GROWING UP INTO CHRIST:
A PASTORAL RESPONSE TO MORAL DISTRESS AMONG MEDICAL RESIDENTS

A THESIS IN THE PRACTICE OF MINISTRY
SUBMITTED TO THE FACULTY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

DOCTOR OF MINISTRY (IN PASTORAL CARE)

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CHICAGO, ILLINOIS
MAY 2011

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ABSTRACT

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Growing Up Into Christ: A Pastoral Response to Moral Distress Among Medical Residents

Moral distress has been identified as an experience of healthcare providers who feel constrained from doing what they believe to be right. Its spiritual and emotional effects have been shown to be both immediate and long lasting. Resident physicians are by no means immune to this problem and do, in fact, experience it in unique ways. The purpose of this study was to examine the incidence and effects of moral distress among family medicine residents at Adventist Hinsdale Hospital and formulate an appropriate pastoral response. Inspired by the biblical imperative to grow up into Christ, the project is grounded in the theological ethics of H. Richard Niebuhr and the moral development theories of Carol Gilligan and James Fowler. Four one hour teaching interventions were conducted with the residents. The classes focused on introducing the topic of moral distress, inviting the residents to reflect on their own experiences, inviting them to explore their sense of vocation, equipping them with specific skills, and encouraging them to begin to formulate strategies for coping with or overcoming moral distress in clinical practice. A questionnaire was distributed at the conclusion of the fourth class in order to assess the efficacy of these interventions.
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The Actual Situation

Adventist Hinsdale Hospital is a 300 bed community hospital in an affluent western suburb of Chicago. Founded by Seventh Day Adventists in 1904, it is still a Seventh Day Adventist institution. It is one of five hospitals that comprise Adventist Midwest Health, a not for profit hospital system related to the Adventist Health System, the largest not for profit Protestant healthcare system in the United States. Hinsdale Hospital is an overtly Christian hospital with the stated mission of “extending the healing ministry of Christ.”¹ The administration maintains a strong commitment to the provision of pastoral and spiritual care, and there are several chaplains on staff, of whom I am one. In addition to my patient, family, and staff care responsibilities I serve on the medical ethics committees at Hinsdale Hospital and three of the other hospitals in the system, and am particularly charged with the responsibility of planning for and providing medical ethics education for committee members and other clinical staff. The chaplains at Hinsdale Hospital share in the leadership of daily worship, departmental devotions, and other special services, and function, in these and other settings, as interpreters and articulators of the hospital’s mission. Chaplains are highly valued and seen as leaders within the institution.

The hospital, as any hospital, is a place of uncertainty. All patients cope with uncertainty, to some degree, as they wonder what’s wrong with them, and why, and how things will turn out. They struggle to come to terms with their uncertainty about the future, wondering when they’ll be discharged, waiting for test results, anticipating surgery, contemplating recovery, or

questioning how long they have to live. That uncertainty can be painful and unsettling, especially, perhaps, in the highly technical, scientific context of modern medicine, where some might expect more clear answers. Families and caregivers struggle with uncertainty as well, wondering how their loved one or patient will do, and wondering, sometimes, what is the right thing to do. Ethical questions abound in modern medicine, and healthcare providers confront them every day. Many of these ethical questions arise out of or are complicated by advances in medical knowledge and technology.

Sarah Drummond reminds us that we live in an age of unclarity, a time of confusion, a "murky" postmodern world. Uncertainty and unclarity characterize our time. Many ethical decisions seem more difficult now than before, and medical ethics decisions are no exception. In a time when we can keep bodies going forever, or so it seems, when is it right to refuse or discontinue life-sustaining treatment? In a context that values gender equality, for example, and also seeks to respect cultural differences, who should be the decision-makers? When should a frail patient, who wants to return to independent living, be allowed to go home, even at some risk to him or herself? What information should we share with patients’ families? Who gets the donor kidney? The nurse’s attention? Access to healthcare at all? All of these questions, and many more, seem more complicated than they used to, in a multi-cultural, postmodern world, where “what is ‘true’ is now a matter of discussion and debate.”

Medical ethicists, for decades, have focused on the resolution of medical ethical dilemmas, when healthcare providers wonder what is the right thing to do. The groundbreaking

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3 Ibid., 11.
work of Tom Beauchamp and James Childress\(^4\) in the late 1970’s provided a method for analyzing morally difficult situations by identifying which of several basic medical ethical principles are at stake and weighing their relative value. Their approach is fundamental to the field, although other approaches, such as narrative ethics and the ethics of care, have emerged in recent years, offering new ways of thinking about medical ethical dilemmas. All of these approaches strive for clarity, which is badly needed. What is at stake as difficult medical decisions are made? What, if any, values are threatened by the choices we make? These questions are central to the task of medical ethics, but they are not the only ones.

Moral distress\(^5\) has been identified as a separate but increasingly important issue within the field of medical ethics. Moral distress refers to the distress that healthcare providers feel when they find themselves in situations where they believe they know what is the right thing to do but are constrained from doing it. It was originally identified as a nursing issue,\(^6\) particularly among intensive care nurses, who sometimes find themselves in the position of carrying out the orders of physicians or the wishes of families for life-prolonging treatment even when they believe those treatments to be futile, or even cruel. It is now acknowledged that moral distress affects other healthcare providers as well,\(^7\) and increasingly so, in a variety of situations.

Medical residents, for instance, sometimes find themselves in situations where they disagree with the orders of attending physicians and yet must carry them out. One study showed


that medical residents experience internal ethical conflicts in a variety of situations related to
telling the truth, respecting patients' wishes, preventing harm, managing the limits of their own
competence, and addressing the performance of others that is perceived to be inadequate.8 When
they feel constrained from doing what they believe to be right, they may experience moral
distress, just as other healthcare providers do. Little research has been reported in this area,
though it is an area of growing interest.

The issue of moral distress was brought to the public's attention in a February 2009
article by Pauline Chen in The New York Times. In that article Chen acknowledges that many
doctors and nurses “feel trapped ... by the competing demands of administrators, insurance
companies, lawyers, patients’ families and even one another ... they are forced to compromise on
what they believe is right for patients.”9 As Chen so clearly points out, the legal and economic
climate of 21st century American medicine also contributes to moral distress. The threat of a
lawsuit or requirements of an insurance company for reimbursement may place healthcare
providers in a position where they feel constrained from providing optimal care for their patients.

Moral distress is not just a moral problem for the healthcare provider, but often an
emotional and spiritual one as well. The experience of moral distress can lead to feelings such as
anger, guilt, and depression. It can lead to emotional withdrawal from patients and coworkers
and has been shown to lead to burnout and, among nurses at least, a tendency to abandon the
profession.10 Beth Epstein has demonstrated that moral distress has a cumulative, “crescendo

8 J. Rosenbaum, E. Bradley, E. Holmboe, M. Farrell, and H. Krumholz, “Sources of Ethical Conflict in Medical
Housestaff Training: A Qualitative Study” in The American Journal of Medicine (Vol. 116, March 15, 2004), 402-
407.


is it and what can we do about it?” in The Pharos (Winter 2006), 16-23.
effect” on healthcare providers, worsening with time and continued exposure and leaving “moral residue”11 that may affect them for years to come.

Hinsdale Hospital provides residency training for family medicine residents. There were twenty six residents in the program for 2009-2010, nine first year residents, ten second year residents, and seven third year residents. Seventeen were women and nine were men. They represented a variety of ethnic, cultural, and religious backgrounds and traditions. One of the goals of this project was to explore the residents’ experiences of moral distress. Another was to formulate an appropriate pastoral response. After some discussion, the faculty of the residency program was supportive of the project, as was the vice president for ministries and mission, who oversees the pastoral care department, and the manager of pastoral care, to whom I report. In their view and mine, the project correlated well with the mission of the hospital and its stated values of excellence, Christian service, stewardship, integrity, and inclusiveness, including the value of “enhancing staff development.”12 I was given easy access to the medical residents, which is, in my experience, unusual, and a unique opportunity for a chaplain. I also received approval from the hospital’s institutional review board, which approves all studies that take place within the hospital.

The Ideal Situation and Impediments to Change

In an ideal world there would be no moral distress, no time when a healthcare provider feels constrained from doing what he or she believes to be right for his or her patient. The

11 I heard Beth Epstein discuss this research in a presentation at a Perinatal Alliance for Grief Support conference at Adventist La Grange Hospital on October 27, 2009.
realization of that ideal seems unlikely in the United States in 2011, however. Impediments to change include the legal and financial pressures faced by healthcare providers and hospitals, the culture of hospital medicine, and the culture of medical education.

Legal and financial pressures are very real for healthcare providers and hospitals. Lawsuits and lack of reimbursement from insurance companies or government programs threaten to bankrupt physicians and hospitals and force them out of business, and they must take these threats seriously if they are to survive. A physician may order tests or treatments that seem unnecessary to him or her, for example, because he or she fears a lawsuit rather than because he or she considers them to be appropriate or in the best interests of the patient. Physicians may feel pressured by the hospital to order extraneous studies or perform procedures so that the hospital can protect itself, or, conversely, to discharge patients before they are ready if the hospital is not receiving adequate reimbursement. Barring major tort reform or sweeping changes in the medical insurance system, it seems likely that these legal and financial impediments will remain for the foreseeable future, and that healthcare providers will continue to suffer moral distress as a result.

Ideally, physicians and hospitals would feel less threatened by lawsuits and less vulnerable to reimbursement concerns. They would be better supported in the appropriate and well informed exercise of their professional judgement and would not be forced to weigh their own financial well being against their desire and duty to act in the best interests of their patients. Changes in the law and national healthcare system which might lead to that ideal may not be politically possible at this time, but it is possible to improve support for the healthcare providers who suffer as a result, and to equip them with tools for coping with their moral distress.
The culture of hospital medicine is another impediment to change. The hospital is an intensely hierarchical place, and it is clear that many of the ethical conflicts that the residents experience are related to their place in the hierarchy of the medical care team.\textsuperscript{13} Power differentials are obvious in the hospital. Attending physicians, for instance, have more power than medical residents, and residents have more power than nurses, though the residents sometimes feel caught in the middle. The residents have described to me how, although they lack the authority of attending physicians, they are sometimes pressured by nurses or others to intercede in patient care issues in ways that the attendings might not. In any case, in the end it is the opinions of the attending physicians that really count and their decisions which are final in patient care. Residents may hesitate to voice their opinions in morally difficult situations because of this power differential. They fear that there will be negative consequences for them in terms of evaluation and employment if they question or disagree with those who are in power over them. This is a prevalent and generally accepted dynamic in hospital medicine, though there are medical educators who have called for change.\textsuperscript{14}

The power differentials in hospital medicine and their impact on the residents may thus be clear, but other, tacit factors have a significant impact on them as well. The culture of medical education is another impediment to change. Many authors suggest that medical residents receive mixed messages about what they should do when they have questions about the morality of a situation. They suggest that “genuine, ongoing dialogue about different ethical perspectives is all

\textsuperscript{13} R. Hilliard, C. Harrison, and S. Madden, “Ethical conflicts and moral distress experienced by paediatric residents during their training” in \textit{Paediatric Child Health} (Vol. 12, No. 1, 2007), 29-35.

\textsuperscript{14} D. Browning, E. Meyer, R. Truog and M. Solomon, “Difficult Conversations in Health Care: Cultivating Relational Learning to Address the Hidden Curriculum” in \textit{Academic Medicine} (Vol. 82, No. 9, 2007), 905-911.
too rare”15 and that there is, in American medicine, a “culture and hierarchy that may hinder reflective criticism”16 despite professional standards that would encourage it. Some authors, most notably Hafferty and Franks, have described this dynamic as “the hidden curriculum.” They describe the process of socialization in medical training and suggest that “students encounter an endless barrage of often conflicting messages about the nature of medical work and their place in it.”17 Another author says that the hidden curriculum is in the dichotomy between what is taught in medical classrooms and what is unspoken but actual in practice.18 Residents may be confused about appropriate responses to morally difficult situations when they hear one thing and see another, especially when they see those in power over them acting in a way contrary to what they have been taught. Even if it is the goal in medicine, “genuine ethical reflection is typically crowded out” and “those who are not attending physicians often lack a sense of participation in decisions.”19

Changes in the law and in the national healthcare system may not be possible now, but changes in hospital culture and in the culture of medical education may be, and changes within and among the residents certainly are. In an ideal world, medical residents would be less intimidated by the power differentials in the hospital, and would be empowered to speak up and speak the truth as they see it in situations where they feel moral distress. They would be able to


18 D. Browning et al.

19 B. Levi, 661.
ask questions and raise ethical issues that disturb them in clinical practice without fear of recrimination or job loss. They would recognize and challenge the “hidden curriculum” where it exists and engage in critical reflection on their experiences, participating fully in discussions of important moral issues.

Hospital chaplains are uniquely situated and equipped to address the issue of moral distress. In my context at Hinsdale Hospital I envision a more focused and concentrated effort to provide emotional, spiritual, and moral support to our residents as they cope with moral distress, so that they can manage it when it is inevitable and overcome it when possible. I envision residents who are aware of moral distress and its consequences and who have begun to develop strategies for dealing with it in order to preserve their moral integrity and to flourish as physicians and as human beings, being spared the effects of “moral residue.”

RESEARCH

What does it take to weather moral distress when it is inevitable, and maintain a sense of personal integrity? What does it take to speak up on important moral issues when one is less powerful than others in the system? What does it take to challenge the “hidden curriculum,” and openly discuss that which is unspoken? What does it take to stand up and stand firm about one’s own moral convictions when it is uncommon to do so? What does it mean, more broadly speaking, to be a morally mature person? Insights from scripture, theology, and moral development theory have informed my thinking on this topic.
Insights From Scripture

Ephesians 4:1-6, 11-16

The letter to the Ephesians differs from other New Testament letters in that it does not appear to address specific problems within a particular congregation. Its recipients are never identified in the body of the letter, either by place or by name, and no personal greetings are included. This fact, along with significant vocabulary and stylistic differences, leads most scholars to doubt that it was written by Paul, despite the traditional attribution. Rudolf Schnackenburg suggests that the letter may have been a circular addressed to several neighboring congregations in the Lycus Valley of Asia Minor. Its emphasis on the importance of resisting the influence of the surrounding culture leads him to conclude that it was most likely addressed to an audience of seasoned urban Christians. Its two main themes, Schnackenburg says, are the unity of the church and the character of the Christian life as one which is lived in opposition to the surrounding culture. He expands on the second theme as “the concept of a commitment, growing out of God’s calling, to a distinctly Christian way of life which should be distinguished from and contrasted to the unchristian lifestyle of the environment.” The Christian communities addressed by the letter were, in Schnackenburg’s view, endangered because “the unity of the faith was being threatened by uncertainty and arbitrary human beliefs.” In Ephesians 4:1-6 and 11-16 we hear these words.

4 I therefore, the prisoner in the Lord, beg you to lead a life worthy of the calling to which you have been called, with all humility and gentleness, with patience, bearing with one another in love, making every effort to maintain the unity of the

21 Ibid., 34.
22 Ibid., 191.
Spirit in the bond of peace. "There is one body and one Spirit, just as you were called to the one hope of your calling, one Lord, one faith, one baptism, one God and Father of all, who is above all and through all and in all. But each of us was given grace according to the measure of Christ’s gift. The gifts he gave were that some would be apostles, some prophets, some evangelists, some pastors and teachers, to equip the saints for the work of ministry, for building up the body of Christ, until all of us come to the unity of the faith and of the knowledge of the Son of God, to maturity, to the measure of the full stature of Christ. We must no longer be children, tossed to and fro and blown about by every wind of doctrine, by people’s trickery, by their craftiness in deceitful scheming. But speaking the truth in love, we must grow up in every way into him who is the head, into Christ, from whom the whole body, joined and knit together by every ligament with which it is equipped, as each part is working properly, promotes the body’s growth in building itself up in love.

This is a paranetic passage in the style of Paul, an exhortation to a particular sort of behavior based on the preceding theological reflection. Theology should lead to action, in other words, and that action is described here. The readers are exhorted to remember and live out their unique callings in order to build up the body of Christ. The goal is that “all of us come to the unity of the faith and the knowledge of the Son of God, to maturity, to the measure of the full stature of Christ” (Eph 4:13), in other words that we “grow up in every way into him who is the head, into Christ” (Eph 4:15). Maturity means standing firm. “We must no longer be children, tossed to and fro and blown about by every wind of doctrine, by people’s trickery, by their craftiness in deceitful scheming” (Eph 4:14). To be mature is to have confidence in one’s self and one’s beliefs. It is to withstand powerful outside forces and speak the truth in love (Eph 4:15). The purpose of this maturity, furthermore, is not individual, but communal, its point not the growth of the individual, but the growth of the community, the building up of the whole body in love (Eph 4:16). In her commentary on this passage Pheme Perkins says, “maturity involves the community as a whole, not just individuals.”

because it contributes to the good of the community, which is, as a whole, growing up into Christ, depending on “each part working properly” (Eph 4:16). Moral maturity is not an end in itself. In his commentary on the passage John Calvin puts it this way, “If each individual, instead of attending to his own concerns, shall desire mutual intercourse, there will be agreeable and general progress.”

How is this maturity, so necessary to the good of the body, achieved? The author of the letter to the Ephesians begs his readers to remember their calling and the gifts that they have been given by grace. He urges them to remember who they are, that is, how God has already been active in each of their lives, calling and equipping them for service. The structure of his argument suggests that his readers will be enabled to stand firm against the forces that might batter them, to become mature, through the recollection of their calling. Perkins quotes Dio Chrysostom, a Greek philosopher of the first century and rough contemporary of the letter’s author, on this point, saying, “people should be reminded of what they know so that they will act accordingly.” This is, after all, the purpose of paranesis. In this case what the reader already knows and what motivates him or her to action is not the truth of a particular doctrine, but the reality of his or her calling in Christ.

Moral maturity, then, emerges from an encounter with God, from a sense of vocation. It is a response to God’s calling, and it benefits the community as a whole, not just the individual. The morally mature individual considers the good of the whole when he or she speaks, “speaking the truth in love,” for the good of the community. He or she speaks out of love for the whole


25 Perkins, 352.
body, not just out of self interest. These insights can inform a pastoral response to moral distress among medical residents. What is their sense of vocation? How can they be helped to recall that sense of vocation, and its significance, in order to stand firm in morally challenging situations, oppose the prevailing culture when necessary, effectively manage moral distress, and so contribute to the good of the whole community?

The power to grow up into Christ, the head of the body, comes from Christ, who is the head of the body, and the ligaments, mentioned in verse 16, play a unique role. According to Schnackenburg, citing F.W. Bayer, in ancient body metaphors the joints or ligaments provided the connection between the individual parts of the body but also, more importantly, the connection between the head and all other body parts, providing the organism “from the head with the necessary powers to move and grow.”26 It is fitting that this passage makes use of medical imagery. Health is the goal here, the health of the whole community and the health of the individuals within it, whose individual well-being impacts the well-being of the whole.

Insights from Theology

What does it mean to be morally mature, if that is the goal, and how do we become morally mature people? What does it mean, particularly, within the context of Reformed theology, with its emphasis on the sinfulness of humanity and the grace of God? How can we be both fallen human beings, utterly dependent on the grace of God, and responsible moral agents?

H. Richard Niebuhr

H. Richard Niebuhr’s concept of responsibility, as explicated in his posthumously

26 Schnackenburg, 189.
published book, *The Responsible Self*, provides an important framework for answering these questions. Rejecting the two poles of ethical thought that he calls “man the maker” and “man the citizen,” Niebuhr suggests a third way of understanding ourselves as moral creatures which he calls “man the answerer.” “Man the maker,” as Niebuhr terms it, is the teleological view of ethics, goal-based and utilitarian. Moral maturity, in this view, is to be clear about one’s goals and pursue them with vigor. In an extreme form it leads to the conclusion that the end justifies the means. In medical ethics, for example, one who holds this view might conclude that the infliction of pain and suffering is acceptable, to any degree, if the goal is the preservation of life, at all costs. The goal is what matters most. “Man the citizen,” conversely, is the deontological view of ethics, the Kantian view, which holds that universal principles are the most important consideration in any decision. In this view one should always act according to the highest and most universal principles. Moral maturity is marked by unwavering adherence to these unchanging standards. Niebuhr calls this view “man the citizen” because he associates it with law-abiding, rule-following behavior. This view is reflected in Beauchamp and Childress’ traditional formulation of the medical dilemma as a conflict between basic principles. Although it may be difficult in practice, principalism requires that, when faced with a medical ethical dilemma, one choose the highest principle and adhere to it. Neither of these views of morality is acceptable to Niebuhr and so he proposes this third way, “man the answerer.”

In keeping with the Reformed doctrine of sin, Niebuhr asserts that the moral problem is not “exclusively in the self - in its will alone.” Our wills are in bondage to sin, as Luther taught, and we cannot free ourselves. Salvation is indeed by grace, and even with all the will in

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28 Ibid., 34.
the world we cannot save ourselves. No matter how hard we try, we cannot will ourselves to be morally mature. The problem is not a lack of will. At the same time, Niebuhr affirms that "God acts redemptively, but there is no redemption until free men respond to the divine act."\(^{29}\)

Holding these two truths together, Niebuhr develops his theological ethics of responsibility. Responsibility, for Niebuhr, refers to our responsiveness to God, not to the fulfillment of duty or the achievement of some ideal virtue. To be responsible is to be alive to God's action in one's life and to respond to it. "Man the answerer" is a "man engaged in dialogue, man acting in response to action upon him."\(^{30}\) Our lives, at their best, are an ongoing conversation with God. We must then, as a part of that conversation, continually interpret God's actions upon us. The first question in ethics is not "what is my goal?" or "what is the law?" but "what is going on?"\(^{31}\)

Our first task is to discern and interpret God's actions upon us, and our second is to respond, and continue the conversation, in a way that is "fitting." Niebuhr puts it this way.

Our actions are responsible not only insofar as they are reactions to interpreted actions upon us but also insofar as they are made in anticipation of answers to our answers. An agent's action is like a statement in a dialogue. Such a statement not only seeks to meet, as it were, or fit into, the previous statement to which it is an answer, but it is made in anticipation of a reply. It looks forward as well as backward; it anticipates objections, confirmations, and correlations. It is made as a part of a total conversation that leads forward and is to have meaning as a whole.\(^{32}\)

A fitting response to God is one that takes all of these dynamics of dialogue into account. It looks backward, as Niebuhr says, to what God has said, and looks forward to what God might

\(^{29}\) Ibid., 38.

\(^{30}\) Ibid., 56.

\(^{31}\) Ibid., 60.

\(^{32}\) Ibid., 64.
yet say. It considers all of the ins and outs, ups and downs, possibilities, connections and repercussions of an action. A fitting response is made in hopes of fitting into and continuing the conversation in a fruitful, positive way. To be responsible is to be engaged in this kind of ongoing conversation with God, a conversation which requires our work of interpretation and action and which looks to the future. We are accountable, in this conversation, to God, the one who initiated it by "flinging us into existence,"33 and the conversation takes place, not in isolation, but within "a continuing community of agents."34 Our actions take place within the community, and affect the community. Morality is more than an individual matter. Furthermore, our willingness to participate in the conversation depends on our faith, which is, for Niebuhr, fundamentally a trust in "being itself."35

God initiates the conversation of our lives and graces us with the possibility of fitting response. Niebuhr's concept of responsibility suggests that it is as we continually discern, interpret, and fittingly respond to God's action in our lives that we are enabled to grow into moral maturity. His approach is both contextual and communal, requiring both insight into the situation at hand and consideration of the needs of the community. His ethics of responsibility is a theologically satisfying alternative to both teleological and deontological ethics, both of which tend to rely too heavily on the human will, and fail to take human sinfulness fully into account. Niebuhr's emphasis on God's action and our fitting response opens new possibilities for interpretation and action in situations of moral distress.

33 Ibid., 115.
34 Ibid., 65.
35 Ibid., 118.
Insights from Moral Development Theory

Carol Gilligan

Lawrence Kohlberg’s pioneering work on moral development\textsuperscript{36} follows closely in the tradition of psychosocial and cognitive development theorists Freud, Erikson, and Piaget. Like them, he proposes a hierarchical theory of development that is both descriptive and normative. Individuals develop morally, in his view, by progressing through six stages of “justice judgement” oriented first to punishment and obedience, then to personal satisfaction, interpersonal concordance, law and order, social contract, and universal ethical principles. At our most immature, in other words, we base our moral decisions on the threat of punishment. Later we base them on personal satisfaction, then on keeping the peace with others, then on social convention and a commitment to law and order, and, then, at the fifth stage, on a more fluid understanding of the law as a social contract which is accepting of differences and aimed at achieving the greatest good for the greatest number. Finally, at the sixth and highest stage, according to Kohlberg, our moral decisions are based solely on universal principles. These principles, he says, are ones which “apply to all persons and situations.”\textsuperscript{37} Kohlberg’s model of moral maturity, then, is a deontological one, based on an ideal of rational objectivity. The best decisions are made with impartiality, he says, or as he refers to John Rawls, “under ‘a veil of ignorance’ in which the chooser does not know which person in a situation or society one is to be and must choose a principle or policy with which one could live best in any position.”\textsuperscript{38} The best decisions are entirely unbiased, and adherence to universal principles is the ultimate


\textsuperscript{37} Ibid., 637.

\textsuperscript{38} Ibid., 636.
achievement. Kohlberg developed this theory by studying the responses of male research subjects to a series of moral dilemmas, most famously to the dilemma of Heinz, who cannot afford a drug that might save his wife’s life, and so considers breaking into a pharmacy to steal it.

Carol Gilligan, who studied and worked with Kohlberg at Harvard, was intrigued to find that women subjects in similar studies tended to respond quite differently to these dilemmas and so to score poorly on Kohlberg’s scale, rarely scoring at his stage six and far more often scoring at stage three, the interpersonal concordance stage. Kohlberg says that individuals at the interpersonal concordance stage are “particularly concerned with maintaining interpersonal trust and social approval.”

A feminist consideration of these results led Gilligan to theorize that the moral development of women is different, though not lesser, than that of men. Her theory is that, for women at least, moral maturity is realized within the context of interdependence and taking care. Moral maturity is characterized by the consideration of the needs of self and others in relationship rather than by the objective application of principles, as in Kohlberg’s theory, or by the pursuit of self interest, as in a utilitarian point of view. Her theory is known as the ethics of care.

Gilligan briefly outlines three stages of moral development, describing how women tend to move from a first stage, where the focus is on caring for the self in order to ensure survival, to a second stage, characterized by self-sacrifice, where “good is equated with caring for others,” and then to a third stage, which focuses on interdependence and the dynamics of relationships. She describes the third and final stage this way.

39 Ibid., 628.


41 Ibid., 74.
Care becomes the self-chosen principle of a judgement that remains psychological in its concern with relationships and response but becomes universal in its condemnation of exploitation and hurt. Thus a progressively more adequate understanding of human relationships - an increasing differentiation of self and other and a growing comprehension of the dynamics of social interaction - informs the development of an ethic of care. This ethic, which reflects a cumulative knowledge of human relationships, evolves around a central insight, that self and other are interdependent.42

An appreciation of the interdependence of human beings, balanced by a healthy differentiation of the self, leads to an ethic of care, a way of making decisions based not on abstract principles or on utility, but on the value of relationships and a desire to preserve and protect those relationships.

When asked to summarize the law, Jesus did not respond with a list of rules to follow or a single-minded goal to pursue, but with a relational ethic like the one Gilligan describes. He said, "‘You shall love the Lord your God with all your heart, and with all your soul, and with all your mind.’ This is the greatest and first commandment. And a second is like it: ‘You shall love your neighbor as yourself.’ On these two commandments hang all the law and the prophets.” (Mt 22:37-40) Jesus commands us to love, and love is a quality of relationship. The quality of relationships is the most important thing, for men, as well as for women.

James Fowler

James Fowler is a Methodist minister and theologian whose theory of faith development is reminiscent of Kohlberg’s theory of moral development in that it parallels psychosocial theories of human development, is descriptive, normative, and hierarchical. Fowler describes six stages of faith development, beginning with an intuitive-projective stage, in which the young

42 Ibid.
child imitates the faith of his or her parents and imagines the characters of the stories of faith as if they were characters in fairy tales. In the second, mythic-literal stage, generally associated with middle childhood, faith is still focused on the faith of authority figures and the stories of faith are taken to be literally true. There is an emphasis on fairness and a tendency toward works-righteousness. In the third, synthetic-conventional stage, the challenge of conflicting or contradictory faith stories is met with an insistence on conformity and a dependence on established authority. Self-reflection is lacking. In the fourth, individuative-reflective stage, individuals take more responsibility for themselves and their own beliefs. They become self-reflective and tend to demythologize the faith. Authority is relocated within. In the fifth, conjunctive stage, there is less preoccupation with the self and a greater acceptance of paradox. Elements of the faith which were previously rejected as irrational may be reclaimed and reintegrated as the individual becomes more accepting of mystery and more open to difference. Priority is given to serving others. Stage six, the universalizing stage, is the culmination of faith development, which Fowler describes as “an activist incarnation ... of the the imperatives of absolute love and justice.” Persons at this stage are described as being heedless of self-preservation in their devotion to these moral imperatives. Mohandas Gandhi, Martin Luther King, Jr., and Mother Teresa are cited as examples. Fowler tempers this theory in a later work, however, responding to the critique that this final, universalizing stage is so rare and unattainable that it cannot be considered normative. He allows that while an individual’s movement to the conjunctive stage is natural, movement to the universalizing stage requires grace. “Human


development toward wholeness," he says, is "always the product of a certain synergy between
human potentials, given in creation, and the presence and activity of Spirit as mediated through
many channels."45 The most important factor for growth into the final stage of faith, he says, is
an openness to the Spirit. Furthermore, according to Fowler, this openness to the Spirit is an
openness to the call of God. Moral maturity, for him, is not a stage to be realized but a way of
being in relationship to God, an openness to God’s calling. That calling, he says, is a universal
calling, to "participate in the widening inclusiveness of the circle of those who count as
neighbor."46 Fowler goes on to discuss vocation as "the response a person makes with his or her
total self to the address of God and the calling to partnership."47 Vocation, for him, is always "on
behalf of others."48 It is "dynamic ... changing its focus and pattern over time, while continuing
as a constant, intensifying calling."49 Elsewhere he describes the conversion to vocation as "a
release from the burden of self-groundedness"50 and affirms the faithfulness of God to "those
who genuinely seek to respond to their callings."51 In his vision of moral maturity, then, Fowler
brings together the themes of calling, responsiveness, and relationality that we have seen so far.

46 Ibid., 60.
47 Ibid., 77.
48 Ibid., 85.
49 Ibid.
50 Ibid, 115.
51 Ibid, 118.
Richard Osmer is a Christian educator whose work addresses issues of education and formation. His theory of teaching for faith\(^2\) suggests that teachers must consider what they are teaching for. Teaching should be planned with outcomes in mind, in other words. He identifies four possible outcomes in Christian education and so speaks of teaching for belief, relationship, commitment, and mystery. Matching methods to outcomes is the key to effective teaching, he says. "Teaching works best if there is a fit between the teaching method we use and the purpose we are trying to achieve."\(^3\)

In Osmer's theory, teaching for belief is akin to teaching for knowledge. Teaching for belief has to do with conveying information, and the lecture is one appropriate method for doing so. This type of teaching correlates with Niebuhr's suggestion that we must carefully interpret what is happening before we can make a fitting response. We must first understand "what is going on."

Teaching for belief is one thing, but teaching for commitment is another. Commitment, for Osmer, is a response to God's action in our lives, most of all to the gift of salvation in Jesus Christ. Echoing the themes that we have seen in Ephesians, Niebuhr, Gilligan and Fowler, Osmer stresses the fact that commitment is not just a matter of the will but an act of responsiveness. "The commitment aspect of faith always is a response to this prior work of God on our behalf," he says, "We must move away from thinking about commitment primarily as a

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\(^3\) Ibid., 18.

\(^4\) Ibid., 33.
matter of the will and begin seeing it as grounded in the personal identity narratives of our students.\textsuperscript{55} Commitment doesn’t come out of nowhere, it comes out of relationship, that is, out of individual relationships initiated by God. Personal identity narratives are the basis for commitment. Individuals are best invited to commitment by examining their own life stories and discerning the call of God within those stories. Commitment is a response to that calling, and it is commitment that makes change possible. Teaching for commitment must take these realities into account.

Osmer outlines five steps in teaching for commitment. They are remembering, reflecting, encountering, sharing, and deciding. Remembering involves recalling one’s own story, and reflecting involves the identification of what Osmer calls “interpretive keys” that help make sense of that story and link it to the present. Encountering, for Osmer, means encountering the Christian story. Sharing creates the opportunity for self-disclosure in a safe environment, and deciding leads to concrete action.

THEORETICAL FRAMEWORK

Moral distress is a form of suffering, primarily moral suffering. It is experienced as a threat to personal integrity and has significant spiritual and emotional consequences. The relief of moral, spiritual, and emotional suffering is one of the primary goals of pastoral care. Chaplains are uniquely suited, as pastoral caregivers, to respond to moral distress in members of the hospital staff, and are, in fact, responsible to do so. Chaplains are called to attend to the

\textsuperscript{55} Ibid., 31.
moral, spiritual, and emotional well-being of healthcare providers in the hospital. Chaplains are called to be with those who suffer and bring the resources of faith to bear as they seek to alleviate that suffering.

Jesus said, “I came that they might have life, and have it abundantly.” (Jn 10:10)

Abundant life is the ultimate goal of pastoral care, a goal beyond the more immediate goal of the relief of suffering. Moral distress is indeed a form of suffering and a painful problem for healthcare providers in the United States in the 21st century, but it is at the same time an opportunity for growth toward moral maturity and its successful resolution can open the way to abundant life. The author of one study of moral distress among nurses suggests that “moral distress has been viewed as a negative experience to be avoided or healed. Yet it could be viewed as a life challenge that develops moral character for those who manage it well.”

Chaplains are called not only to alleviate suffering among members of the hospital staff, but to encourage their moral and spiritual growth. Careful attention to the issue of moral distress and a well conceived pastoral response can facilitate the achievement of that goal.

This project is based on the theological conviction, expressed by H. Richard Niebuhr, that our lives are best lived as a conversation with God. We grow to moral maturity and experience the life abundant as we make fitting response to God’s calling in our lives, carefully attending to our context and community. The conversation makes sense and is fruitful when it there is clarity about where, when, and with whom it is taking place, and the conversation makes sense and is fruitful when it takes the needs of the whole community into account. Our lives are

56 I heard Homer Ashby discuss this concept in a Doctor of Ministry class at McCormick Seminary in May, 2008.

57 D.R. Hanna, “Moral distress: the state of the science” in Research and Theory for Nursing Practice (Vol. 18, 2004), 77.
lived in community, and our conversations with God are never simply one on one. God calls us to love one another, and we “grow up ... into Christ” (Eph 4:15) by recalling our unique, individual callings and living them out. Our individual callings, as the letter to the Ephesians reminds us, are always callings in community and for the good of the community. One who is morally mature is able to speak the truth in love, for the good of all. The truth spoken in love is of the highest value, not for truth’s sake, but for love’s sake, and the best moral decisions consider relationships first of all, as Carol Gilligan has shown. Moral maturity lies in responsiveness to God and in loving relationships with others and is ultimately achieved, as James Fowler explains, by God’s grace as we act in faith. God is a faithful conversation partner who will not let us down. The God who draws us into conversation will not walk away. As we respond, fittingly, to God in the conversation that is our lives, God will respond, continue the conversation, and ultimately bring it to a satisfying conclusion. Individuals can be taught and encouraged to engage meaningfully in the conversation, and grow toward moral maturity and commitment, as Richard Osmer has theorized, by remembering and reflecting on their own personal stories, encountering the God who calls them, sharing what they have learned, and deciding to take concrete action.

OBJECTIVES, STRATEGIES, AND IMPLEMENTATION

The goal of this project was to relieve suffering and to enhance the moral, spiritual, and emotional well-being of family medicine residents at Hinsdale Hospital by teaching them to identify moral distress when they experience it in clinical practice and working with them to
develop effective strategies for coping with and overcoming it.

One of the unique aspects of the project was that the participants came from a variety of religious backgrounds and perspectives. Although the project was based in Christian theology, took place within the context of a Christian institution, and was carried out by a Presbyterian minister, the residents who were the focus of the project were not all Christian. Overt appeals to Christian theology, beliefs, and practices would have been inappropriate in the execution of the project and were not included, with one exception.

I had four objectives for the project. They were to educate the residents about moral distress, to research their experiences of it, to invite them to reflect on their sense of vocation as related to the experience, and to encourage them to begin to formulate strategies for coping with or overcoming it.

Receiving approval

I began the project by discussing the idea with the physician who serves as the director of education for the family medicine residency program. We had worked together previously on the hospital’s ethics committee and when I was invited to give an introductory lecture on medical ethics to the residents in the previous year. She immediately expressed her enthusiasm for the project and encouraged me to pursue it. I was given three dates, several months apart, when the residents would be scheduled to attend one hour lunchtime seminars with me, and was given the freedom to use that time to address medical ethics issues in any way that I saw fit.

My next step was to discuss the project with the vice president for ministries and mission, who was also enthusiastic in his support, particularly because he saw the topic as closely related to the Christian mission of the hospital. Soon thereafter he discussed it with the
coordinator of continuing medical education, who suggested that I present a grand rounds lecture on the topic for the medical staff. This was eventually scheduled and became the first of my interventions with the residents.

I then discussed the issue of moral distress and my tentative plans for the project with the ethics committee. The response from members of the committee was positive, and the response from the nurses on the committee was almost overwhelming. One nurse said, “So that’s what you call it. That’s my experience, but I never knew it had a name. This is so important. We have to do something about it.” That conversation resulted in the establishment of a planning committee that met with the chief nursing officer and eventuated in my presentation of a series of educational in-services on moral distress to the nursing staff.

Finally, I received approval for my project from the manager of pastoral care, from the family medicine faculty, and from the hospital’s institutional review board, which approves all studies that take place in the hospital.

The First Objective

My first objective, as stated above, was to educate the residents about moral distress. I planned to present current research about the dynamics of the experience - its precipitating factors, its signs and symptoms, its consequences, and its prevalence in clinical practice - in order to raise their awareness and increase their understanding of the experience. This objective coheres with Niebuhr’s emphasis on discernment, the “what is going on” question. I chose to achieve this objective by presenting a lecture, in accordance with Osmer’s theory that a lecture is an appropriate strategy for teaching for belief, or imparting information. The grand rounds lecture presented an ideal opportunity for doing so, and all of the residents were expected
to attend.

Drawing heavily on current journal research, I created and presented a powerpoint lecture introducing the topic of moral distress. It was well attended and well received. Most of the residents attended, as well as many other physicians and hospital staff. Several physicians, including one of the residents, approached me with comments or questions about their own experiences of moral distress after the lecture, and one of the physicians subsequently asked me to join him in leading a discussion on the topic at a physician wellness group. Standard grand rounds evaluation forms completed by the attendees indicated that the content of the lecture was clear, relevant, and likely to affect future practice.

The Second Objective

My second objective was to research the residents’ experiences of moral distress. Most of the research in the field has involved nurses and I was curious to find out if moral distress was a significant experience among our medical residents. I decided to devote my second hour with the residents to learning about their experiences. This was one of the three lunchtime seminars that the director of education had scheduled with me, and it happened to occur on the day after I lectured at grand rounds. My strategies were to engage the residents in a group discussion of the lecture and to invite them to reflect on their own experiences in writing.

I began the second session by re-introducing myself, explaining the fact that I was conducting research for a Doctor of Ministry project, and explaining that it was my purpose as a chaplain and pastoral care giver to facilitate their well-being as individuals and as physicians. I acknowledged the existence of many different religious backgrounds and points of view within the group and assured them that all were respected and appreciated. I assured them, too, that
whatever they shared with me that day would be kept in confidence.

I then asked for feedback on my grand rounds lecture and shared further information about moral distress, citing the results of several studies among medical students and residents and posing some questions from a moral distress scale questionnaire.58 There was quite a bit of animated discussion and the residents were unanimously agreed that they do, indeed, experience moral distress. I was intrigued to hear their examples and in particular to learn about some of the unique pressures that they face as residents. Some of these pressures are related to inexperience. One resident described practicing new procedures on patients without telling them as “morally tenuous,” for example, while at the same time acknowledging that “we need to learn.” Others were disturbed by the perceived need to appear confident while performing such procedures, though they might not be, in order to instill confidence both in their patients and in the attending physicians who were supervising them. The residents wondered if their patients were receiving the best possible care, in light of their inexperience, as well as if they were, in effect, lying by not telling patients that they were performing the procedures for the first time. Issues of communication were also much discussed. One resident said, “we’ve all been in a situation where you feel like you can’t say anything,” and described the fear that an attending physician might become angry or dismissive if the resident were to voice a differing opinion. One example cited was the situation where a family member asked the attending not to tell the patient that he might die. The attending physician agreed with the family and ordered the resident not to tell the patient, but the patient asked the resident for the truth. The resident felt unable to approach the

58 Mary Corley and others have developed a moral distress scale which may be used to measure moral distress. See M. Corley, R.K. Elswick, M. Gorman, and T. Clor, “Development and evaluation of a moral distress scale” in Journal of Advanced Nursing (Vol. 33, No. 2), 250-256. Although Dr. Corley graciously shared the physician moral distress scale with me I was, unfortunately, unable to use it as a part of this study.
attending with a differing opinion, believed that her duty to the patient had been compromised, and was left morally distressed. Among other things, the residents also discussed the ramifications of the fact that, although they are physicians, they lack the authority of attending physicians. They described how patients, families, and other members of the hospital staff sometimes have expectations of them that they cannot fulfill because they lack the authority to take action. One area of concern was the delay that can occur when an attending physician or specialist is called but has not yet responded, and the patient has an urgent need.

After the discussion I asked the residents to write about their own experiences of moral distress, and each wrote an account, in some detail. The concept of moral distress clearly made sense to them and evoked powerful emotions. It was a universal experience. In their writing the residents cited a variety of situations in which they have experienced moral distress, the majority of which involved communication with those in authority over them. They again reported experiencing moral distress when they felt unable to speak the truth as they see it, either to patients and their families or to attending physicians. They reported experiencing moral distress in situations related to their own competence and in situations related to reimbursement constraints, such as being pressured to discharge patients from the hospital before they are ready (further examples are cited in the Appendix).

At the end of the class I raised the question of moral authority. What are the sources of moral authority, I wondered, for them, as they decide what to do in these distressing situations? We briefly discussed personal and professional ethical standards. There was no clear answer, certainly no consensus, and I left them with that question.
The Third Objective

My third objective was to invite the residents to reflect on their sense of vocation, particularly as it relates to their experience of moral distress. This objective, arising from the insights of Ephesians, Niebuhr, and Fowler, is at the heart of the project, but was also the most difficult to achieve, in this religiously diverse group. My lesson was based on Osmer’s steps of remembering, reflecting, and encountering, and my strategies again included group discussion and a personal writing exercise. This session took place two months after the previous one.

I began the session with a brief review of the topic of moral distress and our conversation about it. I highlighted several recent newspaper articles that touched on the topic, reminded the residents of my question about the sources of moral authority, and introduced the topic of vocation, referring to Dag Hammarskjöld, who said,

I don’t know Who - or what - put the question, I don’t know when it was put. I don’t even remember answering. But at some moment I did answer Yes to Someone - or Something - and from that hour I was certain that existence is meaningful and that, therefore, my life, in self-surrender, had a goal.59

I asked the residents to write, for themselves alone, about their decisions to go into medicine. To help them remember I asked them to write, in some detail, about when they first thought about going into medicine, who or what had inspired them to think of it, and what they had hoped for at the time. Osmer theorizes that this kind of remembering is the first step in teaching for commitment, teaching, that is, that leads to action. When they were done, I invited discussion, but the group was fairly quiet. I assume that this was, at least in part, because the setting was not conducive to the sharing of such personal material. Having anticipated that this might be the

case, I was glad to have started with the personal writing exercise.

Osmer proposes reflection as a next step in teaching for commitment, reflection, that is, on one's own story and the "interpretive keys" that make sense of it and connect it to the present. The Christian educator's goal in this step is to help students reflect on their own experiences and identify those interpretive keys so that they can move on to the next step, which is that of encountering, anew, the God who has been at work in their lives all along. It was my hope, in this session, to help the residents remember and reflect on their vocations so that they would encounter the source of those vocations again. From my Christian perspective, but with their religious diversity in mind, echoing Hammarskjöld and Niebuhr, I hoped that the residents might reflect on their lives as conversations, remembering who, or what, was calling them years ago and was calling to them even now, so that they might honor those callings in their responses to moral distress. Although I invited discussion as I encouraged the residents to make this connection, I was not surprised when, again, there was little of it. If the connection was made, it was made internally, and not much discussed in the group. Again, it seems to me that this particular classroom, workplace setting was not particularly conducive to personal sharing. I left the residents with the question, "Are you becoming the doctor you want to be?"

The Fourth Objective

My fourth objective was to encourage the residents to begin to formulate strategies for coping with or overcoming moral distress. This objective is related to Niebuhr's concept of fitting responses and is aligned with Osmer's deciding step. My strategies included a brief lecture reviewing our three previous sessions and presenting two models of conflict resolution as well as a more extensive period of group discussion. This session took place two months after
the third session and included a group of nine first year residents who had not been present for any of the previous sessions, as well as the second and third year residents who had been present for the three preceding sessions. Nine of the residents who had participated in the previous sessions had since graduated from the program.

I began the class with a brief powerpoint presentation reviewing the previous sessions. The powerpoint included a slide which detailed the residents’ responses to my questions about their own experiences of moral distress in the second session. This was the first time I had presented this material, and one of the residents said, “I just finished a rotation in ICU. We had all of these.” In general, the discussion revealed that the situations described were commonly experienced and were significant sources of moral distress for the residents. In the powerpoint I then offered a simple self-assessment tool for the residents to use, consisting of four questions. Am I experiencing moral distress? If so, what is it that’s tying my hands/keeping me from doing what I believe is right for my patient? Is it important to do something? If so, what should I do? I encouraged the residents to think especially carefully about the third question, reminding them of the potential burden of moral residue and the importance of moral integrity to their own health and happiness. I introduced the concept, from the letter to the Ephesians, of speaking the truth in love, proposing that in this case, to speak the truth in love might mean to consider the needs of the patient first and foremost, even when to do so might involve, or seem to involve, personal risk. Because both the research in the field and the residents’ feedback to me had revealed that much of the moral distress they experience stems from difficulties in communication, I then presented two models of conflict resolution. These models, from the Harvard Negotiation Project and from Phyllis Beck Kritek’s Negotiating At An Uneven Table: Developing Moral
Courage in Resolving Our Conflicts, were suggested by Dr. Benjamin Levi in an article on ethical conflicts between residents and attending physicians.  

Levi summarizes the Harvard Negotiation Project model in five steps and suggests that residents make use of these steps as they attempt to negotiate conflicts with attending physicians. I suggested to the residents that this model might be a helpful tool for them as they seek to speak the truth, as they see it, in love. The first step is to sort out what’s happening, both from one’s own and from the other’s perspective. The following steps are to seek to understand the feelings behind the conflict, to discern whether one’s own identity or integrity is at stake, to engage the other by exploring an alternate, “third story,” and to acknowledge the feelings behind the assumptions and arguments and the differences in values, interests, and needs. The model also suggests the acknowledgment of any miscommunication that may have taken place and assumes that once these steps have been taken, agreement may become possible.

Like Levi, Phyllis Beck Kritek writes out of a medical context. As a nurse, her concern is that of negotiating conflict among healthcare providers from a place of lesser power. Her work also has the potential to be a useful tool for the residents as they seek to speak up in situations of moral distress. Rather than outlining a series of steps in conflict resolution, Kritek describes ten habits or “ways of being” that she has found to be fruitful, emphasizing being rather than doing. Some of the ways of being that she describes that seem most pertinent to the residents’ experience and which I presented to them are - to avoid the metaphors and tactics of war, to establish a tone of equality, to convey a sense of openness, to clearly communicate what would

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60 Both of these were referenced in B. Levi, “Ethical Conflicts Between Residents and Attending Physicians” in Clinical Pediatrics (Vol. 41, No. 9), 661.

61 P. Kritek, Negotiating At An Uneven Table: Developing Moral Courage in Resolving Our Conflicts. (San Francisco: Jossey-Bass, 1994).
count as compromising one’s integrity, to be prepared for the unexpected (either breakthrough or attack), and to recognize that one’s own is just one of many windows on the truth.

The residents offered several strategies of their own in the ensuing discussion, and I encouraged them to continue to formulate strategies that they might make use of in the future. We discussed the idea that addressing situations which evoke moral distress might alleviate distress even when changes prove to be impossible, in other words, that the residents might better preserve their moral integrity and avoid the damaging effects of moral residue by speaking up, whether they achieve change or not. It was suggested that that speaking the truth in love, no matter what the result, might be one way of weathering the storm.

Two residents stayed after the session and talked with me, at some length, about some of the ways that moral distress has affected them. One has enrolled in law school and plans to leave medicine all together, saying, “I can’t take care of my patients like I want to.” The other said, “I love what I do” but “I wish I had never gone to medical school,” citing external, morally distressing pressures. Both described being disheartened by what they see as the erosion of the physician-patient relationship, which they attribute to increasing constraints placed upon physicians and the public misperception that “doctors are just in it for the money.” Both said that they had expected to find the greatest satisfaction in the practice of medicine in their relationships with their patients, but had been surprised and saddened by the mistrust that they experience.
EVALUATION

At the conclusion of the fourth session I asked the residents to complete a brief evaluation form, responding to a number of questions on a five point scale. There were nineteen responses. Eleven of the nineteen respondents rated the importance of the topic of moral distress at a five, six rated it at a four, and two rated it at three. None rated it lower. In response to the question, “Do you feel better equipped to cope with moral distress in the future?” with “definitely yes” as a five, six respondents circled five, eight circled four, four circled three, and one circled two. I was interested, too, in whether moral distress had been addressed in any other part of their training. Responses to that question clustered in the middle, mostly in the twos, threes, and fours. Responses to my questions about the effectiveness of various aspects of my interventions were not particularly illuminating, with all but a few of the responses evenly distributed in the fours and fives. No one aspect of the four sessions appears to have been more effective than any other. These results demonstrate that the residents consider moral distress to be an important topic that it is not much addressed in other parts of their training, and suggest that pastoral interventions such as this one can be effective in helping them cope with or overcome it.

Perhaps more suggestive of the importance of the project is the fact that as I raised awareness of the topic in the hospital I was approached by numerous individual healthcare providers who wanted to talk with me about their experiences of moral distress, both in the past and in the present. When I gave the grand rounds lecture in three of the other hospitals in our system, I was approached by individuals seeking counsel after each presentation. When a nurse colleague and I led an inservice on moral distress, fourteen separate times, for nurses in our
hospital, we were approached with individual concerns afterwards, every time. An attending physician asked me to meet with him and a physician wellness group to discuss the topic, and moral distress is a matter of continuing concern and conversation in our magnet nursing program, with our chief nursing officer, in the pastoral care department, and in the ethics committee.

The timing of my sessions with the residents was not ideal, and neither was the setting. Although there may have been benefits to introducing the topic and revisiting it later, with increased awareness between the sessions, a more concentrated intervention might be more effective. It might be helpful, too, to conduct the sessions in another setting, away from the workplace and the didactic classroom atmosphere. In the future I would propose a workshop or retreat off site, of at least four hours in length. The same group of residents would then be present for the entire workshop, and an off site setting might be more conducive to personal sharing.

I have learned that medical residents have little opportunity for self-reflection as a part of their training, at least in the area of moral development, and that there is, at least among many, an openness and a need. I was heartened when one resident said to me, “This is wonderful. Thank you for caring about our moral development.”

SIGNIFICANCE

This project demonstrates that moral distress is a significant experience among medical residents and may be alleviated, to some degree, through pastoral interventions focused on
education and moral formation. Hospital chaplains may be better equipped by this project to address the suffering that residents experience in situations of moral distress and to facilitate their moral growth. Chaplains are uniquely situated and qualified to do so, as pastoral caregivers in the hospital who tend to the needs of the staff as well to those of patients and their families. The spiritual, emotional, and moral well-being of resident physicians and other healthcare providers is well within the chaplain’s scope of practice and responsibility. It may be, as well, that the conclusions of this project can be generalized to other healthcare providers, and that similar pastoral interventions would be helpful in relieving their distress and enhancing their well-being.

Little, if any, research has been done on the effects of provider moral distress on patients, but common sense would suggest that providers who deal effectively with moral distress provide better patient care. Providers who withdraw from their patients and colleagues in frustration, depression, or anger, are unlikely to perform at an optimal level. Effective interventions to address moral distress in caregivers may, thus, positively impact patient care.

It has been shown that unresolved moral distress leads to a loss of job satisfaction among nurses. If the same is true for other healthcare providers, hospital administrators and managers would be wise to attend to moral distress as an employee satisfaction and retention issue. Physicians who are equipped to deal effectively with moral distress and feel supported in those efforts may be more likely to stay in the profession. Sadly, those who are most sensitive to moral issues are often those who are most disturbed by them. It is best for our whole society if they stay.

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Furthermore, the decisions that physicians make every day have implications for all of our lives. What doctors do in morally difficult situations makes a difference, as our nation grapples with an escalating healthcare crisis. How many tests do they order, and why? Which treatments do they deem reasonable and appropriate, especially near the end of life, and so recommend to patients and families? How do they respond when patients, families, or other healthcare providers choose treatments that they believe to be futile? Why do doctors make the decisions they do in these and other morally difficult situations, and how do their own thoughts, values, and feelings play a part in those decisions? How willing or able are they to take a stand for what they believe to be right, even in the face of immense cultural, legal, economic and other pressures? Doctors' decisions have societal implications, and their experiences of moral distress affect the kind of doctors they become. This project is compelling and significant not only because it is an opportunity to improve pastoral care for young doctors in training but also because it is an opportunity to bolster their courage and facilitate their growth toward moral maturity. The moral maturity of the individual benefits society. The moral maturity of the physician (or any other healthcare provider) benefits the healthcare system. In the language of the letter to the Ephesians, those who grow up into Christ and speak the truth in love and build up the whole body.

In his meditation on vocation,63 Quaker author and educator Parker Palmer describes the pressures of the social systems in which we live as trying to force us to live in ways which are untrue to who we are. He discusses this problem of being “divided” between societal pressure and inner call, and holds up the example of Rosa Parks, who overcame external pressures and

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lived out her vocation with courage. He describes the societal threat that makes it difficult for us to live out our vocations, and says,

But in spite of that threat, or because of it, the people who plant the seeds of movements make a critical decision: they decide to live “divided no more.” They decide no longer to act on the outside in a way that contradicts some truth about themselves that they hold deeply on the inside. They decide to claim authentic selfhood and act it out - and their decisions ripple out to transform the society in which they live, serving the selfhood of millions of others.  

This decision, Palmer says, is made not in order to start a movement, as Rosa Parks unwittingly did, but because the individual has had enough of living “divided.” Rosa Parks, he says, had “reached a point where it was essential to embrace her true vocation.” She found the courage, as others like her do, in the realization that “no punishment anyone might inflict on them could possibly be worse than the punishment they inflict on themselves by conspiring in their own diminishment.” Society is transformed by individuals who refuse to be diminished and who live out an ethic of responsiveness to God and neighbor. Our society needs healthcare providers who are morally mature, who find the clarity and courage to live out their callings, and who are determined to live “divided no more.”

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64 Ibid., 31.
65 Ibid., 33.
66 Ibid., 34.


Hilliard, R.I., Harrison, C., and Madden, S. “Ethical conflicts and moral distress experienced by paediatric residents during their training.” *Paediatric Child Health* 12, no. 1 (2007): 29-35.


SITUATIONS EVOKING MORAL DISTRESS AS REPORTED BY FAMILY MEDICINE RESIDENTS

situations related to competence
learning procedures on patients (and not telling them because you need to convey confidence)
reporting test results to patients in the off hours even though you are unable to answer all their questions about them

situations related to reimbursement constraints
discharging patients before they’re ready (eg. without adequate pain control, with no one to care for them at home, or if they are forced out of the hospital by insurance)
being unable to obtain appropriate care (eg. surgery) for a patient because he or she lacks insurance

situations related to communication/collaboration
being unable to relieve a patient’s pain at the end of life because a hospice/palliative care consult is lacking
following orders to provide apparently futile care at the end of life
following the family’s wishes instead of the patient’s wishes
following the family’s wishes not to tell the patient the truth about his or her condition
observing incompetent care
observing unreported errors
observing patients or families being pressured to make a particular decision (eg. code status)
observer inadequate communication/lack of clear explanations to patients and families (inadequate informed consent), including inadequate discussion of code status
being caught between attending MD’s and nurses in a disagreement over patient care (eg. being pressured by nurses to write an order counter to attending MD’s order)
being aware of the potential side effects of a treatment and not disclosing them to the patient
writing orders you disagree with
being asked to change a chart note
seeing patient care potentially compromised because an attending MD or specialist is delayed