Moral Regret - The Experience of Breaches of a Nursing Ideal

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Nurses are idealistic. Nursing itself is an ideal. In the author's previous research the ideal of the "good" nurse was a strong motivator, as was the ideal of "good nursing care", for nurses who wanted to practice ethically (Wurzbach, 1996a). When not practicing ethically the belief was that the nursing ideal "good nursing care" had been breached (Wurzbach, 1996a).

Recently, Johnstone and Hutchinson (2015) called for abandoning the construct of "moral distress". For various reasons, they believe that too much attention is paid to it in the nursing literature, that the studies are not sound and that calling for action to relieve moral distress may be a moral imposition in the lives of our patients, families and colleagues. In the author's own research, nurses are more likely to follow an "influence taboo" and purposefully try not to have influence in the ethical decisions of patients, residents and family members as well as colleagues (Wurzbach, 1995).

There is one overriding concern about abandoning the construct of moral distress and that is that the phenomenon exists in the professional and personal lives of nurses despite the terminology. A belief that the ideals of nursing are frequently breached is common among practicing nurses resulting in moral distress.

A construct is a manufactured concept with certain properties while the phenomenon of moral distress actually exists, independently of whether anyone studies or examines it. Whether the concept is called moral distress is another matter. In the author's research the experience of

nurses was that of the concept of moral regret or in a qualitative sense “looking back”. A concept (not a construct) existed independently for many nurses - independently of the organization and of others. The author titled it moral regret or “looking back.” It was a concept that so clearly existed and was experienced by so many nurses personally and professionally that the author made it one of her primary concepts of interest in nursing ethics.

The “construct” of moral distress does exist also but little time has been spent studying the ethical aspects of it. Several aspects of the “organization” have been studied because Jameton (1984) early on defined it as the inability to take moral action based on organizational restrictions. The antecedents to moral distress according to Whitehead, Herbertson, Hamric, Epstein & Fisher (2015) are in the literature and are identified as: practice in an adult setting, direct care-giving, lack of provider continuity, poor team communication, futility in end-of-life (EOL) care, and working with incompetent nurses.

Moral distress generally is defined as the inability to act upon one’s perceived moral obligations or values. In the author’s research the concern of nurses wasn’t an inability to act upon their obligations or values. Nor were nurses unable to be moral agents (Yarling & McElmurry 1986). The concern of nurses was the ethical concern of “knowing what the ‘right’ choice to make is”. The concern was not institutional restrictions or an inability to take action. Many nurses did not want to influence the decision – the influence taboo but, wanted to “know” what the “right course of action” would be if they chose to take action.

The reason moral regret is so important is because it leads to shame, guilt, feelings of loss of control and many nurses equate it with a judgment about their competence as a nurse (Wurzbach, 2008). With moral distress the consequences requiring alleviation are burn-out and possibly leaving a position or perhaps leaving nursing (Whitehead et.al. 2015). With moral regret the penalty is even higher - nurses feeling shame, guilt and incompetence as nurses. With moral distress apparently one can leave the situation and the distress. With moral regret the pain is intrinsic to the individual. Leaving an organization or institution will not alleviate the shame, guilt or feeling that somehow one did something wrong.

In addition, with moral distress the organization can be reformed or practices can be reformed. With moral regret the only solution is to see the outcome as “not me” – to see the outcome in much the way moral distress is seen – as requiring action to reform the system. Moral regret requires changing oneself. The shame, guilt, fear, competence questioning, loss of control, counterfactual thinking (undoing) and loss of sleep are all consequences.

There are many antecedents to moral regret but the one major overriding experience prior to moral regret is moral uncertainty. The nurses in both acute care and long-term care identified the aspects of moral uncertainty that lead to moral regret.

Moral uncertainty is defined by the author as the inability to “know” what the “right” course of action is when confronted with an ethical issue. Many factors prevent a belief that one “knows” what to do in any given situation. Choices and situations are complex and having a sense that one “knows” what to do is difficult under most circumstances in health care. To

"know" generally suggests in the philosophical literature that one is morally certain about what to do.

The definition of an ethical dilemma is a choice between equally unsatisfactory alternatives and commonly occurs in nurses professional lives as well as their personal lives, given that they frequently are the first person that a family member contacts. The nurses the author studied believed many ethical aspects of a situation kept them from "knowing" what to do.

These aspects of ethical situations are sundry and varied. There are conflicts of principles, conflicts of duties, and differing views about what is "good" for the patient. In some cases the priority of a principle was a conflict. Some practitioners believe beneficence (caring) is the most important principle, others believe in autonomy (self-determination). Some believe in justice as the most important principle but there are multiple ways of defining justice.

Duty conflicts may be conflicts between nurse and family, nurse and institution, nurse and patient, or nurse and colleagues. Nurses have conflicting duties to patients, their families, colleagues, supervisors and the organization. Conflicts of duties most often result in moral distress. Differing views of what is "good" for the patient also may affect futile treatment in EOL care – a conflict between a duty to the patient and to society. The priority of a value – the sacredness of life - may also be a factor.

Ethical decision-making frameworks have been taught for many years but, even so, there may be factual knowledge gaps or situational uniqueness interfering with gathering sufficient

information quickly enough to resolve a dilemma. There may be uncertainty about which principles apply to a unique situation. There may also be principles not often taught and differing from culture to culture – fidelity and honor. There may be different definitions of caring, fidelity, honor, truth-telling and other principles. The definition of a principle frequently determines the solution to the issue. Accurate definition of a problem is half of its solution. Inexperience with applying principles may also occur.

Many times it is believed that principleism solves dilemmas easily but conflicts of values, principles, priority of principles, and duties make applying principles difficult. The situational uniqueness found in casuistry is one of the most common causes of moral uncertainty. There may be a sudden change in a situation such that the "known" "right" action changes as the outcome changes. As the nurses in the author's studies state, once one begins a solution the outcome is believed to be appropriate. When the outcome changes despite the belief in the action moral regret may ensue. Or when the situation changes and there is no time to change the decision, moral uncertainty and indecision occur, possibly accompanied by moral regret.

Belief in a "right" course of action and a choice to follow that course of action, followed by a sudden situational change, often leads to moral uncertainty and questioning. Some of the questions these nurses had were: (Wurzbach, 1996a)

What will the outcome be?

What will outsiders think?

What was and is the "right" thing to do?

Was the decision made initially “right”?

What will be the consequences given the change?

There are also outcomes that lead to moral regret - participating in actions leading to a poor quality of life for the patient or the use of scarce resources for minimal benefit. Having a responsibility to patient, family, doctor, colleagues, and institution and not “knowing” who to benefit also may cause moral regret and moral distress. The act of being unable to decide whom to benefit or be loyal to may cause significant stress. These nurses indicated that sometimes they made the “right” choice but that they did not like the outcome.

Even positive emotions may lead to moral regret. Empathy for patient or family or a colleague may require intervention but compounding the issues is helplessness when intervention is necessary but unattainable. In addition, some nurses believe that moral regret reflects on them and their competence. This is especially true when one misses something that others saw in a clinical situation.

Nurses look at the quality of life of the patient, the financial impact of treatment, a perceived ultimate “good” – an ideal, and the benefits versus the burdens. Despite all the best intentions, the moral ideal of “good nursing practice” may still not be met.

Another form of moral regret entails moral discomfort or uneasiness. There are five occurrences nurses identified that caused moral discomfort (Wurzbach, 1996b). Not meeting the ideal of good nursing care was considered most important. Futile treatment, reversal of a

decision by a supervisor, treatments done but not ordered, and staff disagreements with a decision were also identified.

There are degrees of moral discomfiture - mild to so serious that a nurse may "look back" for years or a lifetime. The primary interventions for moral regret have been discussed in another article (Wurzbach, 2015) but there may be several suggestions that bear repetition. Encourage colleagues to look at the situation, the ethical issues involved and above all not to feel incompetent or to assign blame. Forgiveness is the most important outcome for assuaging moral regret (Wurzbach, 2015). When one "looks back" forgiveness is essential (Wurzbach, 2015).

Moral distress may or may not maintain as an important "construct" in nursing but whether or not the words change there is a continuum of degrees of psychologically and ethically devastating, dysphoric feelings. Moral discomfort or uneasiness relates to issues that are difficult but not insurmountable. Moral distress seems to be akin to moral discomfort and based on some of the same differences in institutional priorities and those of the individual. Moral regret is more personal and entails the entire psyche of the person. In extreme forms shame, fear, guilt, loss of control and feelings of incompetence pervade the person's life. Since counterfactual (undoing) thinking doesn't alleviate the emotional impact, there may at times be no other solution than forgiveness – of oneself and others.

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