can impact on individual health professionals at all levels and in all aspects of their lives, including their relationships with others and their care of patients.

Impact Beyond the Individual

At the healthcare unit/team level, the team dynamics can be affected in two ways. Firstly, and more commonly, there may be a moral issue affecting the whole team, causing distress to the team members themselves (Bruce et al., 2015; Corley, 2002). An

example of intrateam moral distress would be different health professionals' conflicting opinions as to the futility of a certain treatment for a patient. Symptoms and signs of a team level moral distress include poor communication, maladaptive behaviours such as fights, anger, over-reaction and poor patient care (Bruce et al., 2015). Interestingly Bruce et al, (2015) noted that all six physicians in their study tended to withdraw whilst five of sixteen nurses became more “emotionally invested” (p. 823).

Secondly, the individual manifesting the above symptoms may affect the team dynamics because of their relationship with other team members. For instance, it is difficult to work with someone who is vulnerable and therefore very sensitive and over-reacts to situations or comments—the “walking on eggshells” scenario. However, in this scenario, it is unknown if the position of authority, for instance a unit manager, or the seniority of the individual experiencing moral distress has a greater or lesser impact on the other members of the team or its dynamic. Again, more research is needed in the exploration of the different experiences and responses of different health professionals to moral distress.

At the organizational level—staff distress or suffering, poor team dynamics and morale may result in poor quality outcomes, especially poor patient care, and high staff turnover secondary to burn out and job dissatisfaction (Karakachian & Colbert, 2019; Rushton et al., 2015).

At the level of the larger healthcare sector there may be a significant loss of qualified personnel as they move to other sectors (Corley, 2002; Humphries & Woods, 2016; Ong, 2015; Rushton et al., 2015), possibly resulting in shortage of skilled workforce.

Recommendations in the Literature to Address Moral Distress

Recommendations to address these impacts of moral distress in the literature follow two approaches—addressing personal and external constraints. The initial recommendations in the literature pertain to addressing external constraints, hence focussed interventions at the level of the team or organisation. However, in more recent literature the focus moves to strengthening individuals' moral resilience. However, these latter recommendations of building moral resilience are not intended to negate the importance of addressing the organisations' role in mitigating moral distress amongst staff (Leiter, 2018).

At the team and/or organisation level recommendations such as promoting a positive ethical climate (Humphries & Woods, 2016; Lützén & Kvist, 2012; Pauly et al., 2009) and the development of moral communities (Austin, 2012; Epstein et al., 2020; Pavlish et al., 2014), ethics education (Grady et al., 2008), moral case deliberation (Molewijk et al., 2008; Spijkerboer et al, 2017) are amongst many suggested. I discuss these further in Chapter Seven: The Moral Equilibrium Framework.

At a personal level, the American Association of Critical Care Nurses (2004) offered their members a document called *The 4A's to Rise Above Moral Distress*. The 4A's are:

- Ask—is moral distress present? Physical, emotional, behavioural and spiritual responses to suffering present?
- Affirm—affirm the distress and validate feelings and perceptions with others; affirm professional obligation to act and commit to address moral distress
- Assess—sources of distress, severity of distress, contemplate readiness to act and analyse risks and benefits
- Act—assess readiness to act, take action, if unsuccessful, maintain desire to change and continue cycle of ask, affirm, assess and act. (p. 2)

The goal is to “preserve your integrity and authenticity.” (p. 11)

Also at a personal level, as mentioned, there is growing literature on developing moral resilience as a significant way forward in dealing with moral distress, spearheaded by Cynda Rushton (2016b, 2017) and colleagues (Heinze et al., 2017, p. 604). Rushton (2016b) defined moral resilience as “the capacity of an individual to sustain or restore their integrity in response to moral complexity, confusion, distress, or setbacks... minimize one’s own suffering, and allow one to serve with highest purpose” (p. 112). Re-establishing personal and professional moral integrity is key to managing moral distress. Others have also promoted the building up of moral resilience as a way of dealing with the growing awareness and probable incidence of moral distress (Lützén & Ewalds-Kvist, 2013, p. 320-321; Monteverde, 2014).

Rushton offers preliminary suggestions to build moral resilience: the person must know themselves well, especially their values and their personal dynamics including strengths, limitations and “moral core” (Rushton, 2016b, p.116). Amongst what she highlights is the need to develop self-regulatory capacities, encouraging mindfulness and transformational learning, as well as developing ethical competence and engaging with others (Rushton et al., 2013). The theoretical concept of moral resilience seems

compelling but has not as yet been substantiated empirically in a significant way as an intervention. However, programs such as “The Mindful Ethical Practice and Resilience Academy” to build moral resilience show promising positive outcomes (Rushton, 2018, pp. 246-247).

The Need for Moral Distress Research in Community Specialist Palliative Care Health Professionals

While there is a substantial body of scholarship on the definition, impact and resolution of moral distress, community specialist palliative care has not been a focus of research. There is very little moral distress research in community palliative care or on other palliative care health professionals, apart from nurses. There is even less on the fast-developing field of community specialist palliative care. A recent literature search of the Medline Ovid, PsycINFO, CINAHL, Embase and Scopus databases revealed no empirical literature on community specialist palliative care health professionals’ experience of moral distress. The literature that is available on community palliative care highlights the issue of moral distress for community care nurses, similar to the Bolton Clarke services here in Victoria³, rather than professionals specifically trained in palliative care (Brazil et al., 2010).

The predominance of moral distress literature in acute care, especially intensive care units (ICU) and neonatal intensive care units (NICU), would perhaps highlight the context where moral distress is most prevalent, that is, at the end of life. Issues such as futile treatment, inappropriate care, hastening dying, offering false hope and providing inappropriate care are often listed as more likely to cause moral distress (Mealer & Moss, 2016, pp. 1615-1616). This is not surprising considering the rapid advancement of medical technologies that have complexified end of life care and added confusion in end of life decision-making. This, alongside the growing medicalisation of dying (Clark, 2002), would probably raise the likelihood of moral distress in health professionals practising in this area. A cross disciplinary study by Houston et al. (2013, p. 107) also revealed that end of life scenarios produced the highest intensity of moral distress amongst physicians, chaplains and nurses. This context and the growing call to legalise assisted suicide and euthanasia, together with my personal interest in end of life care,

³ Bolton Clarke is a private not-for-profit Australian company that provides a range of community home care services including general nursing, allied health and general assistance. <https://www.boltonclarke.com.au/>

makes palliative care an appropriate field for me to explore and add further knowledge to the ongoing research on moral distress.

Palliative care is described as holistic in nature as it incorporates whole patient care—physical, psycho-social, spiritual—as well as care for the patient’s carers, family and loved ones, mentioned in Chapter One. This theoretical concept of holistic or wholeness care recognises the inter-relationship of all aspects of healthcare and may provide a lens through which these specialist health professionals experience moral distress. Again, the influence of this holistic perspective on the moral distress experience has not been explored.

Further to this, the limited knowledge on the community aspect of community-based specialist palliative care justifies moral distress research on this group of health professionals. Unlike acute care where the medical team has sole medical management responsibility for the patient, the community care concept involves negotiating management plans with other health professionals actively involved in the care of patients—including general practitioners, community occupational therapists and social workers who may have less experience in palliative care (Brazil et al., 2010). Community care health professionals also tend to visit patients on their own whereas in the acute setting there are usually other members of the team present all the time. The other element not well known is whether community health professionals, having a different support network, experience more or less moral distress, or to what intensity they experience it.

In community care, health practitioners often work on their own. This brings about a very different role dynamic in the care of patients (Arber, 2007). This may be further complicated by the role of the patient’s primary care-givers, often family members, who may feel they know how best to care for the patient/family member even though it may be against the advice of the palliative care team (Brazil et al., 2012; Young et al., 2017, pp. 858-859). There does not appear to be much, if any, research on the differences in the acute care and community care context specifically in relation to moral distress. Health professionals who have worked in both settings may contribute to this knowledge. This was the case with some of the participants in this project.

Issues noted in Brazil et al.’s (2010) Canadian study of 18 health professionals providing general home-based palliative care include the inability to provide good and appropriate care to patients because of conflictual perspectives between primary carers—often family members—and other health professionals, including GPs who play

a significant role in the care of the patient. These were based on interviews of “critical incidents” resulting in moral distress (Brazil et al., 2010, pp. 1688-1689). One Bristol, UK study exploring the stress that community specialist palliative care nurses experienced, included issues of staff shortages and relationships with general practitioners and social services (Newton & Waters, 2001). Moral distress was not mentioned.

There is clearly an overall need for more research in community palliative care specialist health professionals, including in Australia. As mentioned in Chapter One, there are only a few moral distress studies in health professionals in the Australian setting (Burston et al., 2016; Fronek et al., 2017) and none in specialist palliative care health professionals in the community setting. This research is thus a significant addition to moral distress knowledge, especially in Australia.

There are a number of gaps in the moral distress literature that led me to explore moral distress experiences of specialist palliative care health professionals in the community setting. These gaps include the lack of empirical studies exploring the lived experiences of moral distress in health professionals beyond interviews and surveys; the experience of moral distress in specialist palliative care health professionals in the community setting; across health professional disciplines; and in the Australian setting. What also intrigued me was the lack of consensus on the definition of moral distress and whether something was missing in the current approach to understanding moral distress.

Conclusion

In this chapter I have argued that a significant problem in moral distress literature and research is the lack of consensus on definition. I argued that there are two categories: the specific definition incorporating moral judgement, professional values, constraints and moral wrong-doing, and the broad definition incorporating psychological stress related to moral issues. I named the centrality of moral integrity and its associated personal and professional values in understanding moral distress. I also briefly described the significant consequences of unaddressed moral distress, illustrating why this phenomenon needs further attention and the current recommendations to alleviate moral distress in the literature.

In my engagement with the definitions of moral distress in the literature I identified some gaps in the understanding of moral distress, raising them as questions. These include:

- Is there a way of clarifying the definition of moral distress?
- Is a different approach warranted in understanding the moral distress phenomenon?
- Is it possible that health professionals may reconsider their moral judgements as they reflect on their moral distress experience, or are moral judgements a *fait accompli*?
- Are perceptions of constraints necessary to experience moral distress?
- How important is ongoing reflection on moral values for health professionals experiencing moral distress?
- Does the philosophy of palliative care and its holistic approach help health professionals navigate and mitigate moral distress?
- Are there differences in the experiences of moral distress for the different health professionals in a multidisciplinary team?

This research into the unexplored Australian community specialist palliative care health professionals' lived experiences of moral distress also attends to the above questions. It will employ a combined ethnography and phenomenology methodology (Liamputtong, 2013, pp. 159-160) to gain rich data to explore these issues. I describe this in the next chapter.

Chapter 3: Methodology and Methods

In Chapter Two, I highlighted the lack of consensus on the definition of moral distress. I argued that the elusive definition may possibly be due to two different perspectives: those who see all moral challenges resulting in distress as moral distress, and those who categorise moral distress as specific to situations of limited or no moral agency due to constraints.

In my experience as a general practitioner, when diagnosis of an illness is still uncertain despite extensive investigation, a way forward is to begin again with a clean slate—retake the history, repeat the examination and explore other possibilities. This approach of a clean slate in light of the difficulty of finding a consensus definition of moral distress is appealing as it can fill the gaps and help build a clearer picture. This “clean slate” approach is akin to the qualitative inductive framework I adopted in this moral distress research. Moral distress is triggered by moral challenges. Hence by examining the lived experiences of a group of specialist palliative care health professionals as they faced daily moral challenges in the community setting, a clearer picture emerged (Guillemin & Gillam, 2006; Ulrich et al., 2010, p. 2510). The thesis definition of moral distress was also set aside except at the recruitment presentation to the participants or when a definition was asked for by the participants during the fieldwork.

Fox (2008) defined induction as “a form of reasoning used in pursuit of understanding and knowledge, establishing a relationship between observations and theory” (p. 429). Using a medical metaphor, it is about rediscovering the symptoms and signs once again in order to develop a working diagnosis of what is happening for the patient. Fox (2008) further states that “inductive reasoning is of particular relevance in qualitative approaches that are used to extend existing theory into a new setting or to develop understanding and theory where none currently exists” (p. 429). My research seeks to explore in greater depth the moral distress phenomenon in the relatively unresearched setting of community specialist palliative care, through inductive reasoning.

In this chapter I explain my choice of the combined methodology of ethnography and interpretive phenomenology based on the inductive approach. This is followed by a description of the preparation I did for the field work, including seeking human ethics approval, the field work itself—the service, the convenience sampling I undertook, the participants, and the methods I used in data collection. I then explain how I analysed

the data. Finally, to maintain the ethical rigour of this research, I describe the various roles I unexpectedly played during my fieldwork.

Combined Ethnography and Interpretive Phenomenology

My research question was “How do community specialist palliative care health professionals experience and respond to moral distress?” My intent was to explore this question looking at the whole picture. Bloomberg and Volpe (2016) captured this intent well in their description of a characteristic of qualitative research:

Qualitative research... is concerned with how the complexities of the social and cultural world are experienced, interpreted, and understood, in a particular context, and at a particular point in time. The intent... is to examine the social situation or interaction by allowing the researcher to enter the world of others and to attempt to achieve a holistic understanding. (p. 41)

This holistic understanding invited me to be attentive to the personal, team, organisational and societal contexts within which the health professionals live and work. In this research I paid particular attention to the areas in which there are gaps in the moral distress literature—the setting of a community service, the multidisciplinary team and the evolving specialty of palliative care.

I was conscious that in attempting to understand how health professionals experience moral distress I needed a methodology that captured the whole picture in the thick and rich data that I collected. A combined methodology of ethnography and interpretive phenomenology was appropriate for my examination of the moral distress phenomenon. Applying interpretive phenomenology allowed for accumulation of focussed data on moral distress whilst ethnography allowed for the enriching of the data as it includes the broader observations of culture and relational dynamics within this setting.

Ethnography is the study of “an entire cultural or social group in its natural setting, closely examining customs and ways of life, with the aim of describing and interpreting cultural patterns of behaviour, values and practices” (Bloomberg & Volpe, 2016, p.47). Ethnography goes beyond noting cause-and-effect and allows for consideration of nuances and the subtle influences of relational dynamics at multiple levels (Arber, 2007; LeBaron et al., 2014; Rashid et al., 2015). There are many approaches to this well-established methodology in empirical research, derived from “multiple intellectual

traditions” and “diverse disciplines”—autoethnography, feminist ethnography, visual ethnography and so forth (Bloomberg, 2016, p. 47). My methodological approach was based on interpretivism.

Interpretivism premises that “reality is socially, culturally, and historically constructed” (Bloomberg & Volpe, 2016, p. 41). This paradigm considers the many influences that help individuals recognise, interpret, react and respond to a particular incident or moment, or in this case, an ethical incongruence between the individuals’ own moral values and stance, and what is expected of them. Thus, in understanding how moral challenges and distress are experienced by community specialist palliative healthcare professionals, it is important to understand their worldview and other factors that influence their interpretation of a particular situation. These worldviews are based on individuals’ interpretation of their values, belief systems, past experiences, relationships, culture, social context and other aspects that, in turn, influence their reasoning and how they relate to the world around them (Strom, 2013, p. 354). In other words, to understand their perspectives and their interpretations of situations that in turn become moral challenges, I needed to understand more fully their underlying premises and past experiences. These may have led them to see the situations that arise as moral challenges. I was also interested to know whether these existing premises and past experiences have a role to play in their response to current moral challenges.

Phenomenology, on the other hand, seeks to “understand the lived experience of individuals” especially with regard to “a particular concept or phenomenon of interest” (Liamputtong, 2013, p. 8). Interpretive phenomenology develops through the stages of “fore-understanding, interrogation and reflection” (Maggs-Rapport, 2000, p. 221). The fore-understanding for me as the researcher was knowledge gained from the moral distress literature, described in Chapter Two. The interrogation happened when I analysed the rich data I collected and then compared it with the findings in the literature. As I reflected on this comparison, new understandings emerged in the exploration of moral distress. The inductive and iterative approach I undertook meant that as I gathered data, I was constantly analysing and comparing the data with the literature, and exploring new understandings, bringing these back to the participants for further exploration. This to-ing and fro-ing process and outcome I illustrate further in Chapters Four, Five and Six.

For the participants, the fore-understanding laid in the immediate experiences, before the instance of reflecting on the experiences (Maggs-Rapport, 2000, p. 221). The participants then “interrogated” the experience by noting it and gathering information

on the experience, situating it within the context of what was known, and finally reflecting on the experience and its metaphysical impact on the individuals' sense of self. This process occurred for the participants during in-depth interviews as well as in discussions of situations of moral challenges with their colleagues (Field Notes). Adams and van Manen (2008) rightly state that interpretation of "experiential meanings... are shaped by consciousness, language, our cognitive and noncognitive sensibilities... our preunderstandings and presuppositions" (p. 614). This includes culture and context (Adams & van Manen, 2008, p.614).

In order to achieve a holistic understanding of the participants and their experience of moral distress, I immersed myself in their natural setting, in their day to day activities, including meetings, and engaged where appropriate in their formal and informal conversations. I intentionally precluded any direct patient engagement. I perceived as well as I could the participants' interpretation of situations and how they arrived at specific conclusions and decisions. I sought to understand the culture and context, both personal and professional, within which these health professionals practised. I was careful not to impose my own values, beliefs and perspectives on the participants. How participants interpreted, judged and acted in situations was dependent on how they related to what was around them, as individuals and as a group (Bloomberg & Volpe, 2016, p. 41). I noted this through observations and descriptions of these observations, as well as through conversations and reflective dialogue, so as to interpret their words, behaviour and actions more accurately. I was also adaptable to situations and open to the unexpected (Liamputtong, 2013, p. 162). This included listening and receiving all that the participants shared, regardless of whether the topic related to the research, or sometimes holding the space as they cried tears of vulnerability. It also meant being flexible with appointment times for interviews. As described in the data analysis section, data collection and reflections on the data were done iteratively to achieve clarity and accuracy when field work began. All these elements of my research practice are consistent with the combined methodology of ethnography and interpretive phenomenology approach I used.

In summary, this combined methodology allowed me to explore the phenomenon of moral distress in a more comprehensive way than ethnography of interpretive phenomenology individually. As explained, ethnography describes and explores the cultural, contextual and relational contributions to the group's "patterns of behaviours, values and practices" (Bloomberg & Volpe, 2016, p. 47). This rich data helped inform the personal and external influences that contribute to the perception, experience and

response to moral distress. Phenomenology focuses on the phenomenon of moral distress—having explored its understanding in the literature thus far, I brought that knowledge into the experience of the health professionals in a comparative way. The combined methodology also involved reflecting iteratively throughout the process of data collection and analysis, leading to understandings and theories that can be further validated in future research.

Ethics Approval

Ethics approval was sought from and received by the Human Research Ethics Committee of the health organisation within which this palliative care service operated. This was in accordance with the Australian Government's National Health and Medical Research Council guidelines (2007). This approval was then registered with the University of Melbourne Office of Research Ethics and Integrity. I was aware of the possibility that in sharing their experiences of moral distress, deep unresolved distress, moral or otherwise, might arise for the participants. I knew that if my initial capacity to deal with this by supportive listening was inadequate, I would be able to offer other external options of counselling and follow through for the participants. My experience and counselling skills as a general practitioner would aid in this discernment. Where necessary, advice from my academic supervisors would have been sought. Fortunately, this was not required.

Approaching the Fieldwork Site

The fieldwork site I approached was a community specialist palliative care service in which I had volunteered more than 20 years ago as a pastoral carer visiting patients and their families and offering a listening ear. I had chosen this service for a few reasons. Firstly, I had a relationship with the service from my volunteering days and knew the manager. Secondly, the service was a positive exemplar of excellent palliative care service. Thirdly, this service has been noted for its low turnover of staff. A supportive environment is highlighted in the literature as one of the many ways of mitigating moral distress. I was curious to explore the elements that constituted and provided “a supportive environment” in the field I was about to enter. In Chapter Six I describe further the impact of a supportive environment on the experience of moral distress.

I met Marin, the manager of the service, at a gathering a few months prior to the start of the fieldwork. I floated my research intentions to Marin who sounded keen on the

idea. Marin's immediate response was that moral distress was likely present amongst the staff and manifested in a number of ways. At subsequent meetings I explained the research question, aims and the methods I intended to use, and sought Marin's advice on the best approach to take.

Later I met the Executive Director of the service regarding the research project. She was enthusiastic and supportive of the project and opined that the staff would be very interested in sharing their thoughts and experience. Such information was noted in my fieldwork journal.

The Service

The service within which I immersed myself was a well-established community-based palliative care provider of excellence. This claim of excellence was stated in the service's brochure and affirmed by earlier conversations with an experienced local palliative care physician, several health practitioners who practised in the area, and a small number of local residents I had encountered. The thank you messages, cards and gifts that arrived in the main office daily during my fieldwork were also testimony to the perceived quality of the service provided. The service offered palliative care to an expanding metropolitan region in Victoria, Australia, covering several local council municipalities. Two of these municipalities were rapidly growing with an increase in diversity of cultures and socio-economic backgrounds. It also had a close association with hospitals within its area of coverage.

The service provided a twenty-four-hour, seven days a week service. It also offered bereavement support and grief counselling. When I began my fieldwork, the service had over 600 patients in its program and many new referrals were arriving every week. The physical arrangement comprised a main office, which was the administrative centre, with satellite offices where health professionals who work within that particular geographic area were based. Apart from the monthly multidisciplinary team meetings and the local "huddles", all other meetings were held at the main office site. Huddles were half-hour, local multidisciplinary team meetings usually held three mornings a week to discuss new cases, complicated cases, and patients who had died and whose families may need bereavement follow up. Most of my fieldwork was conducted at the main office. All my observations were made at the office sites and not in patients' homes. I did attend a few of the multidisciplinary meetings at the satellite offices, and data from these were included in the analysis.

As with most specialist palliative care services in Victoria, this service had grown from a nursing and medical service to a multidisciplinary one comprising nursing, medical (palliative care specialists and registrars who are doctors in the palliative care training program), pastoral care, social work, counselling, psychology, physiotherapy and occupational therapy health professionals. Supporting these health professionals were dedicated administrative and volunteer teams. This multidisciplinary setting allowed me to explore the impact of cross disciplines on the experience and response to moral distress for specialist palliative care health professionals. No patients or family members of patients were included in the project. Whilst patients' and volunteers' experiences may add richness to the data, they were not included for two reasons. Firstly, this initial research sought to explore the experiences of moral distress from the health professionals themselves. Broadening the field to include patients, families, carers and volunteers, I believe would be more appropriate in the next phase of further in-depth research, where data would include third party observations of the health professionals. Secondly, patients, family and volunteers would likely represent a vulnerable group. Further procedures including ethics approval for vulnerable groups would be warranted. Volunteers, whilst trained, were often relatives of patients who have died, and did not often interact with the health professionals.

Apart from the convenience in sampling, this service was an ideal setting in which to explore moral distress. The low turnover of staff enabled me to follow through experiences of individual health professionals in the six months of fieldwork undertaken. As very experienced community specialist palliative care health professionals, they had learned relatively successful coping strategies which they employed and found helpful in responding to and managing their moral distress.

Recruitment

The inclusion criteria for participants for this research were all health professionals and administration staff employed by the service. The latter group include receptionists and those working in office administration. As mentioned, no patients or volunteers were included.

Recruitment of participants began with a presentation of the research project at the service's February 2018 staff meeting. I introduced myself as a researcher, general practitioner and a religious sister, emphasising that my role at the service was as a researcher only. The presentation included the aims, the rationale for the research and details of what it would entail. Following the presentation there was an opportunity for

questions before a tea break. My contact details were made available to potential participants for further queries.

The plain language statement was then handed out alongside the consent forms (Appendix A). Some participants returned the consent form immediately, but most did so later in the day. I wrote in my journal:

My trepidation at meeting a whole lot of strangers, uncertain if there would be welcome or resistance to the project, was met with mainly warmth and hospitality. There was also some reticence and uncertainty. The trepidation was not helped by the technology not working due to difficulties with passwords and connectivity. There was hope though when I was surprisingly invited to stay for the nurses' meeting as they worked out a longstanding agenda of rotations. (Field notes)

Such was the openness of the participants to this project. Eventually, written consent was obtained from 70 staff members. Five other staff members felt they were not around enough to warrant signing a consent form but gave verbal consents for my presence at meetings they attended. Whilst participants were advised that they could provide consent for specific parts of the study if that was their preference (for example consent to being observed at meetings but not to be interviewed), all gave consent to participate in all parts of the research.

Participants

Of the 70 staff members who consented to this project (Table 3.1) three were male and the rest female. Of these 70 participants, nine provided consent but their involvement in the project was minimal, if any—they were either on leave or were working at the satellite sites, spending what little time they had at the office documenting their visits to patients or contacting other service providers on behalf of their patients. Hence, I did not include them in the tables listed below. I have chosen not to list the separate roles of the allied health professionals (counsellors, social workers, pastoral carers, bereavement counselling, psychologist) and nurses (registered nurses and clinical nurse consultants) to maintain the confidentiality of the service.

Table 3.1 Participants' professional roles

| Professional Role | Number |
|--|---------------|
| Allied health including pastoral care and bereavement health professionals | 16 |
| Nurses including clinical nurse coordinators | 15 |
| Physicians including one registrar (palliative care physician-in-training) | 4 |
| Manager | 1 |
| Volunteers Co-ordinator | 1 |
| Administration Officers | 8 |
| Total | 61 |

33 of the 61 participants were interviewed and of these, several participants had one to two further interviews. Their professional roles are listed below—the “others” comprising the manager, the volunteers co-ordinator and an administration officer (Table 3.2).

Table 3.2 Participants interviewed and their professional roles

| Professional Role | Number |
|--------------------------|---------------|
| Allied health | 13 |
| Nurses | 15 |
| Physicians | 3 |
| Others | 2 |
| Total | 33 |

Of the 33 participants I interviewed there was a spread of age groups (Table 3.3) and years of experience in palliative care. Life experiences and chronological age have been associated variably with moral distress. For instance, Dodek et al., (2016) found in their survey of 669 health professionals working in intensive care units that moral distress was lower in the older aged non-physician health professionals but greater in more experienced nurses. Whether there was more moral distress in those with less life experiences or greater moral residue in more experienced nurses in Dodek et al.'s study is unclear. I mention the participants' age groups and years of experience here to give a demographic picture of the cohort who volunteered for this project.

Table 3.3 Participants interviewed—age groups.

| Professional Role | 20-29 years | 30-39 years | 40-49 years | 50-59 years | 60-69 years | >70 years |
|--------------------------|-------------|-------------|-------------|-------------|-------------|-----------|
| Allied Health | 2 | 1 | 1 | 4 | 3 | 2 |
| Nurse | 0 | 5 | 3 | 3 | 4 | 0 |
| Physicians | 0 | 3 | 0 | 0 | 0 | 0 |
| Others | 0 | 0 | 0 | 1 | 1 | 0 |

Whilst 14 interviewees had been working at the service for less than four years, the rest had worked in the service for over 4 years, accumulating hundreds of hours of experience (Tables 3.4 and 3.5). I have arbitrarily named those with less than four years' experience in palliative care as junior health professionals and those with more

than four years as senior health professionals, based on the participants' own descriptions of themselves as such.

Table 3.4 Participants interviewed—years working in palliative care.

| Professional Role | < 2 years | 2-4 years | 4-10 years | >10 years |
|--------------------------|-----------|-----------|------------|-----------|
| Allied Health | 3 | 1 | 3 | 5 |
| Nurse | 1 | 1 | 5 | 9 |
| Physicians | 1 | 0 | 2 | 0 |
| Others | 0 | 0 | 1 | 1 |

Table 3.5 Participants interviewed—years at current service

| Professional Role | < 2 years | 2-4 years | 4-10 years | >10 years |
|--------------------------|-----------|-----------|------------|-----------|
| Allied Health | 7 | 1 | 9 | 5 |
| Nurse | 1 | 1 | 0 | 4 |
| Physicians | 3 | 0 | 0 | 0 |
| Others | 1 | 0 | 0 | 1 |

Data Collection

All data contribute to a richer understanding of the cultural, psychosocial, personal and spiritual perspective of the individuals and team, and the influences of these on the experience of, and response to, moral distress. In ethnography, the participants are respected as the source of knowledge and the researcher is there to learn. Information is obtained through a variety of means—observations, informal conversations, interviews, field notes and unobtrusive methods, to name a few. The greater the diversity of sources the more rigorous or authentic is the research (Liamputtong, 2013, p. 172; Rashid et al., 2015, p. 11). The data are also collected over a prolonged period so as to be able to follow the processes participants undergo in dealing with a particular issue or phenomenon—in this case, moral distress.

Other methods of data collection such as moral distress scales and surveys used in moral distress research were considered but not included. Moral distress scales have been used to determine the presence of moral distress and the degree of distress (Corley et al., 2001; Hamric et al., 2012; Lamiani et al., 2017b; Leggett et al., 2013), however they premise the causes of distress before measuring its presence and intensity. The moral distress scales are based on scenarios of moral challenges relevant to the particular group of health professionals being researched. Thus, these questionnaires have to be modified and validated to accommodate the different causes and contexts within which moral distress can occur. This may not capture the many other causes of moral distress present (Af Sandeberg et al., 2015; Haikali et al., 2016; Lamiani et al., 2017a). Whilst providing valuable information, questionnaires may not

be as informative in elucidating the personal and professional influences that result in moral distress that were important to answering my research question. In the same way, surveys give another important piece of the moral distress jig-saw puzzle, for example the causes of moral distress, patient care situations and the significance of participants' professional experience to occurrences of moral distress (Allen et al., 2013; Dodek et al., 2016). However, surveys are limited in elucidating the context and other influences that impact on the moral distress experience.

Six main types of data were collected: observations during meetings; incidental and informal conversations; formal conversational and semi structured interviews; "feedback" groups; unobtrusive data; and field and reflexive journaling. The integration of data from these various methods, also known as triangulation, added to the rigour of this study (Liamputtong, 2013, p. 172). Triangulation helps build a truer picture—"reducing biases and deficiencies" as well as allowing "multiple and different angles or perspectives" (Rothbauer, 2008, p. 892).

Although Human Research Ethics approval was granted for 12 months of data collection, after six months of fieldwork and, following discussions with my supervisors, it was decided that I had reached saturation as far as data collection was concerned. Saturation is reached when no new properties arise from the data for the specific categories as described in the next section (Charmaz, 2014, p. 213).

Patients or Clients

One of the observations I noted was the use of the term "patient" by medical and nursing health professionals and "client" by some of the allied health professionals. I mention this now to explain my use of the term "patient" for the rest of the thesis. This explanation warrants a chapter on its own as there are many connotations in the use of the terms (Neuberger, 1999; Ratnapalan, 2009; Richard Conti, 2008). However, I do not want to detract from the subject matter of moral distress and so shall be brief.

There is a long tradition in medicine in the use of the term "patient". The word patient is derived from the Latin *patior* meaning "to suffer". The patient is "one who suffers." In the doctor-patient relationship, the patient receives the care the doctor gives (Cambridge University Press, n.d. -b). Some argue that the term "patient" implies someone who is subservient and passive, and so should not be used (Neuberger, 1999). I argue that the evolution of the doctor-patient relationship—from the physician as primary decision-maker of care, to that of shared decision-making with the patient, and again to respecting patient autonomy—does not necessitate a change in terminology,

only in attitude and approach. The doctor-patient relationship is more complex and dynamic than the power-play of the passive patient and all-powerful doctor that Neuberger (1999, p 1756) intimates (Chipidza et al., 2015; Turabian, 2018).

The word “client” is derived from the Latin *clinare* which means to lean. “Client” according to the *Cambridge dictionary* is “a customer or someone who receives services... especially from a lawyer or other person who gives advice” (Cambridge University Press, n.d.-a). Ratnapalan (2009) suggests that “patients” could be those who are ill requiring care, whereas “clients” may be those who are not unwell but requiring advice. More importantly, others found that most patients preferred to be called patients rather than clients (Costa et al., 2019; Wing, 1997).

The allied health professionals in this service were not insistent on calling their clients, “clients”. The nurses and physicians in the service however used the term “patients” rather than “clients” and had strong opinions about doing so. Thus, for the purposes of this thesis I use the term “patients”.

1. Observations at Meetings

With the consent of those present, I sat in on regular team meetings that were held. Multidisciplinary huddles or meetings, usually lasting half an hour, were held three times a week at each site to discuss new cases, complicated cases and deaths that had occurred since the previous meeting. These would be attended by doctor(s), nurses and one or two allied health team members. Once a month at each site a multidisciplinary team meeting would also be held. The format of these monthly meetings varied from going through the list of patients in the program for that particular area, to highlighting only patients and families whose care was more complicated. It was also an opportunity to discharge patients from the program who no longer required specialist palliative care.

Where possible I also attended monthly meetings held by the nursing, management, allied health and administration teams. I would also attend the weekly allied health allocation-of-cases meetings. During all these meetings I was attentive to the spoken content of the meetings, the dynamics of group, their approach to providing care as well the situations of possible moral challenge and distress. What was noted was not only the content of the conversations but also the silent pauses that, as subsequent conversations determined, were not just moments of reflection but also moments of

disbelief or a perceived sense of disrespect by the speaker. I would take notes either during or after the meeting.

On rare occasions my opinion would be sought by those present with regard to situations of uncertainty. In such circumstances I would repeat the points already made by the participants, then give my opinion. These situations of uncertainty were more pertaining to structural changes that were happening within the service. The informal moments of conversation as the participants returned to their workspace or the tearoom for a “cuppa” were significant in terms of exploring the moral challenges they faced.

2. Incidental and Informal Conversations.

Following meetings, the conversations sometimes continued as the participants moved towards the workspace and/or tearoom. At times I chose not to intrude on these conversations. I would move towards the tearoom or to my “hot desk” which was any unoccupied desk within the service. Sometimes the participants would drop by for a chat or seek out a colleague nearby and include me in the conversation. At other times, where appropriate, I joined in the conversations and felt welcomed to do so. I also noted the conversations of distress, or ongoing reflections on what was said at the meetings in my journal.

Informal and incidental conversations often took place in the tearoom where I sat in the mornings and afternoons, as health professionals left and returned from their home visits or meetings. These informal conversations also occurred in the tearoom during lunch breaks. Often during the day, I went around the main office site offering potato chips as a mini-break from whatever the participants were doing, and at moments of stress, these were appreciated as comfort food. Incidentally at times, they were also opportunities for informal conversations. On a few occasions I accompanied the health professionals to education sessions or to meetings where they would meet other professionals in other services, for example Carers Victoria. Sometimes these were occasions where morally challenging situations were raised and discussed, often in the journey to and from the place visited. 25 of these informal conversations were audiotaped after verbal permissions were obtained from the health professionals involved.

These informal conversations constituted three kinds of data: new situations of moral challenges; ongoing reflections of morally challenging situations already discussed,

with or without new information; and other personal reflections on situations or contexts within which they found themselves. The latter included the changing structures of the service and increasing complexities of healthcare and social services. Sometimes these were accompanied by strong emotions.

3. Formal In-depth Interviews.

Conversational interviewing was used in the formal in-depth interviews for several reasons (Roulston, 2008). In conversational interviewing, there is flexibility in the exploration of the participants' perceptions of moral distress and the opportunity for the participants to recall and share the relevant information as they recall the situations. Even though I might fail to see the connection, I am able to explore with them the relevance of the information shared to their experience of moral distress. One participant for instance shared about her relationship with her dog and the things her dog would do. She revealed later in the conversation/interview that her dog was the one whom she would debrief with regarding some situations of seemingly insignificant moral distress. The informal nature of the conversation also allowed for trust and rapport building (Roulston, 2008, p. 129).

Once consent was received and my fieldwork began, the participants either volunteered to be interviewed or were gently invited, mindful of avoiding coercion. These formal in-depth interviews were conducted in booked meeting rooms on the main site. One was conducted in one of the satellite sites in a private meeting room. 33 formal in-depth initial conversational interviews were undertaken and audio-taped with prior consent. These would last from 60 to 110 minutes, with an average of 80 minutes.

The initial conversational interviews began with an invitation to the participants to share some of their background including their palliative care experience: their age-group; the number of years working in palliative care and in particular in this service; their training in palliative care; and the current position they hold.

After the sharing of the participants' background, they were then invited to share whatever they wished on their experiences of moral distress. Where the participants asked for a definition of moral distress, I described it as "*the emotion one experiences when one knows the right thing to do but is unable to do so because of constraints whether personal or external.*" After the exploration of moral distress ended, and depending on the participants' availability, I then explored further their experiences and opinions regarding community care, multidisciplinary teams and the evolving

palliative care specialty, posing open-ended questions (Appendix B). As the data from previous interviews were analysed, consistent with the iterative aspect of this research, I explored other concepts that emerged from prior interviews or informal conversations, such as “*feelings of demoralisation*” and “*the future of multidisciplinary teams and the impact of this on moral distress experiences*” with the participants, depending on the participants’ availability and interests. I then finished the interviews with “*Is there anything else you would like to share?*” and thanked them for their time and their sharing of themselves.

In addition, 18 formal in-depth follow-up conversational interviews were also audio-taped with consent. Apart from five follow-up interviews which I initiated the rest were at the request of the participants. The duration of these follow-up interviews varied from 30 to 60 minutes. The subsequent interviews included participants’ further reflections, understandings and exploration of experiences previously shared or new experiences of moral challenges perceived as moral distress. These interviews form part of the many iterations of ongoing data analysis-collection-analysis throughout the six months of fieldwork.

4. Unobtrusive Data

The fourth method of data collection used was unobtrusive data collection (Liamputtong, 2013, p. 171). Unobtrusive data include observations such as the setup of the field site and how this contributed to dynamics and staff relationships. An example of this was the set-up of the open-plan nurses’ room with a side-office for the Quality and Education Coordinator and senior support nurse, and a different room for the allied health professionals which allowed for debriefing within disciplines. Other unobtrusive data included the organisation’s vision and mission statements and possible allegiance to these statements, photographs/pictures that line the walls, the clinical or homely setup of the various rooms, the atmosphere of the place, and other observations that may or may not have contributed to the experience of moral distress. Photographs of the rooms and the main site’s emergency floor plan were taken to aid in recollection whilst analysing data.

With regard to organisational vision and mission statements, Darbi (2012, p. 106) found in his study that if employees take ownership of the organisational values and mission statements it would most likely influence their behaviour. LaSala and Bjarnason (2010) posit the importance of organisational vision and mission statements in providing an environment for moral courage to deal with or ameliorate moral

distress. The contribution of this service's organisational mission and vision statement in the experience of moral distress is described in Chapter Five: Moral Equilibrium.

5. Feedback Groups

After analysis of the above data, feedback on the findings was obtained three and a half months after leaving the field. I returned to the service with a preliminary summary of the data analysis and presented it to three conveniently sampled groups. The first group was the allied health professionals group comprising ten participants and two health professionals who were not present at the time of the fieldwork. Consent was obtained from the group to present the findings in the presence of the two non-participants. Verbal consent was obtained from these two individuals to audiotape the meeting.

Each of the other two feedback groups of five people comprised middle management participants, and a nurse. The manager of the service also joined one of these groups. Verbal consent from those present to audiotape the feedback was obtained. This was an important exercise which achieved two aims: it affirmed my interpretation of the data analysis with those present in the feedback groups; and it was an opportunity for those present to reflect further on their experiences of moral distress and the holistic description of the findings. An invitation was extended to all present to feedback any further reflections they might have had via email, phone conversation or in person. Four emails and three in person feedback were received, all of which affirmed the findings. Three participants specifically expressed views on how the results could be used in the service's staff formation meetings.

6. Field Notes and Reflexive Journaling

Within the interpretive framework, it is acknowledged that the interpretation of the data by the researcher is significant (Adams & van Manen, 2008; Miner-Romanoff, 2012). One way of ensuring rigour in this process is through the process of reflexivity (Guillemin & Gillam, 2016, p. 275; Mosselson, 2010). Dowling (2008) suggests four kinds of reflexivity in qualitative research. The approach I undertook incorporated all four kinds. In my process of reflexivity I noted my "prior assumptions, beliefs and attitudes"; my "feelings" in various situations when these were evident, and I had reflected on the causes of these feelings; my critical examination of the political and social issues that may have influenced the research, as well as the "reciprocity in the interaction" between myself and the participants (Dowling, 2008, pp. 747-748).

Reflexivity is important in what Guillemin and Gillam (2016) call “ethically important moments” which they define as “the difficult, often subtle, and usually unpredictable situations that arise in the practice of doing research” (p. 262). Moments I experienced included being asked to treat a patient who had just fallen down the stairs; this was despite emphasising to participants at the start of the research that my role during fieldwork was to be solely as a researcher and not a general practitioner. Other moments included a participant relating something deeply personal and crying as she remembered the pain of that incident. As part of my reflexive journaling I noted the situations, how I responded and how I would do it differently, if at all. Reflections such as whether my responses or even manner of response affected the participants and the conversation during the in-depth interviews were considered. I was attentive to the common themes that were emerging, and whether I needed to explore other areas further. As Guillemin and Gillam (2016) state “Reflexivity in research is thus a process of critical reflection both on the kind of knowledge produced from research and how that knowledge is generated” (p. 274).

Field notes form another source of rich data. Whilst in the field I journaled in a notebook my observations, experiences and other thoughts or pieces of conversations. Returning often to this journal, ideas and theories developed as I reflected on what was written, and where appropriate, these ideas and theories were raised in conversations with participants on the next occasion.

Data Analysis

Consistent with the inductive framework, and the ethnographic methodology of rich data being analysed iteratively, data analysis began during fieldwork. In analysing the data, I was guided by Charmaz’s (2014) grounded theory approach. This analysis is compatible with an interpretive phenomenological approach (Miner-Romanoff, 2012). As I listened to informal conversations, attended meetings, observed and interviewed participants, I noticed common themes and patterns emerging and, from these, initial hypotheses arose (Charmaz, 2014, p.111). Other data from field notes and reflexive journaling added to the coding and analysis. I was also attentive to my own reflections, feelings and intuition, and tried to minimise any preconceptions and biases I might hold (Miner-Romanoff, 2012). In desiring to determine as many influences as possible on the experience of moral distress, I was also attentive to the larger context within which these experiences were described. This was also explored with the participants in informal conversations, as appropriate.

These codes were then sorted into categories, and hypotheses emerged to explain the lived experiences described by the participants. The hypotheses were tested with data from subsequent interviews, sometimes with the same interviewees, other times with new interviewees depending on the flow of the conversational interviews. Comparing new data and hypotheses with previous data also formed part of the iterative process. Coding in grounded theory is an interactive process of “kneading” all the data, checking them with the participants and new data coming in, and being attentive to both obvious and subtle data. These codes were then arranged into categories and eventually “baked” into conceptual theory/ies representative of the data and the perspectives of both the participants and myself (Charmaz, 2014, p. 115). At times these hypotheses, based on the data, were tested at supervision meetings with my academic supervisors, adding to the rigour of the analysis. At such meetings too, my assumptions were often challenged, which contributed to the strength of my analysis. Whilst all data was analysed, quotes from participants were presented as these were representative of the themes that have emerged.

Researcher Role

In my recruitment presentation to the staff at the service and subsequent explanation of the project to those who were not present, I introduced myself as a doctoral research candidate at the University of Melbourne, a general practitioner and a religious sister. I divulged that what led me to this research project was my interest in bioethics, especially at life’s end, and its relevance as a general practitioner and religious sister. I disclosed that, as well as my medical degree, I also hold a Master of Arts in Bioethics and Health Policy. However, I emphasised that my role at the service was solely as a researcher.

As I delved into my fieldwork, my roles unexpectedly increased. I found I was not able to keep strictly to my role as researcher. As previously mentioned, I was called upon once to see a patient who had fallen down the stairs. Even though there were nurses around, I acceded to the request without much hesitation, despite being conscious of the fact that my role there was solely as a researcher. Ethically as a medical practitioner I am obliged, as well as personally willing, to provide medical assistance where needed. I saw the patient and fortunately there was no major injury. However, as the patient was a ward of the state, the carer rightly followed protocol and the patient was taken to the Emergency Department at the local hospital. A few other times my medical opinion was sought by the staff, and I willingly responded, emphasising that the staff or family

member needed to see their own general practitioner. I saw these as reciprocating their generosity in participating in the research.

The second request from the manager of the service was to give a presentation at a staff meeting on the ethical considerations of the then impending enactment of the Victorian Voluntary Assisted Dying Act 2017. Once again, I was happy to contribute to the education of the staff, thus, reciprocating their generosity in participating in the research. The manager had also invited the staff to seek any ethical advice from me whilst I was there—“*use Carol while she is here*” (Marin), in exchange for their participation in the research. I was happy to be the sounding board for the staff regarding any ethical issues they might want to raise. This happened on a number of occasions. Unintentionally, on three occasions the “consults” led to an exploration of moral challenges and distress the staff members were experiencing.

The third role that was unintended but very much in keeping with my role as an ethnographer, was to be a sounding board for the staff, and as some staff perceived, to “provide pastoral care” for them (Dickson-Swift et al., 2007, pp. 335-336). This was a natural progression as relationships develop between the researcher and the participant (Dickson-Swift et al., 2007, p. 334). The kind of relationships that develop would be in keeping with the role and personality of the researcher and participants, as with any relationship.

The principles of ethics, including non-maleficence—in my reflexivity, as well as discussions with my academic supervisors later—guided my decisions to move into the aforementioned roles when requested. In all of the above, I do not believe that the participants were harmed in any way and there were no complaints to the manager nor to the Research Officer of the service’s organisation. In performing those roles I felt I was able to give back to the participants and the service, after having received so much in the data I collected and in the relationships that developed over the six months. This principle of reciprocity is common in qualitative research (Dickson-Swift, 2007, p. 334).

Conclusion

In this chapter I have outlined the inductive, interpretive framework and the combined methodologies of ethnography and interpretive phenomenology through which I chose to answer my research question. I have outlined the reasons why I chose this combined methodology and the methods I used to obtain as much thick and rich data as I could. I

described the data analysis I undertook, emphasising its iterative nature and the steps taken to ensure rigour in the research.

I acknowledge the limitations of this research, in that it is representative of health professionals in only one community-based specialist palliative care service in Victoria. Williams (2000) argues that despite the specificity of findings to one group, these specifics can be considered moderate generalisations when there is cultural common ground and where multiple methods, triangulation and rigour are ensured. Despite this limitation of specificity to this one group, as I describe in the following chapters, the findings of situations of moral distress and responses to the experience are consistent with the literature, and this service has potential commonalities with other healthcare contexts. This suggests that the findings can be useful beyond this specific setting.

The next chapter describes the many moral challenges that the participants encountered daily and how these moral challenges affected them.

Chapter 4: Moral Challenges in Community Specialist Palliative Care

I really like the work. But I think it is the overwhelmingness of the job that gets to me... we are told we are not doing enough, you are not meeting the targets... in order to get more funding you need to meet the criteria and benchmarks... it is the amount of work that we need to get done and the complexities of our patients, new medicines in treatment and more paperwork and referrals, there is so much we have to do and fit it in your eight and a half hour shift....I still love palliative care.... You just don't feel like you have done the best you can....
(Ricky, senior nurse)

Ricky's comment captured some of the moral challenges that the participants faced daily in this community healthcare setting. She named the tension felt between their personal desires as well as their professional moral responsibilities to care for patients, and the constraints they felt which were preventing them from doing so. For Ricky, this was an experience of moral distress.

This chapter explores the categories of moral challenges the participants shared, by first defining moral challenges and the significance of emotions in relation to the development of moral distress. It introduces the phenomenon of team moral distress not previously described in the literature, and the emergent concept of moral equilibrium-disequilibrium which I explore further in the next chapter.

Defining Moral Challenges

For these participants, situations of moral challenge arose in everyday practice which disrupted the health professionals' sense of fulfilling their moral responsibilities and obligations of excellent care for their patients. These moral responsibilities and obligations of care were consistent with their personal, professional and social values. These, in turn, caused a state of dis-ease. When they felt constrained from being able to do what they believed was morally right, moral distress ensued.

For Ricky, the workload demands meant that she had limited time with each patient and so was unable to provide the excellent care she valued as important. This tension led her to question the fulfillment of her moral values of excellence and compassion in meeting their obligations of care to patients. This left them feeling that their moral integrity was challenged. Such experiences were congruent with moral distress literature which recognises moral distress as causing compromised moral integrity

(American Association of Critical Care Nurses, 2008; Austin et al., 2005; Hardingham, 2004; Holtz et al., 2018; Kelly, 1998). Hence, moral challenges for these participants were circumstances in which individuals' moral values were questioned and/or their moral integrity tested.

Emler (2019) described moral challenges as "circumstances in which there are strong pressures or inducements to act contrary to moral standards" (p.33). However, on the basis of these participants' experiences, I suggest that moral challenges could also be situations where the validity of the individuals' moral standards, and the values on which the standards are based, are disputed or questioned. This would be consistent with one of the *Oxford dictionary of English's* definitions of *challenge*: "a call to prove or justify something" or "to dispute the truth or validity of" (Oxford University Press, n.d.). These moral standards could be

- i. personal: based on personal values and beliefs;
- ii. social: based on societal moral standards; and/or
- iii. professional: based on the moral standards determined by a professional body such as the *Australian Medical Association code of ethics* (Australian Medical Association, 2016), *Good medical practice: A code of conduct for doctors in Australia* (Medical Board of Australia, 2020), *The ICN code of ethics for nurses* (International Council of Nurses, 2012), and the *Australian Psychological Association code of ethics* (Australian Psychological Association, 2007).

The data from this research showed that moral challenges arose when health professionals' moral standards were questioned or unfulfilled. These moral standards were consistent with their core values. The challenges in turn resulted in moral distress when individual health professionals could not act according to their chosen values because of personal and external constraints. In these situations where there were inconsistencies between health professionals' moral values and actions (or inactions), the health professionals' moral integrities were compromised (McFall, 1987, p. 7).

The psychological impact of these experiences of moral distress were common, though varied, amongst participants. For Ricky it was overwhelming. For G Andrea it left her with a grumbling feeling of constantly being constrained in doing what she believed was the right thing. This grumbling feeling was consistent with cumulative unresolved moral distress.

Awareness of Moral Challenges: The Role of Emotions

Midway through my fieldwork, as I reflected on the interviews, I noted two ways in which emotions played a role in the experience of moral distress. Firstly, emotions alerted health professionals to the presence of moral challenges. Statements such as “*it did not feel right, but there was not time to deal with it*” (Ricky), highlighted the sense of a disturbance in the equilibrium of day to day functioning for the health professionals, and expressed as a feeling or emotion.

Secondly, emotions were also consequential to the experience of unresolved moral challenges:

I talked it over with the manager and CNC [Clinical Nurse Consultant—a senior nurse often in management role] ... we decided there was nothing I could do as the carers are the ones giving the medications...but it still didn't feel right.
(Ridley, senior nurse)

This was a situation akin to reactive distress (Jameton, 2013) or moral residue (Epstein & Hamric, 2009). Ridley, the manager and the clinical nurse consultant had made a moral judgement as to the right course of moral action, but they were constrained from following it through as they were not the primary carers of the patient.

In capturing the examples of health professionals' moral challenges, I also noted a spectrum of emotional responses that the participants described. These responses included participants' verbal description as well as their body language. This ranged from a “*niggling feeling*”, “*discomfort*” or “*disturbing*”, “*challenging*” to “*feeling very upset*”, “*I was wild,*” anxiety, anger and distress. However, actual distress with associated physical and physiological symptoms such as restlessness, palpitations, high anxiety, insomnia and nightmares was uncommon. One very experienced nurse who dealt with moral challenges by choosing not to react commented:

...when you have been in the game as long as I have, you learn not to let it affect you. I keep reminding myself it is not my life... so you get on with it. (G Rhonda, senior nurse)

Emotions alerted the health professionals that something was amiss. For some it caused them to deliberate further with their colleagues. For others, like G Rhonda, the moral challenge may not have been significant enough to warrant further exploration, having resolved or accepted similar situations in the past. The lesser feelings of

discomfort or unease tended to be dismissed unless they were persistent. This awareness of the significance of emotions related to moral challenges had alerted some participants to the presence of moral challenges. This insight had encouraged these participants to address these moral challenges, even at a later time, rather than ignore them because of the busyness of work. G Andrea, in an informal conversation in her office, noted:

You know after our conversation [interview], I've begun noticing how I felt when certain things happened. It helps me figure out what was happening for me at the time, or chat with the others when I come back to the office—whether I did the right thing. It's good. (G Andrea, senior allied health professional)

The range of emotions that participants described was similar to that described in the literature (Corley, 2002, p. 642; Edwards et al., 2013). Wilkinson (1987/1988, p. 22, 27), for instance described her participants' feelings of anger, frustration, guilt leading to depression and loss of self-esteem. Only one participant described significant distress such that it affected her personal relationships and behaviour, and manifested in physical symptoms such as palpitations, diarrhoea, insomnia and headaches:

It was awful... I'm sure my husband was going to divorce me!... only kidding I don't think he would have.... I was having nightmares, couldn't sleep, getting palpitations and shaking most of the time. If it weren't for G Rhonda and everyone being so caring, counselling, supervision and all that, I don't know what I would have done. All my physical symptoms settled soon after. (Remy, junior nurse)

Whilst the moral distress empirical literature describes a variety of emotional responses to moral distress, the emphasis has been more on the consequence of moral distress than on the initial emotions alerting individuals to moral challenges. However, it is also important to note that symptoms such as panic attacks, high anxiety and insomnia do have consequences as the associated psychological state can impact negatively on patient care (Baggs et al., 1999 #9323; Burston & Tuckett, 2013; Corley, 2002). In other words, the psychological disequilibrium, in itself can impact on patient care resulting in a cycle of poor patient care and increasing moral distress, which in turn causes further psychological disequilibrium and poor patient care and so forth.

When the participants gave examples of moral distress, it was likely that they equated any emotion, regardless of its intensity, as moral distress. The criteria for them was the emotion related to a moral constraint situation.

So, when you asked about moral distress... I think I can give you many examples when things weren't right and there is nothing you can do about it or you can only go so far... then you have to let it go. They weren't distress-distress but still moral distress, you know what I mean? ... you can't do what you think should happen.... (Ridley, senior nurse)

This is congruent with some of the literature where no emphasis is given as to the degree of emotions necessary to qualify as moral distress (Kälvemark et al., 2004; Meltzer & Huckabay, 2004; Rushton, 2016a). Wilkinson (1987/1988) defines moral distress as “the psychological disequilibrium and negative feeling state experienced when a person makes a moral decision but does not follow through by performing the moral behaviour indicated by that decision” (p. 16), but does not define psychological disequilibrium, nor the intensity of disequilibrium needed to fulfil the criteria of distress.

I posit that the degree of emotion that health professionals experience may be a manifestation of the impact of the moral situation on their moral integrity, and the commitment they have to their values. Senior nurse Rein for instance believed strongly that ending a person's life prematurely was morally wrong. Witnessing a doctor give morphine to a patient in incremental doses to relieve suffering and the eventual death of the patient, left Rein feeling very distraught.

“I was so convinced that the doctor killed the patient, I had to take time off work. I was so distraught for three to four days. I was going to talk to the consultant, but the CNC [Clinical Nurse Consultant] told me not to... eventually someone explained palliative sedation to me, and I understood what happened. I was doing a training certificate then. (Rein, senior nurse)

Rein did not feel so strongly about another patient whose family members were reluctant to give the patient more pain relief, despite Rein advising them to do so:

It's very different to the case where the family member refused help but at least that patient wasn't in too much pain... and you can't force the family members to give more pain relief. Maybe I could have done more, but I didn't lose too much sleep over it. The family complained about me, so another nurse took

over. And we found out that the patient's relative thought that if the patient got more pain relief then she was close to death and he couldn't cope with that....
(Rein, senior nurse)

Ending a patient's life prematurely contravened a strong core value for Rein, resulting in days of significant distress. Patients' carers refusing advice resulting in some degree of patient discomfort was a minor challenge to Rein's moral responsibility of patient care, resulting in a discomfort from which Rein did not "*lose too much sleep over....*"

The degree of emotional response may also be a manifestation of the strength of health professionals' moral resilience, as it was for G Rhonda in her comment above, when situations that used to disturb and challenged her moral integrity were acknowledged then let go.

My research question was how moral distress is experienced by specialist palliative care health professionals in this Australian community healthcare setting. I found that initially they experienced the emotions of dis-ease including discomfort, feeling disturbed or demoralised, a grumbling unease, anxiety and, for very few, distress. These alerted the health professionals to challenges, and in situations pertaining to moral values, moral challenges. If the health professionals moved to the next phase of moral deliberation and moral judgement, a second wave of emotions of dis-ease/distress arose when they felt unable to act according to those judgements. This was consistent with Jameton's (1993) description of reactive distress (p. 544).

Moral Challenges in Community Specialist Palliative Care

Some of the morally challenging situations the participants in this project shared were similar to those reported in the acute care setting, whilst others were unique to community healthcare. Despite this, the process appeared to be the same: a situation arises that challenges the health professional's or team's moral stance, resulting in a state of dis-ease. This can be aligned with Nathaniel's Stage of Ease in her Moral Reckoning Theory, in which she states at this Stage of Ease the nurses "enjoy a sense of satisfaction and at-homeness in the workplace. They feel comfortable with their knowledge and skills" (Nathaniel, 2013, p. 334). I argue that at this Stage of Ease, health professionals' moral values and standards are in keeping with their action and motivation—they are in a good enough moral equilibrium.

Yet in the daily experiences of palliative caring, situations can arise that challenge this good enough moral equilibrium, giving rise to moral distress/disequilibrium. The following were some of the moral challenges that resulted in what participants named as experiences of moral distress.

Three major themes were identified as moral challenges. The first resulted in health professionals' inability to fulfil committed moral obligations and responsibilities. The second were circumstances where health professionals' goals of care differed from those of patients and others involved in their care. The third theme was a sense of powerlessness to act on what the health professionals believed was morally appropriate for the patient/family/carers. This was associated with a loss of moral agency secondary to both personal and external constraints. Again, this is akin to Jameton's (1993) description of reactive distress (p.544).

Inability to Fulfil Moral Obligations and Responsibilities

Central to participants' moral integrity was living and working according to their personal and professional moral standards and core values. The specialty of community palliative care provided the setting within which they were able to do this. Participants described being passionate about working in palliative care. For most of the nurses it was their ideal job, describing themselves as "*feeling called to... [palliative care]*" and "*wanting to make a difference in patients' experiences at the end of their lives.*" Phrases such as "*being passionate about,*" "*enjoyed doing,*" "*wouldn't do anything else,*" "*something I've always wanted to do even though I was advised to try other kinds of nursing,*" and "*I've found my niche*" were relatively common. One senior nurse shared that she "*knew from the start that this [palliative care] is it,*" after four years of nursing, 45 years ago. Another nurse described "*fulfilling patients and family wishes is very satisfying.*" One allied health professional described feeling "*privileged to be with patients at this time in their life*"—a sentiment shared by eight other allied health professionals, many nurses and two of the physicians.

This passion for palliative care contributed to the experience of moral distress in two ways:

- it exposed the health professionals to greater distress as providing good palliative care was very important to them;
- it contributed to a persistence in finding a solution, or, led to burn out if not resolved.

When the participants were not able to provide the care that they passionately believed patients should receive, coupled with the inability to fulfil their professional moral obligations and responsibilities, moral distress ensued. Causes such as inadequate staffing with increasing demands, lack of resources, increasing complexities in palliative care, the healthcare sector and socio-economic structures, all contributed to the inability to provide best care for patients and families. The following are examples of how these causes challenged the participants' sense of moral integrity in acting according to their moral values.

Andi, a senior allied health professional who had worked in palliative care for more than ten years, described the constraint of inadequate staffing as a cause of her moral distress. This was a significant moral challenge for almost all the participants and is also described in the literature (Brazil et al., 2010; Corley et al., 2005; De Veer et al., 2013; Jansen et al., 2020; Ohnishi, 2010).

Even in the... months that I have been here it's become busier and busier. Our workload is more fast paced than it used to be. ...because we get two to five referrals a week. My struggle is having to leave the ones that are okay... I think they are okay, but you just don't get the time to check in again... particularly in bereavement... where we should support them as long as we think they need it but because our capacity... is so limited that occasionally I think "oh I really would have liked to follow up". Whenever I leave a family I would say "Don't forget we are here always. Don't feel like you can't call us. If you think you need us just ring." I find that hard.... I should be the one ringing and checking up on them... It feels like there's a little bit left behind... yet undone.... So that's a struggle for me.... Volunteers do contact them, but the volunteers don't know them whereas I have seen them for many months... it's not the same. But there isn't the capacity 'cos you have to move on to the next one who needs you. It is a source of moral distress. (Andi, senior allied health professional)

Andi called this experience moral distress based on the definition of moral distress given at my recruitment presentation. In my field notes I noted the anxiety that was evident in Andi's body language as she continued to relate the feelings of guilt at not being able to follow through on the patient's bereavement. The health professionals were stretched to meet the rising demands on the service, resulting in the inability to fulfil their desired moral obligations and responsibilities of care for their patients. For Andi this was an ongoing, unresolved struggle... always leaving "a little bit... behind."

With the increasing demand on the service and the inadequate capacity for follow up, an interim solution was put in place whereby patients who were relatively stable received a phone call from volunteers to ensure that they were not in need of assistance. For some of the participants however it was “*not the same.*” This ongoing unresolved struggle was moral residue. The same was noted for another participant:

It's like having to prioritise who you see when the preference is for all to be seen as soon as possible... I feel like I am compromising my professional integrity.... It's like you can never close the books properly.... So you have to compromise and explain to patients and families your limited capacity... and say to them to call us anytime... Sometimes you have to rely on the volunteers to check in on them. You know it is not good enough, but what can you do? Often times I feel like I am letting them down... that I am not doing my job properly. That's moral distress for me. (Alex, senior allied health professional)

Alex's use of the term moral distress was unprompted. For her there was again the sense of not fulfilling her professional moral responsibility or providing good patient care, or in her words: “*not doing my job properly.*”

The nurses' experiences were the same, as Rita shared:

I often feel I'm walking a fine line between being able to care for patients as I would like to and the barriers that stop me from doing so, like the demands because of the patient load. (Rita, senior nurse)

One of the service's review reports noted a weekly average of over 30 admissions, 25 deaths and a patient load of 610 and growing, which affirmed Rita's experience. I noted at the time when this report was given to the staff, there was a sense of relief amongst a few of the participants—the report explained the workload stress they were experiencing.

Lack of staffing has been named frequently as a cause of moral distress in the literature (Browning, 2013, p. 146; Caram et al., 2018, p. 4; Corley et al., 2001; Hamric et al., 2012), and associated with this, the lack of trained staff (Brazil et al., 2010; Hamric et al., 2012). It was no different in this community palliative care setting:

There is a general shortage of specialist care nurses. All the community palliative care services are advertising.... It means having to employ less experienced staff and having to train them, which unfortunately puts more

demands on the experienced staff. (Reska, senior nurse)

Skilled workforce shortages and the rapidly growing population needs within the area of service were not the only causes of stress for the participants. Adding to the work stress was the evolving complexities of healthcare and palliative care: medical advances; scope of practice; organisational structure and administration. The participants named factors such as: increased complexities in patient management with new medicines and their associated side-effects; increased documentation related to funding and accreditation with the Victorian Department of Health and Human Services⁴; and increased complexities in healthcare structures and organisations and referral pathways, as contributing to the participants' stress. Time constraints and frustrations with social services such as Centrelink, the Australian Government program providing social services and payment of social security, added to the social workers' stress and led to moral outrage. Moral outrage can be defined as "anger at the violation of a moral standard" (Batson et al, 2007, p. 1272). Ange, a senior social worker angrily declared:

Don't get me started on Centrelink! They've implemented this new system. Now the only way you can apply or communicate with them is online! Now tell me how many of the families and patients we see can use the computer let alone have one! I haven't time to go through this... and you can't even save what you've done! It's not fair on the families! And there is nothing you can do about it! You spend so much wasted time getting one patient right—what about the others?... And then there's the stupid superannuation laws that keep changing making it harder for people to get their own money.... That's moral distress! (Ange, senior social worker).

Social workers, like Ange, experienced both moral distress and moral outrage. The social workers felt they were not fulfilling their role adequately when not all patients were seen in a timely manner. They had to prioritise the more vulnerable patients who were in crisis. This was experienced and described as moral distress. Long and frustrating hours were spent on the telephone navigating the complicated systems of Centrelink. Continually changing laws around superannuation was another source of frustration and stress for the social workers as they advocated for the patients' early access to their entitled superannuation because of illness. These vulnerable patients would often lack family supports, were often elderly, had no access to computers or

⁴ For further information see <https://providers.dhhs.vic.gov.au/human-services-standards>

were computer illiterate, and facing significant financial stresses. The non-English speaking patients had the added difficulty of not knowing the language and having to deal with a complex social security system. This led to experiences of moral outrage for the health professionals as they felt the injustices of social and legal systems that seemed to cause more suffering than assist people. These systemic constraints on the participants' ability to fulfill their moral values of providing excellent care for their patients were some of the moral challenges they faced daily.

Participants who provided counselling, bereavement and pastoral care services struggled to keep up with the demands as they continued to support patients and families at very vulnerable times in their lives. Like the senior nurses quoted above, they often felt that they were not supporting patients and their families as well as they could. The feeling of guilt was also present to varying degrees, as not all patients and/or families who needed their help received it. With growing demands for their assistance, the participants had to prioritise patients according to their needs. There were many entries in my fieldwork journal of my observations of their frustration, anger and associated guilt of "failed duty"—though for most it was short lived. Most participants seemed resigned to the fact that "*the system is broken*" (Andi, senior allied health professional).

The stress associated with the increasing demands on the service meant that participants had to limit the care they could provide for patients and their families. Hospitals inaccurately raising patients' expectations of the services the participants could provide, left participants feeling that they were unable to fulfil their moral obligations to patients. The hospital teams, on discharging patients, advised patients and carers that the community palliative care service would meet all their needs including showering and wound dressings. Showers and wound dressings however were the purview of community health nurses, not community specialist palliative care nurses. The added stress of meeting angry and frustrated patients was challenging for a few participants. Remy, a junior nurse, noted:

It leaves you feeling that you have let the patients down even though you know it's not your job as a specialist nurse to dress wounds, but dressing wounds is what nurses do too... but it's not the patient's fault either. Sometimes it is easier to dress the wound just this once and organise for [general community nurses] to take over. (Remy, junior nurse)

Remy's scope of practice as a specialist palliative care nurse was clear to her—dressing wounds was not the role of a specialist palliative care nurse. Dressing it would mean a longer visit with this patient and less time for the next patient. However not dressing the patient's wound might have caused her more moral angst as she might have perceived herself as not fulfilling a general nursing responsibility of care.

The anger associated with unmet expectations of patients and carers also negatively affected the patient-health professional trust relationship. Ruby, a specialist palliative care nurse with almost ten years' experience vehemently explained:

These hospitals! They keep promising patients and their families we will do everything for them even though they know that we don't do showers and dressings.... They know we are a specialist palliative service... we've told them many times.... Sometimes it's just because they want to ease their own concerns about the patient, they want the patient seen urgently... then they discharge patients without sorting them out and tell the patients we'll sort them out... but we haven't got the resources and it is harder in community [context] to get anything done!... Then when we can't do what the hospital promised them, they get angry with us... Certainly leaves the patients feeling like they can't trust us... and that's bad. (Ruby, senior nurse)

Without trust, patients and carers were less likely to follow the advice of health professionals, and patients were likely to have a poorer health outcome (Birkhauer et al., 2017). The participants, aware of this, were thus “forced” to try to meet the patients' expectations, increasing their workload and consequent stress. However, more experienced nurses would be firmer in refusing to meet the perceived unreasonable expectations:

You can't do everything... you'll kill yourself in the process if you do. Patients and families just have to understand that. You have to make sure their needs are seen to asap though. (G Reese, senior nurse)

Whilst it is useful to distinguish moral distress from other stresses or distress, stresses often cause moral distress when the result is the inability of health professionals to fulfil their professional obligations and personal value-driven desires or expectations. These stresses include lack of skilled staff within the service and general skilled workforce shortages; the need to train inexperienced staff; increasing demands of the services—in terms of complexities of care and patient load; and increasing complexities

and structures in the healthcare, social welfare and legal settings. This highlighted the significance of considering the evolving broader context of an under-resourced healthcare sector in addressing moral distress adequately in community settings.

Different Goals of Care

Another significant source of moral distress named by the participants was when the patients, families, carers, hospital medical teams, general practitioners (GPs) and other contributors of patient care had different goals of care or management pathways. These differences in goals of care manifested in situations such as patients and carers refusing participants' advice, specialists pursuing what participants perceive to be futile care and GPs refusing to administer what participants believe to be appropriate care. Moral distress ensued for participants as they were unable to act according to what they believed was morally right in caring and advocating for patients and families at a very vulnerable time in the patients' and loved ones' lives.

Differing Goals of Care Between Healthcare Professionals and Patient/Family

The participants in this project were committed to respecting and honouring patients' autonomy as well as the relational autonomy of the families and care givers. Senior nurse Reska reflected "*We must remember that in the end it's the patient's life and their relationship with their loved ones... that's what's important.*" They also held firm to the value of providing the best care for their patients, consistent with their professional roles and obligations. Rein, a senior nurse having witnessed a family member's lack of care in their dying stated "*it is about providing the best care at the most vulnerable time in their life... as a nurse that takes top priority... whatever best care means for the patient.*"

These two values of respect for patients'/carers' autonomy and provision of best care, were conflicting at times, especially when the care, goals and expectations of the patients and families were different to those of the participants. One particular case that exemplified the situation when carers were refusing advice because they had different goals of care to the carers was patient Doreen⁵. Reska related the story:

So, there is this family... the patient is Doreen who has a nasty cancer with brain secondaries. She is looked after by her family, including a dominant

⁵ Doreen is a pseudonym as are the names of the health professionals and family members. Whilst the story was altered a little to protect the identity of the family, the main points were retained.

partner. Her siblings would also take turns looking after her. She has four teenage children who each have a close relationship with Doreen, more so than with her partner Dan. Unfortunately, she has no advance care plan even though her cancer was diagnosed over a year ago. The difficulty we have is that I don't think her family knows how sick she is... certainly one of her siblings, I think, doesn't believe she is dying.... She's at the stage now where I don't think she is able to make rational decisions, but her family keeps referring to her still for decisions.... What's so hard is that they, especially Dan, don't want to give her analgesia even though she seems to be in obvious pain... that's really hard 'cos you really don't want her to suffer.... Doreen was getting counselling, though I don't know how many times, but it's really hard to catch her on her own without the family listening in.... I don't think she is at the stage now when she can benefit from it. The family doesn't think they need it [counselling] either. She is also incontinent, but the family is refusing to have a catheter put in... she struggles even to stand now, let alone go to the bathroom.... I keep thinking about her and how much she is suffering but the family, especially Dan, won't give her the morphine. The counsellor is also struggling with it...and I think the consultant [physician] too. It's certainly a situation of moral distress because you want Doreen to not suffer at this time but there is nothing you can do. I think we are all experiencing it [moral distress]. (Reska, senior nurse)

This experience not only revealed the moral distress of the senior and experienced nurse and senior allied health professional, but also of the palliative care physician.

Team Moral Distress

Whilst the literature focusses on individual experiences of health professionals, this situation illustrates that moral distress can also be a team experience. This and other examples in the data showed that where there were common values shared by healthcare teams, and when faced with moral challenges associated with conflicting values and/or constraints, team moral distress can occur. The nurse, allied health professional and physicians held similar values and goals of care which were not congruent with those of the family caregivers, and perhaps the patient as well. The team as an entity experienced moral distress, in their inability to provide what they believed was excellent palliative care to Doreen such that Doreen would not suffer.

At the time it was believed that Doreen did not have decision-making capacity. The health team believed that Doreen was in pain and therefore suffering unnecessarily, as morphine and other medications to relieve the pain were readily available. Comfort care was important to the team. Transferring from bed to the bathroom was difficult and may have resulted in falls because of weakness, drowsiness and poor balance. Urinary catheterisation was suggested to the family for Doreen, but they refused, believing that it would not be what Doreen wanted. This deep concern for Doreen's well-being and suffering and the lack of success in advocating for Doreen left the team in moral distress, feeling frustrated, upset and at a loss regarding what more could be done for her.

Other examples of compromised team moral integrity included situations where the palliative care team looking after patients, was not able to fulfil their professional role of being the patients' advocates. One such situation was related by Ridley who had worked in the service for more than four years. Ridley described going to a patient's home and encountering a dominant partner who would answer for the patient each time. Attempts to talk to the patient on her own were always thwarted by the intimidating partner. Ridley recounted:

The partner was a big man... and spoke in a domineering and at times threatening way. We even tried to separate the partner and the patient by having two of us visiting. One of us distracted the partner, whilst I tried to talk to the patient. But the partner kept eavesdropping on our conversation and interrupting us. So that didn't work very well. The partner would say that the patient was not in pain every time we asked the patient if she was. But you could see she was in pain when she got up to make a cup of tea for us... it was the partner who offered us the tea! We kept saying that it was okay to give the patient pain killers even if she is in a little bit of pain, but he kept insisting she wasn't. Then when we asked her in front of him, he would jump in and say 'no'... then when we repeated the question asking him to let her answer, she would look at him and say 'no'! (Ridley, senior nurse)

The palliative care team believed they had let the patient down in their failure to advocate for her and described the experience as moral distress—being constrained from taking the morally right action by the intimidating partner.

This revelation of the existence of team moral distress is a significant contribution to understanding of moral distress in health professionals as it raises the need to be

attentive to the presence of team moral distress, not solely individuals' moral distress, and to address it as a team.

GPs with Different Goals of Care or Management of Patients.

Some of the harder cases of moral distress is when the GPs think they know the patients better. We'd suggest different medications to help with the patient's nausea and pain, but they wouldn't give the patients what we suggested. They'd say it's not what the patient wants, but when we ask the patient, they'd say they never said it. Sometimes you'd have to get the [palliative care] consultants [physicians] involved. It works sometimes but other times it doesn't! The consultants write to the GPs but sometimes it doesn't make a difference. So you give up! Some GPs you can't argue with cos you know they won't change their minds... and you might want them on side for other things. Most GPs are good though. It's tough. (Ricky, senior nurse)

In this community care setting, the specialist palliative care service was primarily a consultative service for GPs. The GPs had the ultimate responsibility for patient care and were the main prescribers of medications for patients. For Ricky and her colleagues, moral distress ensued when they were unable to regulate what they believed was appropriate management for the patient. As GPs were their treating doctors, the nurses found themselves having to tread lightly and at times receive verbal abuse without retaliating, for fear of GPs refusing to engage with the service, resulting in both current and future patients, not receiving adequate care.

Hospital Physicians and/or Patients with Different Goals of Care

Yet another significant moral challenge the participants recalled and expressed as moral distress, was when patients (and their family members) would not admit that the patients were dying. Sometimes this would be encouraged by the hospital medical team promising new treatment and hope for a longer life. The distress felt by the palliative care team was at times associated with the patients refusing the management advice of the palliative care team. In doing so the patient was perceived by the palliative care team as suffering needlessly, and there was nothing the participants could do. Other times it would be watching patients undergo burdensome treatment when they could have been spending precious time with their loved ones. Whilst the participants understood that it was the patients' decisions, they still felt that they were not providing the best care they should be providing. One participant described feeling so incensed and morally distressed that she put in an incident report accusing the hospital medical

team of mismanagement. She angrily described the situation and her unresolved moral distress:

I was wild! It's not fair for the patient or the family. The patient is obviously dying but the physicians kept offering her treatment! And she'd go back each time.... In the end she died two days after her treatment... precious time lost and there was nothing more I could do.... Sometimes I do wonder if I could have done more, but I knew there wasn't. (Audrey, junior allied health professional)

In situations where patients had decision-making capacity but refused medical advice, there were fewer incidences of moral distress. Where present, the intensity of distress was less. One participant gave as an example of team moral distress, a situation where the patient, with decision-making capacity, refused medical advice from both the oncology and the community palliative care teams. Instead, the patient sought treatment via complementary therapies. The degree of negative emotional feelings was not as significant as those involved in Doreen's case. The palliative care team was not as involved in his care as they were in Doreen's care. Corridor moral deliberation between the nurse, the palliative care physician and the Clinical Nurse Consultant concluded that there was nothing further that could be done apart from responding, when and if, the patient or family sought care. The feeling in this situation was more of sadness and a sense of loss of what could have been for the patient, than moral distress. There was no loss or compromise of team moral integrity as such, even though they felt that the patient had made a wrong decision.

The majority of the participants were experienced specialist palliative care health professionals with a wealth of knowledge of end of life holistic care. In general, they had a passion for what they did and offered to patients, their families and carers. Knowing what was possible for patients and meeting moral challenges that were contrary to what they believed was morally right for their patients led to experiences of moral distress. These examples of different goals of care and different management approaches that resulted in less than ideal care of patients left them with a feeling of unease and likely compromised moral integrity. The experiences of moral distress shared by the participants above also highlighted that where there were common goals of patient care and perceived moral obligations, team as well as individual moral distress occurred.

Powerlessness

Common to health professionals' experiences of moral distress was the sense of powerlessness to act on what they believe was the right moral action. Examples of a sense of powerlessness causing moral distress is common in the literature (Mason et al., 2014; Prentice et al., 2016; Rushton, 2016b; Stanley & Quill, 2011; Young et al., 2017). In this research project there were many participant examples of a felt sense of powerlessness to act on what the participants believed was the morally right action for those for whom they cared. The context of community care seemed to contribute to this cause of participants' moral distress.

In community care the primary caregivers were family members and loved ones. Whilst the health professionals advised caregivers on what medication to administer for particular symptoms, ultimately the health professionals were powerless in ensuring that the medications were administered accordingly. This resulted in experiences of moral distress as the participants believed that the patients deserved better care. Ridley's example noted above regarding the dominating partner's refusal to administer analgesia to the patient who was in pain, highlighted this. The example of Doreen's relatives not administering the appropriate medications as related by Reska above was another example. Reska later compared this to the hospital care setting:

In the hospital, this wouldn't be a problem... because you have professional nurses taking care of the patients and administrating the right medications for the specific symptom and the patient would just take it. In community you have no control... it leaves you feeling guilty... wondering if you should do more even though you know you can't.... (Reska, senior nurse)

Participants also described the powerlessness they felt in organising appropriate care for patients in the community: medications from pharmacists, prescriptions from busy GPs who would return calls much later or not at all, and specialists who would discharge patients late Friday afternoons without prescriptions, leaving the weekend nurse on duty to organise this for the patient. Ruby described:

It's really frustrating when the hospitals discharge patients late on Friday without medications or services and expect us to organise it all. So in the midst of seeing patients who call us, we have to organise their scripts from GPs—and you know that's very difficult on weekends—organise for it to be sent to the pharmacies then get the relatives, if they have any, to pick them up from the

pharmacy before we can go and set up the syringe driver for the patient. Meanwhile the patient is in pain because they have no meds [medications]. It's just wrong!

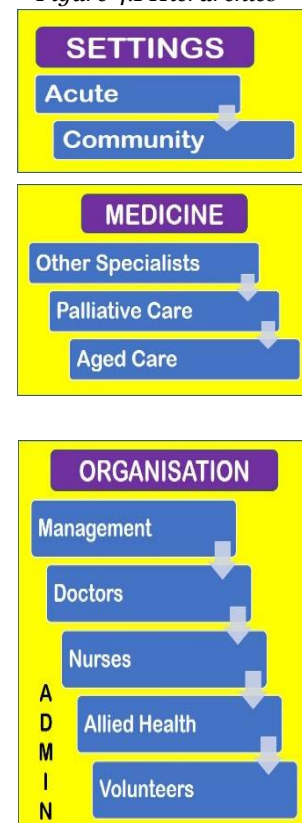
There was one patient we couldn't do any of that for, so we sent her back into the hospital... and that's not right either for the patient or the family! The hospitals have a lot to answer for! They just don't get how hard it is in the community! (Ruby, senior nurse)

Here the challenge lay in caring for patients with limited, less accessible resources and the complex nature of healthcare provision in a community setting with multiple stakeholders. It became a moral challenge when participants were unable to provide patients with the excellence of care they believed every patient was entitled to, and for which the participants were morally and clinically responsible.

Another aspect of powerlessness that participants experienced lay in the hierarchies of power which operate in healthcare and medicine. Three hierarchical structures were named by various participants—physicians, nurses, allied health professionals and was observed by one administration officer interviewed (see Fig. 4.1):

- *The context or setting*: where acute care services were deemed more important than community care in patient management or care.
- *Medicine*: where other specialties including oncology were deemed more significant and such specialists having greater authority than palliative care specialists; the lowest amongst all specialties being aged care.
- *Organisation-disciplines*: where management is seen as having the highest authority dictating care through policies and procedures; doctors have to follow these policies and procedures but have highest authority in directing patient care as they are ultimately responsible for the care of patients; nurses have less authority than doctors in patient care and have to follow doctors' instructions; allied health professionals are lower than nurses in the hierarchy; and lowest in this paradigm are

Figure 4.1 Hierarchies



volunteers. Administration officers are there to ensure the efficiency and smooth running of the service.

In these perceived hierarchies, when there was a conflict in patient management, a sense of powerlessness ensued, causing moral distress. Patients, for example, soon after discharge would follow the directions of oncologists or other specialists before the healthcare professionals in the community, even after establishing prior and good relationships with the community health professionals. Ronnie, a senior nurse with more than five years' experience in palliative care observed:

Haven't you seen the patients in hospitals? As soon as they enter the hospital, they become submissive. It's like they leave their power behind and they are there to obey. You offer them drugs and they will take it dutifully. They think that if they don't do that, "they [doctors] may not help me." In the community it is different. You are entering their home, their space... and if it is "no, I won't" then it's no! You have to cajole and convince them what's good for them. And if they disagree... you're stuffed! Well, not quite... it gets hard. They believe the hospital but not us. But they have the last say.... Then that's moral distress!
(Ronnie, senior nurse)

As Ronnie shared her experience, she laughed, acknowledging that the sense of powerlessness she experienced in such situations did cause her angst and will continue to do so, but over time she came to accept patients' choices.

Another experience of powerlessness was shared by senior nurses who recalled a previous palliative care registrar who constantly "*undermined and clashed*" with the nurses in management discussions and finished off arguments with "*because I am the doctor*" (Reska). The participants perceived such interactions as sources of significant moral distress, as they were being forced to perform what they believed was inadequate even inappropriate care. This perceived lack of respect, and "misuse of power" inherent in the structural hierarchy, is common in moral distress literature (Corley et al., 2005; Jameton, 1993; Yeganeh et al., 2019; Pavlish et al., 2014).

The data from this research revealed that perceived powerlessness causing moral distress occurred mostly within the context of hierarchical paradigms. As the moral distress literature describes, the sense of powerlessness often arises from an interplay between personal constraints and external constraints (Austin et al., 2005; Jameton, 1993). Personal constraints described by participants include certain personality types

especially those who were highly anxious and those lacking self-confidence and moral agency. The participants also named: negative past experiences; minimal experiences of being challenged; a lack of clinical knowledge and experience; and a perceived lack of respect from others, as further contributors to personal constraints.

Participants named external constraints such as intimidation by colleagues, management, patients and carers. The above are but a few of the many examples the participants shared in describing their experience of moral distress associated with feelings of powerlessness. I conclude that this sense of powerlessness has a significant role in health professionals' experiences of moral distress and is an important consideration in addressing the moral distress the participants experience.

Conclusion

In this chapter I described some of the moral challenges that the participants experienced as moral distress. Moral challenges arose when the health professional's personal and professional values were challenged. This caused an unease or discomfort in their moral equilibrium which I explain in the next chapter. These challenges resulted in moral distress when the health professionals could not act according to their moral values due to various constraints. Some had continued to experience moral residue which they accepted given the circumstances of limited resources, their consultancy position of providing advice to GPs who make the final management decisions, and the fact that the specialist palliative care health professionals were not the primary carers.

Recall the thesis definition of moral distress in Chapter Two: "Moral distress is the psychological stress affecting the mind, body, or relationships resulting from a situation in which the individual is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgement about a correct action; yet, as a result of real or perceived constraints, participates, either by act or omission, in a manner perceived by the individual to be morally wrong." Whilst the participants did experience the psychological stress, acknowledged moral responsibility and made moral judgements, I argue that their actions were not morally wrong.

"Moral wrongdoing" was for many participants their inability to provide the standard of care, according to their personal and professional values. This care included direct patient care and advocacy for their patients with others—carers, GPs, hospital specialists and others involved in caring for their patients, and the patients themselves.

It also involved advocating for their patients and the patients' families within the complex social welfare, financial and healthcare systems.

I argue however, that these examples were not moral wrongdoings per se, but a less than ideal practice in accordance with their moral beliefs, values and professional responsibilities. What the participants were experiencing, in general, was the tension between what they believed was their professional responsibility based on ideals of care, and the circumstances that mitigated the fulfillment of those ideals. In the absence of wrongdoing, hence by the specific definition of moral distress, the participants' experiences were not moral distress. I suggest that a new concept may be helpful—the concept of moral equilibrium-disequilibrium.

In the next chapter I explore more fully my proposed concept of moral equilibrium-disequilibrium, including its relationship to moral integrity, core values, personal characteristics and moral resilience.

Chapter 5: Moral Equilibrium

I think moral distress does manifest in a lot of ways—tiredness, complaints, feeling stressed. The work is hard but if you love the work, if you are passionate about it, the stress is just a minor part and you cope with it. But if you feel you can't care for patients the way you believe they should be cared for, then you're not quite right. You're finding fault in things you normally can handle. You need to do something about it, otherwise you'll be miserable, unhappy... talking to the others helps you get back.... (Riva, senior nurse).

Riva's observation captured a number of points which I draw upon in exploring moral equilibrium in this chapter. Firstly, Riva recognised the stresses inherent in her role as a specialist palliative care nurse working in the community setting—“*the work is hard.*” It was demanding at all levels: physically, psychologically, spiritually. This was evident by the participants' experiences shared in some of the interviews and my own observations. These stresses were not unique to this group of participants and have been named in palliative care literature (Ablett & Jones, 2007; Hulbert & Morrison, 2006, p. 246; Peters et al., 2012; Skilbeck & Payne, 2003). The context within which health professionals operate contributes to the understanding of their moral equilibrium dynamic.

Secondly, being passionate about the work and buoyed by significant satisfaction in what they were doing aided resilience to challenges. Resilience is defined as “the ability of an entity... to withstand, adapt, recover, or rebound from adversity, stress, or trauma” (Rushton, 2018, p.105). Healthcare professionals like Riva, often found creative coping strategies to counteract the daily stresses inherent in the work (Ablett & Jones, 2007). As Riva remarked, “*you cope with it.*” Riva alluded to a significant observation—passion and job satisfaction helped build resilience to the stress of work. This resilience included creative coping mechanisms which enabled Riva to continue her passion and job-satisfaction.

Thirdly, Riva's comment of “*when you can't care for patients the way you believe they should be cared for, then you are not quite right,*” was revealing. I posit that she was alluding to the challenge to her moral integrity—when she was unable to do what she believed was in accordance with her professional and personal values. The “*not quite right*” feeling, I argue, was the feeling of disequilibrium.

Finally, Riva's observations in her management role also led her to believe that unaddressed moral distress contributed negatively to general wellbeing: "*tiredness, complaints, feeling stressed.... You're finding fault in things you normally can handle.*"

In the previous chapter I outlined some of the moral challenges that participants had experienced which resulted in moral distress. I also argued for the importance of awareness of the phenomenon of moral distress and how emotions can signal the possible presence of moral disequilibrium/distress. I explored the situations that brought about moral disequilibrium and moral distress.

In this chapter I explore further the concept of a moral equilibrium that is dynamic, and some of the components of this process, including those named by Riva above. I argue that moral equilibrium is a practical and valuable concept in capturing and understanding the participants' experiences when faced with moral challenges. I explain why core values are important in moral equilibrium, relating them to moral integrity, identity, and moral agency. I then name the participants' accounts of elements that contributed to their moral equilibrium. These "contributors" were complex and dynamic and relate to the concept of moral resilience. Finally, I focus on an aspect of participants' experiences which has been underexplored in the moral distress literature to date—the occurrence of team moral disequilibrium/distress.

Moral Equilibrium

In Jameton's book *Nursing practice: The ethical issues* (1984) which describes moral distress, Jameton defines morals as "a set of values or principles to which one is *personally* committed" (p. 5, original emphasis). Jameton goes on to explain that these "moral values or principles may be formal or informal, explicit or implicit," and continued to give examples of personal "moral principles as 'Do unto others as you would have them do unto you'" (p. 5). Hence, moral distress is a value or principle-based concept. It can be subjective—based on the individual's values and belief systems, or objective—based on societal, cultural or professional values (Hanna, 2005, p. 108; Schwartz, 2012).

For the participants in this research, their understanding of "moral" constituted what they believed was right and coherent with their own personal beliefs and values. Such values and beliefs were formed by past experiences, familial, societal and cultural values, upbringing, organisational and professional values, and other influences that

contribute to their individual identity, meaning and purpose in life (Rushton, 2018, pp. 13-15; Schwartz, 2012). This was affirmed by ten participants across disciplines who, when questioned, noted the bases of their values and belief systems. Andi, a very experienced and senior allied health professional noted:

I think I have a very strong belief system... my mother used to say 'put yourself in their shoes'... it's about respect.... I guess part of the reason why challenges are challenges is your background and part of your belief system, and I think they also help you through a lot of those issues, as well as your training of course, but I think your training is a very small part of it... I think your faith and your upbringing, your experiences all contribute more. (Andi, senior allied health professional)

The participants also recognised a commonality with the values of the team and the organisation:

I think the organisation's values are the same as mine... and they guide me as to what I should and shouldn't do and how we go about doing things... how we treat patients. (Reska, senior nurse)

Alex remarked,

For the most part I think we all think alike, you know, we care for the patients, we advocate for them, even [the manager] has a low threshold in giving financial help to the poor families. (Alex, senior allied health professional)

There were many similar acknowledgements by other participants. This led me to the conclusion that the values professed by healthcare practitioners can be individual, team, professional and/or organisational. This is significant when considering team moral disequilibrium.

Equilibrium is defined in the *Online Oxford English dictionary* as “The condition of equal balance between opposing forces; that state ... in which the forces acting upon the system, ...are so arranged that their resultant at every point is zero” (Oxford University Press, n.d.). Haroutunian (1983) in her book *Equilibrium in the balance: A study of psychological explanation*, notes:

...the equilibrium principle asserts a relation between a system (or an organism) and the environment in which it functions, such that if the environment changes,

the organism will adjust its behaviour to maintain certain desired conditions. Should the environment become modified, the system (be it living or non-living) will vary its behaviour *so as to preserve itself*. (p. 2, my emphasis)

Whilst the *Online Oxford English dictionary* definition simply defines equilibrium as a state of balance between opposing forces, Haroutunian (1983) extends the definition further by indicating the purpose or intention of achieving this state of balance—the preservation of self. Similarly, I argue that the intention of achieving a good enough moral equilibrium is “the preservation” of the individual’s or team’s moral integrity. I elaborate more on the concept of moral integrity later in the chapter.

Moral equilibrium and this preservation of integrity is not simply linear, or a two-dimensional, reality. It is not just about maintaining balance between the “inner force” of values and the “outer force” of challenges to these values. There is a third dimension to this process of regaining moral equilibrium—the transformation of self. This may involve a re-evaluation of moral values to affirm, adjust or gain a deeper understanding of the meaning and implication of these values. Doing so can also aid moral resilience to further moral challenges as the individual is more certain and committed to the values. It is akin to the tenet developmental psychology that states that “human development is transformational”, rather than an addition of human experiences (Henning, 2011, p. 445).

I have named “values” as central to moral equilibrium and moral integrity. Now I explore the concept of values and core values in further detail.

Core Values

In daily practice, moral decisions are based on moral judgements which, in turn, are based on moral values (Wilkinson, 1987/1988. p. 18). Hence, clarifying and articulating these values are significant and necessary steps in the deliberation of moral conflicts and dilemmas (Tarzian, 2013, p. 5; Wocial et al., 2016, p. 232). Clarifying and articulating these values could also help health professionals understand why certain situations become moral challenges. For the participants, knowing the values that were being challenged also gave them the opportunity to re-evaluate their values and make informed moral decisions, as I elaborate later.

As to why values are central to our moral equilibrium and moral integrity, I turn to Schwartz’s (2012) explanation of the importance of values to the psychological equilibrium of health professionals. Schwartz’s reasoning also reflects the participants’

explanations of the importance of their subjective values in their moral equilibrium. This interdisciplinary approach is helpful as, whilst the moral distress literature states the importance of moral values to individual well-being, I find Schwartz's description more comprehensive in elaborating the reason for its significance.

In his exploration of what he found to be "culturally universal" psychological principles that underlie values, Schwartz (2012) determined six characteristics of values (p. 3). I name them here to highlight the importance of values, especially core values, to our identity, perception and motivation, and their relationship to moral disequilibrium.

Firstly, Schwartz (2012) notes that values are "beliefs linked inextricably to affect" (p. 3). For example, if the provision of excellent care for patients is important for health professionals then they feel fulfilled when they are able to do so. However, when that value of excellence in care provision is threatened, for example when the health professional is time-constrained from providing excellent care, the health professional would feel "aroused" and "despair" (Schwartz, 2012, p. 3). This feature of values being inextricably linked to affect is important in moral equilibrium. Emotions or affect, as mentioned in the previous chapter can be perceived as heralding the presence of moral disequilibrium for the health professional. Moral *disequilibrium* can be negative (as in enforced moral wrongdoing) or positive (as when the health professional is being challenged to consider other moral values such as just and accessible care for all patients).

Secondly, Schwartz (2012) posits that subjectively, values refer to "desirable goals that motivate action" (p. 3). Moral values thus motivate moral action and agency. For health professionals, naming and recognising their moral values aided understanding as to why they believed they needed to act in particular ways. When these moral judgements and decisions to act in particular ways were challenged by situations or actions that were not congruent with their own, it led to moral disequilibrium. The participants then sought to make sense of the moral challenges, often with the assistance of their colleagues. This was made easier when they were able to recognise their subjective values that were being challenged.

Recognising the importance of values to their own moral equilibrium might also encourage health professionals to be open to the other person's values knowing those values are important to the other person as well. Remy for instance, shared:

As a nurse I want to care for patients... that's why I did nursing...and why I

love nursing.... But I guess I can't force it on patients. I guess when the CNC [Clinical Nurse Consultant] and the counsellor helped me name what was happening, you know, how the patient's goal was different from mine... it's not so bad. I didn't realise why I was so upset until I saw the difference, but I'm still doing what I believe is important, that is caring for the patient.... I just care in a different way. (Remy, junior nurse)

This is a useful example of the difference that can happen when the value perspectives of others are considered.

The third feature of values in Schwartz's Theory of Basic Values (2012) is that "values transcend specific actions and situations" (p. 4). In other words, regardless of time, place or local culture these values still hold for the individuals, unlike norms or attitudes. I believe that this is related to identity, which also transcends the specifics of time, actions and situations. In his conceptual and empirical study of values and identity, Hitlin (2003) found that values "produce" (p. 125) or shape identity. Hitlin (2003) noted that when individuals aspired to certain values and lived them in their daily choices, their role identity and how they saw themselves, also changed. Values therefore are integral to identity. Individuals may modify the expressions of the values with each experience, but the essential element of the values tends to always hold true. Remy's example of excellence in care provision for patients still holds true but her concept of what this meant had changed—she "*just care[d] in a different way*" (Remy). Values also motivate action and agency and transcend the specifics of both action and situations, making them central to the complex moral equilibrium dynamic. In other words, when moral disequilibrium occurs, it is because the individual's moral values are challenged, as is their identity and motivations.

Fourthly, values, according to Schwartz (2012), also serve as "standards or criteria" for behaviour and action, as well as "selection or evaluation of actions, policies, people and events" (p. 4). This implies that not only are moral values motivators for action, but they are also criteria by which the individual judges the morality of any action, behaviour or situation. Thus, moral judgements and consequent critique of actions/behaviours are based on these moral values. When these judgements are challenged, the moral compass or guide can also falter, and moral disequilibrium ensues. It is important to highlight here that these judgements and the sense of being morally challenged are largely unconscious, as Schwartz (2012) found. Knowing this may encourage health professionals to take time to acknowledge their own values so as to ascertain the cause of their moral disequilibrium.

The degree of disequilibrium also depends on the hierarchy of these values, which is the fifth feature of Schwartz's Theory of Basic Values (Schwartz, 2012, p. 4). Schwartz (2012) claims that it is the "relative importance of multiple values [that] guides action" (p. 4). In the context of moral disequilibrium, I argue that not only is the importance of the values significant, it is also the commitment that individuals have to these values that determines the degree of disequilibrium. For the participants, the more that the participants' identities were intertwined with their moral values and the greater the health professionals were committed to the values, the greater was the disequilibrium. Alex's comment alluded to this:

I found that the more I understand how important the work I do is... and the more I care for patients and see them struggle... poor things some of them really struggle and often it's not their fault, the more I am committed to get them through it... then when you hit a brick wall the harder you fall.... You get very angry and frustrated... there you go, I do have moral distress. (Alex, senior allied health professional)

Alex saw value in her work and became more committed as she witnessed the struggle of the patients and families. As this commitment to caring well and advocating for patients deepened, the consequence was greater moral disequilibrium when she was constrained from fulfilling her moral value—"You get very angry and frustrated" (Alex).

Rani, a senior nurse, noted:

My real passion is end of life care. I haven't been able to do it properly for years now.... And if you can't do what you are passionate about and it becomes emotionally draining then what's the point? There are others [staff members] who left... didn't stay very long... but I don't think the work was their passion... it didn't take them long to decide the work was too hard... I don't think they had any moral distress. I think they valued their lifestyle more than the work.... (Rani, senior nurse)

For Rani, her passion was in end of life nursing care. Her inability to fulfil this role adequately in the latter years caused her the greatest moral angst. She believed that other younger nurses who did not stay long had other priorities, like lifestyle. Rani believed that the younger nurses' seeming lack of commitment resulted in minimal

moral distress, if any. From Rani's perspective, a lack of commitment led to less moral disequilibrium.

The sixth feature common to all values according to Schwartz (2012) is that the “*relative importance of the multiple values guides action*” (p.4, original emphasis). In other words, given a particular context, how individuals decide on the appropriate action is dependent on the importance individuals assign to those values. For the participants, the primary core value was respecting the autonomy of their patients. For most this outweighed their other core value of excellence in the provision of care. As junior nurse Remy remarked: “*Ultimately, it's their end of life, their decision... I just care in a different way.*”

There is contention in the moral distress literature as to whether the moral values in question should be personal or professional. Epstein et al. (2019) for instance argue that in moral distress, the wrongdoing that takes place is with regard to professional values and not personal values (p. 114). Huffman and Rittenmeyer (2012) in their systematic review of professional nurses' experience of moral distress focussed on professional values. Others state that the values that are being contravened are both personal and professional (American Association of Critical Care Nurses, 2008; Carpenter, 2010). Yet others situating moral distress as a personal experience name personal values as those being challenged (Austin et al., 2008, p. 89; Barlem et al., 2013, p. 81; Cox, 2008, p. 201).

In proposing the concept of moral equilibrium, I do not distinguish personal values from professional values. Ultimately the moral disequilibrium experience results from a challenge to held moral values, regardless of whether those values are personal, professional, team or organisational. In the same way, the values being challenged resulting in team moral disequilibrium would be the moral values the team as an entity holds, whether they include the shared individual members' moral values, professional moral values or the organisation's values.

There is another argument for not distinguishing personal from professional moral values. For individuals to continue to be professionals in a particular discipline there must be some intersecting of personal and professional values if the individuals are to adequately function in that role with integrity. I do however acknowledge that when professional moral values differ from personal moral values, it can be a source of moral disequilibrium. This point was argued by Farsides et al., (2004) when they use the phrase “moral equilibrium” to describe the reconciling of values conflict such as

personal values, clients' values and cultural values (pp. 505-506). However, in this thesis, I use the term "moral equilibrium" to mean not only the reconciling of value conflicts but also a coherence of motivation and intention with moral values. The participants in this study did not report any incongruence between their personal values and their professional values, as Rani explains:

I think one of the reasons why I've stayed here so long is that we all share similar values—we all want the same thing for our patients, and they are no different to the professional codes [of ethics]. We are really lucky here. (Rani, senior nurse)

In summary, the moral values held by health professionals in their care of patients are central to: (1) their identity, (2) their perception of moral challenges and situations, (3) their motivations for action and agency, and (4) their judgement as to what constitutes good moral behaviour and action. The greater the importance of the moral value, the greater the moral disequilibrium, when the value is challenged. The greater the number of challenges to the moral value, as in many people challenging the moral value instead of just one person, the greater again is the moral disequilibrium. This was borne out by the participants in this project, as highlighted in Chapter Four: Moral Challenges.

I posit that health professionals' awareness of their own values and the hierarchy of these values, would assist them in understanding why they are experiencing moral disequilibrium when faced with moral challenges. This understanding would also assist the health professionals in their discernment as to whether to hold on to these values, modify them or be open to new expressions of these values. This process aids in bringing them back into moral equilibrium. The values that are central and of greatest importance to the individual or group, and from which the individual or group is least likely to swerve or waver, are considered core values.

Participants' Core Values

Core values according to McFall (1987) are a "set of principles or commitments that make us who we are... they are the most fundamental commitments we have" (p. 13). Core values can also be defined as the values that are central to an individual's or group's identity, purpose and moral compass. These values give meaning to the individuals' or groups' existence and purpose, and guide their motivations for actions and agencies (Collins & Porras, 1996; McFall, 1987). Pant and Lachman (1998) emphasise this by offering that a core value is "when the social control it exerts

supersedes that of most other values in a value system” (p. 195). What Pant and Lachman mean by social control is the “the behaviours permitted and proscribed by the given values” for the individuals within a social context (p. 195).

Whilst individuals hold their own core values, what was interesting in this study was the core values this group of health professionals held in common. These common core values reinforced the individuals’ core values and most likely ensured support for the individuals in living them out. These common values, and especially core values, were important elements in the experience of team moral disequilibrium and distress.

Emerging from the data, three core values were clear for these participants. In order of commonality, the first was the value of **respecting the autonomy of the patient** (or surrogate decision makers) and carers in end of life decisions. This value was named by all participants. It was also the ultimate criterion in the participants’ moral deliberation when faced with moral challenges, as evident in the quotes already mentioned.

Associated with this value was the commitment and desire to provide the best care possible for their patients and their families, at the patients’ vulnerable end-of-life time. This value of excellence in care provision however held a lower place in their hierarchy of values. Whilst differing goals of care between the participants and patients and/or their carers were evidently causing moral disequilibrium for the participants, the ultimate core value the participants held, that assisted them in accepting and respecting the difference, was respecting the autonomy of patients and/or carers. Repeated comments by nurses, allied health professionals and physicians, such as “*it’s their life after all*” and “*what’s important is that it’s what they want*” were consistent with this core value of respecting patient’s/carer’s autonomy.

The second core value voiced by most, but not all, participants, was **equal access to good palliative care** in their area of service for all who needed it. A few, when queried if this was a core value for them, replied that whilst this value was important and ideal, it was not one to be held on to when the resources were not there. Others believed that even with limited resources it was still possible:

I believe we can still provide equal access to all. We just have to be smart about it... it might mean changing process and setting priorities... we are looking into that. (G Rhonda, senior nurse).

The third core value raised by several participants was ***the dignity and value of human life***—they would not partake in ending a life prematurely. This value of respecting the dignity and value of human life meant that regardless of any circumstance, including patients' request for assisted suicide or euthanasia, they would not partake in intentionally causing the death of a patient. It was a line they would not cross, respecting their own conscience.

That's not palliative care... I'm glad I work for [a faith-based organisation] where the values are the same as mine... it just goes against every grain in my body. (G Rhonda, senior nurse)

G Rhonda's remark echoed a number of other participants' stance. Another participant had a differing stance. For this participant, the first core value of respecting a patient's autonomy took priority:

... if that's what they want I could be part of that... after I made sure there were no other issues that is. (Remy, junior nurse).

Whilst both participants experienced moral disequilibrium when faced with the moral challenge of ending life prematurely, both deliberated and came to their respective stances based on their hierarchy of core values.

Living according to these core values and other values held by health professionals is to gain moral equilibrium and so live with moral integrity. When individuals' moral intentions, judgements and actions, are coherent with their core values, their moral integrity is maintained. Doing so is central to the individuals' well-being (McFall, 1987). I now explore moral integrity in relation to core values and moral equilibrium.

Moral Integrity

In my field notes I had noted that these health professionals lived according to these three core moral values, amongst others, at various levels of commitment—for some their actions consistently adhered to these values whilst others allowed greater flexibility in their observance of their values (Field notes). When these moral values were challenged, their sense of moral integrity was also challenged. This was especially so if they were constrained from doing what they believed was morally right. In the last 20 years, the concept of compromised moral integrity emerged in the literature definitions of moral distress (American Association of Critical Care Nurses, 2004;

Canadian Nurses Association, 2008) highlighting the central role of moral values in the experience of moral disequilibrium and moral distress.

Two aspects of integrity that the participants alluded to in some of the interviews were: integrity in relation to personal moral values which incorporated professional and societal values to varying degrees; and the ongoing reflection on life situations that challenge the individuals' expression of the moral values (Laabs, 2011, p. 433; Rushton, 2018, pp. 78-79).

Rushton (2019) equates integrity with "moral wholeness" and "living in alignment with one's fundamental values..." (p. 78). She goes on to describe integrity as arising "when intentions, words, thoughts, and actions align and there is adherence to ethical commitments, norms and conscience" (p. 78). In other words, a person with moral integrity would always act in a manner consistent with their moral values. This would be evidenced by a general state of feeling whole or undivided. However, integrity may also have "alliances to conventional standards of morality" such as "truth and fair dealing" and other ethical standards (McFall, 1987, p. 5) or as Rushton (2019) states "adherence to ethical... norms...." (p. 78). This distinguishes moral integrity based on personal values (subjective) from that of societal values (impartial and universal for that particular society) (McFall, 1987, pp. 15-20). Hence, in considering moral integrity, it is beneficial for individuals to discern if their integrity lies with their personal values or societal values, or both.

I mention this here to acknowledge that there is a further understanding of moral integrity that could be explored but which is not the focus of this thesis. Suffice to say that, as individuals and health professionals live in relationship with each other and society at large, it is highly probable that personal, professional and societal values do intersect. However, in the experience of moral disequilibrium, what is being challenged are individuals' moral values, which include professional and societal values that the individuals have integrated into their own values (McFall, 1987, pp. 19-20). This is similar to my previous argument for not distinguishing personal from professional values.

Alongside moral integrity related to personal, professional and societal values, the second aspect of moral integrity that the data highlighted was the dynamic nature of moral integrity. Part of living lives of integrity includes ongoing reflection on one's moral values and the expression of these values in the many life situations health professionals face (Laabs, 2011, p. 433; Rushton, 2018, p. 79). Ongoing reflection on

the team's moral values by the team, following team moral disequilibrium experiences, is just as important for team moral integrity (Traudt et al., 2016, p. 208). Senior allied health professional Alex offered "*I think we need to work out what's important for us as a team in this situation, then taking all that into consideration work out what we need to do then....*" In this thesis my focus is on both the individual health professionals' personal moral integrity and team's moral integrity, and the evolving understanding of their moral values as part of maintaining moral integrity in both senses.

Whilst the philosophical concepts of moral integrity are varied and complex (Audi & Murphy, 2006; Cox et al., 2017), I use McFall's (1987) much cited philosophical ethics exploration of what constitutes integrity in relating moral values and moral integrity. McFall's exploration of integrity is also in keeping with the data from this study. McFall (1987) begins her analysis with the coherence principle. According to McFall (1987) for integrity to be present there needs to be a coherence or consistency between three elements: the individual's principles/commitments/[values], the individual's motivation for action/behaviour and the action/behaviour itself (pp. 7-8). She argues for four requirements of integrity:

...that an agent

- (1) subscribe to some consistent set of principles or commitments [or values] and
- (2) in the face of temptation or challenge,
- (3) uphold these principles or commitments [or values],
- (4) for what the agent takes to be the right reasons. (McFall, 1987, p. 9)

In other words, the moral values that health professionals hold as core values must be consistent and important enough to them to be prepared to suffer loss if not upheld (McFall, 1987, p. 13). When an individual cannot uphold integrity to these moral values there is moral suffering (Rushton, 2018, pp. 12-19).

Rushton's (2018) conceptual map of possible pathways of moral suffering may be helpful here (p. 53). Rushton (2018) describes an initial stage of moral stress akin to moral disequilibrium (p. 58), when faced with moral adversity. When unresolved, "moral suffering, including moral distress and moral outrage... can be experienced as threats... to integrity and well-being..." and if still unaddressed, can lead to "moral injury" or "moral decline" (p. 54). Moral injury occurs when "the threat to integrity becomes an actual violation that erodes our moral core" (p.66). Moral decline can be

described as a state of impairment in moral “competence, character and function... even to the extent of taking pride in misdeeds” (p.68). At any stage along this trajectory, there is opportunity for “restoring, preserving or deepening moral integrity” and “sustained capacity for principled moral action,” and the building of moral resilience (p. 54). These possible conceptual pathways of imperilled moral integrity experiences suggested by Rushton were aligned with several of the participants’ experiences, but not beyond the experience of moral distress as actions were taken to restore their moral integrity. For instance, junior nurse Randy described a situation when she felt that her moral stress/disequilibrium had progressed to moral distress when she was unable to fulfill her moral responsibility of ensuring that her patient received excellent palliative care—in this case adequate pain relief. Randy had noted that her patient was not receiving adequate pain relief which was managed by the patient’s partner. For Randy adequate pain relief was one of the tenets of excellent palliative care which was a core value for her. Randy tried advocating for her patient by encouraging the patient’s partner to administer more analgesia. The patient’s partner refused. Randy was constrained as she was not the patient’s primary carer and became morally distressed. Randy recalled:

I didn’t do what I should have done. I should have been a better nurse. Fortunately, another nurse saw the patient the next day and sorted it all out. The patient’s partner agreed to give the patient more analgesia. I really felt I let the patient down and let myself down. I didn’t do what I knew was important... the right thing to do. I kept blaming myself and started getting nightmares. I did get counselling and that helped. (Randy, junior nurse)

Her moral integrity as a good nurse in providing excellent palliative care was imperilled as she tried to convince the patient’s partner to administer more analgesia. When the patient’s partner refused, feeling constrained she became morally distressed. Fortunately, through counselling her moral integrity was restored.

The concept of moral equilibrium-disequilibrium is offered as a practical dimension in the initial stage of Rushton’s conceptual pathway—at the stage of facing moral adversity/challenge before moral distress or moral outrage. Moral disequilibrium alerts health professionals to moral values that may be different to their own. The individual’s moral integrity may not yet be threatened. Moral integrity is threatened when the moral challenge impedes or constrains the health professional from living their core values. There is still significant moral disequilibrium when this dissonance threatens moral integrity and impacts negatively on the living of these core values. When the

latter happens, it results in moral suffering (Rushton, 2018, pp. 12-19). Hence the concept of moral equilibrium-disequilibrium encompasses all experiences of moral challenges to moral values from mild disequilibrium to the severe disequilibrium of moral injury, decline or total loss of moral integrity.

There are however two categories of values that are at play in the dynamic of moral equilibrium-disequilibrium. McFall (1987) distinguishes these two kinds of commitments/principles/values as : (1) those that are *defeasible* or which can be “sacrificed without remorse” (p.12) and (2) those that are identity-conferring—“what we take to be the most important and so determine, to a large extent, our (moral) identities” (p.13). In maintaining our moral integrity, the choices we make depend on the identity-conferring values to which we are committed (McFall, 1987, p. 8).

In the same way, when these values are challenged, our identities are also challenged. I highlight this link here between principles/commitments/values and identity, as they are intrinsically related (Covaleskie, 2011; Hitlin, 2003). Understanding this gives credence to the need to address moral disequilibrium when it occurs. When unaddressed the snowballing negative consequences of a loss of identity can result in despair, mental illness (Severinsson, 2003), and can impact not just the individual but also all with whom the individual is in relationship, including other members of the team (Wiegand, 2012). Angie, a senior allied health worker, in describing the impact of a colleague’s moral distress on the team remarked:

It would be better for her to seek outside counselling instead of adding fuel to fire by talking to one of us. (Angie, senior allied health professional)

Identity

The importance of healthy identities buoyed by healthy moral integrity is that identity empowers individuals to exercise their moral agency and gives them the confidence to continue to reflect on and re-evaluate their core values. The choices made and the standards by which individuals judge themselves and others are based on the values they hold (Schwartz, 2012, p. 4). Covaleskie (2011) argues convincingly that these values are related to the individuals’ sense of identity (pp. 312-313). “Identity” is defined here generally as who we see ourselves to be, that is unique (Oxford University Press, n.d.; Strohminger, 2018). Our moral identity, Covaleskie (2011, p. 314) posits, comprises an integration of all that we have been exposed to culturally from birth and in different settings. Whilst differing roles in different settings may cause different

behaviours in the various settings, ultimately people of integrity will live out their own core values and make coherent choices (Covaleskie, 2011, p. 309). This constitutes a significant part of their identity—“what we should *do* depends on who we *are*” (p. 312, original emphasis). Covaleskie (2011) adds that our identity is never formed in isolation and that “our individuality is formed in and by a normative community” (p. 314).

Our identity therefore is integral to our moral integrity and vice versa. Both our identity and moral integrity are conditioned upon our core values. The state of moral equilibrium then is intrinsically intertwined with our core values, our moral integrity and our identity. When our judgements and actions align with our values, our integrity is intact, and our identity assured. We are in a good enough state of moral equilibrium, despite our vulnerabilities, work stresses and other day to day challenges. However, any moral challenge to our beliefs and values, challenges our moral integrity and identity to some degree.

This understanding of the intimate relationship between moral integrity, core values and identity is important in the moral equilibrium process. Firstly, it calls us to be attentive to our core values, how we live out these values and so maintain our integrity. This awareness aids in the subsequent process of moral deliberation as we re-evaluate our values and the importance of these in discerning the appropriate morally right judgement and subsequent action. Here I return to McFall’s (1987) definition of integrity: integrity involves upholding a subscribed set of values/principles “in the face of temptation and challenge, ...for the right reasons” (p. 9). Whilst McFall’s definition of integrity is reasonable, there is an extension to this concept that she does not capture. This lies in the commitment to personal growth that, along with others (Noelliste, 2013; Rushton, 2018, pp. 80-81), I argue is part of maintaining one’s integrity to oneself. It implies a capacity to be open to re-evaluating one’s values and belief system so as to be as certain as possible that the values upon which one bases one’s judgements, motivations and actions are true to one’s whole subjective sense of self. It is a commitment to ongoing development of the moral self which is part of the process of maintaining a good enough moral equilibrium and integrity (Rushton, 2018, pp. 79-81). It is an important dimension in the dynamic of moral equilibrium I mentioned at the beginning of this chapter—the transformation of self.

Secondly, understanding that moral integrity, core values and identity are intimately related, invites us to be open to understanding the perspectives of others, knowing that these perspectives are likely to have arisen from others’ core values intertwined with their integrity and identity. This has relevance in the moral deliberation process in

attempting to regain a good enough moral equilibrium, as it encourages discussion that is responsive (that is, responding after reflecting), rather than reactive (without prior reflection). It also highlights the importance of a safe environment for healthy moral deliberation, that is, one that encourages openness, understanding, acceptance of differences and growth, rather than condemnation or rejection of difference.

Another integral part of this dynamic relationship of core values, identity and integrity is how we behave and act. When integrity is in place, and when we are in a good enough space of moral equilibrium our behaviour and actions would be consistent with these values. This confidence in the importance of our values, integrity and identity gives us the courage to exercise our moral agency, which in turn reinforces our values, identity, and integrity.

Moral Agency

Moral agency has a significant role in regaining and maintaining our moral equilibrium. Unless we exercise our moral agency, it is harder to regain and maintain a good enough moral equilibrium. According to Carnevale (2013) “moral agency has been commonly construed as a person’s capacity to engage in deliberate actions that are morally relevant; i.e., touching on matters of right and wrong, good and bad, or just and unjust” (p. 36). Rushton (2018) goes further and highlights the congruence with “intentions, character, choices, behaviours, and actions, as well as one’s responsibility for them,” ensuring that they are continually evaluated and discerned as morally justified (pp. 81-82). Moral agency calls for courage to act according to the values, commitment and conscience one holds. It calls for one to act in the presence of moral disequilibrium, to address the disequilibrium or challenge, and one’s threatened moral integrity when present. Having determined the source or cause of the disequilibrium, moral agency calls one to act according to the outcome of the moral deliberation, and with responsibility. Acting on our values builds confidence, helps affirm or reassess our intentions, integrity, and meaning and purpose regarding who we are and what we do.

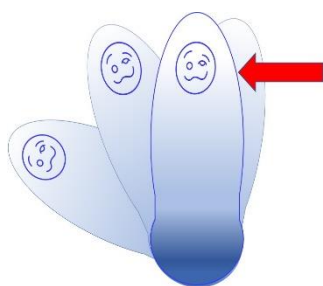
A compromised moral agency may not only impede the regaining of moral disequilibrium but may also worsen the disequilibrium. Varcoe et al. (2012) introduced the concept of compromised moral agency into moral distress understanding. They defined moral distress as “the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards” (p. 59). If all seriously compromised moral agency results in moral distress, then it would be important to explore the situations or conditions that would compromise this

agency—the constraints that impede the capacity to take the morally right action, resulting in further moral disequilibrium.

Definition of Moral Equilibrium

Moral equilibrium is a dynamic state of equilibrium whereby health professionals' motivations, intentions, judgements, and actions are coherent with their moral values. When in moral equilibrium health professionals' moral integrity, identity and moral agency are maintained or intact. It is a dynamic state as there is a constant flux of conditions that can disrupt the equilibrium, such as varying moral residue, personal and workplace stressors, and moral challenges.

Fig. 5.1 Bop Bag



A metaphor that can help explain the dynamic of moral equilibrium is that of the bop bag. A bop bag is a large life-size bag with two compartments: a base that is filled with water, and an upper larger compartment filled with air. The bop bag illustrates that with a solid foundation or base, when the upper part filled with air is hit, the bop bag leans over because of the force of the hit. But it then bounces back to the upright position because of the stable water base. When there is little water in the base, it may stay down. The air-filled part of the Moral Bop Bag represents the part of the individual that is “exposed” to daily interactions with the external world, including the moral challenges explored in the previous chapter. The water-base represents the elements or aspects of the health professional that help maintain the equilibrium—the bouncing back—and can be generally classified as contributors to the moral resilience of the health professional. The greater the moral resilience, the greater is the health professional's well-being and capacity to deal with daily disruptions, including moral challenges (Back et al., 2016; Cavinder, 2014). Moral resilience is defined by Rushton (2018) as “the ability of an entity... to withstand, adapt, recover, or rebound from adversity, stress, or trauma; to be buoyant in adverse circumstances; and to adapt flexibly to the changing contours of stress or adversity” (p. 105). The less the moral resilience or stabilising constituents of the moral base, the more likely is the Moral Bop Bag to stay down and not bounce back, leading to moral distress, moral injury and other states of more severe moral disequilibrium.

Contributors to the Dynamic of Moral Equilibrium

Some of the elements contributing to the complex dynamic of moral equilibrium and

disequilibrium mentioned above were the hierarchy of moral values especially core values, moral integrity, identity and moral agency. Naming all the contributory elements would most likely be more complex than a spider's web. The participants did share their own list of contributing elements which were inter-related. Some elements for one health professional promoted moral equilibrium, but for another they hindered the regaining of moral equilibrium. Also, at one time some elements facilitated moral equilibrium and at another time impeded it. Most were related to the character of health professionals and the ways in which they addressed any challenges to their sense of self, not only to their moral self. These inter-related and integrated aspects of self include the psychological and the spiritual self.

The contributing elements that were named by most participants were passion for the work, past experiences, the support and respect they received, and health professionals' individual personalities. There were other elements that some participants named which I have called "undercurrents". According to the participants, these undercurrents were mainly subconscious and only emerged on reflection.

Passion for the Work

Recall in Chapter Four: Moral Challenges, the positive contribution of the participants' passion for palliative care in their capacity to adapt to the daily work stresses and how when this passion was challenged it resulted in greater moral distress. The "passion" that the participants described was congruent with harmonious or healthy passion rather than obsessive or unhealthy passion, as described by Vallerand and his colleagues (2010). They defined passion "as a strong inclination toward a self-defining activity that individuals like (or even love), that they value (and thus find important), and in which they invest time and energy" (p. 291). *Harmonious* passion as described by Vallerand and colleagues, is when "the activity occupies a significant but not overpowering space in the person's identity and is in harmony with other aspects of the person's life... the authentic integrating self is at play" (Vallerand, 2010, p. 292). Health professionals' passion for their work is related to their identity, integrity, and their values, and contributes to their resilience (Ablett & Jones, 2007; White, 2008).

Contrarily, *obsessive* passion is the uncontrollable urge to engage fixatedly on the activity regardless of all other aspects of life, leading to a "more rigid and conflicted form of task management" with others and other activities (Vallerand, 2010, p. 291). This was not evident in any of the participants.

Resilience to stress increased significantly if the work was not only the passion for the health professional but was also rewarding (Ablett & Jones, 2007). Junior nurse Remy, when asked about the work expectation of five patient-visits a shift remarked: “*I love the work... it’s hard, but I can’t think of anything else I would rather do... 5 visits? 10 visits? Bring it on!*” This passion for her work contributed to Remy’s resilience to work stress and helped maintain her wellbeing and equilibrium. For Remy, when her moral integrity was maintained and she was in good enough moral equilibrium, the impact of work stress was not significant, and she could find creative ways of coping with the stress.

However, acknowledging the stresses present and the fact that palliative care “*work is hard*” (Ruby, senior nurse) (Ablett & Jones, 2007) is also important, as the context within which these health professionals serve contributes to their resilience to challenges in positive and negative ways (Back et al., 2016; Ungar, 2013; Waller, 2001). Their resilience may falter when the challenges they face also result in moral disequilibrium and a loss in moral integrity. Nonetheless, the participants who practised according to their core values and passion, maintaining their moral equilibrium and integrity, were able to adapt to stress in general. Past experiences contributed to this moral resilience.

Past Experiences

In the first month of my fieldwork listening, observing, conversing and reflecting, I wondered if the participants did experience moral distress. Whilst moral challenges were evident, the degree of distress related to actual patient care was mild and easily addressed, with little evidence of moral residue. The early interviews were often recollections of past experiences of moral distress. These experiences, in general, occurred whilst in their previous employment in other organisations. I surmised two possible reasons for this. Firstly, there was little or no moral distress in these community specialist palliative care health professionals which was consistent with one study (Parola et al., 2017). Secondly, these health professionals had learnt to address moral disequilibrium, therefore showed little evidence of moral distress. I believed it was the latter, given their stories of past experiences of moral distress and some responses to my comment on there being minimal moral distress experiences amongst the participants. Consequently, I decided, they had much to offer to those who still struggle with moral distress or need to build moral resilience. Senior nurse G Reese responded to my query:

Oh there certainly is moral distress, but you've seen it once, you've seen it many times... you've worked through it, and you are different... you don't worry too much... and ultimately it's their life. (G Reese, senior nurse)

Reese's comment "*you are different*" offered a significant insight into the consequence of the internal process she undertook in addressing her moral disequilibrium/distress—her values had evolved, and she saw herself as being different. Her hierarchy of values had changed, presumably from one of excellence in the provision of care according to her perspective, to that of respecting her patient's autonomy in deciding their goals of care and management—"*ultimately it's their life*" (G Reese).

Alex also remarked:

After a while you learn that it is the system, and you can only do what you can do... so you just let it go. (Alex, senior allied health professional)

G Rhonda had this to add:

I think it is also how you've been brought up. If you have had "helicopter parents" you are less likely to handle moral distress. If you have had a hard life with lots of challenges then they [moral challenges] don't phase you too much, cos you've got the strategies and the capacity to deal with it.... Some of it I think is that when you've kind of been there, done that, you are more confident about what you think and believe. You know yourself better. (G Rhonda, senior nurse)

For both Alex and G Rhonda, their experiences and the internal process they undertook resulted in the affirmation of their values—"*you just let it go*" and "*you are more confident of what you think and believe.*"

Past experiences, not only in dealing with moral distress, but also other life challenges, were significant components in the dynamic of moral equilibrium for these participants. Coping strategies, self-knowledge and self-confidence were some of the consequences of these past experiences that helped build their moral resilience.

Reska recounted the past experiences she believed had helped her build her moral resilience:

...Personal experiences; professional experiences; family experience; things you learnt as a child, adolescent and adult; all the learnings from background

and professional learnings; it all shapes your world perspective and how you manage things, learning from things that worked and didn't work; CPDs [Continuing Professional Development]; the way you are as a human being; your natural inclination towards things. 5 years ago, no way I'd report a colleague—you don't air dirty laundry; not wanting to get people in trouble... and nothing would happen probably.... I guess it's the life experiences, how you dealt with things in the past, similar situations, genetics—anxiety, upbringing, supports—family, the outlets you have, outside work, for example debriefing, meditation, (some meditation causes more distress), exercise, Pilates, yoga, marathon.... (Reska, senior nurse)

Reska had named some of the things that had helped her build resilience to disequilibrium/stress, not just moral resilience. In contrast, a couple of participants described negative past experiences, in the acute care setting, which led to unresolved moral distress. Fortunately, these were addressed when similar situations arose in this community setting, which resolved their moral residue.

The participants with less experiences both in life and in dealing with moral challenges appeared more susceptible to moral disequilibrium that caused distress. Junior health professionals across disciplines—doctors, nurses and allied health professionals—all sought support from others when past experiences were not enough to address moral disequilibrium or assist in regaining a good enough moral equilibrium. Past experiences especially those related to previous moral challenges were an important component of building moral resilience, as were the support and respect they felt from others.

Support and Respect

One of the many important observations I made during my fieldwork was the significant support that the health professionals within this service provided for each other. It was not unusual for colleagues—nurses, allied health professionals, middle-managers, the manager, administration staff—to answer one another's queries or to ask each other how their day was. G Andrea remarked:

It's so important for us to be together, cos it is hard out there and sometimes we need to debrief... Often times you see the faces when they come back [from their visits] and you just know they had a bad day and so you talk about it. ...Like the other day I happened to see Alex and she asked me how I was and I

just blurted out... and I didn't know I had so much to say... what I was carrying.... (G Andrea, senior allied health professional)

Remy remarked:

This is an amazing place to work in. I've never worked in a place like this before... everyone talks to everyone, and everyone is so supportive. I can ask any question and not think that they think I am stupid. The CNCs [Clinical Nurse Consultants] have their door open all the time... they must be sick of me asking all those stupid questions. (Remy, junior nurse)

Remy later revealed that some of the “stupid questions” were the moral challenges outlined in the previous chapter of inability to fulfill her perceived moral responsibilities, different goals of care with others involved in patient care, and a sense of powerlessness. Related to this was a comment from a few participants that sharing common values was also a significant source of support.

It's so good when you work with people with the same values and thinking... it's like they know where you are coming from and you don't need to explain....
(Arnie, junior allied health professional)

Everyone was aware of the “open-door” policy that was in place; if the office door of colleagues, middle-management or the manager was open, they were welcome to enter to “*debrief*” (Rani, senior nurse), ask questions or just “*chat*” (Alex, senior allied health professional). This easy availability of opportunities to discuss daily moral challenges and feel supported in their moral deliberations and decision-making at that moment, was beneficial. It meant minor causes of moral disequilibrium could be addressed in “everyday” conversations, and more significant causes of moral disequilibrium could be flagged and followed through either immediately or at a later time. The respect participants felt from their colleagues was significant in contributing to their self-esteem, self-confidence and sense of agency, as Remy noted above.

In contrast, when respect was not perceived by the health practitioner, as for Audrey, a junior allied health professional, there was a sense of feeling demoralised. “*What's the point? I've tried to explain over and over again, but no one's listening... yeah, I think demoralised is the right description,*” was Audrey's comment when describing her sense of not being respected. Audrey gave two examples of moral distress situations when describing this sense of lack of respect. The first involved one of the hospital oncologists pursuing futile treatment, giving the patient false hope. The second was the

continued inappropriate referrals, despite informing both those requesting her services and the manager the reasons why they were inappropriate. Audrey and others, including a palliative care physician, two nurses and another three allied health professionals, believed that this perceived lack of respect stemmed, in part, from the hierarchical structures that have been embedded in the health care system mentioned in Chapter Four: Moral Challenges. Audrey, and a few others, also related this sense of not being listened to with their sense of powerlessness to take any action. Audrey commented, *“not listening to what I have to say also implies they don’t trust me... I’m not sure how long I can put up with that.”*

Within the team however, this perceived lack of respect was not experienced by those who had developed mutual respect in their relationships with each other over time. For a number of participants, healthy self-esteem and self-confidence also helped in preventing despondent feelings of lack of respect from others. In part this was related to their personalities.

Personalities

When queried as to why one health professional might experience more moral distress than another, the contribution of personality-types was named by almost all the participants interviewed. The following were a few examples.

I think those tough on themselves and self-critical tend to experience more moral distress... probably also related to confidence. (Ruby, senior nurse)

I tend to overthink a lot, so sometimes I can’t get to sleep when I think about whether I should have done what I did... whether it was right. (Reska, senior nurse)

I’m not very good at thinking that what I have done is right... I often have to ask other people before I know whether something is right to do or not.... I’ve always been like this. (Rein, senior nurse)

I’m kind of a perfectionist. I have to make sure things are right... I guess so I worry more than others [about the right moral action] I also tend to stay late to make sure the notes are right.... When I get tired and irritable, things bother me more. (G Andrea, senior allied health professional)

I’m kind of a hard person to get ruffled... I’m a hard person to offend... we are

all human with good and bad days... so you make allowances. (Riley, senior nurse)

Ultimately if they [other medical specialist teams] don't listen to us it's their problem, we can't do anything more. I just feel for the patients... that's the same with other things in life, isn't it? (Dom, doctor)

Contributing to the tension or dynamic involved in maintaining a good enough moral equilibrium, was the personality types of the participants and their perspectives as to the significance of the challenges to their moral integrity. The same moral challenge situation elicited different responses from different participants. The more anxious personalities tended to experience more distress than those who are “*hard... to get ruffled*”. Again, personalities were only part of the picture—even Riley who was “*hard... to get ruffled*” experienced distress when patients were not cared for adequately, one of Riley’s named core values. Core values and the participants’ level of commitment to these were most significant in their experience of moral disequilibrium and distress.

Recalling Riva’s comment at the start of this chapter that the work is hard, the participants also acknowledged on reflection, that what they “*bring to work*” would also contribute to their moral resilience to the day to day moral challenges. I have named these as undercurrents, as whilst these affected the participants’ moral resilience, they were also primarily in their subconscious. I categorise them as cumulative emotions, and the stress not associated with patient care.

Cumulative Emotions

Cumulative grief was common among the participants. These included difficult deaths and the loss of intimate relationships developed with patients and families after the death of patient. One senior nurse and another senior allied health professional wondered if this cumulative grief was the reason why there was an increasing number of health professionals with abdominal complaints within the service. A cumulative exposure to deaths was one of the reasons that contributed to a younger health professional leaving palliative care. Another senior nurse commented “*I’ve had enough of people dying*” but added “*Faith helps me contain it better*” (Rani, senior nurse).

For some it was hard to pinpoint the cause for the emotions they carried though Riley noted:

Seeing people suffering all the time turns into almost desensitisation in nurses. Sometimes the admin. staff appear more compassionate.... I cry like a tap at movies ... I guess it's releasing the valve... others in a PD [Professional development] session agreed too. (Riley, senior nurse)

Only after reflection was moral residue named by some participants as a significant contribution to decreasing moral resilience. Rani, for example noted:

There is the emotional strain of ringing families as it brings them back to the reality of illness rapidly, even seeing them in the supermarket and so on. Nothing's private. We want to know all the 101 questions. It also reminds us of how we are not really doing our jobs properly each time we meet someone.... Each time it adds to the feeling that you have let them down and you are not doing your job properly... kind of like a build up of the many times you've disappointed them and yourselves. (Rani, a senior nurse)

Rani was commenting on follow up bereavement phone calls and meeting families in social settings, which she felt caused the families more harm than good, leaving her feeling uneasy. Rani felt there was nothing she could do about it, yet each time she encountered this unresolved moral challenge of “*not doing your job properly,*” her feelings of discomfort increased.

Rein, another senior nurse noted:

Things like being unable to have the face-to-face to get the full picture versus phone calls.... It leaves you feeling you are not fully doing your job but what can you do?... You carry it and at some stage I'm sure it affects you.... The younger ones can accept it because it's what they've always known. (Rein, senior nurse)

Another source of moral residue was the cumulation of

things that bother you but not enough to do something about it, like mini disagreements with a colleague about doing the right thing.... (Audrey, junior allied health professional)

Relationship dynamics also contributed to their moral resilience and moral equilibrium. Two senior nurses remarked: “*Nobody likes those difficult conversations*” and “*If I say something they might call me a B-I-T-C-... you know,*” and other

situations where health professionals chose not to take action so as to “keep the status quo” in relationships (comments from five nurses/allied health professionals). This lack of action and likely unresolved moral challenges also had a negative cumulative effect on their moral disequilibrium. Associated with this was the sense of powerlessness experienced in the medical hierarchy of authoritative power mentioned in Chapter Four: Moral Challenges.

Stresses Unrelated to Patient Care

The participants were also aware of other stresses that contributed to their responses to moral challenges, that is their capacity to maintain a good enough moral equilibrium. These included personal stresses such as family demands, poor work-life balance and lack of sleep. Three such examples were Ricky’s, Alex’s and Ruby’s experiences:

When you have a sick child and work full time it is hard sometimes to advocate for patients on the small things that don’t matter so much... as when you’ve had a good night’s sleep. (Ricky, senior nurse)

If you constantly give and go the extra mile without caring for yourself, you’ll have an empty tank and won’t be able to handle the stuff you normally can... especially when it’s about doing the right thing. (Alex, senior allied health professional)

I know I’m going to have a bad day when one of the kids gets sick and you can’t find a baby-sitter and you know they are short staffed... so it just throws you for the rest of the day... you’re kind of out of balanced! (Ruby, senior nurse)

Organisational stresses were also named as contributing to the capacity to respond to moral challenges. The transition to a new model of care and the re-organisation of staff towards a more multidisciplinary focus was also a source of stress for some participants. This left them feeling unsettled and vulnerable, which they believed lessened their moral resilience.

There were many other undercurrents that other participants had voiced which I have not included as the list would be as long as the number of participants. Suffice to say that undercurrent experiences contribute to the equilibrium-disequilibrium dynamic as well as to health professionals’ moral resilience.

Team Moral Disequilibrium

As described in Chapter Four: Moral Challenges, team moral disequilibrium and distress, as opposed to individual moral distress within a team, was a surprising theme that emerged from the data. Whilst team-family conflict is mentioned occasionally in the literature (Austin et al., 2009), team moral distress is not highlighted as a common phenomenon. Within this palliative care service though, a number of participants shared experiences of moral distress that involved the whole team caring for the patient and family. The shared values were the basis of the experience of moral disequilibrium. There was however an additional consideration in my proposing this concept of moral equilibrium for the team as one of importance. To explain this, I draw on Holtz et al.'s (2018) concept of relational integrity which emerged in their study of interprofessional clinicians' definition of moral resilience.

Feminist ethical theory recognises that moral agency is inherently “relational, contextual and interconnected” (Rushton, 2018, p. 91). In other words, whilst individual participants maintain their own moral integrity through decisions and actions according to their moral values, they do so in relationship with others involved in that patient's care. Relational integrity is sustained when individual participants are able to maintain their moral integrity whilst remaining open, flexible and accepting of others' views and values (Holtz et al., 2018, p. e491; Rushton, 2018, pp. 90-94). Holding shared values, and having developed relationships over the years, the participants in this study most likely had a healthy relational integrity. When these shared values and relational integrity were challenged, team moral disequilibrium developed.

Recall the example in Chapter Four where Reska related the team moral distress situation regarding Doreen. Doreen's family had refused to give Doreen what Reska and the team believed was adequate pain relief despite numerous attempts at explaining how morphine works, and that Doreen was too unwell to make informed decisions. The team held the common value of the provision of excellent patient care, yet they were unable to ensure that Doreen had adequate analgesia nor were they able to advocate for Doreen with her family. The team's relational integrity was intact but the relational integrity with Doreen and her family was challenged. The health professional team experienced moral disequilibrium as an entity.

Conclusion

In this chapter I proposed the new concept of moral equilibrium. I explored the importance of recognising the occurrence of moral disequilibrium for health professionals when faced with moral challenges. The concept of moral equilibrium contributes a new dimension in the moral distress understanding that is practical and relevant to health professionals. It reflects participants' experiences and respects the health professionals' indifference to categorising their experiences as moral distress, moral dilemma, moral conflict or any other states of moral suffering (Rushton, 2018, pp. 10-19). All of these are experiences of moral disequilibrium with varying degrees of severity from mild to severe.

In proposing the concept of moral disequilibrium, I do not negate the need for defining moral distress, or other categories of moral suffering, as these various concepts and phenomena warrant research in their own right. However, recognising the experiences of moral challenges to their moral values as moral disequilibrium, allows health professionals to recognise the presence of mild moral disequilibrium and so to address it before it progresses to moral distress and other forms of increasing moral disequilibrium.

I named core values as central to this experience of moral equilibrium-disequilibrium and described how these core values are integral to the health professionals' identity, moral integrity and moral agency. I explored the importance of core values to the individuals' moral judgements, decisions, motivations and actions.

I also named the elements contributing to the experience of moral equilibrium that the participants believed helped build or lessen their moral resilience. This can help explain why, in the same situation, a health professional may experience moral disequilibrium whilst another would not.

Finally, I described the concept of moral equilibrium as it pertains to team moral disequilibrium experience. Once again, the latter also fills a gap in the moral distress research which has, to date, focussed on the experience of moral distress as primarily an individual experience.

In the following chapter I outline how the participants responded to their experiences of moral disequilibrium, focussing on their experiences of regaining a sense of "good enough" moral equilibrium.

Chapter 6: Responding to Moral Challenges

Most of the time you get through the day without too many hassles. If they bother you, I think you need to talk about it or do something about it, otherwise it eats you up, and then your family cops it, then you feel guilty because they shouldn't have to put up with Mum in a bad mood. It's good to talk to the CNCs [Clinical Nurse Consultants] and others about it... sets you right again... and you know you are not alone. (Ricky, senior nurse)

This chapter is about how the participants responded to their moral challenges and Ricky's comment is one reason why this is important—"sets you right again... you know you are not alone" (Ricky). I begin this chapter by explaining the concept of a good enough moral equilibrium which the participants alluded to as the goal in their response to the moral challenges they face daily. Good enough moral equilibrium was Ricky's "sets you right again." I then describe the primary strategy of reflection/deliberation Ricky and the other participants undertook in regaining good enough moral equilibrium. I elaborate on the participants' naming of conditions conducive to the process of reflection and deliberation, the possible outcomes of this process, and the ongoing growth from the learnings of such experiences. I also describe the strategies the participants utilised to build their moral resilience including self-care. This overall strategy of responding to moral disequilibrium formed the foundation of the novel Moral Equilibrium Framework I propose in Chapter Seven.

Good Enough Moral Equilibrium

The concept of "good enough" is often attributed to Donald Winnicott (1953), a paediatrician and psychoanalyst, referring to the good enough mother. Winnicott (1953) states that the "good enough 'mother'... is one who makes active adaptation to the infant's needs, an active adaptation that gradually lessens, according to the infant's growing ability to account for failure and to tolerate the results of frustration" (p. 94). A "good enough" stance thus invites growth and healthy adaptation to challenges and frustration as these are encountered. It differs from 'perfection' that is static, mechanistic and unrealistic in accommodating context, contingency and dynamic relationships (Flett et al., 1996). Perfection possibly stifles growth and leaves individuals in states of constant anxiety, fear, and feeling like failures (Flett et al., 1996).

Ratnapalan and Batty (2009, p. 239) raised the difficulty of introducing the concept of

“good enough” in healthcare, highlighting that both society and healthcare professionals themselves have the expectations that patients should be given the best care, regardless of circumstances. Questioning the realistic nature of this, given limited healthcare resources, Ratnapalan and Batty argue that “physicians should aim to be and train others to be good enough doctors instead of perfect ones” (p. 239). This worldview of “good enough” can also add to moral resilience in facing moral challenges as it allows for greater flexibility in maintaining the non-negotiable identity-conferring values. Hence for a particular moral challenge, accepting that the perfect fulfillment of one’s non-negotiable values cannot be achieved because of circumstances, the degree of moral disequilibrium may be lessened. As senior allied health professional Alex’s comment above attests: *“After a while you learn that it is the system, and you can only do what you can do... so you just let it go.”* Once moral disequilibrium is lessened, moral resilience improves. Ultimately, as van Willigenburg (2000) argues, the question is “Can I accept this, and carry on as the same person?” (p.402).

It may be argued that a “good enough” stance involves a need to compromise one’s moral values and is inconsistent with moral integrity. There are two counter views. Firstly, it is better to gain a good enough moral equilibrium than to continually struggle to achieve an unattainable perfect moral equilibrium, given limiting circumstances such as lack of resources (van Willigenburg, 2000) and other constant ongoing opposing forces such as unexpected stresses and demands of everyday living. van Willigenburg (2000) points out that whilst moral integrity involves moral values that are significant to us as human beings (p. 394), compromise “is part of communal living at any level” (p. 386). van Willigenburg argues convincingly that compromising one set of values to maintain another set is part of retaining moral integrity. He does this using the lens of normative pluralism, which claims that norms and values are derived from plural, valid and irreducible principles, hence there are no always-correct answers to normative questions (pp. 395-402). I concur with van Willigenburg’s argument that whilst commitment to core values is critical to integrity “it has to be mediated with the aspect of wholeness” (p. 389 n.8). There is a risk of fanaticism rather than integrity (p. 389 n.8) if the committed values are not considered with other aspects such as relational integrity and biopsychospiritual integrity.

The second counter view pertains to perspective. Is a good enough moral equilibrium a compromise or is it the ongoing formation of our values? I suggest that it is a recognition that values can be expressed in a myriad of ways depending on the circumstances. This flexibility of expression of values is not a compromise of values but

a mature recognition that as we live our values we grow in appreciation of their many nuances (Bent-Goodley, 2017). Understanding the nuances of our values also implies a capacity to live these moral values, with consideration given to the context, and the improbability of change within that context (for instance, an unlikely drastic increase in funding). It is akin to Lach's (2009) concept of good enough in his philosophical exploration of freedom as finite beings in a pluralistic world:

Things good enough are truly good or even great... they do not need to be better. This does not mean that they are perfect or that they could not be... improved. But they are good enough for me or for us as finite, thoroughly limited beings operating under circumstances we may not be able to improve.... [We] enjoy what is fine and permit [ourselves] to feel fulfilled, refusing to search for some elusive ideal. (p. 2)

It is important to recognise that the concept of a good enough moral equilibrium is not about letting go of moral values either, especially those that confer identity. It is about accepting and respecting that people have different values and negotiating these differences. I concur with Ratnapalan's and Batty's (2009) recommendation of "excellence through good enough" in the following statements:

- There are sufficient benefits.
- There are no critical problems.
- The benefits sufficiently outweigh the problems.
- In the present situation, and all things considered, further improvement would be more harmful than helpful.... (p. 240)

Alex summed it up when she noted:

I can live with the fact that I can't be all to all people... I can accept that our limited capacity which is beyond our control may mean I don't get full closure with everyone...that's okay. (Alex, senior allied health professional)

To push to achieve closure would likely be at the cost of Alex's wellbeing. Reska, responded similarly:

You can tell them till you are blue in the face. The next day you come back and it's the same. You have to get comfortable at some point knowing that you have done all you can... and that it's quite likely a crisis will occur... but then hopefully you'll be there to pick up the pieces. (Reska, senior nurse)

Reska could not ensure that her patient was receiving the best care she believed the patient needed. However, given the circumstances she was comfortable knowing that she had done all she could. She regained her good enough moral equilibrium.

Regaining a good enough moral equilibrium that still enables one to live with moral integrity can be seen as maintaining relational integrity—respecting differences within common values. It affirms the evolution of our moral values, continually being formed by past and present experiences, including relationships.

The concept of a good enough moral equilibrium invites health professionals to take on a wholeness perspective that primarily focusses on core values, considers contexts and all contributors of the dynamic of moral equilibrium described above. Hence, core values, especially identity-conferring ones, are important. However, in living them out, it is also important to take into consideration what is realistically possible, balanced and contributes to the well-being of both the health professional, and the patients and families under their care.

Recognising Moral Disequilibrium

After the talk we had the other day, I began asking myself what's happening if I feel upset—if I have time of course... or I'll do it later when I get back [from visits]. Sometimes I don't realise it until after I get back and others ask me how the day was and I realised, yeah, that didn't feel right. It's good to talk with the others about it, whether I did the right thing or not. (Ricky, senior nurse).

Ricky's comment was not dissimilar to G Andrea's in Chapter Four when she described how paying attention to her emotions helped her note her moral disequilibrium and questioning of "*whether I did the right thing*" (G Andrea, senior nurse).

The role of emotions, in their full spectrum—from mild discomfort to distress, has been described in Chapter Four. I repeat this here for convenience: mild emotions of discomfort which are secondary to moral disequilibrium, were often left unattended, either deemed insignificant or taken over by more pressing issues demanding attention. Significant emotions such as distress from moral disequilibrium led to functional impairment such as physical symptoms of anxiety and panic attacks, insomnia, psychological states of lack of confidence, identity and vulnerability, spiritual crisis, as well as relationship tensions and breakdown. The degree of functional impairment was likely dependent on three aspects. Firstly, the significance of the core values being challenged. Secondly, the intensity of the moral challenge—one person challenging or

an organisation challenging the individual health professional. Thirdly, the moral resilience of the health professionals.

Recognising that “*something is not right*” then led the participants to the internal process of reflecting on the underlying cause of the emotion.

Reflection/Deliberation

Depending on the individual health professional, reflecting on the cause of the emotion occurred either privately or with others. For the purpose of this thesis, reflection is defined as a personal internal process of recounting and making sense of the experience based on past experiences, values and beliefs, whilst deliberation includes input from others’ experience and knowledge (Karimi et al., 2019, p. 1312). In the process of deliberation individuals continue reflecting on what is being said and how it aligns with or changes their understanding of the situation, and their own beliefs and values. Both processes involve recalling the moral situation or challenge, gathering any information needed to make sense of the experience and drawing conclusions.

Reflection

Some participants tended to self-reflect on their experiences of disequilibrium. This was dependent on the participant’s personality, or whether the experiences were perceived to be minor or easily solved. For instance, G Reese, a senior nurse, shared:

I try not to bring anything home... so if there is something upsetting me, I try to work it out on my own. I find the best time is in the car when I drive from one patient to another, that is if I’m not on the phone trying to organise something for patients. Otherwise my drive home is my space time... thinking about the day... what happened, why I felt that way... could I change anything? So, by the time I get home the kids have their Mum. It took me a while to learn that. (G Reese, senior nurse)

G Rhonda, a more senior nurse, would

work through it [the challenge] ... then consider how I could have acted differently ... or make necessary changes ... or even whether it was my problem or not... then I can let it go. (G Rhonda, senior nurse)

The internal process of reflection helped participants understand why particular events gave rise to the emotions associated with moral disequilibrium. These events were often

related to challenges to their moral values described in Chapter Four: Moral Challenges—inability to fulfill moral obligations and responsibilities, differing goals of care and feeling powerless. Opportunities to reflect on the experiences enabled them to resolve the moral challenges and regain their good enough moral equilibrium. Ricky explained:

I think when you realise what the real issue was... after thinking of all the bits that make up the picture, you have to decide whether what you did was right and if not then you try to make it right the next day or the next time it happens... It's about doing what you believe is important... I guess it's about your values. (Ricky, senior nurse)

Reflection for Ricky involved noting the relevant facts of the moral situation, then making a moral judgement. For Ricky decision-making was based on her values.

When queried about what they did if they could not resolve their moral disequilibrium, both Ricky and G Reese advised that they talked it over with their colleagues, primarily the Clinical Nurse Consultants. Deliberating about their experiences with others was common amongst the participants.

Deliberation

You whinge a lot... to anyone who would listen ... the CNCs [Clinical Nurse Consultants] are great. It depends ... you kind of have to let it out, otherwise your family or other people cop it... then you feel bad... and get into a whole vicious circle.... Sometimes that's all you need... you complain then you can let it go. Other times it can really get to you... but we are lucky here... there is always someone you can talk to. (Ruby, senior nurse)

When something did not feel right—when Ruby's equilibrium, moral or otherwise, was challenged—one of her first reactions was to share her experience. Ruby was not the only one. Many comments such as “*it gets a bit lonely when the office is empty and there's no one to share your experiences with*” (Angie, junior allied health professional), “*it's easier when you can share it [experience] with others*” (Alex, senior allied health professional), and “*I just have to tell someone*” (Riley, senior nurse), attested to this impulse to “*tell the story of what happened*” (Audrey, junior allied health professional). Sharing the moral disequilibrium experience had four benefits—to vent the emotions, to validate and normalise the emotional response to the experience,

to maintain relational integrity, and to begin reflecting on the experience with others. The following are examples.

Sharing the experience allowed participants to vent their emotions, as Riley shared:

It's somewhere to dump it [emotions] when you talk about it [experience], even though it doesn't solve anything... it calms the molten lava of the volcano in me.... (Riley, senior nurse)

Regardless of whether the moral challenge was addressed, releasing the energy of the emotion was of itself therapeutic. This was important for the participants, as not doing so could paralyse creativity in addressing the challenges. Alex indicated when elaborating on another team situation of moral challenge:

The allied health team has been in shock, which doesn't give [room] for creativity to find solutions. (Alex, senior allied health professional)

Once vented, the intensity of the emotion settled, which in turn allowed for rational processing of the experience, and “*not take it out on the family*” (Riley). The participants were also selective as to the people with whom they would share their experience. Trust in the other people was a primary consideration.

These relationships of trust have an important role in regaining moral equilibrium. We are to some degree reliant on relationships to affirm or bolster our sense of self. Sharing experiences allows for the validation of the impact of the experience on our sense of self or identity. If another person empathises with our experience then our response to the experience is validated or legitimised (Edwards et al., 2013, p. 331)—we are not over-reacting or “*going crazy*” (Ruby, senior nurse). We are also affirmed in the normalcy of our response, and possibly even its intensity. Similarly, if the listener notes the response to be an over-response and reflects this back to the health professional, then sharing the experience could open opportunities to explore the underlying reason(s). One reason could be the emotive crescendo effect of moral residue or unresolved moral disequilibrium.

In addition, sharing our experiences and having them validated helps retain relational integrity, which in turn aids moral resilience. As described in Chapter Five: Moral Equilibrium, relational integrity pertains to the capacity to hold one's personal moral integrity in solidarity with another's moral integrity, “while establishing effective engagement and boundaries in relationships and decisions” (Holtz et al., 2018, p.

e491). Recall junior nurse Remy's gratitude for senior nurse Reska's mentorship and her sense that "*I can ask any question and not think that they think I am stupid*" and on another occasion "*even if we think differently [moral values] it's okay, we still respect each other*" (Remy).

Having explored how and why participants dealt with the emotions associated with moral disequilibrium, I now discuss the moral deliberation process itself, first from the moral distress literature, then in the experiences of the participants themselves.

The Process of Moral Deliberation

Moral deliberation is regarded as the ethical dialogical approach based on a hermeneutic perspective which aims at resolving real cases through discussion and critical reflection. It is one's capacity to present and discuss one's own perspective about the phenomena, taking into consideration the perspectives of others, discussing rationally their points of view and progressively modifying the vision of the process. Deliberation is a way of action that results in a final solution that not always coincides with the opinions initially held. (Barlem Ramos, 2014/2015, p. 609)

Moral deliberation involves a dialogue between "human experience [of moral challenges], general principles [or values], and intersubjective perspectives in decision-making" (Molewijk et al., 2011, p. 385, my inclusions in square brackets). Moral challenges are interpreted or understood through the lens of principles, values and worldviews held by those deliberating. This meaning-making process is further enriched when there are varying perspectives. Insights developed from the mutual exchanges of experiences, principles, values and perspectives are educative, relational and transformative (Costantino, 2008; Frank, 2005). It is educative as information shared may not have been known before. According to Constantino (2008), through non-judgemental, uncoerced and equitable communication and exchange of ideas, insight is sought and constructed. Hence the dialogical process can also be transformative. In the exchange of ideas there is often self-reflection which may result in greater knowledge, insights, understanding and opportunity for growth. This mutual exchange of ideas is relational and can be reconciliatory (Costantino, 2008).

Moral deliberation is also hermeneutical as it is grounded in real-life practices, and is not abstract or black and white (Molewijk et al., 2008, p. 121). Pragmatic hermeneutics encourages an openness to "contextuality and contingency" (Molewijk et al., 2011, p.

384). This is especially relevant within the participants' tight time constraints, as, in general, discussions can be held in the immediate for a particular moral situation or event. Here moral deliberation conclusions are case-specific and relevant to those deliberating. Again, personal and professional growth can happen as new insights can be gained on how one lives one's life and values, and who one chooses to be, in similar situations.

The goals of formal moral deliberation as proposed by Bert Molewijk et al., (2011) are threefold:

1. to reflect on the case and improve quality of care within the case;
2. to reflect on what it means to be a good professional and enhance professionals' moral competencies;
3. to reflect on institutional and organisational issues and to improve quality of care at that level. (p. 384)

I suggest that moral deliberation is also an avenue to regain moral equilibrium. The goals of moral deliberation are similar to what contributes to the state of moral equilibrium: reflection on the case being considered and how health professionals can maintain their moral integrity through improvement of their quality of care for their patients and families.

G Reese, a senior nurse described how she responded to an experience of moral disequilibrium and the process of moral deliberation she undertook:

I think caring for patients in aged care facilities carries a lot of ethical issues. The families kind of dictate the management of the patient... and bad medicine distresses me. There was this family that kept demanding that the patient be given a syringe driver, I suspect because they wanted to move things along.... It doesn't help that the aged care facility was poorly resourced so the nurses [at the aged care facility] are stressed too, wanting to do what the family wants. So, you explain to the family that she doesn't need it. They are not convinced. You speak to the CNC [Clinical Nurse Consultant]... we explore the facts, we agree it's bad medicine... then there was a question [raised by the CNC] that there may be something else going on, so the allied health people get involved. They have their point of view. Then you get the doctors involved in the conversation, you hash it out, see each other's point of view, consider your goals for the patient and eventually you come to an agreement—the patient

doesn't need a syringe driver. Because the patient has a GP, we ended up withdrawing our services... the CNC was pretty gutsy, I thought. (G Reese, senior nurse)

In G Reese's brief description of her experience of the moral deliberation process, she captured the elements necessary for moral deliberation according to Barlem and Ramos (2015, p. 611). Firstly, G Reese experienced moral disequilibrium when she was asked to give her patient a syringe driver by the family when she believed this was not necessary or appropriate, and called it "*bad medicine*". G Reese's suspicion of the family wanting to "*move things along*" presumably led her to believe that providing a syringe driver to the patient was not only clinically inappropriate but morally wrong.

In G Reese's sharing of her experience with the Clinical Nurse Consultant, and through the Clinical Nurse Consultant's queries for clarification, facts of the moral challenge were revealed. The family's demand for inappropriate care in the use of the syringe driver against advice was one fact. The Clinical Nurse Consultants were also abreast of patients' situations in the service areas they oversaw and contributed information that may have been missed by G Reese, giving G Reese further insights into the family. It was also likely that G Reese chose to share her experience with the Clinical Nurse Consultant as the Clinical Nurse Consultants had the authority to take further action where G Reese felt she could not (Edwards et al., 2013, p. 331). Policies and procedures inherent in service provision were also incorporated into the deliberation of the moral challenge at hand. These were known to G Reese and the Clinical Nurse Consultants. Moral values were renamed and affirmed in the deliberation—provision of good and appropriate patient care. Advice, opinions and perspectives were also sought from other members of the team including allied health professionals, doctors, the volunteer coordinator and the service's manager. New learnings and insights were gained by G Reese and other members of the team.

G Reese's example of moral deliberation did not happen in one sitting. Deliberation was held over a number of days and there were times when she did not participate in the moral deliberation process. The initial moral deliberation process instigated by G Reese's moral disequilibrium resulted in a team moral deliberation. With the team then involved in the care of the patient, all agreeing that providing a syringe driver was inappropriate and morally wrong, team moral disequilibrium may have occurred as demands from the family grew. Considerations not previously taken into account by G Reese, such as the involvement of the allied healthcare team, were raised and actioned. Involvement of the consultant to ensure that all aspects of management were taken into

consideration was made. Moral judgement and clinical decisions not to provide the syringe driver and to withdraw services were made by the team. This decision was made, knowing that the patient's GP would continue her care, albeit with different management and goals of care from what G Reese and the team envisaged. 'Bad medicine' was not practised by G Reese and the service, and G Reese's and the team's moral equilibrium were regained.

The above account was one example of many the participants shared. What emerged from the data was that the participants' process of moral deliberation involved:

- the sharing of the moral challenge in a safe, non-judgemental environment;
- gathering more accurate facts about the situation and the elements involved in the moral challenge from internal and external sources;
- drawing on self-knowledge and past experiences, and ensuring that personal agendas were put aside;
- involving other members of the team;
- being open to the experiences and wisdom of others;
- utilising the dialogical process which involved an iterative process of listening respectfully, responding after further consideration and listening again till common ground was found;
- a preparedness to learn from others; and
- a willingness to change one's perspective or compromise without losing one's moral integrity, if appropriate.

Elements Conducive to the Deliberation Process

Participants in this study found the moral deliberations they had with each other beneficial and routine. In situations that were not easily resolved, they had minimal hesitation in involving management or other colleagues. I observed and posit that this ease in moving into moral deliberation can be attributed to their trust in each other, their commonly held values, their attitudes of respect and appreciation for each other, and the supportive environment of the service. According to Costantino (2008), it is through non-judgemental, uncoerced and equitable communication and exchange of ideas, that insight is sought and constructed. Trust and respect are important bases for such communication and exchange.

Trust

The primary people the participants opened up to were those they trusted. Two themes within this category emerged: shared experiences, perspectives and approaches to care; and relationships of trust formed.

Shared experiences, perspectives and approaches to care provided a more conducive space for deliberating, especially if colleagues were in the same discipline. A few nurses, allied health professionals and doctors had commented that “*nurses get nurses*,” “*allied health get allied health*” and “*doctors... understand doctors*”. The significance of this was highlighted by the angst experienced by some allied health team members when it was suggested that they move offices into a more multidisciplinary setting. For some participants, the inclination to explore their moral disequilibrium with those within the same discipline extended to professional friends external to the service with whom they have developed relationships over time.

Nonetheless, there was also the freedom to deliberate with team members from other disciplines, especially if the other members were caring for the same patient:

I tend to also talk with others who are looking after the patient too, like the counsellor or social worker who know the situation and the family. (G Rhonda, senior nurse)

This happened especially in situations of team moral disequilibrium or distress. Other trusted colleagues the participants turned to were those in middle management and management, especially the Clinical Nurse Consultants, and informal mentors within the service. Participants were unwilling to share their experiences in detail with those whom they did not trust:

I don't say very much to [named person] ... 'cos you don't know where it [experience shared] will go. (Alex, senior health professional)

Even in the formal context of professional supervision⁶ which were mandatory for junior participants, unless the nurses and allied health professionals trusted the

⁶ Carroll's (2007) definition of supervision is most proximate to my observation of the nurses' group supervision sessions. “*Supervision is a forum where supervisees review and reflect on their work in order to do it better. Practitioners bring their actual work-practice to another person (individual supervision), or to a group (small group or team supervision), and with their help review what happened in their practice in order to learn from that experience*” (p. 36).

external supervisor, they were reluctant to enter into deliberation. Where there was no trust or they felt not heard by the supervisor, supervision became more burdensome:

What's the point... she [supervisor] doesn't listen anyway... so I just say whatever and not engage... it's a waste of time. (Aria, senior allied health professional)

The network of trusted people with whom the health professionals felt safe to share their moral disequilibrium experiences included their spouses, other family members, and other health professionals at social gatherings or professional development events. Less frequently the health professionals engaged in the Employee Assistance Programme (EAP)⁷ especially in situations of team moral distress so as “*not to add fuel to the fire*” (Angie, senior allied health professional).

Common Values

Commonly held values for these participants were based on two sources. The first were the values of this faith-based organisation,⁸ regardless of participants' own personal faiths and those named as core values. The latter were: respecting the autonomy of patients; equity of access to good palliative care; and the dignity of people and the value of human life (Chapter Five: Moral Equilibrium). The second source were the values of palliative care which include dignity, empowerment, compassion, equity, respect, advocacy, excellence and accountability (Palliative Care Australia, 2018a, p. 7). Rein and Donna noted:

Even though I'm not [named religion] I still believe in the values... they are my values too... otherwise it would be too hard to work here... you'd be clashing all the time or hitting brick walls.... (Rein, senior nurse)

I think we all believe in the same things as far as patient care is concerned, so it makes a difference.... I guess it gives for a good foundation. (Donna, physician)

The concept of commonly held values serves three purposes in the moral deliberation for these participants. Firstly, it served as a starting point or foundation as Donna intimated—the goals of care and deliberation, in general, were accepted by all present.

⁷ EAP is an independent “work -based early intervention aimed at the early identification and/or resolution of both work and personal problems that may adversely affect performance” and “includes services for immediate family members” (Employee Assistance Professional Association of Australasia, 2009, p. 36).

⁸ I do not mention the organisation's specific values here to preserve the confidentiality of the service.

Secondly, having common core values meant there was no need to “fight” for these values. Rein alluded to this when she remarked “*otherwise it would be too hard to work here.*” This likely gave some assurance of safety in their vulnerability of being morally challenged. This sense of safety enhanced the capacity to be more open to sharing and receiving. Thirdly, there is the sense of belonging to a community with common values and goals—encouraged by the open-door policy—probably leading to earlier moral deliberation and regaining of good enough moral equilibrium (Pauly et al., 2009).

Common values also led to increased likelihood of support by colleagues for the participants in their intentions, motivations and goals of care for patients. Deliberation based on these common values led to further clarification of the nuances of the expressions of these values in actions as described in Chapter Five: Moral Equilibrium. Participants’ identity, moral and relational integrity relating to these values were more likely to be preserved.

It may be argued that these common values may not necessarily be the moral values accepted by all health professionals or ethicists. However, in general, my observations of moral deliberations and judgements were that they were not in total contradiction to other ethical theories, including virtue ethics and deontology, principlism (Clouser & Gert, 1990, pp. 230, 234) or the various professional codes of ethics (Australian Medical Association, 2016; Australian Psychological Society, 2018; International Council of Nurses, 2012; Medical Board of Australia, 2020).

Respect and a Supportive Environment

Palliative care provides holistic healthcare and thus values the contribution of a multidisciplinary team. One of the service’s physician Donna described it as such:

It’s a bit different to other specialties where there is more competition and having [sic] a need to prove how good you are.... Even as consultants we still do make mistakes. I certainly have a healthy respect for nurses.... Even if there are differences of opinion.... It’s how you do it [share the opinion]. Maybe it’s also because palliative care as a specialty is not respected, so we stick together.
(Donna, physician)

Donna observed that the specialty of palliative care draws health professionals who were not as competitive as other specialties. Palliative care health professionals are possibly less likely to hold to the paradigm of hierarchical authority, as palliative care

emphasises a team and wholeness approach to patient care (Swetz et al., 2009). This perspective of multidisciplinary care likely encourages an environment of mutual respect, and acknowledgement that each member has a contribution to the overall care of patients. As Remy remarked

Because you are part of the team—CNCs [Clinical Nurse Consultants], other nurses, allied health and others, you don't have to be the one to do it all. (Remy, junior nurse)

More research is needed to explore the role the philosophy of palliative care has on the experience of moral distress. Two possible explanations emerge as I observed the way the participants interacted with each other. The first is that the philosophy of palliative care encourages mutual respect and the perspective of the whole, which in turn is conducive to safe and productive moral deliberation, and the regaining of good enough moral equilibrium. This was voiced by the participants and was consistent with Swetz et al's (2009) study of hospice and palliative care physicians. Swetz et al. (2009) found that palliative care physicians believed that interdisciplinary teams were vital for the service of good palliative care hence, building relationships within the team and good teamwork were essential.

Secondly, the philosophy and nature of palliative care may attract a certain group of people who tend to be more resilient to moral challenges. This latter possibility interestingly was noted by Ablett and Jones (2007) who found that hospice nurses are often: experienced professionals; committed to palliative care having chosen it; are self-aware; are comfortable with mortality and their own spirituality; and have their own story of significant loss and grief. These characteristics reinforce resilience (Ablett & Jones, 2007).

A respectful and supportive environment also allowed the participants to be vulnerable. The participants highlighted the importance of a safe environment where they were respected regardless of their own insecurities. Remy shared her experience of having Reska as her informal mentor:

Reska is so good and kind... she said to ring her anytime... so I did when I wasn't sure, even though she was not on [duty]... you just know she would understand and wouldn't think you are stupid. (Remy, junior nurse)

In a safe, non-judgemental environment there is greater willingness to be vulnerable and be open to other perspectives. This allows for reflection and discernment of the

relevance of what is being said to one's own values and identity (Edwards et al., 2013, p. 331). Even in situations of moral confusion, moral deliberations could reveal and resolve the value conflict (Grönlund et al, 2016). Musto and Schreiber (2012) found in their study of mental health nurses qualities of trusted confidants included "being trustworthy, ...a safe individual, having values similar to... the participant, being experienced and practising in a way that the participant respected, having an understanding of the work setting, being non-judgemental, and having a non-disciplinary role..." (p. 141).

Conversely, Deady and McCarthy (2010), in their empirical study of Irish psychiatric nurses, found that unsupportive environments instil a sense of powerlessness, threat and vulnerability in health professionals. This resulted in avoidance strategies "to intellectually immunise them from the distress," (Deady & McCarthy, 2010, p. 217), which led to increasing moral residue, and I add, persistence of moral disequilibrium. Similarly, moral distress is more prevalent in environments where voices are not given credence, for example where nurses' moral opinions and challenges are suppressed (Pauly et al., 2009; Rodney et al., 2002). The participants themselves found the supportive environment and culture within this service very conducive to moral deliberation and the regaining of their moral equilibrium.

Possible Outcomes of Reflection and Deliberation

Having reflected and deliberated on their moral disequilibrium, three possible outcomes emerged that led to the regaining of a good enough moral equilibrium: participants' affirmation of their core values; participants' re-evaluation and re-alignment of their values; and the acceptance of differences in core values between the participants and others, without compromising their moral integrity.

- **Core values were affirmed.** Following deliberation, the team concluded that the moral challenge they faced, if followed through, was morally wrong and not consistent with their core values. A moral judgement was made, and moral action(s) undertaken, resulting in the regaining of a good enough moral equilibrium. An example of this was in G Reese's description of moral deliberation mentioned above. The team's moral values were affirmed and to act otherwise would not be consistent with these values. Thus, the decision was made by the service to withdraw care of the patient in the aged care facility.

- **Core values were re-aligned or changed.** Having listened to their colleagues' varying perspectives and reasons underlying those perspectives, some health professionals found that their core value(s) was/were changed or re-focused. Remy's priority, for example, was to provide the best care she could for her patient, including ensuring good pain control. However, when this was challenged by the patient preferring a lower dose analgesia so as to be more alert, Remy experienced significant moral disequilibrium. Remy perceived she was not fulfilling her moral obligation to provide good nursing care. Following moral deliberation with her team and through supervision, Remy concluded that respecting the patient's wishes took priority as a value. Since then, Remy's primary moral value was in ensuring that her patient's autonomy was always respected, and she regained her moral equilibrium.

This possible outcome is important as the moral distress literature often assumes that once a moral judgement is made it is right for the individual and immutable—a *fait accompli*. What this study has shown is that in the moral deliberation process, moral values and judgements can change.

- **Accepting differences in values**—“*being able to live with it*” without losing moral integrity. The participants' common conclusions following moral deliberations resulting in this outcome included: “*It's not my life*” (Reska); “*it's the patient's choice*” (Remy); “*I'm here to support patients not to persuade them to do something against their will*” (G Andrea). G Andrea continued “*if she [patient] chooses assisted suicide then that's her choice. So long as I don't participate or witness it, I'll support her in all other ways.*” Reska, an experienced nurse noted, “*You have to accept that the ideal is not always possible. Sometimes you just can't fix it. I can live with the fact that I can't be all to all people.*”

Whilst accepting that patients' values were different to theirs, the health professionals still held to their core values without compromise. Rein, on reflection, said “*What I wanted for them may not be what they wanted... but what I feel [they needed] is right too.*” This regaining of moral equilibrium by accepting difference is also noted in the literature (Carse, 2013, p. 148; Epstein & Hurst, 2017, p. 37).

Persistent Moral Disequilibrium or Moral Distress

There were a few occasions for participants when, having made a moral judgement and a decision to take a particular action to right a morally wrong situation, the action could not be undertaken. Whether these were due to personal or external constraints, they led to the occurrence of greater moral disequilibrium, even moral distress. In such situations the cause of moral distress was escalated to managerial or organisational level, as deemed appropriate. This either resolved the moral distress situation or left the participants dealing with the fact that they had done all they could.

Whilst individuals could try to address their personal constraints, such as lack of self-esteem, ultimately, as Epstein and Hurst (2007) declared, “moral distress is a phenomenon of the industry. In the end [moral] resilience does not cure moral distress” (p. 38). This is consistent with Deschenes et al.’s (2020) position, mentioned in Chapter Two: Moral Distress, that the onus of addressing moral distress needs to be on the system and organisations causing the external constraints (p. 1127). External constraints such as: blanket policies and procedures that do not take context and contingency into account; bullying and power play in hierarchical paradigms; and attitudes of arrogance and hubris, do not assist in encouraging moral equilibrium and well-being (Rasoal et al., 2016).

For some participants like Ruby:

You have to get comfortable knowing that you have done all you can.... Some things are out of your control and you can't beat yourself up for it....

At the end of the day you have to be true to yourself; you always have to get up and look at yourself in the mirror in the morning and hope that after all that is said and done [post moral deliberation and action] you come good in your head and heart. (Ruby, senior nurse)

Ruby and others (Musto & Schreiber, 2012) were describing the state that I have called good enough moral equilibrium. In this state Ruby accepted that there were some things out of her control and that “*knowing that you have done all you can... you can't beat yourself up for it,*” and “*you come good.*”

Growing from Moral Disequilibrium Experiences

Apart from the likelihood of regaining a good enough moral equilibrium, the participants experienced moral deliberation as an educative process. Junior nurse Remy for instance noted:

Talking it out and listening to what the others say is really helpful. I learn a lot from their experiences, especially those who have been around for a while... not just about management of patients but also how to be a better nurse. Generally, we end up with the same conclusion about how to manage the situation. You kind of feel supported that way. We all want the same things for our patients... just to do what we can for them, so they are not suffering... and remind ourselves that really, it's their life, their decision. (Remy, junior nurse)

Listening to her colleagues' perspectives gained from past experiences of living these common core values and facing their own moral challenges, allowed Remy the opportunity to grow in her understanding of how to maintain her own moral integrity in light of these challenges—and “*how to be a better nurse*” (Remy). Her colleagues' experiences, wisdom and openness to learning from each other encouraged Remy's own growth. Remy noted:

Sometimes you have to put your own agenda away and listen to others... then you find yourself changing your opinion so your own agenda doesn't hold.... (Remy, junior nurse)

Other participants had indicated that sharing perspectives also helped them be more realistic in their expectations: “*You can't do everything... just the best you can, given the demands.*” (Alex, senior allied health professional). Coming to a new understanding and approach to challenges is also described in the literature (Grönlund et al., 2016, p. 321), as is the value of team moral deliberation (Edwards et al., 2013, pp. 330-331). Hence, this process of dialogical moral deliberation also helped Remy regain her good enough moral equilibrium and grow or evolve in her moral understanding and the living out of her moral values.

Regaining a good enough moral equilibrium was not the full response to moral disequilibrium or moral distress for the participants. A common theme that arose as part of participants' responses to moral distress, was to minimise the recurrence and impact of future occurrences of moral disequilibrium and the building of moral resilience.

Building Moral Resilience

You get demoralised ... you feel like you are giving 110% and instead you get into trouble for not doing what they [management] think you should do. They are not there on the ground—they don't really know what it's like. So, you learn the lesson—sometimes you do the best you can, and things don't turn out right... and that's life. You come to terms with it. I felt that feeling before so it's easier the second time round. You don't feel so demoralised the next time cos you've kind of worked through it... helps build resilience. Eventually it's not a problem. (Ricky, senior nurse)

For Ricky the experiences of working through moral challenges and regaining a good enough moral equilibrium—“*you come to terms with it,*” left her more resilient to further moral challenges, even to the extent that similar situations may not be challenges anymore.

As mentioned, Rushton (2018) defined resilience as “the ability of an entity (an organism, person or system) to withstand, adapt, recover, or rebound from adversity, stress, or trauma; to be buoyant in adverse circumstances; and to adapt flexibly to the changing contours of stress or adversity,” (p. 105) and I add, for some, even to thrive. The adaptive response to change, similar to the “adaptive response” definition in neuroscience, has the goal of “maintaining homeostasis and performance where possible” (Fornito et al., 2016, p. 399). For the health professionals in this service, it was about maintaining their good enough moral equilibrium and moral integrity (homeostasis), continuing to care as best they can for their patients (performance), and growing in moral understanding and self-improvement. This adaptive response is consistent with Holtz and Rushton’s (2018) definition of moral resilience: “the capacity of an individual to sustain or restore, or deepen (his or her) integrity in response to moral adversity” (Holtz et al., 2018, p. e489; Rushton, 2016b, p.112).

The exploration of resilience in the literature is wide and varied (Adger & Adger, 2000; Masten, 2007; Pangallo et al., 2015; Stewart & Yuen, 2011; Windle, 2011). The concept of moral resilience spearheaded by Cynda Rushton (Holtz et al., 2018; Rushton, 2016a ; Rushton, 2016b, 2017, 2018; Rushton & Carse, 2016) appropriately relates strategies of moral resilience to moral integrity. Rushton (2016b) also recognises that:

the moral domain is interconnected with all dimensions of human beings’ biological, psychological, cognitive, spiritual, and relational resources. Hence,

the psychological aspects of resilience are involved in a synergistic web of processes that can also be leveraged to support moral resilience. (p.112)

Rushton affirms Masten's (2007) view of the need to look at resilience, and I add moral resilience, as an integrative concept of personal capacity rather than categorising it within specific disciplines. This was affirmed by the experiences of the participants. Whilst I name four themes which emerged from the data, I am conscious of the web within which these themes lay, that made up the integrated self. The themes that emerged were: dynamic and evolving self-knowledge; openness and acceptance of differences of worldviews; spirituality; and self-care and minimising stressors.

Dynamic and Evolving Self-Knowledge

In distilling what self-knowledge was needed to build moral resilience, participants described knowing their own moral values and their hierarchy of values as primary. Personal qualities and openness to growth and change were other tools in building moral resilience.

The participants' values form a significant lens through which the participants negotiated the world—their non-negotiable, identity-conferring values and other values that were negotiable. Through these values they interpreted their responsibilities and obligations and how they went about fulfilling these. Thus, in building moral resilience, the participants described the importance of knowing their core values, as these not only motivated their approach to their roles as health professionals, but also how they dealt with moral challenges.

Recognising their hierarchy of values enabled health practitioners to know what was and what was not negotiable. Remy for instance, in meeting one of her moral challenges that led to moral distress discovered that her non-negotiable core value was respect for patients' autonomy. Other commitments, such as excellence in the provision of care and ensuring patients were pain-free, were more negotiable. If patients chose to have pain in order to be more fully present to those around them, Remy was able to accept the patient's choice, and maintain her good enough moral equilibrium. She was more adaptable and flexible in her living out of her commitments with values that were negotiable. Her non-negotiable core value of respecting the patient's autonomy was preserved, as was her moral integrity.

Self-knowledge in terms of understanding ones' own personal qualities and the way they addressed challenges was another common theme. Senior nurse Ruby for instance described herself as a “no-nonsense person” who did not “suffer fools gladly” (Ruby). Knowing this about herself, she often tried to see the other person's point of view instead of dismissing their opinion if it did not align with hers. Reflecting on her own reactions to challenges helped her grow in self-knowledge. In reflecting on the importance of self-reflection and self-knowledge, G Rhonda noted the qualities of those who she believed practiced self-reflection and who were self-confident:

I think when you are talking about resilience, you are also talking about personalities. Some people have just got it: they've got common sense; don't over-think; they are self-contained but can stand up for themselves; have a great sense of humour and can laugh at themselves—you really need that, doing this kind of work. You can't take life too seriously. (G Rhonda, senior nurse)

G Rhonda was naming the characteristics that other researchers have found significant for resilience: courage, humility, self-regulation, self-stewardship (Holtz et al., 2018; Matheson et al., 2016).

The participants considered self-knowledge in the context of moral resilience as an evolving, life-long dynamic process of self-reflection and growth towards being better health professionals and people. This awareness highlights the dynamic and transformational nature of moral resilience-building. This is consistent with other participants' comments including:

It's about growing isn't it... you never stop learning... you kind of have to keep at it. (Alex, senior allied health professional)

If you know yourself well you'll give yourself the tools you need to cope... you can deal with everything; empowering yourself to nurture and grow. (G Rhonda, senior nurse)

Rushton (2016b) describes it “as a commitment to ongoing exploration, refinement, or in some cases revision of one's values, ideals, and point of view” (p.112). She relates it to maintaining moral integrity. G Reese shared this observation:

The tough ones are those who've been through a lot, not just professionally but life in general.... Kind of like solid citizens: self-confident but not over-

confident; has common sense; doesn't get too worked up and can put things in perspective. (G Reese, senior nurse)

For G Reese, “*solid citizens*” were those who had significant adverse life experiences, had learnt from these experiences and regained their good enough equilibrium. I suggest that these adverse life experiences included moral adversities that challenged their moral integrity and identity.

Whilst none of the participants mentioned the devolution of moral resilience and moral integrity with recurrent negative experiences, it would be naïve to suggest that it does not occur. Rushton (2018) sees this resulting in moral suffering, injury and decline (pp. 53-54).

Openness and Acceptance of Differences

The participants recognised that to regain a good enough moral equilibrium in a pluralistic world, they needed to accept differences of views and values. They described ways in which this worldview of acknowledging the validity of other worldviews—being non-judgemental, empathetic, patient and compassionate—was often modelled in their upbringing and in their workplace, such as in this faith-based service, and arose out of past experiences and learnings. It enabled the participants to be resilient to moral challenges and regain their good enough moral equilibrium.

As senior participants described their past moral challenges and moral disequilibrium experiences, they also shared the process they undertook to work through them and their learnings. Again, comments such as “*we don't know the whole story,*” (Andi, senior allied health professional), “*even if you are right, it really is their life,*” (Angie, senior allied health professional) and “*you have to let go and respect their wishes... and choose your battles*” (Donna, physician), were conclusions following moral deliberations that caused changes in worldviews and in addressing future similar challenges. Senior nurse Riley, who was often not ruffled, also described this: “*I've been there, done that... but you also have to be open to those who might know more or see things differently.*” Riley understood that each situation was different, requiring an openness to different solutions despite similarities in presentation.

Spirituality

The participants' openness and acceptances of differences without losing their moral integrity was often based on the spiritualities informing their worldviews. Swinton

(2012), writing on the importance of spirituality in healthcare, defines spirituality as relating to

the way in which people understand and live their lives in view of their sense of ultimate value and meaning.... It can be seen as comprising elements of meaning, purpose, value, hope, relationships, love, and for some people, a connection to a higher power or something greater than self. (p. 102)

The significance of spirituality in building moral resilience appeared in many different contexts in the data. It formed the bases for participants' passion for palliative care, their values and openness to differences, and non-judgemental stances described above. According to Richardson (2002) it is also the motivation for desiring re-integration following adversity (p. 313) or in the language of moral disequilibrium, the innate motivation to regain a good enough moral equilibrium. Nurturing one's spirituality is an important part of building moral resilience.

The participants' spiritualities were the foundation for their passion for palliative care which in turn contributed to their resilience (Ablett & Jones, 2007). *"You could not do this [palliative care] if you didn't have some sort of spirituality, it grounds you... and it is all you've got when there is nothing left"* was Alex's comment. Aman, a senior allied health professional, remarked *"in the end, when there is nothing more you can do, you just have to hand it over to God."* *"Sometimes when there is no or very little reserve left, I just pray and pray, and I tell you, miracles do happen. Then you come good again"* was senior nurse Ricky's experience. For other participants like junior allied health professional Audrey, the simple explanation for desiring a return to moral equilibrium was *"because it feels right or good"* (Audrey).

At 8 am on Tuesday mornings, the pastoral care service of this organisation offered simple five-minute reflection sessions. A lit candle or another object of focus stood in a dimly lit meeting room. Staff would enter and leave quietly. The session would often begin with a quiet chime of a Tibetan bell, followed by the reading of a short reflection on the theme for the week, then silence, till the bell chimed again marking the end of the session. These well-attended sessions were open to all members of staff, were non-denominational/religious, and not compulsory. Participants found these sessions with themes such as hospitality, grace, caring and other values-based foci, very helpful in settling them and focussing them on why they do what they do. For some participants, it reminded them of their passion for palliative care and their purpose. *"It helps me re-focus on what's really important"* (Ricky), *"It calms me down and readies me for the*

day and sometimes even the week” (G Reese) and *“it reminds me of things I don’t really think about when I’m on the go, go, go.”* (Remy), were some of the comments on the benefits of these sessions. It was an opportunity for participants to reconnect with their spirit/soul/force and build resilience including moral resilience.

Self-care and Minimising Stressors

Addressing the stressors that caused moral disequilibrium was another theme that emerged from participants’ strategies to improve their moral resilience to moral challenges. This included gaining knowledge in clinical palliative care and strategies to deal with moral challenges, self-care, and the building of supportive relationships.

Junior health professionals, like Remy, felt that *“ongoing professional development including palliative care education would help my self-confidence...”* both in their professional roles and in dealing with moral disequilibrium. Audrey, a junior allied health professional, remarked: *“you don’t tend to be confused about whether something was right or wrong when you’re taught the right thing to do—the education sessions help.”* Cognitive behavioural strategies were also helpful in building moral resilience and competency according to Remy: *“The counselling sessions with EAP [Employee Assistance Program] were very helpful. They helped me to see things differently... how I have more control about things than I think.”* Gaining competency through education helped minimise stressors by alleviating uncertainties and building confidence and moral resilience.

Conversations with management regarding lack of staffing resources and advocating for better workflow systems to minimise work stress were also part of strategies to minimise moral disequilibrium. This was the recognition that the onus to build moral resilience was not solely with the participants but also lay in the organisations’ obligations and responsibilities to staff.

Unanimously, the participants named the importance of self-care, especially as *“palliative care is emotionally draining”* (Donna; G Rhonda; Remy; Alex; Audrey), and *“it wears you down wholistically—with a ‘w’ not ‘h’, not just physically but also mentally and spiritually”* (G Andrea). Attitudes and actions such as *“leave work at work”* (Andi), and *“to separate this place from my home. And I think that’s why I’ve been able to last”* (Riley), were attempts at self-care. Good sleep, exercise, yoga, meditation, journaling and relaxation apps were other self-care strategies utilised by the participants. Others found enjoying a glass of wine, going to movies with friends

and spending time with their families helped them return to “*normality from the hectic, crazy and draining activities of community palliative care*” (Riley).

G Rhonda felt strongly that caring for each other and teamwork was part of caring for self. According to all participants, nurturing good supportive relationships, both at work and outside work were essential in regaining a good enough moral equilibrium and strengthening moral resilience. These supportive relationships were safe places to “*unload,*” deliberate and discern and “*just be.*” “*Knowing that someone has my back, makes a huge difference to my resilience in all that life throws at me including the moral [challenges]*” (Ricky). These safe relationships encouraged self-knowledge: “*My husband knows me so well and tells me when I’m kidding myself*” (Ruby). There was also shared wisdom: “*there is a demand for wanting to work together... and to learn from each other*” commented G Rhonda on the feedback received in the evaluation of smaller multidisciplinary team meetings. Nurturing good supportive relationships helped build moral resilience for these participants.

Conclusion

In this chapter I outlined the themes that have emerged in participants’ responses to moral challenges. I argued for the important concept of a good enough moral equilibrium; this was the goal participants aimed for, in resolving their moral disequilibrium and distress.

I described the internal process that the participants shared when faced with moral challenges—the recognition of moral disequilibrium through emotions; the internal process of resolving the moral disequilibrium through self-reflection and moral deliberation with others towards a good enough moral equilibrium; the possible outcomes of such deliberations; and the evolution or growth of self as a person and as a health professional, as well as in moral understandings through such experiences.

I named the elements that were conducive not only to good moral deliberation but also to building moral resilience. These were the building blocks of the participants’ moral strength, integrity and resilience. In keeping with Rushton’s (2016b) and Masten’s (2007) views of resilience as an integrative concept of personal capacity, I highlighted the importance of: ongoing self-knowledge and self-reflection; openness to differences; spirituality; minimising stressors and self-care; and supportive relationships.

The rich data that emerged from this research led to the development of the novel Moral Equilibrium Framework. How the participants experienced moral challenges and

how they responded to these in positive ways are captured in this framework. In the next chapter I describe in detail the Moral Equilibrium Framework and how the application of this framework could assist palliative care health professionals regain their sense of good enough moral equilibrium with their personal and professional core values, as individuals and as members of a team.

Chapter 7: The Moral Equilibrium Framework

I guess for us, we never thought of what we were going through as moral distress... we didn't know that there was a name for it. But when you mentioned it, we recognised it straight away... well I did. I think it's better now that we can name it. (Alex, senior allied health professional)

In this statement Alex was unconsciously highlighting a gap in some health professionals' experiences when faced with daily moral challenges—the benefit of recognising and being able to name the experience. Alex and the other participants named their moral disequilibrium “moral distress” because it was the label I used in my recruitment presentation at the service's staff meeting. However, as mentioned in Chapter One, I found in my analysis that many of the experiences the participants later described as moral distress did not fulfil all the named criteria of its specific definition, which included moral wrongdoing and moral judgements. (Epstein et al., 2019, p. 114; Nathaniel, 2006, p. 421). What the participants were describing however were challenges to their moral values and ideals.

From the analysis and reflection on the moral challenges participants faced and how they navigated a resolution to their moral disequilibrium, The Moral Equilibrium Framework (MEF) emerged. In proposing the MEF, I believe that the framework fills a gap in moral distress understanding at the point where health professionals first experience moral challenges. Whilst the moral distress literature is voluminous in the description, definition and management of moral distress, there is very little research on the experience prior to the development of moral distress for health professionals. This is significant as recognition and resolution of this prior experience of moral disequilibrium may pre-empt the development of moral distress.⁹

The MEF provides a language to describe the experience of moral disequilibrium and the response to it. The MEF therefore enables health practitioners to recognise, understand and address moral challenges at this early stage of moral disequilibrium. Moral disequilibrium can begin at the point of facing a moral challenge, and if unattended to, can progress unhealthily into moral distress and other states of significant moral suffering (Papazoglou & Chopko, 2017; Rushton, 2018). If moral

⁹ However, I do acknowledge that the time frame between experiencing the moral challenge and the development of moral distress may be immediate.

disequilibrium is recognised early, it is hoped that something can be done to address it, and that the unhealthy progression into further disequilibrium would not occur.

This chapter outlines the three phases of the MEF I am proposing—identification, resolution and evolution, based on the experiences of the participants. In elaborating on the first phase of identifying the presence of moral disequilibrium, I briefly explore the role of emotions and moral values. The second phase of resolution includes the processes of reflection and moral deliberation, and taking the necessary right moral action—which may include doing nothing. The outcome of the second phase is the regaining of a good enough moral equilibrium. The MEF's third phase of evolution emphasises the learnings from such experiences so as to grow from these experiences. This includes the invitation for health professionals to clarify, affirm or re-evaluate their moral values. Each experience of regaining a good enough moral equilibrium invites the health professional to choose to do more to evolve their living of a moral life. Resolving moral challenges can also help health professionals minimise further moral disequilibrium, should similar challenges arise again, thus helping to build their moral resilience (Lachman, 2016; Rushton, 2017).

The richness and usefulness of the Framework is also contingent upon what the individual health professionals and team bring to the processes, including their attitudes and intentions. I also outline these, based on the experiences of the participants.

The Moral Equilibrium Framework

Emerging from the experiences of the participants, I offer the Moral Equilibrium Framework (MEF) as a new approach for health professionals to use in dealing with their daily moral challenges and so regain and maintain a good enough moral equilibrium. This good enough moral equilibrium may assist health professionals to continue practising their profession in a healthy way. It also encourages further evolution in their sense of self and how to live their moral values more fully. Being able to name and frame these experiences of moral disequilibrium and the processes towards their resolution, may assist health professionals to work together with greater clarity to resolve their moral disequilibrium not only as individuals, but as a team.

The MEF enables the individual and the team to achieve two goals:

1. to regain a good enough moral equilibrium when faced with daily moral challenges, hence resolving the moral disequilibrium, and

2. to grow or evolve as an individual or team in the process of (1), and so build greater moral resilience.

Moral Equilibrium Framework

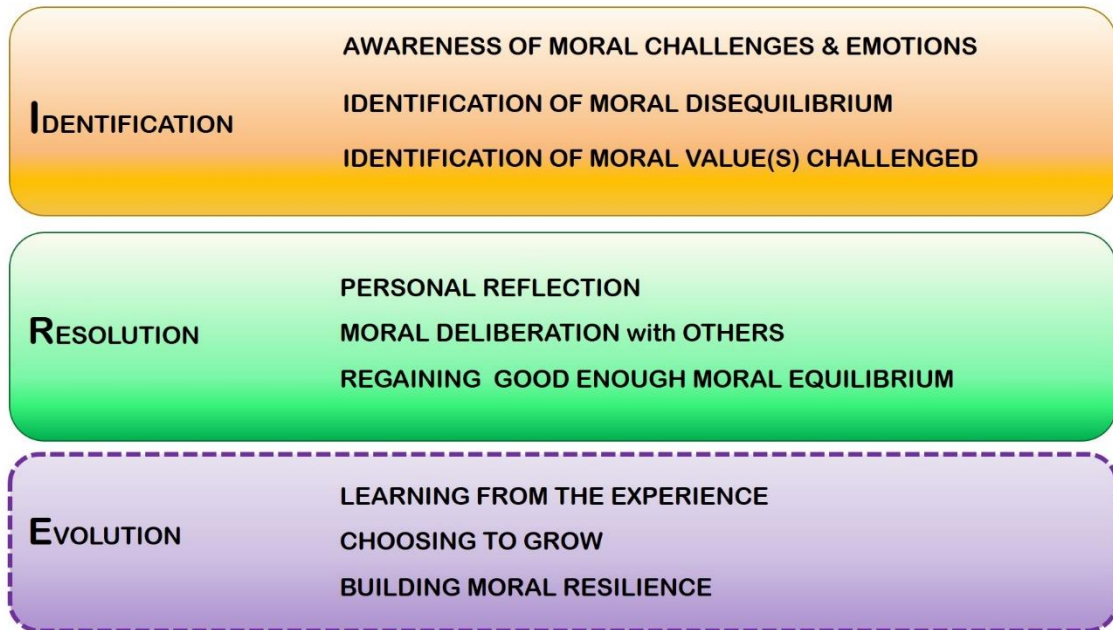


Figure 7.1: The Moral Equilibrium Framework

The MEF includes three main processes outlined in Figure 7.1. These are not fixed linear processes. Instead, it is a dynamic framework with a constant interplay between the processes involved—identification, resolution and evolution. For instance, awareness and identification of the moral values being challenged may alert the health professional to their hierarchy of values. Recognising that the moral value being challenged is negotiable may directly result in the resolution of the moral disequilibrium, without the process of moral deliberation. A second more straightforward example would be that in regaining a good enough moral equilibrium the health professional could gain self-knowledge and grow in moral understanding, thus building moral resilience. Building moral resilience would help minimise the impact of moral challenges and so minimise future moral disequilibrium.

The MEF offers a process that is dynamic, iterative and potentially leads to moral growth. In other words, the MEF’s underlying perspective is that of an integral unit, or the one entity in dynamic function, rather than linear processes. However, for the sake of simplicity I outline the MEF according to the three phases of identification, resolution and evolution. As I describe each phase of the Framework, I use an example of moral challenge that Rina a junior nurse shared that illustrates the Framework and

its processes. Whilst the moral situation and the names of those involved are altered to maintain confidentiality, the essential elements are retained. Rina was visiting a new patient to the service on a regular basis. The patient, Karen, was cared for by her husband Paul at home. Karen had breast cancer with secondaries in her spine and ribs thus pain management was a priority for Rina. Rina recalled:

One that caused me great concern was a family member who kept asking for more and more morphine for his wife. He says she's in pain all the time but every time you'd visit, she'd be drowsy. When I first met them, I just went along with it but then after a while I got sus... something's not right. (Rina, junior nurse)

Rina recognised that “*something's not right.*” Rather than dismissing the feeling, Rina noted it and pondered the situation causing it. At this stage Rina had not determined if the “*something's not right*” feeling was secondary to a clinical problem or moral disequilibrium. This stage is captured in the Framework in the process of identification of the presence of moral disequilibrium through emotions.

Identification

Awareness of Moral Challenges and Emotions.

The first step in identifying moral disequilibrium for health professionals is the awareness that moral challenges do occur in everyday encounters. Moral challenges are situations that challenge the health professionals' sense of what is morally right, which, in general, would be in alignment with the health professionals' moral values. I highlight the importance of awareness of the presence of moral challenges; naming some of the participants' experiences as moral challenges seemed to offer some relief for them in understanding the source of their feelings of unease or irritation.

Similar moral challenges affect different individuals differently and the degree of challenge varies. Some moral challenges need to be dealt with, whilst others may be minimal enough not to cause any moral disequilibrium and could be ignored. This relates to the importance of the moral values and the hierarchy of these values to the health professionals.

Moral challenges can also arise with health professionals' direct or indirect involvement in the situation. An example of direct involvement is a disagreement in management or goals of care for a patient under the care of the health professional. An indirect moral

challenge may be the observation of, but not participation in, an action the health professional perceives to be morally wrong.

These moral challenges may be anything from subtle to blatant, resulting in the corresponding spectrum of emotions. The emotions alert health professionals to the presence of moral challenges and moral disequilibrium. Thus, it is important for health professionals to be attentive to them and not dismiss them. However, there are many reasons why emotions arise in caring for patients. Therefore, it is useful to ascertain the cause of the emotion—whether it is due to the presence of a moral challenge, or to something else, such as a tragic accident or the death of a young patient.

In alerting health professionals to the presence of moral challenges, emotions can also highlight the importance of the moral value being challenged. The greater the intensity of the emotion the more likely it is that the moral value being challenged is important to the health professional. There is then a greater imperative for the health professional to address the resultant moral disequilibrium.

Associating emotions with a particular morally challenging situation can also give the health professional the opportunity to choose not to take the psychological consequence—for example anxiety or anger—into the next patient visit, or to minimise its impact on the next patient.

Returning to Rina's situation, she continued:

I started questioning the husband as to whether Karen really needed the increasing dose and each time he would say yes but couldn't say why he thinks she's in pain. It annoyed me for a while, and I started asking myself what if he is taking the morphine himself? What if he is trying to end her life? I'd be helping him and that's not right. (Rina, junior nurse)

Rina's questioning began changing from a clinical challenge to a moral challenge: was she helping the husband do something morally wrong—misappropriation of morphine for self-use or ending the patient's life prematurely? Rina was experiencing moral disequilibrium.

Once it is determined that the cause is a moral challenge, attention can then be given to identifying the specific moral challenge, to reflect on and address it, either at that point

in time or in the near future. Dealing with moral challenges as they arise within an appropriate timeframe can minimise the occurrence of moral residue¹⁰.

Identification of Moral Disequilibrium.

Moral equilibrium, as described in Chapter Five, is a dynamic state whereby the health professional's motivations, judgements and actions are coherent with their moral values, resulting in an intact moral integrity. Moral disequilibrium, on the other hand, can occur when there is incoherence between their experiences and their moral values. Identifying the presence of moral disequilibrium may alert health professionals to address the cause of the disequilibrium.

As described in Chapter Four: Moral Challenges, participants had described moral disequilibrium manifesting psychologically and/or physically in a variety of ways, from uneasy feelings or discomfort, to distress with anxiety and sleepless nights.

Unaddressed, this state of moral disequilibrium may affect the health professional's capacity to fulfil their role with compassion and efficiency, or in the manner in which they believe they should or could. Senior nurse G Reese remarked: "*it's hard to be nice and compassionate when you are anxious or worried about something else.*" It may also result in moral residue and the crescendo effect. (Epstein & Hamric, 2009). Hence the importance of identifying the presence of moral disequilibrium.

Whilst emotions alert health professionals to the presence of moral challenges, not all moral challenges result in moral disequilibrium. Moral challenges that have been explored and resolved in the past may no longer cause moral disequilibrium.

Recognition of the presence of moral disequilibrium is dependent on whether the health professionals are self-aware. There may be occasions when the individual health professional is unaware of their own moral disequilibrium but demonstrates behaviours that may suggest they are experiencing it. Examples given by the participants include irritability, "*compassion fatigue*", "*constantly complaining*", "*not themselves*" and other changes in behaviour. The care of colleagues in asking the individual if they are "okay... you seem..." may assist the health professional involved to identify the cause as moral disequilibrium.

¹⁰As described in Chapter Two: Moral Distress, moral residue is the lingering effect of unresolved moral distress, a form of moral disequilibrium. With repeated experiences of moral distress, moral residue builds up resulting in a crescendo effect whereby stronger reactions are evoked (Epstein & Hamric, 2009).

The awareness of and identification of moral challenges and moral disequilibrium is described in some detail here as a stepwise process. However, it is most likely that the emotions, stirred by the moral challenge causing moral disequilibrium, occur instantaneously. Again, what is important is that the experience is identified as moral and not due to other non-moral causes such as a natural event or the unexpected death of a child. In Rina's example, her questioning led her to moral challenges based on unfounded possibilities: was she assisting Paul in his possible drug addiction by providing morphine, or aiding him so he could end Karen's suffering by ending her life prematurely?

Identification of Moral Value(s) Being Challenged.

Knowledge or awareness of one's core values and hierarchy of values can alert the individual/team as to the cause of the moral disequilibrium, which can occur when these held values are challenged. Reflecting on the experience of moral disequilibrium in turn can help health professionals identify the moral values being challenged. Identifying these particular values, can aid health professionals make sense of their moral disequilibrium, ease the uncertainty as to what is happening for them, and give them confidence to take steps to address the challenging situation.

Knowing their hierarchy of values, especially their core values, can help health professionals in determining negotiable and non-negotiable values. In other words, by identifying the values that are being challenged, health professionals can then make choices as to whether the moral challenge can be dismissed, or whether the challenge needs to be addressed. Ridley, a senior nurse, for instance, had observed that a colleague did not appear to treat a patient compassionately which left Ridley feeling some moral disequilibrium. Ridley's moral value of compassion for patients was being challenged by the observed situation. However, she acknowledged that she put aside her value of compassion for patients when she reasoned that it might be that her colleague was having a "*bad day*" (Ridley). That is, compassion, whilst an important value, can be put aside given certain circumstances.

Recognising their moral values also enables health professionals or the team to make choices as to whether to compromise, hold on to, or modify these values, not just address the moral challenge. This evaluation of moral values may be helpful in the short term, for example in the moral deliberation process. It may also be helpful in the long term as it determines whether or not a similar situation becomes a moral challenge.

Knowing which values are being challenged also helps make sense of the experienced emotions. For instance, the stronger held values are more likely to elicit stronger emotions. This may mean that more time and effort need to be spent in resolving the moral challenge.

For some, distinguishing between personal and professional values may help determine whether to hold on to these values, or be more flexible. Some participants determined that, as professionals, their profession's code of ethics took precedence over their own personal beliefs: *"as a nurse you need to follow the nurses' code of ethics even though you may not hold them as strongly, but because you are a nurse you need to follow them"* (Randy, junior nurse). However, this view was not shared by others as G Reese, a senior nurse, declared *"the professional code of ethics are just guidelines and individual cases need to be judged individually."*

Ultimately, it is the individual and the team who need to decide for themselves what their values are, as the experience of moral disequilibrium is experienced by the individual and the team. It is important to note that moral values and hierarchy of values can change over time. With each experience of moral disequilibrium, values may be clarified, which in turn influences decisions. This may assist in the moral deliberation process for all concerned and consensus on decision-making may be easier.

For Rina, on further reflection, the value of excellence in patient care and not causing harm were the moral values and principle being challenged. She elaborated:

I think it was that I was harming the patient that got me upset or that I was helping the husband with his drug habit or even a friend. (Rina, junior nurse)

Resolution

Having identified the moral values being challenged, the next phase is to resolve the moral disequilibrium so as to be able to regain a good enough moral equilibrium and function normally once again.

Reflection.

G Rhonda, a senior nurse, found the process of reflecting whilst driving home helpful for her in navigating her moral disequilibrium. This individual internal process of recalling the moral value that is being challenged and the subsequent moral

disequilibrium, is helpful, not just for significant moral challenges but also the moral challenges that are often set aside because they are less impactful.

Gathering facts that will contribute to this reflection, health professionals then assess the accuracy of their interpretation of the moral situation. Consideration is given to possible assumptions made by the health professionals and others involved in the situation. Differences of opinions, moral values and goals of the different people involved in the situation are also reflected upon. Health professionals then decide whether further deliberation with others is needed, or whether the moral challenge could be dismissed without any lingering moral disequilibrium.

Depending on the personalities of individual health professionals and the learnt behaviours of dealing with challenges, this process of reflection may be undertaken in silent spaces, such as driving home, or in the sharing of the morally challenging experience with others. This sharing of morally challenging experiences precludes the sharing of sensitive and confidential material. From the experience of participants, this sharing is easiest and safest with people they trust, both professionally and socially. In the sharing of the experience, health professionals may find themselves reflecting on the facts, the assumptions and the nuances of the values being challenged. These reflections may help them clarify the moral challenge and resolve the moral disequilibrium themselves. According to the participants, sometimes all the listener did was listen and seek clarification.

In situations where moral disequilibrium persists, health professionals may choose to deliberate with others in the workplace. This moral deliberation process can be both informal, as in corridor conversations, or formal as in pre-arranged meetings. For Rina, it was deliberating her moral disequilibrium informally with others:

I kept thinking about it... maybe I should give him the benefit of the doubt. Maybe she is in pain... I'm not there all the time so I don't really know. But it's like she's getting too much and I'm contributing to that... she's not getting the care she deserves. He seems okay... maybe he's just scared and doesn't want her to be in pain. All this was going through my mind. I had to talk to someone... and the CNC [Clinical Nurse Consultant] was great. (Rina, junior nurse)

Rina, on self-reflection, realised that she was making assumptions as she considered the situation. These assumptions led her to believe that she was not fulfilling her value

of providing excellent care and that there was a possibility of her contributing to patient harm. These reflections did not resolve her moral disequilibrium and she “*had to talk*” to the Clinical Nurse Consultant, which led to the moral deliberation process.

Moral Deliberation.

Within the MEF, moral deliberation is key to helping resolve moral disequilibrium and regain a good enough moral equilibrium. Epstein and Hamric (2009) allude to this when they state, “the presence of moral distress indicates a lack of meaningful ethical discussion that includes all perspectives and all relevant stakeholders” (p. 2 of 19). Based on the participants’ experiences, I propose a moral deliberation process for the MEF that is both dialogical and hermeneutical building on that described by Molewijk et al. (2011).

This proposed moral deliberation process invites health professionals to self-reflect, then share their perspective and any other relevant information with others. These others (colleagues, management, spouses, or friends) in turn listen attentively, reflect on what is being said and respond accordingly. Again, sensitive and confidential information is not shared outside the workplace. This dialogical process is described by Molewijk et al. (2008) as an “open and constructive dialogue” in the “joint reasoning process” of investigating and resolving the moral question and “improving quality of care (policy)” (p. 384).

The moral deliberation process is hermeneutical in that it is relevant to the moral situation at hand. It takes into account the context, the historical background, the people involved, relationships and their dynamics, and other contingent factors (Molewijk et al., 2008, p. 121). This was noted by some of the participants in their deliberations with the Clinical Nurse Consultants, as at times the Clinical Nurse Consultants had information about the families that was unknown to the health professionals.

Emotions also have a role in this dialogical process. Emotions can alert health professionals to be attentive to the dynamic that is happening within themselves at the time of deliberation (Gillam et al., 2014; Molewijk et al., 2011). Emotions are gateways to exploration of rational thoughts, assumptions, interpretations and conclusions (Molewijk et al., 2011). For instance, a health professional may notice increasing irritability at what is being said during a deliberation. In exploring the reason for this irritability, the health professional might find that what was being said further challenged their moral values. This can be clarified with further dialogue. Another

possibility for the irritability might be that an assumption that the motivation for an action was morally wrong, and again this can be clarified with further dialogue.

I have outlined the participants' informal moral deliberation process in Chapter Six: Responding to Moral Challenges. For convenience I repeat it here. For these participants moral deliberation involved:

- the sharing of the moral challenge in a safe, non-judgemental environment;
- gathering more accurate facts about the situation and the elements involved in the moral challenge through internal and external sources;
- drawing on self-knowledge and past experiences, and ensuring that personal agendas were put aside;
- involving other members of the team;
- being open to the experiences and wisdom of others;
- utilising the dialogical process which involved an iteration process of listening respectfully, responding after further consideration and listening again till common ground was found;
- a preparedness to learn from others; and
- a willingness to change one's perspective or compromise without losing one's moral integrity, if appropriate.

In the MEF, the moral deliberation process explores the moral issues and helps resolve moral disequilibrium. Moral deliberation in this framework encourages health professionals to gain further knowledge and possibly a more comprehensive understanding of the moral issues present.

What is significant in this moral deliberation process is that the health professionals are central to the deliberation. The moral deliberation process does not impose algorithmic solutions formulated by experts that may not take into consideration all of the context or possible contingencies regarding a particular moral challenge being deliberated. Imposition of solutions is often not helpful in resolving personal moral challenges and may leave many persistent questions unanswered. In the MEF's moral deliberation process, the dialogical exploration and the hermeneutical relevance of the specific situation provide opportunities for health professionals to explore values, challenges, motivations and perceptions relevant to the moral situation and to themselves personally.

The moral deliberation process is beneficial not only to the individual health professional or team experiencing moral disequilibrium, but also to other participants of the moral deliberation process who may not be directly involved in the case or experiencing the moral disequilibrium. The learnings from the dialogical process can assist these other health professionals to reflect on how similar moral challenges can result in their own moral disequilibrium. It may also guide them to regain their good enough moral equilibrium.

In the busyness of day to day activities, opportunities for moral deliberations are more likely to occur informally. Experienced health professionals who are already stretched for time may find that informal moral deliberations address their particular moral challenges in the immediate situation and context rather than at an organised time in the future. Once resolved, and a good enough moral equilibrium is regained, health professionals can continue with their day of caring for patients.

Informal occasions of moral deliberation include corridor or tearoom conversations and reflecting on the day's events with colleagues or senior staff. Such encounters can be facilitated and encouraged by environments conducive to such interactions.

Examples given by the participants include:

- the “open door policy” at all levels of management within this service.
- the caring of colleagues with questions such as “*how was your day?*”, “*are you okay?*” and “*you look like you’ve had a big day. Would you like to talk about it?*”
- the building of supportive and safe relationships of trust and openness to differences, including through events such as social gatherings.
- education on the skills of deep listening, understanding and openness, reflecting and responding, and possibly coming to a consensus; in other words, true dialogue. Implied in this is encouragement to gain further self-knowledge and skills such as emotional intelligence, thus enabling healthy dialogue;
- informal mentoring especially of junior health professionals or those struggling with moral challenges.

The goals of moral deliberation are to regain a good enough moral equilibrium and in so doing, to learn from the experience. This was Rina’s experience as she shared:

I had a good chat about the situation with the CNC [Clinical Nurse Consultant] after I next saw the patient and asked more questions.... The CNC was great

and gave me more information about the family situation, and we talked through things, you know what's right or wrong and what to do... but we still weren't sure why the husband felt she needed more morphine. So, the CNC thought we should get the counsellor involved cos the husband said something about wanting to make sure she wasn't in pain. And a different opinion is also good. I'd gone through the signs she would have if she was in pain, but he was still uncertain, still felt she needed more. There was nothing I could do about it as he had control of her pain management and I had to leave the morphine there for breakthrough pain. The counsellor got involved... it turns out he was scared and had a whole lot of other issues. (Rina, junior nurse)

The informal moral deliberation that Rina had with the Clinical Nurse Consultant helped clarify Rina's assumptions and her sense of moral and clinical wrongdoing. The decision was made that further information was needed. This was sought through the assistance of the counsellor. Counselling helped allay the husband's anxiety that was also related to grief, and he was then less anxious about the patient being in pain.

Regaining Good Enough Moral Equilibrium.

The outcomes of moral deliberation may be varied. As explored in Chapter Six: Responding to Moral Challenges, three main outcomes emerged for this group of participants, all of which pertained to their moral integrity.

1. Affirmation of moral values and judgements with morally right actions to be undertaken. In this outcome, moral deliberation resulted in the decision that the challenge was morally wrong, and actions needed to be undertaken to right the wrong.
2. Re-alignment, refinement of, or changed moral values. Having listened to other perspectives and the reasons underlying these perspectives, health professionals may find that their moral values, interpretations of these values and their hierarchy of values may need to be re-aligned, refined or even changed.
3. Acceptance of differences in moral values and "being able to live with it" without losing moral integrity. In this outcome of "agreeing to disagree" there is openness and acceptance of the plurality of moral values. Whilst disagreeing with the conclusions of others, the health professionals were able to live with the consensus.

These outcomes generally result in the regaining of a good enough moral equilibrium. In Chapter Six, I explored the concept of a good enough moral equilibrium. I argued that to achieve a constant state of perfect moral equilibrium can be very difficult, if not impossible, given the limited healthcare resources, the unpredictable daily moral challenges and the pluralism in values and perspectives amongst healthcare professionals. I contended that achieving perfect moral equilibrium can be counterproductive to well-being, especially when all personal resources are focussed on the elusive goal of perfection. A good enough moral equilibrium allows for the maintenance of moral values with consideration given to the context and contingencies of the moral challenges faced. The good enough state is not static or fixed. I posit that the state of good enough moral equilibrium is dynamic and does not preclude future progressive development in moral understanding, or the genuine living out of moral values with each moral challenge.

Here I name again Ratnapalan and Batty's (2009) criteria of "good enough":

- There are sufficient benefits.
- There are no critical problems.
- The benefits sufficiently outweigh the problems.

In the present situation, and all things considered, further improvement would be more harmful than helpful.... (p. 240)

Resolving the moral challenge and regaining a good enough moral equilibrium enables health professionals to continue caring for patients and families without significant threat to their moral integrity and identity, or the carrying of unresolved moral disequilibrium residue. A good enough moral equilibrium means that for now, given the circumstances and the balancing of all other demands or stresses, the health professional's moral integrity is maintained. It is akin to the well-known Serenity Prayer of having "the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference."¹¹ This state of good enough moral equilibrium contributes to the well-being of both the health professional and the patients and families under their care.

Returning to Rina's experience, she explained:

We [the team] talked about it, we listened to each other, then we talked about it some more... in the end I was okay about the whole thing. In fact, I felt good

¹¹ Attributed to Reinhold Niebuhr. See <https://www.hazeldenbettyford.org/articles/the-serenity-prayer>

and could carry on. I decided I was giving her good care advocating for her, and the husband was more trusting of us. He agreed that she was getting too much morphine and learnt how to give the appropriate dose given her symptoms and signs. (Rina, junior nurse)

For Rina, the outcome of the moral deliberation was the affirmation of her moral values of excellence in patient care, including advocacy, and the regaining of her moral equilibrium such that she “*could carry on.*” This was the provision of the appropriate dose of morphine to ensure that the patient’s pain was under control. She was initially constrained from doing so as the patient’s husband, being the primary carer, controlled the dosing of morphine for the patient. Moral deliberation led to the involvement of the counsellor in dealing with the husband’s anxiety and grief. In the end the patient received the appropriate amount of analgesia and, to Rina’s relief, was receiving excellent care.

Evolution

The MEF recognises not only the importance of resolving moral challenges and the associated moral disequilibrium, it also recognises the importance of health professionals’ evolving in moral knowledge and understanding. This growing clarity of moral values and how to live out those values with integrity adds to the capacity of the health professionals to navigate the daily moral challenges they continue to face. Becoming more morally resilient to moral challenges also contributes to the moral equilibrium and well-being of health professionals, and in turn, the quality of care to patients and their families.

Learning from the Experience.

Learning is the process whereby knowledge is created through the transformation of experience. (Kolb, 1984, p. 38)

Whilst experiences of moral disequilibrium are not pleasant, they can provide opportunities for growth. Each experience of moral disequilibrium, moral deliberation and the regaining of good enough moral equilibrium, is an opportunity to learn, to gain clarity and knowledge, and to build upon what is already known (Kolb, 1984, pp. 26-27). Each time health professionals reflect, deliberate and resolve their moral disequilibrium, their moral understandings evolve. New insights through the dialogical process can help health professionals re-interpret their values, re-evaluate and refine them or even change them (Rushton, 2018, pp. 80-81). These evolving understandings

and values may in turn influence motivations, intentions and actions. Wisdom is gained with each experience.

The moral deliberation process also paves the way to learn new strategies for dealing with moral challenges. These strategies are shared by more experienced colleagues who have gained wisdom through their own past experiences of dealing with moral challenges. Health professionals may find these learnings helpful in minimising future moral challenges and moral disequilibrium.

In other words, each experience changes the individual health professional in terms of their understanding of themselves, their moral values and how they deal with moral challenges. Each experience of identifying moral challenges, the moral values involved and resolving them, may invite the individual health professionals and the team to evolve towards becoming who they envisioned themselves to be and how they see themselves acting morally. The processes outlined in the MEF may assist health professionals to maintain moral integrity in a pluralistic society.

Rina believed she grew from this experience and decided that next time she would have a different approach as she shared:

I learnt all about assumptions and that sometimes excellent care involves patience and deeper understanding without too many assumptions. After that I decided that next time I'll ask more gently and tactfully about why, instead of making assumptions and letting my mind run out like a roller coaster. (Rina, junior nurse)

Rina did not elaborate on the conversation she had with the Clinical Nurse Consultant about her moral values. Nonetheless, the opportunity to discuss them led her to affirm her value of excellent care provision. Rina learnt that living this moral value involved not making assumptions but exploring reasons as to why she perceived this value was not being met.

Choosing to Grow

Resolving moral disequilibrium and regaining a good enough moral equilibrium often result in health professionals being able to continue caring for patients, unencumbered once again. However, a few participants recognised the importance of continuing to grow from each moral disequilibrium experience. G Rhonda for instance voiced that:

Life is about growing from our experiences. The best thing is to just go through it [addressing moral disequilibrium] rather than avoiding it... it'll just catch up with you some time. (G Rhonda, senior nurse)

For these few participants, it was beneficial to actively choose to respond to moral challenges and moral disequilibrium, even when it may seem too painful or onerous. This was G Rhonda's insight:

Sometimes growing from such experiences means having to let go of who you think you are... but that's not a bad thing... so long as you become a better person. It's not about how you look to others... it's more about being true to yourself...like growing pains. (G Rhonda, senior nurse)

In saying this I noted in my journal “*like any experience it is about what you make of it: choosing to grow or choosing to be the victim*” (Field notes). Choosing to grow means choosing to evolve into a “*better person*” (G Rhonda) and live a life of greater integrity. I include this “*choosing to grow*” as a part of the process of evolution, as I believe this choice facilitates the progress towards maintaining a good enough moral equilibrium. G Rhonda commented on her observation of another participant who seemed to be constantly unhappy as someone who resisted change and wondered if an interview with me to explore her presumed moral distress might help. The interview with that participant led to exploration of her moral values and why some values were non-negotiable. As the participant related her experiences, she changed her perspective and chose instead to be more open to differences:

I think I can agree to disagree and not think they were having a go at me... as my husband said, “someone's got to grow up.” (Aman, senior allied health professional).

All I offered was a listening ear. Aman came to her conclusion by reflecting on her experience, sharing it with me and made the conscious choice to grow. Rina in her decision to do things differently the next time, also chose to grow from her experience.

Building Moral Resilience.

The third process of the evolution phase is that of building moral resilience. The greater the moral resilience, the easier it is to maintain moral equilibrium. However moral resilience, like the regaining of a good enough moral equilibrium, is not static but continually evolving. Each time health professionals take steps to build their moral

resilience they grow in confidence in dealing with moral challenges—they are not as easily “knocked down” and they “bounce back” more readily.

Building moral resilience involves having a solid foundation in meeting the many moral challenges that arise daily. For the individual, this foundation is based on, amongst other things, self-knowledge and self-care. For the team, continual and repeated informal moral deliberations can lead to heightened awareness of moral issues and the evolution of a moral community.

Self-knowledge. Growth in self-knowledge for one participant was understanding her emotional intelligence and utilising it in her communication with others. The more she familiarised herself with the underlying reasons for her emotions, the more she was able to reflect on and respond to the situation or what was being said, instead of reacting impulsively. *“You kind of have to pause and see where that [emotion] is coming from... then open your mouth”* (G Rhonda). Over the years Reska had grown in self-knowledge of herself: *“I’m a worrier and over-think things... so I’ve learnt to stop myself spiralling with my thoughts”* (Reska). Health professionals understanding their own assumptions, motivations, reactions, and utilising their emotional intelligence can help them obtain a clearer perspective on the moral challenge before them. The more health professionals continue to evolve in their self-knowledge, the more beneficial that knowledge is in addressing their moral disequilibrium and in engaging in moral deliberation.

Self-care and Care for Team. The promotion of self-care and care for others is also important in minimising moral disequilibrium and building moral resilience. Living a well-balanced life enables individuals to better deal with challenges (Cheshire et al., 2017). When there was an imbalance in their psychological, social, physical and spiritual health participants found themselves more vulnerable to the moral challenges they faced.

So much more was happening in my life that really this [the moral disequilibrium/distress] was the last straw. I crashed and needed time off... We’ve heard of self-care, but that was for others... we are tough.... Well, I wasn’t that tough. (Rani, senior nurse)

According to senior health professionals G Reece, G Rhonda, Alex, G Andrea and others, building moral resilience includes leading a well-balanced life, with enough time for all other important aspects of life—relationships, exercise, sleep, healthy

eating, mindfulness practices such as yoga and meditation and other resilience building practices. This is also affirmed in the literature (Epstein & Krasner, 2013; Rushton, 2017; Stutzer & Bylone, 2018).

Unanimously, the participants believed in the importance of self-care. This was emphasised especially by senior health professionals and palliative care consultants, speaking from past experiences of not caring for themselves. Recommendations for self-care are also prominent in moral distress and resilience literature (American Nurses Association, 2017; Debra et al., 2007; Epstein & Krasner, 2013; Rushton, 2018; Sanso et al., 2015).

As individuals in constant relationship with others, caring for self inevitably also implies caring for others (G Rhonda). In caring for each other, a sense of community can be engendered leading to supportive relationships and greater moral resilience. As G Rhonda commented:

When we care for others, we are really also caring for ourselves. Relationships improve and we are less stressed and can focus our energies on caring for patients. (G Rhonda, senior nurse)

Whilst it is important for health professionals to take responsibility in caring for themselves, organisations can have a role in encouraging and facilitating their staff to care for themselves. Providing self-care days where health professionals learn ways of caring for themselves and reflecting on whether their lives are well-balanced are important. This was affirmed also by most of the participants when the service held two self-care days.

Moral Community. Dharamsi (2006) defined moral communities as “those that share ethical concerns, value pluralism, have a keen sense of social responsibility, and strive for a broader moral identification and sense of duty beyond social, economic, cultural, or political differences” (p. 1235). These common characteristics and goals can contribute to the moral resilience of members of the community, and the team as an entity, in the support they provide each other. In the context of moral disequilibrium, this support of each other may also be in assisting each other in resolving moral challenges and disequilibrium, towards the living out of their common and shared values. This could involve moral deliberations in safe, respectful and non-judgemental environments. Attitudes of openness to “value pluralism” also facilitates the

maintenance of moral and relational integrity¹² which in turn helps build moral resilience. Through caring, supportive relationships, moral communities could also assist members who are unaware that they are experiencing moral disequilibrium, when this is apparent to those observing their behaviours (Wilson, 2018).

Two themes emerged from the data that led to my inclusion of the process of teams evolving into moral communities in the MEF. Firstly, there was a sense of belonging to a community of like-minded people with similar or common values and intentions—*“we are in it together”* (G Andrea, senior nurse) and

We are more than workmates, we’re a community. We tend to want the same things for our patients. We care for each other, help out when others are struggling.... (G Rhonda, senior nurse)

Secondly, there was a sense of individuals caring for each other in their various roles. This sense of caring and belonging with no real sense of “each person for themselves” was noted by a number of participants—nurses, allied health professionals, doctors and administration officers. For some this sense of care and belonging, not experienced elsewhere, was a strong attraction to continue working within this service.

I posit that underlying this care for each other is mutual respect, trust and openness to differences in the psychosocial and spiritual aspects of colleagues. These are elements that are conducive to, and enhance, moral dialogue. Qualities of respect, trust and openness engender safe, non-judgemental environments that allow for discussion and discernment of moral values, intentions, behaviours and actions that are part of one’s identity. “Speaking up” and sharing what constitutes the individual’s identity can put a person in a vulnerable position. Hence moral communities that hold their members without judgement allow for good, open communication without the need to be defensive.

Engendering a sense of moral community cannot be enforced. Genuine relationships are built on trust and grow with time. However, I argue that the palliative care context is conducive to the growth of a moral community. This sense of community, of individuals uniting towards a common and shared purpose of caring for patients, is

¹² Relational integrity as mentioned in Chapter 6 is defined by Rushton (2018) as “a communal stance that embraces one’s interconnection with others who share a common humanity and the broader ecosystem one resides within. In clinical practice, it is the ability to be grounded in one’s own moral principles and commitments whilst interfacing with others in ways that do not impose those values on others or discredit or disable the integrity of others” (p.129).

akin to the palliative care philosophy of holistic care provision by an interdisciplinary team.

I think we really need to practice what we preach. We talk about working as a team and palliative care offers a whole person approach to dying... but really this thing about working together as a team is relatively new. Depends on who you talk to, we do work well as a team with our different expertise and time constraints. I think here, more than anywhere else I've worked, we do that... of course with all things, there is always room for improvement. But in general, we are a good community. (G Rhonda, senior nurse)

In a well-functioning moral community, professionals within each discipline have their own role and expertise and come together sharing insights, wisdom and experience in the care of the patient (Austin, 2007). Thus, each member of the moral community is a valued contributor to the shared moral values, motivations, intentions, behaviours and actions of the whole group.

Pavlish et al. (2014) describe moral communities as “characterised by respectful team relationships, timely communication, ethics-minded leadership, readily available ethics resources, and provider [health professional] awareness and willingness to use ethics resources” (p.130). The authors based their conclusions on their empirical study of participants working in acute and clinic-based oncology settings as well as academia. Pavlish et al. go on to describe the benefits of moral communities which I suggest are significant in minimising moral disequilibrium at a team level. The benefits include a sense of common moral purpose; the ease and comfort of routine moral deliberation through repeated practice; and rich interdisciplinary moral deliberation, to name a few. The authors add an important consideration: “transforming systems of care into moral communities where interdisciplinary dialogue, deliberation, and documentation on ethical considerations becomes expected, comfortable and routine...” also recognises “the collective moral obligations and mutual accountability” (p. 137-138). Pavlish et al. also emphasise the need for sensitising health professionals to ethical conflicts (or moral disequilibrium), and so respond “rapidly, effectively and efficiently” to ethical issues (and moral challenges). Transforming existing interdisciplinary teams into moral communities can more easily occur if supported by the management and organisation.

Elements Contributing to the MEF

In the introduction I stated that the richness and usefulness of the Framework is contingent upon what the individual health professionals and team bring to the processes, including their attitudes and intentions. Based on the experience of the participants, attitudes of openness to differences and to change, being respectful of plurality of thoughts, values, beliefs and spirituality promote effective moral deliberations and the regaining of a good enough equilibrium.

Self-respect and being non-judgemental of differences, being flexible and adaptable yet maintaining moral integrity, are other considerations in determining the potential usefulness of the MEF. Recall the conflict of the patient preferring to have pain rather than drowsiness, and the nurse's belief that a patient being pain-free is good nursing care; the nurse may be less inclined to experience moral disequilibrium knowing that her ultimate value of respecting a patient's autonomy is upheld. This flexibility and openness to difference, might have been the result of resolving similar past experiences of moral disequilibrium and learning from them, or in reflecting on their colleagues' experiences.

An attitude of seeing adversities as opportunities for growth encourages health professionals to meet the moral challenges with hope and creativity, rather than with resignation and despair (Dweck, 2015; Yeager & Dweck, 2012). This optimistic attitude encourages health professionals to engage more fully in moral deliberation and is also more likely to build moral resilience and minimise moral disequilibrium.

MEF and Team Moral Disequilibrium

The description thus far of the MEF has been focussed on the individual health professional. I argue that this framework is also relevant for the team as an entity in their experience of team moral disequilibrium.

For the participants, awareness of team moral disequilibrium arose during informal conversations about patients, or during the many multidisciplinary team meetings, as individual health professionals voiced their concerns and found their colleagues experiencing the same emotions or moral challenges. Almost always the Clinical Nurse Consultants would be involved in the subsequent moral deliberations. In the application of the MEF this would be no different, especially if the Clinical Nurse Consultants were more alert to the presence of team moral disequilibrium. The subsequent processes in the resolution and evolution phases were similar to those for

the individual health professionals as for the team as an entity. Informally these were evident in the multidisciplinary meetings.

Senior nurse Reska recalled the moral challenge the team faced during one of their multidisciplinary team meetings:

I remember discussing a patient and their family at one of our huddles [short multidisciplinary team meetings usually held three times a week]. The partner was a very aggressive man and the patient's GP wasn't very easy to get hold of either... and when you did get hold of him he would always contradict our advice. The funny thing was when I mentioned it at the meeting the other nurses who visited the patient also had the same problem and were also wondering how to handle it. So did the social worker. Suddenly we realised that the whole team including the doctor, were in the same dilemma. The patient needed the analgesia; the GP couldn't be convinced to increase the dose even though our palliative care doctor spoke to him; the husband didn't want to give her more than the GP advised; and we could see she was in pain. It's wrong that she is in pain and we needed to do more to advocate for her, but we were stumped as to what to do. I think we were all in moral distress cos' we knew it was wrong that she was in pain... we weren't doing our job. We all talked about it, and in the end decided that really apart from taking the case to court there was nothing more we could do.... We reminded ourselves that we can only do what we can do. (Reska, senior nurse)

For Reska and the team recognising that there was similar discomfort amongst the team members helped them identify the presence of team moral disequilibrium. The moral challenge was to the moral value of providing excellent patient care which included ensuring adequate analgesia and advocating for the patient for more analgesia from the GP and the husband. They informally deliberated on the moral challenge during the multidisciplinary meeting. The resolution was that their moral value was affirmed and that given the circumstances, there was nothing more they could do apart from taking the GP and husband to court which would most likely cause more harm than benefit. Recognising this led to a state of good enough team moral equilibrium such that they could continue their daily tasks without moral residue. The growth was the affirmation and the acceptance that there were situations that were beyond their control. There may have been a further strengthening of their relationships as a moral community.

Limitations of the MEF

The MEF is derived from the experiences of this particular group of specialist palliative care health professionals within a specific context. The participants were a relatively stable group of staff in a faith-based organisation, practising in a community setting, as palliative care health professionals. As such, the scope for the current offering of this innovative framework is limited to this particular context until further research is undertaken across various groups and settings.

Specific to this group of participants was the culture and relationships that had been established and built over a significant number of years—turnover of staff was low. There was a level of trust that enabled openness to differences of perspectives and a sense of a very supportive community. According to most participants the hierarchy of authority within the multidisciplinary team was not as evident compared to the acute sector. These were positive contributions to the functionality of the MEF. The usefulness of the MEF has not been tested in settings where there are high turnovers of staff with less opportunities for developing trusting and stable relationships.

The organisation was faith-based, and whilst it drew many health professionals of different faiths and spiritualities, the participants, in general, shared common values and goals. How helpful this MEF would be in the context of a greater plurality of moral values in a different setting is yet to be determined.

The MEF was also developed in the setting of community health where it can be argued that the relatively slow pace of healthcare would allow for more opportunities for informal moral deliberations. The versatility of this framework in other settings such as in acute healthcare, in adult or neonatal intensive care units where most of the moral distress research is based, is an important topic for further research.

The participants were also specialists in palliative care—a speciality with a focus on holistic care of patients, families and loved ones and where the authoritarian hierarchy is not as evident. In situations where the hierarchy of authority is enforced and there is no facilitator to moderate the power-play that can happen, the outcome of constructive informal moral deliberation is unclear. As described in Chapter Six: Responding to Moral Challenges, the palliative care philosophy is also holistic and team-based, with less evidence of competition. How effective the MEF would be in the competitive environment of acute care and other specialties is an area for future exploration.

In a broader context the MEF and its processes may not be as beneficial or fruitful if they are not endorsed or supported by the organisation. Opportunities for moral deliberation need to be encouraged and outcomes involving further actions supported by the organisation. With appropriate training and encouragement from organisations the MEF has the potential to make a substantial difference to the well-being of those who encounter moral challenges in their daily living.

Conclusion

This research project began with the intent of filling a gap in the moral distress exploration—how moral distress is experienced, and responded to, by specialist palliative care health professionals in an Australian community health setting. There was a secondary aim of contributing to the clarification of the definition of moral distress where consensus is lacking in the existing literature.

The findings instead led to addressing another significant gap in the larger moral challenge understanding—the experience of health professionals at the point of encountering a moral challenge, and prior to it escalating to moral distress. The term “moral disequilibrium” captures the state of being that health professionals experience when the moral issues they face challenge their moral values. “Moral disequilibrium” is the umbrella term that can capture the various moral states that caused researchers to broaden the definition of moral distress.

What emerged from the findings of this project is my proposal of the Moral Equilibrium Framework, comprising the three phases of identification, resolution and evolution. The goal is not to achieve perfect moral equilibrium but a good enough moral equilibrium that enables health professionals to continue caring for patients and families without being encumbered by unresolved moral disequilibrium.

Whilst individual health professionals assume responsibility for themselves within the framework, the identification, resolution and evolution processes are most beneficial when undertaken with others. As such, ongoing transformation of teams into moral communities benefits not just the individual but the team, the service/organisation, and the patients and their carers.

For the participants, the MEF would give them a language and a reference point in which to frame what they were doing to navigate their moral disequilibrium. The MEF may help clarify and simplify the processes already being utilised by the participants. Clarification of the processes may also encourage creative improvements of the same

processes. Naming the resolving process they were already using as moral deliberation, may alert the health professionals to any additional elements that might be helpful for them to bring into the deliberation process, such as attitudes and intentions.

In short, the MEF names and formalises for the participants what they were doing to address their moral disequilibrium. The framework encourages the participants and potentially other health professionals to further enforce their practice of “identification, resolution and evolution,” and to do so with clearer intent and awareness of what is required to further enrich the processes involved.

The scope of the MEF as presented in this chapter is limited to experiences of this group of community specialist palliative care health professionals. However, I envision the potential of this novel framework as relevant in wider sectors of society. Until more research is done on the benefits and relevance of the MEF in the broader health sector and beyond, in the next and concluding chapter I shall confine my recommendations on how this MEF can be developed to be even more useful within the context of community specialist palliative care.

Chapter 8: Conclusion—Becoming

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time.

(Eliot, 1959, p. 59)

T.S. Eliot's words in the final section of his *Four Quartets* capture this project well. The “place” described by Eliot was the experience of moral distress amongst community specialist palliative care health professionals, in a faith-based service. In my exploration, I discovered that the “place” was bigger than moral distress *per se*. The experience these health professionals described was more congruent with moral disequilibrium, and their response was to regain a good enough moral equilibrium.

In Chapter One I described my interest in the area of moral distress and the general context within which I undertook this project. This included: specialist palliative care services in Victoria, Australia; community-based healthcare in Victoria; and the multidisciplinary team approach to healthcare.

I began this research project with the question: “how do specialist palliative care health professionals, in the community setting, experience and respond to moral distress?” However, the data led me to a different, as yet unexplored, dimension of the moral distress exploration. I discovered that the participants had a bigger perspective on their experiences than moral distress itself.

My literature review on moral distress identified gaps in the moral distress research, such as a lack of consensus on the definition of moral distress and the paucity of moral distress research in countries other than the United States, although this is growing (Chapter Two: Moral Distress). I also described the significant impact of moral distress on the individual, team and organisation identified in the literature, hence the importance of exploring the moral distress phenomenon further.

Without preconceived ideas or expectations, my exploration followed the methodological approach of combined ethnography and interpretive phenomenology (Chapter Three: Methodology and Methods). Situating myself within the service for more than 700 hours, I collected rich data which included in-depth interviews, informal conversations, observations, unobtrusive data, and reflective and reflexive

journaling. The participants described the daily moral challenges they faced in caring for patients and families, working as part of a multidisciplinary team in the community setting (Chapter Four: Moral Challenges). Whilst some of the moral challenges they named resembled those in the acute care setting, others were more specific to community-based health services. Examples given include constraints in administering appropriate dosages of medications, as carers were the ones giving patients the medications; and negotiating with specialists and general practitioners, some of whom had different goals of care.

What emerged from the data was that participants were experiencing a larger phenomenon than moral distress. Participants' comments such as feeling "*out of kilter*" or "*uneasy*" led me to name the experience as moral disequilibrium (Chapter Five: Moral Equilibrium). The moral disequilibrium described by the participants in this workplace resulted from challenges to their moral values and moral integrity. Their lived experiences of moral disequilibrium encompassed experiences of moral dilemmas, moral conflicts, moral outrage, moral distress, and other moral challenges and moral sufferings (Mänttari-van der Kuip, 2019; Rushton, 2018). These latter experiences have led others to call for a broader definition of moral distress (Campbell et al., 2016; Fourie, 2015; Hanna, 2004). I propose that adding the moral equilibrium/disequilibrium dimension to the taxonomy of moral distress brings greater clarity to moral distress understanding. Moral disequilibrium is the umbrella experience ranging from mild (moral dis-ease, moral discomfort), to progressively severe moral disequilibrium (moral distress, moral outrage, moral injury, moral decline or moral dysfunction and disintegration).

The participants' responses to their moral disequilibrium (Chapter Six) led to the development of the Moral Equilibrium Framework (Chapter Seven) and its associated strategies in addressing moral disequilibrium.

At the end of this project's exploration, I had indeed arrived where I started and "knew the place for the first time" (Eliot, 1959, p. 59). The place I had envisioned as moral distress, I now see as moral disequilibrium. To conclude my exploration, I name three main contributions of this research to the knowledge of moral experiences in specialist palliative care health professionals in the Australian community setting, and moral distress understanding. I also propose a number of recommendations based on my research.

Significant Contributions of this Research

The Concept of Moral Equilibrium

Moral equilibrium is the ongoing state of balance experienced by individuals (or teams) when their moral values and the expression of these are, in general, aligned. The expressions of these values are manifest through the moral intentions, motivations, judgements and actions of the individuals. It is a dynamic equilibrium in that, if the environment changes and challenges the individuals' moral values, the individuals in turn will adapt to maintain their moral integrity. If other contributions to the equilibrium are affected, the capacities to adapt to the challenges are also affected. These include their psychological, spiritual and physical well-being.

This new concept of Moral Equilibrium draws on the lived experiences of health professionals and, in a practical way, helps health professionals make sense of their experiences when faced with daily moral challenges. It adds a dimension to the understanding of moral distress based on data obtained, beyond surveys and intermittent interviews. It is based on ethnographic research of being embedded in the workplace of health professionals observing their day to day interactions, picking up nuances and information that surveys and interviews may not.

Moral *disequilibrium* names the experiences of health professionals at the point where their moral values are being challenged and they are unable to adapt so as to maintain their moral integrity. These challenges to moral values can vary from minor to significant for individuals. The more important the moral values are to the individuals the greater are the perceived challenges. It is likely that the more situations or people who contest the individuals' moral values, the greater are the perceived challenges.

Whilst it may be argued that moral equilibrium equates to moral integrity, I posit that there is a difference. I argued in Chapter Five that moral integrity describes the state of cohesion of moral values, motivations and actions. Moral equilibrium on the other hand also brings into consideration the constant challenges and resilience to this state of moral integrity. As mentioned, it takes into consideration the individuals' or teams' well-being—including their psychological, spiritual and physical well-being—that supports or makes vulnerable their capacity to resolve the moral disequilibrium. Regaining moral equilibrium involves the processes that come into play when individual health professionals attempt to achieve and maintain moral integrity. Such processes gave rise to the Moral Equilibrium Framework.

Having a positive perspective also has a role to play in the well-being of individuals and the team. Moral disequilibrium does not necessarily infer a negative experience, a suffering or a sense of failure. Rather it can be described as an “off-balance” experience, with an invitation to take steps to get back into balance. The moral equilibrium concept also encourages the perspective of seeing the experiences as opportunities for growth.

As mentioned, “moral disequilibrium” encompasses participants’ experiences of moral dilemma, moral confusion, moral conflict, moral outrage and other moral challenges. Classifying these experiences as moral disequilibrium negates to some degree the call to broaden the definition of moral distress. In other words, moral disequilibrium can be considered the umbrella experience resulting from moral challenges, be they dilemmas, conflicts, uncertainties, distress or other causes of moral suffering as described by Rushton (2018) and others (Campbell et al., 2016; Fourie, 2015; Mänttari-van der Kuip, 2019; Wocial, 2016). This enables researchers to explore moral distress according to the specific definition of moral distress given by Jameton (1993) and Epstein et al. (2019). This is also true for research into the other categories of moral disequilibrium experiences such as moral injury, moral outrage and so forth. The concept of moral equilibrium is also foundational to the development of the Moral Equilibrium Framework.

Moral Equilibrium Framework (MEF)

This research provided the participants with opportunities to reflect on and voice their lived experiences of encountering daily moral challenges, not just moral distress. The participants described the steps they undertook to resolve these challenges, and how in doing so, they had grown in their moral understandings and confidence in themselves as individuals and health professionals (Chapter Six: Responding to Moral Challenges). Through grounded theory analysis, and reflexive and reflective approaches, the Moral Equilibrium Framework emerged (Chapter Seven).

This framework is of itself an original and significant contribution to addressing the moral challenges that specialist palliative care health professionals face daily in the community setting. Whilst it is a novel framework that reflects this group of health professionals, I suggest it has the potential to be useful for other health professionals from various disciplines and in similar settings, and possibly in wider settings and sectors. The Moral Equilibrium Framework and its processes are useful in a number of ways.

The MEF provides a frame and a common language for what was already being practised by a multidisciplinary team of community specialist palliative care health professionals in Melbourne, Australia. This framing and naming may facilitate the processes for navigating the moral challenges these health professionals face daily, either as individuals or as a team. For instance, being familiar with the MEF, the health professionals may be more likely to undertake moral deliberation with confidence and ease, knowing what to expect, and be assured that everyone else understands and agrees to the goals. This in turn may facilitate the moral deliberation process.

Whilst moral distress and moral disequilibrium may be viewed as a failure of personal moral courage in the face of moral challenges, the MEF offers positive connotations to these challenges. The Framework is based on the understanding that moral disequilibrium occurs as a consequence of engagement in a pluralistic society with diverse moral values and views. The MEF suggests processes to name the moral values, identify the presence and causes of moral disequilibrium and to resolve these so as to regain a good enough moral equilibrium. A good enough moral equilibrium enables health professionals to provide healthcare in their respective roles, unencumbered by moral residue. The processes of the Framework also encourage the transformation of these potentially negative experiences into positive growth experiences, thus help build moral resilience. (The anagram of MIRE may aid in recalling the three phases of the **M**oral **E**quilibrium **F**ramework—**I**dentification, **R**esolution and **E**volution.)

The MEF goals are for health professionals to regain a good enough moral equilibrium, and to grow as individuals or team in the process (Chapter Seven). In doing so the individuals' or team's moral integrity, identity and moral agency is likely maintained, and potentially further developed and strengthened.

Another benefit of the MEF is that it emphasises a more realistic goal of good enough moral equilibrium rather than the ingrained expectation that health professionals provide the best care regardless of capacities (Ungerleider & Ungerleider, 2019). There is a perception that healthcare is about excellence and anything short of excellence is not good enough (Callahan, 2009; Kaplan & Patterson, 2008). Whilst this paradigm is commendable it does not take into consideration the resources and capabilities of the individuals involved (Robeyns, 2005) and the well-being cost to the health professionals. Fortunately, this perception of what constitutes a good health professional, in particular for doctors, is changing (Ratnapalan & Batty, 2009; Smith, 2003). The MEF approach reinforces the attitude of good enough, that is, excellence

that is contingent upon capabilities and resources at the time, and with encouragement towards advocating and building further capability and resources for the future.

The MEF and its processes can also encourage the building of supportive relationships. As social beings it is through relationships that individuals grow and refine their moral values and build moral resilience. For the participants, the working environment of mutual respect, safety in their vulnerability, acceptance of differences, openness to learning and change, were significant in their discernment and exploration of what was important to them. Listening deeply to each other's moral values and the various points of view and actions, aided in the understanding of each other's motivations and reasons behind such motivations. This understanding in turn helped in the development of caring relationships which consequently built moral resilience. These would also help build moral communities.

The above are but some of the many uses and benefits of the MEF for health professionals in this setting of community palliative care. Further research may also reveal other benefits in other settings in health care. However as moral distress, hence, moral disequilibrium is also experienced across other disciplines and sectors such as academia and business, its usefulness may extend to other sectors.

Team Moral Disequilibrium

Another contribution of this research to moral distress exploration is that it provided evidence that *team* moral distress and *team* moral disequilibrium do occur. The moral distress literature has predominantly focussed on the effect of moral distress on the individual. However, this project revealed that in this setting of community specialist palliative care, the health professionals also experienced moral disequilibrium as a team. Recall in Chapter Five that the participants unanimously named respecting patient autonomy as a shared core value. The majority of participants also named justice or equity of service as another shared core value. It would perhaps be fair to assume that there were other core values that the participants shared as a team. When these shared moral values were challenged, the team as a unit experienced moral disequilibrium. This was evident in the corridor conversations that occurred resulting in team and managerial moral deliberation. It included contradicting values and goals between the team and others involved in patient management such as general practitioners, oncologists and even patients themselves.

Whilst there is some literature on intrateam moral distress, for example moral conflicts between members of a team (Bruce et al., 2015; Rushton, 2016b; Thomas et al., 2016; Vincent et al., 2020), the situation of team moral distress or moral disequilibrium has not been previously identified. I suggest that team moral distress/disequilibrium is another gap in the moral distress literature and that more attention needs to be given to its existence and management.

This is important to acknowledge, as whilst the MEF would be relevant in addressing team moral distress and moral disequilibrium, other considerations would also be relevant. For example, the determination of common and shared goals and the significance of relational integrity (Rushton, 2018, p. 90-99) mentioned in Chapters Five and Six.

Recommendations

The novel MEF is based on the experiences of specialist palliative care health professionals in the community setting, hence its relevance is in this particular setting. Reflecting on the recommendations made in the moral distress literature described in Chapter Two, I believe more can be done to strengthen the MEF's usefulness and/or to develop it further. This research has also highlighted the contribution that organisations and health professionals can make in minimising moral disequilibrium, which in part also contributes to the usefulness of the MEF. I thus make the following recommendations:

- Include formal moral deliberations in the MEF—moral case deliberation and clinical supervision with ethical mindfulness.
- Encourage organisational contributions to MEF processes including facilitating opportunities for moral deliberation, supporting moral deliberation outcomes and educating health professionals on the MEF.
- Minimise moral disequilibrium:
 - Encourage strategies for health professionals to minimise moral disequilibrium including building moral resilience.
 - Encourage organisational strategies to minimise health professionals' moral disequilibrium including minimising causes of stress and facilitating the development of moral communities.

MEF—Formal Moral Deliberation

The moral deliberation process in the MEF was based on informal deliberations that occurred as the participants sought to resolve their moral disequilibrium. Reflecting on the processes involved and other proposed solutions to moral distress in the literature I believe that formal moral deliberation would be an important addition to the moral deliberation process in the MEF. Formal moral deliberations tend to be not as immediate, nor necessarily specific to those attending, hence may not seem to be as inviting for health professionals already stressed and hard pressed for time. However, formal moral deliberations have their own advantages. I recommend two formal or organised settings for moral deliberation: moral case deliberation and clinical supervision with ethical mindfulness.

Moral Case Deliberation (MCD)

Whilst formal moral case deliberation was not instituted in this service, I argue that for more complex moral challenges, moral case deliberation may be beneficial in regaining good enough moral equilibrium (Molewijk et al., 2008; Rasool et al., 2016). MCD are regular facilitated multidisciplinary meetings, offered as part of ethics education within healthcare institutions (Molewijk et al., 2008). The trained facilitator, an ethicist or someone trained in ethics and conversational methods, “foster[s] an open and constructive dialogue amongst the participants, keep[s] an eye on the moral dimension of the case, support[s] the joint reasoning process and help[s]... plan actions to improve the quality of care (policy)” (Molewijk et al., 2011, p. 384).

Hence, in the formal setting, moral deliberation not only explores the moral issues but also situates health professionals as central to the deliberation. Molewijk et al (2011), explain that the “primary goal of a moral case deliberation session is to create a critical and respectful moral inquiry into both the moral issues in a clinical ethics case and the [diverse] way[s] the participants feel and reason” (p. 384). MCD can assist health professionals navigate the resolution of moral disequilibrium.

The deliberation process can also help health professionals evolve in their moral understandings and develop skills to navigate future moral disequilibrium. In situations where MCDs are open to other health professionals indirectly involved or those not involved in the clinical case, these other health professionals may also benefit. These MCD meetings may offer them the opportunity to reflect on how similar moral challenges could result in their own moral disequilibrium and guide them in regaining

a good enough moral equilibrium. Contributions from health professionals not involved in the case can also add new perspectives to the group's moral deliberation.

The presence of a facilitator who is skilled in ethics and the dialogical process also provides the expertise that a number of scholars believe is necessary for complex cases (Doran et al., 2015; Fuscaldo et al., 2019; Sokol, 2005). This expertise can also counter possible arguments that informal moral deliberations may be too insular, focusing on specific moral values of health professionals which may not reflect normative ethics. In my observations the conclusions that the participants arrived at, following informal moral deliberations, were not contrary to those of normative ethics,¹³ and often included the principles of beneficence, non-maleficence, autonomy and justice. Nonetheless, the ethical approach underpinning the MEF is that of value pluralism, argued for in Chapter Five: Moral Equilibrium.

Another form of formal moral case deliberation that would be beneficial in regaining a good enough moral equilibrium is Clinical Ethics Consultations. These consultations have been found to be helpful in addressing moral distress (Austin, 2017; Gold et al., 2011; Rasoal et al., 2017). Thus, I recommend its inclusion in the formal moral deliberation process of the MEF. In general, in Australia, these consults are conducted by a sub-group of the organisation's clinical ethics committee in situations where ethical advice is sought urgently. In the Australian context these urgent moral case deliberations are conducted under the auspices of the organisations' or local health districts' clinical ethics committees. Some clinical ethics consultations may include the patient and/or family members in their deliberations. Examples of these formal moral deliberations include the Clinical Ethics Response Group at the Royal Children's Hospital, Melbourne (Gold et al., 2011) and those provided by the New South Wales Health Clinical Ethics Committees (NSW Ministry of Health, 2015).

Clinical Supervision with Ethical Mindfulness

As the practice of clinical supervision can vary from discipline to discipline, the Australian Clinical Supervision Association broadly defines clinical supervision as “a formal professional relationship between two or more people in designated roles, which facilitates reflective practice, explores ethical issues, and develops skills. ...it includes individualised development and personalised support” for the clinician (Australian Clinical Supervision Association, 2018). Clinical supervision can be offered both in an

¹³ Normative ethics, in general include ethical approaches such as virtue ethics, deontology, consequentialism. Exploration of these ethical approaches in moral deliberation is beyond the scope of this discussion.

individual or group setting. Generally, clinical supervision meetings are held with no set agendas and are focussed on any clinical issues that may arise in the course of the health professionals' clinical work.

However, in the context of moral challenges I believe these formal, regular, prearranged meetings can be helpful avenues of exploring moral challenges and moral disequilibrium. If supervisors are encouraged to be “ethically mindful”, that is, “being sensitized to, and engaged with, the ethically important moments that arise in everyday practice” (Guillemin et al., 2009, p. 197) in their supervision of health professionals, opportunities to address moral disequilibrium may not be lost. This would be especially so for those who: have not found the right opportunity to explore their moral disequilibrium; are reluctant to raise their moral disequilibrium at the formal moral case deliberation sessions; or who do not realise that what they are experiencing is moral disequilibrium. Reasons for the reluctance to raise experiences of moral disequilibrium may include believing that the moral challenge is “*too minor*” or “*stupid*” (Remy, junior nurse), lacking in self-confidence or feeling unsafe or vulnerable. Exploration of health professionals' moral disequilibrium in this one-to-one or group context may be another avenue for health professionals to regain a good enough moral equilibrium. Thus, I strongly recommend the inclusion of formal moral deliberation in the Moral Equilibrium Framework.

MEF—Organisational Contributions

Participants have noted that in their experience of regaining moral disequilibrium organisations had a significant role. Whilst they found ways to deal with their moral disequilibrium, many participants believed that the organisation also had a role in and responsibility to enable them to do so more easily. Reflecting on their comments and the suggestions in the literature I recommend the following organisational contributions.

Facilitating Opportunities for Moral Deliberation

Opportunities for organisations to facilitate the resolving of moral disequilibrium and to encourage moral growth amongst the health professionals include:

- the institution of formal moral case deliberations;
- the availability of ethics resources, including establishment of clinical ethics committees and opportunities for case consultations;
- the encouragement of informal moral deliberations with opportunities for ethics

- education as part of professional development offerings;
- the availability of individual and/or group supervision; and
- the encouragement and training opportunities to build moral resilience, including self-care.

Supporting Moral Deliberation Outcomes

Giving a voice to health professionals who feel disempowered, especially when it comes to expressions of identity-conferring values, and supporting health professionals in their deliberated actions, are important ways organisations can help staff regain a good enough moral equilibrium.

Where the deliberated morally right actions cannot be supported by the organisation, for example for legal reasons, then transparent and genuine conversations with the relevant health professionals are also recommended, in the spirit of trust.

Organisational attitudes of respect and valuing staff do help engender relational and moral integrity.

Education on MEF

The Moral Equilibrium Framework is one important pathway in addressing moral disequilibrium. I believe it is a significant offering to health professionals who experience daily moral challenges in caring for patients. I noted in my field work journal following comments from participants about being able to name their experiences of moral disequilibrium: *“Being able to label the experience as moral distress was perhaps the first step of empowerment or encouragement to do something about it”* (Field notes).

The MEF may prove to be a helpful framework for participants beyond the scope of this project and at all levels of practice. If so, it could be introduced during the course of training health care professionals. Other opportune times could be during staff orientation into organisations, and/or as ongoing professional development, and at executive and governance levels. I believe it would benefit not only the individual and the team, but also the service, the organisation and ultimately, the patients and families for whom they care. At my recent thesis completion seminar *Moral Distress, Moral Equilibrium and the Moral Equilibrium Framework* attended by over 40 health professionals including palliative care physicians, nurses and several research participants, attendees commented that the moral equilibrium concept and the MEF would be very relevant to their everyday practice.

Minimising Moral Disequilibrium

The third group of recommendations is to minimise the causes, impact and experiences of moral disequilibrium. Moral disequilibrium is experienced by individual health professionals and/or teams and the contributions to this disequilibrium have been described in Chapter Five. Therefore, whilst health professionals themselves can choose to take steps to minimise moral disequilibrium and build moral resilience, organisations can also support the health professionals to do so, leading to a happier and healthier workforce (Hamric et al., 2012). This approach of considering improvements at different levels is essential (Chapter Two: Moral Distress). Rumbold (2012) in his excellent article on restoring compassion in palliative care and healthcare called for approaches that involve: health professionals being compassionate; organisations, systems and structures that enable health professionals to be compassionate; and a society that promotes compassion. Whilst this holistic approach would be invaluable in minimising moral disequilibrium, I shall limit myself to making the following recommendations for both health professionals and organisations in this thesis.

For Health Professionals.

During the course of this project most participants expressed appreciation for the opportunities to reflect on their experiences of moral disequilibrium and insights gained on how they can minimise their moral disequilibrium. These insights have reinforced the importance of building moral resilience in minimising the incidence and impact of moral challenges for health professionals. It demonstrated the importance of self-knowledge, self-care, and an ongoing openness to growth in moral understandings and skills, in addressing moral challenges and maintaining moral integrity. Self-knowledge includes awareness of personal moral values, worldviews, spirituality, vulnerabilities, and the dynamics involved when health professionals relate to others in meeting moral challenges.

Building moral resilience not only applies to the individual but to the team. Awareness of the teams' shared values, worldviews, and the informal and formal moral deliberation processes engaged when meeting moral challenges may also build the team's moral resilience and minimise team moral disequilibrium. Caring for each other and the development of moral communities may also add to the building of moral resilience.

If this can be encouraged in all health professionals and facilitated by the organisations employing them, it is likely that health professionals will have greater moral resilience when faced with moral challenges. Whilst this urging is not new for individuals (American Association of Critical Care Nurses, 2004; Austin et al., 2005; Back et al., 2016; Epstein & Krasner, 2013; Rushton, 2016b, 2018; Stutzer & Bylone, 2018), what this research offers is affirmation that in this cohort of community specialist palliative health professionals, it is just as relevant and important. It is also relevant in minimising team moral disequilibrium.

For Organisations.

Organisations are urged to have moral values and ethical practices amongst their highest priorities. This is important not only for the moral integrity of the organisation, but also for the moral and general well-being of their most valuable asset: the human resource. Incorporating good moral values and ethical practice into policies and procedures and in the day to day management of the service, not only attests to the organisation's moral integrity but would also lead to its good reputation and thus attract high calibre staff, and ultimately excellent patient care. One testimony to this could be in organisations taking initiatives to minimise staff moral disequilibrium.

This research, congruent with the moral distress literature (Corley et al., 2005; Hamric, 2000; Svantesson et al., 2017), emphasizes the contribution of organisations to the experiences of moral disequilibrium and moral distress. Alongside the MEF, what has also emerged from the data are recommendations for organisations to minimise staff moral disequilibrium.

I highlight two contributions that have emerged from the data, that organisations can make to mitigate moral disequilibrium amongst their staff: minimising systemic causes of stress for health professionals; and facilitating and encouraging the developing of moral communities.

Minimising Systemic Causes of Stress

Workplace stress has been named as a significant cause of stress contributing to moral distress (Atabay et al., 2015; Dodek et al., 2019) and moral disequilibrium. The management of this service recognised the contribution of time-consuming procedural requirements on the overall stress of their health professionals. A consultant was engaged to recommend a more efficient procedure when triaging and admitting patients. Though this was still being discussed when I finished my field work it was an

example of how organisations can help minimise causes of stress for their staff. Such a review of the procedures and required documentation in order to improve efficiency might give staff more time with patients and opportunities to have tea and lunch breaks. This better balance of work:break ratio might improve health professionals' well-being and resilience to daily moral challenges.

Where possible, alleviating stress through adequate staffing and resources might also give health professionals more time with patients. This in turn may alleviate the moral disequilibrium resulting from perceived inadequate caring for their patients because of time constraints. Whilst this was a familiar "wish" amongst the participants, they also recognised the funding constraints of the organisation. G Rhonda, a senior nurse in middle-management suggested that "*it's about working smarter not necessarily harder.*"

Good communication, transparency and collaboration between management and health professionals in organisational decision-making was named by the participants as important mitigators of stress and moral disequilibrium. Knowing the reasons behind decisions, for example, helped build their moral resilience and capacity to adapt to changes. These are doable actions that organisations can take to minimise work stress.

Facilitating the Development of Moral Communities

Whilst the development of moral communities is reliant on respectful and supportive relationships of the health professionals themselves, the organisation has a role in facilitating and encouraging the development of such communities. Encouraging moral consciousness amongst health professionals is important and can be facilitated by those in positions of authority leading by example. Highlighting organisational values as bases for the development of policies and procedures would be an example of prioritising moral values.

Encouraging relationships of trust, respect and deep listening amongst staff may be facilitated by policies and actions that demonstrate openness, transparency and good communication. An example of this was the service manager's support of the Tuesday morning reflections instigated by two members of the pastoral care team in this service (Chapter Six: Responding to Moral Challenges). Such programmes offer opportunities for health professionals to reflect regularly on aspects of their moral values, their moral identity, meaning and purpose, thus raising moral consciousness within the team.

Limitations of Research and Future Research

This research is significant, both in filling gaps in the moral distress knowledge, as well as in the proposal of a new framework that guides community specialist palliative care health professionals in addressing moral disequilibrium and growing from these experiences. Its limitation however lies in its current specificity. Both the concepts of Moral Equilibrium and the Moral Equilibrium Framework are based on the experiences of a group of 70 specialist palliative healthcare professionals working in a faith-based organisation within a community setting in Australia. The participants were predominantly women with a broad range of professional and life experiences, and in general, knew and related well with each other. Whilst the data are consistent with some of the empirical research in the moral distress literature, and fill some of the gaps outlined in Chapter Two, the results and conclusions of this study are currently limited to this particular cohort and setting.

Further research could explore other cohorts and settings. It may be that in different settings and different groups, further modifications need to be made to the framework. Additional research could investigate the significance of the various contributions of personal attributes, spirituality, worldviews, and past experiences in the development of moral disequilibrium. It could also explore the impact of external influences such as culture, gender and health systems, on the experience of moral disequilibrium. For instance:

- Would a group comprising men and women in relatively equal numbers have the same tendency to informal moral deliberation?
- Does the philosophy of palliative care as a specialty contribute to the ways with which health professionals resolve moral disequilibrium? This project suggests it does, but further investigation is needed with more empirical studies.
- Would the processes in the Moral Equilibrium Framework differ in different cultural settings?
- Would acute health care settings with more health professionals, and arguably faster paced workflow, be conducive to the processes suggested in the Moral Equilibrium Framework?

The specialist palliative care service was a growing, yet relatively small service. It is not known if opportunities for informal moral deliberation or the transformation into moral communities are more difficult in larger organisations where relationships may be more distant. Further research may answer this question. Whether the Moral

Equilibrium Framework could facilitate the development of moral communities proposed by other authors (Hardingham, 2004; Pavlish et al., 2014; Traudt et al., 2016) by encouraging more open communication and deliberations is another research question.

When I began this project, I saw the opportunity to explore various aspects of moral distress in the service within which I did my fieldwork. My focus has been on moral equilibrium and the Moral Equilibrium Framework. Further explorations could include:

- how health professionals from various disciplines—alleged health, nursing, or medical—differ in their experience and response to moral disequilibrium as part of a multidisciplinary team;
- aspects of community settings that influence experiences of moral disequilibrium and how these were different to the participants' experiences in acute care/hospital settings;
- the role of leadership and management in the experiences of moral disequilibrium.

Conclusion

In answer to my original research question of “how do specialist palliative care health professionals, in the community setting, experience and respond to moral distress?” I would give this answer: specialist palliative care health professionals in the community setting experience moral distress as moral disequilibrium, and their response is outlined in the Moral Equilibrium Framework.

Naming the experience of being challenged morally as moral disequilibrium adds an empirical-based dimension to moral distress understanding. It may assist, in part, in addressing one of the many distractions to moral distress research—the constant call for a broader definition of moral distress. The awareness of the presence of moral disequilibrium does not negate research into moral distress, or any of the other moral challenges or sufferings that others have sought to include in the definition of moral distress. In fact, it was against the backdrop of moral distress research that the phenomenon of moral disequilibrium emerged as being more in keeping with the participants' lived experiences. The participants were not concerned about whether the experience was moral distress, moral conflict, or moral dilemma. They just knew it was “not right.” Nonetheless the readily available and relatively voluminous moral distress

literature also informed the development of the concept of moral disequilibrium and the Moral Equilibrium Framework.

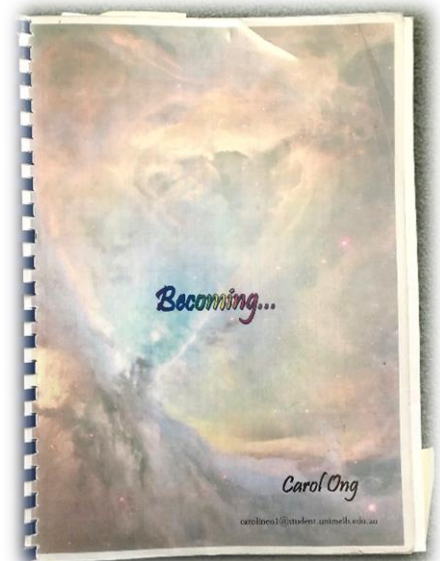
The “end of all my exploring” (Eliot, 1959, p.59) is to also recognise that the experience of moral disequilibrium is not a pathology, rather it is an inevitable part of the experiences of life as a healthcare professional. Through this new lens, the MEF provides a constructive approach to working with moral disequilibrium and using the learnings as stepping stones towards growth and moral well-being. Within this paradigm, the health professionals, teams and the organisation, all have their respective contributions and responsibilities to help mitigate the negative impact of moral disequilibrium and assist in the building of moral resilience.

Maintaining the dynamic of a good enough moral equilibrium for the individual health professional, the team, the organisation, and ultimately the patient and their family is, I believe, worth the effort, maybe even the struggle, of meeting these moral challenges as creative opportunities for growth.

Eliot’s description of the process of discovering something new with each experience is part of life’s process of “becoming...”. What we finally “become” is unknown in the here and now. Hopefully, it will include becoming more resilient, becoming wiser, happier, and more compassionate in our care for others. I return to a participant’s quote which captured my attention from the beginning and came back to me often throughout this research: “*I am first and foremost a human being*” (G Andrea), and I add, always in relationship and in the process of becoming.

With Eliot (1959), I find that at the end of all my exploring, I arrived where I started and knew the place for the first time (p. 59). Before beginning this journey of doctoral research, the word “becoming” was present in my consciousness such that I entitled my research journal “Becoming...”. Having now come to the end of this journey, I understand the significance of the word.

Fig. 8.1 Research Journal



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APPENDIX A—Plain Language Statement and Consent Form



THE UNIVERSITY OF
MELBOURNE

PARTICIPANT INFORMATION AND CONSENT FORM

Centre for Health Equity
Melbourne School of Population and Global Health
Faculty of Medicine, Dentistry and Health Sciences

| | |
|---|--|
| Title | How is Moral Distress Experienced by Community Palliative Care Health Professionals? |
| Short Title | Moral Distress in Community Palliative Care. |
| Coordinating Principal Investigator/ Principal Investigator/ PhD Student | Dr Caroline Ong rsm [Phone number and email address given] |
| Research Supervisors | Dr Ros McDougall, University of Melbourne. [Phone number and email address given] Dr Marilyns Guillemin, University of Melbourne. Dr Eleanor Flynn, University of Melbourne |
| Location | [stated]. |

Part 1 What does my participation involve?

1 Introduction

You are invited to take part in this research project, which is called “*How is Moral Distress Experienced by Community Palliative Care Health Professionals?*” You have been invited because as specialist palliative care health professionals you have unique experiences that would be valuable in understanding the ethical challenges of your work.

This Participant Information Sheet/Consent Form tells you about the research project. It explains the processes involved in taking part. Knowing what is involved will help you decide if you want to take part in the research.

Please read this information carefully. Do ask questions about anything that you don't understand or about which you would like to know more. Before deciding whether or not to take part, you might want to discuss it with a relative, friend or colleague.

Participation in this research is voluntary. If you don't wish to take part, you don't have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- understand what you have read.
- consent to take part in the research project.

- consent to be involved in the research described.
- consent to the use of your personal and health information as described.

You will be given a copy of this Participant Information and Consent Form to keep.

2 What is the purpose of this research?

The aim of this study is to explore the experiences of community palliative care health professionals when they feel they are unable to act according to what they believe is the right thing to do. This may result in a feeling of distress, known in the literature as moral distress.

The project hopes to help understand how community palliative care health professionals recognise and respond to these situations and the factors that may contribute to this experience. Whilst there is an abundance of literature and research on moral distress in nurses in acute care, there is very little known about how moral distress is experienced by community palliative care health professionals. This research hopes to begin to fill this gap. If more can be understood about moral distress perhaps more can be done to alleviate it.

This research is part of my doctoral thesis at the University of Melbourne. It is not funded by any grant nor is it sponsored. The results of this research will be used by me to obtain a Doctor of Philosophy degree, under the supervision of Dr Rosalind McDougall, Professor Marilyns Guillemin and Associate Professor Eleanor Flynn within the Melbourne School of Population and Global Health. The research will be monitored by the supervisors with whom I will be in regular contact.

3 What does participation in this research involve?

Should you agree to participate, you will be invited to contribute in any one or more of the following ways:

1. Consent to observation and note-taking of your contribution in clinical team **meetings**. With the consent of participants, I will be an observer at these meetings. I am interested in the occasions where there may be an emerging conflict of moral opinions which can cause unease for individual team members. I would like to understand how these occasions arise and how they are handled. It is hoped that these observations will continue for 12 months.
2. **Interviews**. You may wish to accept invitations to be interviewed to explore further any situations observed at meetings. You would also be welcome to volunteer for interviews at any time. These interviews may last approximately 30-60 minutes. They can be held during break times or after hours so as not to disrupt your work. With your consent, they will be audiotaped. The interview can be stopped at any stage and/or any information withdrawn at any time prior to its analysis.

At any time during the project if there is any information shared that you would prefer not included in the project please let me know.

The information you share will be analysed alongside information from others, and emerging themes noted. It is hoped that these themes explored in the context of [name of service] and with the current academic literature on moral distress, may further increase our knowledge of this phenomenon.

It is anticipated that this field work will be undertaken for a period of approximately 12 months. This will be predominantly at the Sunshine campus and may include observation of meetings at other sites. The consent form will need to be signed before the research can begin.

There are no costs associated with participating in this research project, nor will you be paid.

4 Other relevant information about the research project

It is hoped that all staff will take part in the project. This will allow for a better understanding of the influences that contribute to moral distress and its complexities.

5 Do I have to take part in this research project?

Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. It will also be possible to withdraw any information you have contributed prior to the information being analysed. If you wish, you can take part in some of the components of the project but not others, for example, observation in team meetings but not interviews. If you wish to withdraw you may do so by contacting me or the supervisor, Dr Ros McDougall. (Please see contact details above or below.)

If you do decide to take part, you will be given this Participant Information and Consent Form to sign and you will be given a copy to keep.

Your decision whether to take part or not to take part, or to take part and then withdraw, will not affect your relationship with other staff or your relationship with [name of organisation].

6 What are the possible benefits of taking part?

There may not be a direct benefit to you, but findings from this research may add significantly to further understanding and knowledge of the complex phenomenon of moral distress. It will also begin to fill the current knowledge gap of how specialist palliative care professionals experience it. Moral distress has been shown to negatively affect the well-being of individual healthcare professionals, as well as negatively impact all levels and sectors in healthcare. In becoming more aware of it in daily practice, healthcare professionals, like yourselves, may be able to minimise its negative effect before it escalates. Knowing the moral issues that may arise within palliative care, organisations may be able to put into place processes that can help minimise moral distress.

7 What are the possible risks and disadvantages of taking part?

There is a small possibility that you may experience unease or distress during an interview for a variety of reasons. At all times, you have the choice of whether to continue or stop. If you become distressed because of your participation in the research project, counselling or other appropriate support will be offered, for example [the service's] employee assistance program with [name of company] (Tel: [number given] Email: [email given]). Any ongoing counselling or support will be provided by qualified staff who are not members of the research team. This counselling will be provided free of charge.

Confidentiality is paramount in any of the observations or interviews and every possible action will be taken to ensure anonymity. Pseudonyms will replace the names of all participants as information is collected and these pseudonyms will be used in all subsequent publications. All interviews will be confidential and their contents not shared with other members of the team. The only exception to this will be if it is anticipated that the participant intends self-harm or harm to another, or if there is clear evidence of illegal and/or serious unprofessional behaviour that requires mandatory reporting on my part as outlined by the Australian Health Professional Regulation Agency. There may be a possibility that during the course of the interview, you may become more aware of the misconduct of a colleague or a team member and the duty to report the person. You will be encouraged to do so through the usual pathways, though strict confidentiality will be maintained by the researcher whether you choose to do so or not. Please note that it is not the focus of the research to identify or address any misconduct of staff members.

As the group of participants is small and all work together, it may be possible for participants to identify other participants. As there are only a few community palliative care services in Victoria, there may also be a possibility that the service will be identifiable. However, every attempt will be made to maintain confidentiality. This will include using pseudonyms, changing details whilst ensuring that the information will not be compromised, combining information from different participants so that they are not readily identifiable and not mentioning the geographical area of the service.

If patients are discussed during the meetings their personal details are not recorded and their histories are altered to protect their identity.

8 What if I withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify either the researcher Caroline Ong or Dr Ros McDougall before you withdraw. If you do withdraw, you will be asked to complete and sign a 'Withdrawal of Consent' form; this will be provided to you by the researcher.

If you decide to leave the research project, no additional personal information from you will be collected, although personal information already collected and analysed will be retained to ensure that the results of the research project can be assessed properly. Prior to analysis your information may be withdrawn. If you do not want your information to be included, you must let me know when you withdraw from the research project.

9 Could this research project be stopped unexpectedly?

Though very highly unlikely, this research project may be stopped unexpectedly for a variety of reasons including a change in circumstances for the researcher.

10 What happens when the research project ends?

The research findings will be reported back to you and other participants in the project, if you are interested. Any feedback would be gratefully accepted. The outcome of the research findings will form part of my doctoral thesis, which would be made available to any participant who would like a copy. The completed and published thesis will be made available through public theses databases such as Minerva.

As well as this, the results will be presented at conferences, meetings and seminars, and in publications for academic and other audiences. A newspaper opinion piece highlighting some of the ethical difficulties palliative care health professionals face and the impact of these on them may be written to advocate for change, is also possible.

Part 2 How is the research project being conducted?

11 What will happen to information about me?

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be easily identified. There may be a small likelihood that your team members can identify you given the nature of your group. Confidentiality will be maintained using pseudonyms, or by altering identifying details. Another way of maintaining confidentiality will be to combine a variety of stories into one representative story.

Your personal information will be protected. Your name and contact details linked with the interviews will be held in a separate password protected computer file and will be used only to contact you.

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to request access to the information about you that is collected. You also have the right to request that any information with which you disagree be corrected. You may contact me if you would like to access your information.

Any information collected including audio recordings of interviews, transcripts, notes from meetings will be stored electronically, password protected and backed up on three separate storage devices, and/or in locked filing cabinets, in accordance with Melbourne University's data storage policy.

All data will be stored securely for a further period of five years after the project ends. After this the data will be deleted. Access to this data lies with me.

In accordance with the National Medical Health and Research Council guidelines, the Human Research Ethics Committee is required to conduct audits of research projects from time to time. It may therefore be possible that the Human Research Ethics Committee which has approved this research, will seek to view a copy of your signed consent form, or to contact you, to ensure that the research is being conducted according to the ethical standards required by these guidelines.

12 Who can I contact if I have any concerns about the project?

This research project has been approved by the Human Research Ethics Committee of [organisation's name]. If you have any concerns or complaints about the conduct of the project, which you do not wish to discuss with me, you should contact:

[Organisation Name]: [contact name] Administrative Officer, Human Research Ethics Committee tel. [given] or email [given] for referral of this concern to the Human Research Ethics Committee.

All complaints will be treated confidentially. In any correspondence, please provide my name or the name or ethics ID number [number given] of this research project.

13 Who is organising and funding the research?

This project has no direct funding.

14 Is there any potential conflict of interest?

As well as a researcher, I am also a general practitioner, a Sister of Mercy and a member of several ethics committees, [names of committees given] However, my role here is as a researcher only. Confidentiality is paramount and my approach is that of one seeking to learn from others, without prejudice.

Currently I have no patients under the care of [the service]. Should there be an occasion when a patient of [the service] needs a GP, I would refer them to another GP in the clinic.

15 Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).

The ethical aspects of this research project have been approved by the HREC of [organisation]. This approval is also registered with the Ethics Committee of the University of Melbourne.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007)*. This statement has been developed to protect the interests of people who agree to participate in human research studies.

16 Further information and who to contact

The person you may need to contact will depend on the nature of your query. If you want any further information concerning this project or if you have any problems which may be related to your involvement in the project, you can contact me or any of the following persons:

Research contact person

| | |
|-----------|---|
| Name | Caroline Ong |
| Position | Research Student / Principal Researcher |
| Telephone | [Phone number given] Or text me to arrange a time to meet. |
| Email | [email given] |

Complaints contact person including any ethical concern

| | |
|------------|--|
| Name | [name given] |
| Position | Administrative Officer |
| Department | Human Research Ethics Committee, [organisation name] |
| Telephone | [phone number] |
| Email | [email address given] |

Research Academic Supervisor

| | |
|-----------|---|
| Name | Dr Ros McDougall |
| Position | Primary Supervisor, University of Melbourne |
| Telephone | [Phone number given] |
| Email | [email address given] |

Participant Information Sheet/Consent Form

Health/Social Science Research - *Adult providing own consent*

| | |
|---|---|
| Title | How is Moral Distress Experienced by Community Palliative Care Health Professionals? |
| Short Title | Moral Distress in Palliative Care. |
| Coordinating Principal Investigator/ Principal Investigator/ PhD Student | Dr Caroline Ong rsm Tel: xxxxxxxx Email: xxxxxxxxxxxxxx] |
| Research Supervisors | Dr Ros McDougall, University of Melbourne. Tel: xxxxxxxxxxxxxx Email: xxxxxxxxxxxxxx Prof Marilys Guillemin, University of Melbourne A/Prof Eleanor Flynn |
| Location | [xxxxx] |

Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language that I understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my job.

Please indicate if you do not wish to participate in certain aspects of the project e.g. in-depth interviews:

I understand that I will be given a signed copy of this document to keep.

If I have an ethical concern, I can contact the Administrative Officer, Human Research Ethics Committee [given] for referral of this concern to the Human Research Ethics Committee.

I consent to the [organisation] Human Research Ethics Committee which approved this study to access my information, or to contact me to ask about my research experience, in order to ensure that the project is being run in accordance with government standards.

| | | |
|--|------------|--------------|
| Name of Participant (please print) _____ | | |
| Contact details: | Ph: _____ | Email: _____ |
| Signature _____ | Date _____ | |

I would like feedback on the results of the project.

Declaration by Researcher

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

| | |
|---|------------|
| Name of Researcher [†] (please print) _____ Caroline Ong _____ | |
| Signature _____ | Date _____ |

[†] An appropriately qualified member of the research team must provide the explanation of, and information concerning, the research project.

Note: All parties signing the consent section must date their own signature.

APPENDIX B—Question Guide

These questions were used only as a guide when the conversation/interview did not flow easily, except for the demographic questions which were asked of every participant.

Demographics

- How long have you worked at [organisation]?
- How long have you been working in the palliative care field?
- Age group?

Moral distress

- What is the best thing and worst thing about working in palliative care?
- What is the best and hardest thing about working in [organisation]?
- Are there many moments of discomfort? Or distress?
- What are the circumstances?
- What are some of the ethical issues you are confronted with each day?
- What are some of the external factors affecting your ethical practice?
- Do you feel safe and supported raising these issues?
 - With the team
 - With the manager
 - With the wider team
- Were you familiar with the term “moral distress” before this research?
- Do you have a memorable patient? Can you tell me about her/him?

Multidisciplinary Team

- What are the best and most difficult thing about working in a multidisciplinary team?
- Do you think there is more or less moral distress than if you weren't?

Palliative Care

- Do you think working in palliative care makes a difference to your experience of moral distress?

Community Setting

- What are the best and most challenging aspects of working in the community setting?
- Have you experienced more moral distress in the community or hospital setting? Why?

Do you have anything you would like to add?

APPENDIX C—Letter of Invitation



THE UNIVERSITY OF
MELBOURNE

Centre for Health Equity
Melbourne School of Population and Global Health
Faculty of Medicine, Dentistry and Health Sciences

Dear

My name is Caroline Ong and I am a PhD student researcher at Melbourne University. I would like to invite you to take part in a project which forms part of my doctoral research. I am interested in exploring how health professionals working in community specialist palliative care experience moral dilemmas and how they manage them.

Whilst there is significant literature on nurses and their experiences of moral dilemmas in hospitals, very little is known about how this is experienced by health professionals in community palliative care. [Service name] is known for its excellence in providing palliative care to the community and as such can make a significant contribution to knowledge in this area. I hope to spend time at [Service name] to receive whatever information staff might like to share.

If you would like to learn more about this project or would like to participate in it, please contact me:

Email: [email given]

Phone or text: [mobile number given]

RESEARCH TITLE: How is moral distress experienced by community palliative care health professionals?

STUDENT RESEARCHER: Caroline Ong (PhD student)

SUPERVISOR: Dr Ros McDougall
Email: [email given]
Centre for Health Equity
Melbourne School of Population and Global Health
The University of Melbourne

With thanks

Caroline Ong

APPENDIX D—Non-consent to Participation



THE UNIVERSITY OF
MELBOURNE

Centre for Health Equity
Melbourne School of Population and Global Health
Faculty of Medicine, Dentistry and Health Sciences

Non-Consent to Participation.

Full Project Title:

How is Moral Distress Experienced by Community Palliative Care Health Professionals?

I do not consent to participate in the research project described above and understand that such a decision WILL NOT jeopardise my relationship with [organisation name] establishment.

Name (printed)

Signature

Date

APPENDIX E—Withdrawal of Consent



THE UNIVERSITY OF
MELBOURNE

Centre for Health Equity
Melbourne School of Population and Global Health
Faculty of Medicine, Dentistry and Health Sciences

Withdrawal of Consent Form

Full Project Title:

How is Moral Distress Experienced by Community Palliative Care Health Professionals?

I hereby wish to WITHDRAW my consent to participate in the research proposal described above and understand that such withdrawal WILL NOT jeopardise any treatment or my relationship with the [organisation named].

Participant's Name (printed)

Signature

Date