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Moral Distress, Disempowerment, and Responsibility

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Abstract

Since Andrew Jameton first introduced the concept of moral distress, a growing theoretical literature has attempted to identify its distinctive features. This theoretical work has overlooked a central feature of morally distressing situations: disempowerment. My aim is to correct this neglect by arguing for a new test for theories of moral distress. I call this the disempowerment requirement: a theory of moral distress ought to accommodate the disempowerment of morally distressing situations. I argue for the disempowerment requirement and illustrate how to apply it by showing that recent responsibility-based theories of moral distress fail to pass the test.

1. Introduction

Andrew Jameton first coined the phrase "moral distress" to refer to a problem that arises for nurses when they know "the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton 1984, 6). Say, for example, a nurse working in a hospital is instructed to give all new patients unnecessary and expensive blood tests. The nurse, according to Jameton's account, feels moral distress if they object to the practice but have no authority to prevent it. A voluminous body of theoretical and empirical research on moral distress has shown just how much of a problem such experiences can be. Moral distress, at least in the form measured by Corley's Moral Distress Scale, is experienced by a majority of nurses.[1] It can lead to burnout (Fumis et al. 2017, 71), compassion fatigue (Maiden, Georges, and Connelly 2011, 340), and a decrease in moral sensitivity (Epstein and Hamric 2009, 336). Many morally distressed nurses leave the profession (Corley et al. 2001). *Pace* Jameton's original, narrow definition, it has been claimed that moral distress is felt about obstacles presented by legal prohibitions (Kälvemark et al. 2004, 1080), uncertainty on the part of nurses (Batho and Pitton 2018, 20), instruction from physicians (Corley et al. 2001, 253), lack of organizational resources (Fachini, Scrigni, and Lima 2017), and exclusion from decision making (Young, Froggatt, and Brearley 2017, 858). And many studies have observed moral distress outside of nursing, among, for example, other health workers (Fumis et al. 2017) and police (Papazoglou and Chopko 2017).

[1] In Corley et al.'s 2001 study, 69% of nurses said they had to compromise their values because of hospital policy, physician requests, or administrative requirements (see Kälvemark et al. 2004, 1076).

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More often than not, working definitions of moral distress do not distinguish the phenomenon from other similar stressful responses to workplace pressures. This does not always detract from the value of moral distress research. Nonetheless, some theorists of moral distress have attempted to be more precise about what distinguishes moral distress. This has generated a growing literature that takes up the task of identifying the distinctive features of moral distress in order to show that it cannot be reduced to other, similar-seeming attitudes. Attempts to distinguish moral distress have appealed to its affective features (Kälvemark et al. 2004; Weber 2016), the characteristic features of morally distressing situations (Campbell, Ulrich, and Grady 2016), and the self-directed attitude involved in moral distress. Among the latter, a recent set of responsibility-based accounts maintain that one of the defining features of moral distress is that morally distressed health workers feel responsible for the situation they are in (Gorin 2016; Tessman 2020; see also Fachini, Scrigni, and Lima 2017; Kälvemark et al. 2004; Tigard 2019).

In the process of becoming more precise about the concept of moral distress, this literature has lost sight of an important feature of many morally distressing situations: those who experience moral distress often feel significantly constrained and disempowered. My aim is to turn the attention of theorists of moral distress back to experiences of disempowerment by arguing for what I call the disempowerment requirement (DR): a theory of moral distress ought to accommodate the disempowerment of morally distressing situations. There are conceptual and empirical reasons for DR. The conceptual case for DR (detailed in section 2) is that the disempowerment of moral distress distinguishes it from guilt; an account that cannot accommodate disempowerment will struggle to make this distinction. I make a provisional empirical case for DR in section 3, explaining some of the forms of disempowerment reported by health workers in moral distress studies, though a thorough empirical study of the disempowerment of moral distress is beyond the scope of this article.

DR should be acceptable to most theorists of moral distress, but it is not so low a standard that all theories can meet it, and some theoretical adjustment is needed to correct for neglect of the disempowering nature of moral distress. In the second half of this article, I demonstrate the application of DR by considering whether it is met by responsibility-based accounts. I detail (in section 4) one way in which we can apply the requirement: a theory that renders moral distress an *unfitting* response to disempowerment fails to meet DR. I then argue (section 5) that responsibility-based accounts fail to meet DR in precisely this manner. My concluding remarks (section 6) address moral distress reported by those who either are responsible—or believe themselves to be responsible—and particularly the question of what we are to say to those health workers who report moral distress when their attitude does not reflect whatever concept of moral distress we settle on.

My general goal is to steer conceptual work on moral distress back to an appreciation of its disempowering nature, and I suggest we do this by respecting a requirement that constrains our theories of moral distress and maintains a focus on disempowerment. If we prevent our concept of moral distress from excluding the moral distress of disempowered health workers, we stand a better chance of understanding and preventing moral distress in practice.

2. Differentiating Moral Distress

One reason to think DR holds is that we reach it by way of attempts to differentiate moral distress from similar-seeming attitudes. We can demonstrate this by considering how theories of moral distress have attempted to refine Jameton's original definition. Critics of Jameton typically complain that his account is too narrow. Sofia Kälvemark et al. (2004) have suggested that our concept of moral distress should include stress that responds to legal constraints, not just institutional constraints. Others have suggested that our concept should include health workers who feel unable to act, not because their moral convictions are thwarted, but because they lack moral conviction to begin with (Batho and Pitton 2018; Fourie 2015). It has also been observed that Jameton's account, and many that have followed, identify the circumstances that prompt moral distress but do not tell us much about its phenomenal content (Tigard 2018).

Not all research on moral distress neglects its phenomenal content. However, many attempts to characterize that content have failed to distinguish it from other similar-seeming emotions. For example, Elijah Weber has suggested that moral distress is a "negatively-valenced feeling state" (2016, 245). But not every negative emotion felt by a health worker facing institutional constraints will count as moral distress. A health worker may feel angry or depressed as a result of their limited power to act as they believe they ought to. But if that is moral distress, we might ask why we need the concept of moral distress since we already have concepts to understand such emotions. We might instead maintain that the phenomenal content of moral distress is more specifically "traditional negative stress symptoms" (Kälvemark et al. 2004, 1082). But if moral distress is the occurrence of stress symptoms, why not just call it stress?

Perhaps, as Kwisoon Choe, Youngmi Kang, and Youngrye Park (2015) suggest, moral distress is stress that is accompanied by ambivalence about treatment of a patient. However, a health worker could be ambivalent about the treatment of patients with whom they have no involvement—perhaps they know about controversial treatment in another hospital where they do not work—and no work on moral distress would count this as moral distress. Hence, Stephen M. Campbell, Connie M. Ulrich, and Christine Grady (2016) stipulate that morally distressed health workers perceive themselves in some sense to be involved in their morally distressing situation. But involved how? A patient may acknowledge the constraints that obstruct their nurse from acting, suffer stress symptoms about this, and is undeniably involved in their treatment. Yet, if we allow our concept of moral distress to extend to the emotional response of the patient, we fail to identify what is distinctive about the emotional burden of the health worker.

Moti Gorin proposes that a morally distressed health worker perceives themselves to be involved in the situation insofar as they perceive themselves to be *responsible* for the situation (Gorin 2016, 11). Gorin is not alone in claiming that morally distressed health workers perceive themselves to be responsible. Some ascribe this attitude to morally distressed health workers with no further comment (Kälvemark et al. 2004, 1077; Fachini, Scrigni, and Lima 2017, 114). Some have noted that morally distressed health workers perceive themselves to be complicit in their situation (Tigard 2019, 602). But though Gorin shares the responsibility claim with others, to my knowledge he was the first to claim it as the distinguishing feature of moral distress.

We thus arrive at what I call the responsibility account of moral distress. The responsibility account provides answers to three questions that, when answered together, help us

explain what is distinctive about moral distress. First: what is the affective quality of moral distress? Like most other theories of moral distress, the responsibility account tells us that moral distress is a negatively valenced and self-directed attitude. Second: what kind of situation prompts moral distress? According to the responsibility account, a morally distressing situation is one that the health worker finds morally objectionable. Third: how does the morally distressed person perceive themselves to be involved in that situation? This prompts the responsibility account's primary claim: a morally distressed person takes themselves to be responsible for the situation.

However, the responsibility account still does not succeed in differentiating moral distress from other similar attitudes. Say a health worker believes a patient has been treated immorally, believes they are responsible for that mistreatment, and feels guilty. This health worker's experience fits the responsibility account: they hold a negative self-directed attitude; they find the mistreatment of their patient morally objectionable; and perceive themselves to be responsible for the mistreatment. But, unless we are willing to accept that moral distress is just another term for guilt—and thereby abandon the project of differentiating moral distress—we must be more specific about moral distress's distinctive features.[2]

What, then, distinguishes moral distress from guilt? The problem arises because the responsibility account has abandoned an important feature of Jameton's original definition: constraints imposed on the morally distressed health worker.[3] Such constraints typically prevent a health worker from doing what they believe is morally required, which more often than not will mean doing what is required in order to meet the needs of a patient. In a word, morally distressing situations are disempowering. This much is already acknowledged in some studies of moral distress. Constraints on the actions of morally distressed health workers come in many forms: sometimes they are constrained by a lack of staff or equipment (Fachini, Scrigni, and Lima 2017), or under-resourcing, which often reflects broader systemic underfunding of healthcare systems (Morley, Ives, and Bradbury-Jones 2019); sometimes they are constrained by conflicting moral duties (Fourie 2015); sometimes they are physically removed from patient treatment (Batho and Pitton 2018, 11). Constrained capacity to act is a recurrent feature of moral distress. I use the term "disempowerment" to refer to this constrained capacity to act.[4] The benefit of retaining disempowerment in our accounts of moral distress is that it helps us to explain the difference between moral distress and guilt. Disempowerment distinguishes morally distressing situations from moments when a health worker is in control of patient treatment, makes a mistake, and feels guilty about this.

My concern for the moment is not whether the responsibility account can incorporate the disempowerment of moral distress. I return to this in section 5. For now, I mean only to show that the conceptual task of differentiating moral distress requires that we accom-

[2] Perhaps one could maintain that moral distress is a form of guilt, but a distinctive form. However, we would then still need an account of what distinguishes moral distress from other forms of guilt.

[3] Gorin acknowledges that moral distress might indicate moral wrongs caused by institutional problems but does not include those institutional factors in his definition of moral distress. In this respect he follows Campbell, Ulrich, and Grady (2016), to which Gorin's comment on moral distress is a response. Neither explains why their definitions do not stipulate that moral distress is a response to constraint.

[4] It might be objected that the term "disempowerment" overstates the constrained capacity to act in morally distressing situations, since those who experience moral distress do not always take themselves to be completely powerless. Any concerns that I have overstated the limited capacity to act in morally distressing situations should, I hope, be allayed by the detail in section 3.

modate the disempowerment of moral distress in our theory. In order to distinguish moral distress from guilt, moral distress must be understood as a response to a situation that disempowers the person experiencing moral distress. A theory of moral distress that does not account for this disempowerment is, at best, incomplete. A theory of moral distress that *cannot* account for disempowerment is thereby in error. Hence, DR: a theory of moral distress ought to accommodate the disempowerment of morally distressing situations.

3. Varieties of Disempowerment

Thus far I have argued that in order to successfully differentiate the concept of moral distress our theories must accommodate the disempowerment of morally distressing situations. But this argument is limited in two respects. First, it tells us little about the kind of disempowerment we find in morally distressing situations. Second, it carves out theoretical space for a phenomenon that, once differentiated from other similar attitudes, may no longer be empirically identifiable—that is, it is possible that once we have successfully identified the concept of moral distress, we find that all of the identified cases in the empirical literature are not moral distress but are, in fact, other attitudes for which we have other more appropriate descriptors.

Both of these limitations of section 2's conceptual argument can be overcome by surveying cases that reveal the various ways in which morally distressing situations disempower health workers. I present a brief survey of such cases here, though I am aware that doing justice to the disempowerment of moral distress would require a much longer and more detailed analysis. Below I recount four forms of disempowerment found in accounts given by health workers who report moral distress.[5] This list is not designed to be exhaustive but rather an illustration of the variety of disempowerment found in morally distressing situations.

3.1 Thwarted Action

Sometimes morally distressed nurses have been disempowered insofar as they are prevented from performing a particular action. That action is something they think is morally right, typically an action regarding patient treatment. The latter feature of the thwarted action distinguishes it from other moral actions a health worker may be prevented from performing. Say the health worker's conscience also insists they should devote their energy to stopping climate change, but they find this incompatible with the demands of their job. They may thus find themselves prevented from fulfilling the demands of their conscience outside of work, but this would not count as moral distress because the concept is generally reserved for instances of disempowerment on the job.

Accordingly, when a morally distressed health worker experiences obstacles to a particular action, the health worker believes that action is something that someone in their job ought to do. David Batho and Camilla Pitton note a case in which a morally distressed nurse was physically removed when trying to prevent resuscitation because they believed it

[5] In addition to empirical studies cited throughout this article, I draw on accounts of moral distress in a symposium issue of *Narrative Inquiry in Bioethics* (Rushton and Boss 2013) and accounts cited in Batho and Pitton (2018).

was against the wishes of the patient (2018, 11). The nurse felt moral distress in response to a situation in which they were prevented from doing what they believed a nurse ought to do.

3.2 Moral Uncertainty

Not all accounts of moral distress include moral conviction. Sometimes health workers feel unable to act because they are uncertain about the morally right thing to do. Sometimes this uncertainty ultimately prevents further action. Sometimes action is necessary even in conditions of uncertainty, in which case an action is performed but without moral conviction. For example, a physician is presented with a deceased patient for organ donation (Mack 2013). The case concerns an instance of maternal brain death with a viable but premature fetus. The case is handed to the clinician with no explanation of the prior decision-making process, and no information about whether the option of maintaining pregnancy was considered. The physician requests an ethics consultation but this is denied. The urgency of the situation leads to a decision to proceed with organ donation that the physician feels has not been given proper thought. They feel uncertain about whether the decision was right and distress about not having had the chance to reach certainty.

3.3 Withdrawn from Decision Making

Sometimes morally distressed health workers are prevented from even entering a decision-making situation. Consider the following example (Anonymous 2013). A student nurse is working with a patient (named AG) with a severely debilitating neuromuscular disease. One day, the student witnesses AG clearly communicate to a physician that they do not wish to live. The physician asks the student to retrieve 30 mg of morphine. The student complies, despite not understanding the reason for the morphine. After retrieving the morphine, the student nurse is told that they must leave and attend to a new patient on the ward. The student does so, again unsure of the reason for the new instruction, and later returns to find that AG has died.

The student's moral distress is a response to a scenario in which they were asked to leave to allow others to make a difficult decision. The physician judged it better that they take responsibility for this, and removed the student before they had a chance to understand what would happen. This student felt disempowered, not because they cannot prevent the assisted suicide (their retrospective account at no point objects that this was the wrong thing to do), but because they were prevented from even facing the decision.

3.4 Prevented from Discussing Treatment

Some accounts of moral distress describe disempowerment after treatment has been administered. This after-the-fact disempowerment occurs when health workers are prevented from retrospectively discussing patient treatment. Among the great variety of morally distressing situations recounted in the literature, this feature is remarkably common. Very often morally distressed workers complain that their attempts to raise questions with colleagues are repeatedly frustrated (see, for example, Anonymous 2013; Batho and Pitton 2018, 11; Choe, Kang, and Park 2015, 1690). The prevalence of this form of disempowerment in moral distress is further indicated by the frequent suggestion that

moral distress can be mitigated through better communication with colleagues (see, for example, Helft et al. 2009).

This appears, for example, in the story of the student attending to AG. Their account, written decades later, notes: "I never found out what happened to AG and neither my instructor nor the charge nurse ever spoke to me about my experience" (Anonymous 2013, 94). The lesson the student learned from this experience, and later applied as a registered nurse, "was to 'debrief' with the nursing student after a patient death" because "it was my belief that a student should never go home without understanding." Thus, in addition to their withdrawal from decision making, this student felt disempowered because they were prevented from understanding the treatment after the fact.

Morally distressing situations thus disempower health workers in a variety of ways. I will not attempt a thorough characterization of the disempowerment common across this variety, though I want to make three observations. First, each of the scenarios discussed here imposes a constraint on a health worker's capacity to act, and these constraints are enough to render morally distressing situations different to situations that typically prompt guilt. This is because at least three of these forms of disempowerment exculpate the health worker; guilt would be inappropriate in these situations (I explain what I mean by inappropriate in more detail in sections 4 and 5).[6] Thus, to return to the concern that opened this section, we have reason to think the features that theoretically distinguish moral distress are not just conceptual possibilities, but bear out in cases in the literature. Moral distress does differ from guilt insofar as it arises in situations in which the health worker is disempowered.

Second, the term "disempowerment" admits one important ambiguity that these cases help to disambiguate. Earlier, I said that I use the term "disempowerment" to refer to the constrained capacity to act. But not all constraints to our capacity to act are relevant features of a morally distressing situation. No health worker has the capacity, for example, to run faster than the speed of sound, but this constraint to a morally distressed health worker's capacity to act does not help us understand their moral distress. Since there are very many other similar examples of constraints that are irrelevant to moral distress, it would help to identify a distinguishing feature of the constraints that *are* relevant.

One candidate for this would be constraints that involve removing a capacity that the health worker had previously. But there are two reasons to think this is not a satisfactory way to identify the constraints relevant to moral distress. First, there are many plausible examples of constraints on health workers that fit this description but do not seem relevant to moral distress. Perhaps due to a combination of high inflation and stagnant wages, a nurse finds that they are no longer able to take as many holidays abroad as they used to. This might be a source of unhappiness but it is not a plausible source of moral distress. Second, some of the cases of moral distress considered above do not clearly involve a health worker struggling with the fact that they used to be able to do something that now they are prevented from doing. The student nurse in the case of AG was prevented from participating in the decision about AG's death and in any discussion about what happened to AG after the fact. Since the nurse was a student at the time, it is likely that they were not prevented from doing something they were previously able to do. Thus, their disempowerment does not lie in the constraint of a capacity to act that they previously exercised.

[6] The culpability of a health worker who fails to do the right thing because of *moral uncertainty* is arguable.

How else, then, to specify the disempowerment relevant to moral distress? I propose that we understand the capacities constrained in morally distressing situations to be those that the morally distressed health worker thinks ought to be exercised by someone in their professional role. In the case of thwarted action cited above (Batho and Pitton 2018, 11), the nurse is prevented from delivering on what they believe to be the wishes of their patient. In the case of the morally uncertain physician (Mack 2013), they are prevented from clarifying whether proceeding with the organ donation meets the ethical standards relevant to the donation. And, in the case of AG, the student nurse is prevented from participating in the discussion about how the patient's end of life should be handled. In short, each of these cases are cases of health workers who are struggling with the fact that they have been prevented from doing their job well or, in some cases, from doing their job at all. This helps us to understand not only the source of the negative feeling central to moral distress, but also the extent to which the health worker feeling moral distress feels involved in the morally distressing situation in a way that an uninvolved onlooker would not (see section 2). It also helps explain discussion of moral compromise that sometimes comes up in studies of moral distress (for example, Campbell, Ulrich, and Grady 2016). Feeling compromised can be understood as being prevented from living up to an idea of what being a good health worker entails, of doing a good job, and ultimately of caring well for patients.

Third, though I have identified some general paradigmatic features of the disempowerment of morally distressing situation, the cases cited above show that there is some variety to the disempowerment that moral distress responds to. Moreover, this variety should lead us to expect that the action we can take to prevent and to remediate moral distress will depend on which variety of disempowerment a health worker's moral distress responds to. The student nurse in the case of AG is clear in their account that their moral distress could have been ameliorated had they been given an opportunity to properly debrief with colleagues about what had happened with their patient. But an opportunity to debrief might be less likely to help if a health worker is overruled by an authoritarian senior colleague, or physically removed from treating a patient; such direct disempowerment will likely require more significant action to remedy the harm to the health worker. And cases of such direct disempowerment are also significantly different to situations in which health workers are prevented from doing their jobs by institutional budget cuts or broader systemic underfunding of the healthcare system. The variety of the disempowerment of morally distressing situations thus calls for a variety of practical responses to moral distress. This gives us one reason to think that, as I suggested in section 1, further conceptual clarity about morally distressing disempowerment can help us better understand what to do to prevent and ameliorate moral distress.

4. Appropriateness

The disempowerment of morally distressing situations is a feature that plays an important role in distinguishing moral distress from similar emotions. It is also evident in a number of reported cases of moral distress. On these grounds, I am arguing that theories of moral distress should accommodate the disempowerment of morally distressing situations (hence, the disempowerment requirement, DR). But what would it mean for a theory to succeed or fail to accommodate disempowerment? If we are to return theoretical attention

to disempowerment by according with DR, it would help to have a better understanding of precisely how to deploy this requirement.

The test posed by DR could be one of conceivability, in the sense that a theory that renders moral distress a wholly unintelligible response to disempowerment would fail the test. Thus, for example, a theory which stipulated that moral distress always includes a belief that one is omnipotent would fail this test. This would be a very low bar to clear and, as my example suggests, it is difficult to imagine a plausible theory of moral distress that could not pass this test. I want to adopt a more challenging interpretation of DR, in which theories of moral distress must allow for the possibility that moral distress could be an appropriate—not only conceivable—response to a disempowering situation. A theory committed to maintaining that moral distress is never an appropriate response to disempowerment thus fails to meet DR.

The sense of propriety at play here needs some unpacking. The standard we use to determine whether a given attitude is appropriate depends on the nature of the attitude. Beliefs, for instance, are subject to epistemic norms that determine whether a given belief is, inter alia, justified or true. Emotions, too, are subject to norms of propriety; this much is evident in the fact that emotions are subject to correction. Say that I am frightened by what appears to be a venomous snake by my foot. When my friend tries to calm me down by pointing out that the snake is, in fact, an inanimate object, they attempt to correct not only what I believe about my surroundings but also my emotions; my fear turns out to be mistaken. Accordingly, theories of emotions will often make claims about the norms that apply to those emotions.

Our explanation for the normativity of emotions will depend on a number of relevant theoretical commitments, including whether our theory of emotions is noncognitivist. Judgmentalists can borrow epistemic norms in order to determine whether an emotion is appropriate (for example, my fear was inappropriate in the sense that it was irrational, or based on a false belief). Noncognitivists can instead appeal to Justin D'Arms and Daniel Jacobson's rational sentimentalism (2000a, 2000b). On their view, emotions are evaluative attitudes that ascribe value to a situation; fear responds to the fearsome, shame to the shameful, amusement to what is funny. This ascription of value implicit in emotion is capable of misfiring, and is thus subject to a norm of what D'Arms and Jacobson call fittingness. When I am afraid of a snake by my foot, my fear fits my situation only if there is indeed a fearsome animal within striking distance of me. When I realize the snake is not a snake, I should also realize that my fear is unfitting.

In their efforts to distinguish moral distress from similar attitudes, the theories recounted in section 2 already depend on implicit norms of fittingness. In theorizing the conditions that must hold for a given attitude to count as moral distress, those accounts appeal to common features of scenarios that give rise to moral distress to construct what we might call the paradigmatic morally distressing situation. For Jameton (1984), a morally distressing situation is one in which the health worker is under institutional constraints; for Kälvemark et al. (2004), it is a situation of either institutional or legal constraint; for Campbell, Ulrich, and Grady (2016), it is a situation in which the health worker is involved; for Gorin (2016), it is a situation for which the health worker feels responsible. These theories thereby depend on an account of the kind of scenario that moral distress is responding to in order to distinguish moral distress. In other words, theorists attempting to distinguish moral distress are already in the business of identifying a scenario with which

the attitude of moral distress fits, and thereby establishing a norm that distinguishes fitting from non-fitting tokens of the type.

DR tests the adequacy of these implicit norms of fittingness. I am arguing that one way we can deploy DR is to assess where a theory stands on whether moral distress can be an appropriate—fitting—response to disempowerment. DR will dismiss any theory which maintains that moral distress is never a fitting response to disempowerment. There is a simple reason for this: given, as I have argued in sections 2 and 3, moral distress is by definition a response to a disempowering situation, a theory which maintains that moral distress can never be a fitting response to disempowerment must be a theory that renders all instances of moral distress unfitting. In short, a theory that fails this application of DR is inadequate because it must conclude that moral distress is never an appropriate attitude.

Why think it is a problem for a theory if it renders all instances of moral distress inappropriate? After all, plenty of other attitudes are partly defined by their inappropriateness—for example, cognitive biases, hallucinations, and neurotic projections. A theory of these attitudes must, presumably, conclude that all instances are unfitting, precisely because it is in their nature to misconstrue the world. Why must theories of moral distress be held to a different standard?

Emotions afford the possibility of correction and, with it, a tacit standard of fittingness. Thus, when I fear an object that seems like but is not a snake, a bystander would do well to correct me, tacitly invoking the norm that fear is fitting only if there is indeed a fearsome object in my vicinity. Moral distress also admits of analogous cases of correction. Say a morally distressed health worker mistakenly believes that their patient wanted a treatment that the health worker has been unable to administer because of institutional constraints (such as lack of funding). This moral distress is open to correction by showing the health worker that their patient did not, in fact, want the treatment that they were unable to provide; the health worker simply got their facts wrong.

A more complicated and less certain process of correction could occur when a health worker believes that people in their job are subject to norms or expectations that others in the profession disagree with. Sometimes, such disagreements hinge on whether a particular standard of care is realistic or within the responsibility of the relevant health worker. At other times, such disagreements could be generated by differing views on whether a given treatment or approach to patient care is morally permissible. Where such disagreements occur, attempts to ameliorate moral distress might take the form of discussions about whether the health worker has a mistaken view of what someone in their role ought to do. Since, on my account, moral distress is a response to the constrained capacity to act as a given health worker ought to, the attitude of moral distress admits of attempts to correct the attitude that focus on the question of exactly which norms are appropriate to the health worker.

However we go about it, the point is that sometimes moral distress is an attitude that is incorrect in the sense that it fails to fit the situation, or at least that a debate can be had about whether it does. And moral distress is, crucially, only sometimes unfitting. Thus, when moral distress does admit correction, this correction is unlike the correction of a cognitive bias or a hallucination. When we correct intrinsically unfitting attitudes, we attempt to make a person see that their attitude is an instance of a certain type of attitude—a bias or a hallucination—and that the person is thus mistaken ("There is no pink elephant; you are hallucinating"). But if we correct moral distress, it is not enough to correct a health

worker by simply pointing out to them that they are experiencing moral distress. The mistake is not intrinsic to moral distress but is contingent upon whether moral distress fits the situation. It is plausible that we might tell the health worker, "Your moral distress would make sense if the patient had received the objectionable treatment, but don't worry; they didn't." A theory that does not allow moral distress to ever be fitting cannot afford this possibility.

5. Assessing Responsibility Accounts

I do not mean to overstate the significant of DR; it is just one requirement among others. A theory may meet this requirement and fail in other ways. My claim is not that DR exhausts assessment of moral distress theories but that moral distress theories must at least meet this requirement. I also mean for the fittingness interpretation of this requirement to be relatively forgiving. A theory fails to meet this interpretation of DR only if it can be shown that the theory is committed to denying the fittingness of moral distress in situations of disempowerment. This does not mean that to meet DR a theory must accept that moral distress is always fitting in disempowering situations. And theories that take no stance on the fit between moral distress and disempowerment are incomplete but do not thereby fail to meet DR. Theories that demonstrably fail to meet DR are specifically those that must conclude that, in all cases, if a health worker feel moral distress in a disempowering situation, their moral distress is unfitting.

Thus, DR need not be very demanding. But even with these qualifications, not all theories will pass DR. To demonstrate this, I return to the responsibility account. Is the responsibility account committed to the position that moral distress can never be a fitting response to disempowerment? The problem for responsibility accounts is that the disempowerment of moral distress appears to undermine any ascription of responsibility to the person experiencing moral distress. A health worker who perceives themselves to be responsible for a situation that they were powerless to avoid is at least prima facie mistaken about their responsibility. The issue of whether this is specifically an error of fit between attitude and situation—and thereby whether this is a failure to meet DR—is complicated by the fact that moral distress is unlikely to be a single simple emotion, and is not clearly theorized as such by responsibility accounts. This rules out a straightforward analogous comparison between the fittingness of, for example, an occurrence of fear and the fittingness of an occurrence of moral distress. Nonetheless, moral distress and simple emotions are both instances of evaluative attitudes—they both ascribe value to a situation—and accordingly are subject to correction and implicit norms of fittingness in comparable ways. Though a complex attitude, the responsibility account tells us that moral distress includes a self-ascription of responsibility, and this ascription can succeed or fail to accurately track a situation, much like fear's ascription of fearsomeness can succeed or fail. The question is whether the ascription of responsibility can be fitting in situations of disempowerment. I argue that it cannot.

If a health worker is prevented from acting, as in the cases briefly detailed in section 3, this disempowerment at least prima facie excuses them. Though the health worker's innocence is clearer in some cases than others, it would be overly moralistic to judge that any of these health workers should be held responsible for that which they are prevented from doing. The problem for responsibility accounts thus does indeed have the form of a

failure of fittingness. The nature of the disempowerment of morally distressing situations is such that any ascription of responsibility to the health worker must be mistaken. Given that this ascription is the primary feature of moral distress for the responsibility account, such accounts render moral distress inevitably unfitting in situations of disempowerment. As a result, responsibility accounts fail to meet DR.[7]

There are a number of ways responsibility theorists might respond to this. Some theories of responsibility deny that disempowerment, in the form of an inability to do otherwise, exculpates. One influential theory, first proposed by Harry Frankfurt, argues that I am morally responsible for my actions if they reflect my "deep self," in the form of my higher-order desires, regardless of whether I was able to act otherwise.[8] Another approach taken by many has been to differentiate the kind of moral responsibility that requires freedom to do otherwise from other forms. Thus, we might say, for example, that we are answerable whenever what we do is open to demands for justification, which unlike other forms of responsibility does not apply exclusively to actions that I could have performed differently (Shoemaker 2011). A third alternative, attributive responsibility, can apply when an action reflects a nonconscious evaluative attitude, again regardless of the ability to act otherwise—for example, forgetting a friend's birthday may betray my lack of regard for her (Smith 2005).

But though these concepts of responsibility do not require the power to act otherwise, they do require that actions for which a person is responsible reflect something about that person, whether that be a higher-order volition, an evaluative attitude, or their justification. The disempowered health workers in section 3 do not act in ways that reflect something about their "deep self," whether that be higher-order volitions, evaluative attitudes, or even their own reasons. Accordingly, these health workers are not morally responsible in any of these nontraditional senses.

The kinds of responsibility considered above are kinds of moral responsibility. What if the responsibility theorist argued instead that morally distressed health workers are *causally* responsible for the distressing situation? The distinction between moral and causal responsibility could be explained in a number of ways (see, for instance, Zhao 2020) but, for the sake of argument, we can illustrate the difference with Bernard Williams's famous example of "the lorry driver who, through no fault of his, runs over a child" (Williams 1993, 28). Though Williams did not, we might say of this example that the driver is causally but not morally responsible for the child's injuries, perhaps meaning that the driver's actions have partly causally determined harm but the driver is nonetheless not culpable (though, again, there are multiple ways of explaining the moral/causal responsibility distinction). Perhaps, like the driver, morally distressed health workers are not morally responsible but nonetheless are responsible in the sense that they partly causally determine the morally distressing situation.

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[7] Could it be that morally distressed health workers feel responsible not for failing to do what they ought to, but rather for taking a job that puts them in situations that prevent them from acting as they ought to? Perhaps, but this will not help the responsibility theorist. Were the responsibility theorist to stipulate that moral distress is a response specifically to the action of entering a disempowering profession, they would face a dilemma: either the relevant health workers were not disempowered when they entered their profession, in which case any remorse they feel about this is better described as guilt, rather than moral distress, or they were disempowered even at the point of entering the profession (forced into it by lack of options in the job market, for instance), in which case their belief that they are responsible is still undermined.

[8] A higher-order desire is a desire for a first-order desire—for example, a desire to want to exercise tomorrow morning. See, for example, Frankfurt (1971).

Note that the lorry driver example is used by Williams and many others to illustrate situations in which what Williams calls agent-regret would be fitting. If the fitting attitude of a morally distressed health worker is comparable to that of the lorry driver, we might then ask whether the most parsimonious conclusion would be that moral distress is a variant of agent-regret, rather than a *sui generis* attitude. Hence, if we wish to save the responsibility theory by maintaining that moral distress is fitting when a health worker is causally but not morally responsible for their situation, we might be forced to concede that moral distress is not distinct from agent-regret. Still, this is not necessarily a bad outcome for the responsibility theorist, who might be happy to accept that moral distress is a variant of agent-regret.[9]

However, the appeal to causal responsibility has a deeper problem, for the comparison between the lorry driver and morally distressed health workers is misleading. Although accounts of agent-regret differ on a range of details, one feature common to many is that agent-regret is fitting for cases such as that of the lorry driver because their action has resulted in a regrettable outcome and yet they are not culpable for that regrettable outcome.[10] Guilt is not fitting, but the driver's regret is different to that of a spectator because the driver's actions have caused grave harm. However, many cases of moral distress do not involve a health worker whose actions have caused a regretful outcome. In cases of thwarted action (section 3.1), moral distress is a response to a situation in which a health worker is prevented from stopping what they consider to be harm. In cases of moral uncertainty (section 3.2), moral distress lacks agent-regret's conviction that one's actions have led to something terrible. In cases of health workers prevented from discussing treatment (section 3.3), their moral distress is a response to being excluded from discussions about patient treatment. The closest analogue to the lorry driver case considered above is the case of the student nurse and AG, and we might interpret this nurse's moral distress as a response to the fact that their retrieval of morphine for a physician appears to have played a causal role in ending the life of the patient in a way that the nurse regrets. But it is also clear from the nurse's account that their distress is not primarily a response to the fact that their actions appear to have played a causal role in the death of the patient, but rather a response to the fact that their colleagues excluded the nurse from the deliberations about whether and how to end the patient's life. Rather than a response to causal responsibility for a regretful situation, the nurse's moral distress is better described as a response to being prevented from taking responsibility for their patient.

Alternatively, a responsibility theorist might accuse me of the moralistic fallacy (D'Arms and Jacobson 2000a): inferring from the moral inappropriateness of an attitude that it must not be fitting. One treatment of similar issues in moral distress by Lisa Tessman (2020) counsels us to avoid this fallacy by recognizing that moral distress, and its ascription of responsibility to the health worker, might be fitting even in circumstances where we think it would be morally wrong for other people to hold them responsible. We could say that although morally distressed health workers are being unfair to themselves by holding themselves responsible, this does not mean their attitude is unfitting.

Tessman is right about the fallacy. But this demonstrates only that it is wrong to infer unfittingness from moral inappropriateness; it does not demonstrate that responsibility-

[9] Tessman states as much (2020, 167).
[10] Wojtowicz (2022, 71) names this the "standard picture of agent-regret," albeit in the process of disagreeing with this picture.

ascription is, in fact, fitting. Tessman does offer a separate argument for this. She argues that responsibility-ascription successfully fits situations in which a health worker has committed an action that should be "unthinkable" for them, regardless of whether they were capable of avoiding that action (Tessman 2020, 174). But even if we accept this conclusion, Tessman has shown only that an ascription of responsibility could be fitting where a health worker has, unavoidably and non-culpably, committed a moral wrong. The varieties of disempowerment surveyed in section 3 involve no clear wrongdoing on behalf of the morally distressed health worker. Absent a reason to think that responsibility-ascription fits these cases of disempowerment, the moralistic fallacy argument fails to show that the responsibility account can meet DR.

Perhaps, instead, the responsibility theorist could observe that the complexity of moral distress brings with it diverging perceptions of the situation within the same attitude. Moral distress could be, for instance, intrinsically ambivalent. Moral distress might consist of both frustration at constraints on one's actions and guilt about one's responsibility for mis-treatment. Most importantly, ambivalence is not in all cases unfitting; some situations do indeed fit with diverging emotions—for example, envy *and* happiness about a friend landing a job that I also applied for. Might not moral distress be an instance of fitting ambivalence?[11]

The problem here is that fitting cases of ambivalence are disanalogous to the putative ambivalence of moral distress. The reasons why ambivalence can sometimes be fitting is that multiple attitudes can fit the same situation. Ambivalence about a friend's success can be fitting because both envy and benevolent pleasure could fit the circumstances, and thus an attitude consisting of a mixture of these emotions could also be fitting. This is not so for any complex of attitudes that includes the ascription of moral responsibility to a disempowered health worker. The problem is not that there are diverging attitudes within the complex of moral distress. The problem is that, according to the responsibility account, at least one part of that complex must be an ascription of responsibility that cannot fit a morally distressing situation.

6. Fittingness in Theory and Practice

I have argued in favor of a requirement for theories of moral distress: such theories ought to accommodate the disempowerment of morally distressing situations. Specifically, moral distress theories fail to meet the requirement only if they are committed to denying the possibility of a fitting case of moral distress in a disempowering situation. I have made a conceptual and empirical case for the requirement: arguing that we must acknowledge the disempowerment of moral distress in order to distinguish the attitude from similar-seeming emotions (most notably, guilt) and analyzing examples of such disempowerment in reported cases of moral distress. I intend the requirement to be relatively forgiving, but it

[11] Ambivalence is slightly different to cases in which a person reports moral distress and is uncertain about their responsibility. But appeal to such cases is unlikely to help the responsibility theorist. Not only would this be a significant climbdown for the responsibility theorist, it would also mean that the only form of fitting moral distress left available to them would be moral distress in situations where the responsibility of the health worker is objectively indeterminate. This would place significant burdens of proof on the responsibility theory, raising questions about, inter alia, the meta-ethical possibility of objectively indeterminate moral facts, and empirical cases cited in section 3 where the health worker appears evidently non-culpable, regardless of whether the health worker is unsure about that.

still has some critical bite and I have attempted to demonstrate this by applying the requirement to responsibility theories, showing how such theories fail the test.

I have thus focused on whether theories can afford the possibility of fitting moral distress in disempowering situations. But what are we to say about converse cases, when a health worker reports moral distress when they are or believe themselves to be responsible? I have argued that morally distressing situations are disempowering in a way that undermines claims to responsibility about the health worker. But this may lead some to worry that DR leads us to exclude some cases of reported moral distress, not unlike the way that responsibility theories must exclude moral distress felt in disempowering situations. Will DR lead us to replace one overly narrow theory with another?

I want to close by trying to allay this concern. First, it makes a difference whether the cases I am accused of illegitimately excluding are cases in which a person is responsible for their situation, or cases in which they believe they are responsible. Consider the latter. If a health worker tells us that their patient has been mistreated, they feel bad about this mistreatment, and they feel responsible for it, the moral distress they report is indistinguishable from guilt. A theory of moral distress can accommodate such cases only at the cost of abandoning the goal of a theory that distinguishes moral distress from guilt. For some, this cost will be worth paying, but the literature I am engaging with here has thus far taken distinctiveness as an explicit theoretical desideratum.

What if the health worker reports moral distress, does not think they are responsible, but in fact they are? If these features of their situation can indeed be clearly identified (bear in mind that responsibility is very often a matter we cannot easily resolve), we have a case of unfitting moral distress. The attitude felt by the health worker seems to meet the description of moral distress, but it does not fit their situation because their situation does not include the kind of disempowerment characteristic of morally distressing situations. To cite such cases as counterexamples would be to beg the question against my arguments in sections 2 and 3 for the claim that morally distressing situations are disempowering.

But the point I most wish to emphasize here is that most of the time the most important responses to cases like this should not, and probably will not, be driven by the needs of theory building. Readers may worry that my application of fittingness norms invites us to be dismissive of health workers who are not disempowered and nonetheless report moral distress. But to do this would be to make an egregious mistake about what follows from the requirements of an accurate theory. In most contexts, pointing out to a person who complains of moral distress that their emotion is indistinguishable from guilt, and thus not a good candidate for moral distress, is at best pointless, regardless of whether it is true. And, where our theory tells us that a person's moral distress is unfitting, it does not necessarily follow that we ought to correct that person. Whether we do so ought to be informed by many other considerations, including what is most likely to result in a sustainable amelioration of a health worker's suffering. Sometimes telling a person who reports moral distress that their attitude is unfitting would be cruel and unhelpful, even if it is true, and even if this fact is important for our theories. Other times, telling a person that their distress is unfitting, and more importantly explaining why this is the case, can be part of a beneficial therapeutic process. Sometimes fittingness is important both for our theory and for our practice of how we respond to the emotional burdens of health work. But excluding a case in theory is not always a good guide as to whether we should dismiss it in practice.

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