Editorial

What are surgeons' feelings of moral (di)stress?

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In the March edition of *Annals of Palliative Medicine*, Millis *et al.* provide a well-structured and interesting review of the literature on the underexplored moral distress among surgeons (1). This review provides a broader perspective of moral distress. The authors have made an excellent effort, but they have encountered several challenges to present a coherent result. They point out a major limitation of their review is the lack of universal consensus on the definition. We see this as the major weakness of the articles reviewed, but a strength of the authors dealing with this by broadening search terms. However, to cover such a variation of descriptions of moral distress also including psychological aspects as well as mixing qualitative and quantitative results under the same categories makes the result less coherent. Below we will try to sort the components of moral distress presented in the review and compare with our suggestion of model (2). We will proceed with a particular focus on one component, that is, moral stress among surgeons. The authors place surgeons at specific risk of moral distress by their unique role of "*healing through harm*".

Definition of moral distress

First, before we proceed to the question about defining moral distress, we need to focus on the aim in the review: "*to review the existing literature regarding the known and suspected factors contributing to moral distress among surgeons*" (1). We suspect that the authors might have changed the aim after data-collection to fit with analysis of data. As a matter of fact, the authors claim that the choice of Social Ecological Model (SEM) for analysis was due to the diversity of factors found. We are not sure what the authors mean by factors, also coined as "*drivers of moral distress*" (1).

Second, the authors deal with different moral and psychological terms and relations. In the proposed model in *Fig. 2*, relations between burnout, moral distress, and moral injury are presented. Other terms mentioned are occupational stressor, moral stressor, risk and protective factors and coping (1). In our findings in the article "*Moral and exhausting distress working in the frontline of COVID-19*" (2), we found another pattern and relations between moral and psychology. In line with the authors' proposed model we also distinguished occupational stress with or without a moral stressor. We call it stress in own work situation as a self-concern as opposed to stress in concern of others as moral stress. Furthermore, we distinguish stress from distress. We argue that stress may not be a negative response, particularly moral stress, but rather a normal reaction detecting an ethical issue. Distress is a reactive stress to unmitigated stress which may have psychological consequences, such as burn-out or moral injury, also proposed by Gustavsson *et al.* (3). Thus, we do not agree that occupational stress leads directly to burn-out as the authors propose.

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Third, approaching the definition of moral distress, in our above mentioned study (2), we found three kinds of moral (di)stress. We found "*being deprived of possibilities to respond to humane and professional responsibility*" (2) in line with Jameton's definition (4) used in the survey. The other two, not in line with Jameton's defintion emerged as "*a burdening guilt*" with internally directed emotions and an experience of "*uncertainty about right and good*" (2). From this we concluded that a broader definition of moral distress was needed. We landed on the proposal by Campbell *et al.*: "*One or more negative self-directed emotions or attitudes that arise in response to one's perceived involvement in a situation that one perceives to be morally undesirable*" (5). This definition differs particularly regarding one aspect from the authors' proposed definition by British Medical Association (BMA) (6): "*the psychological unease generated where professionals identify an ethically correct action to take but are constrained in their ability to take that action… (and) by witnessing the moral transgression by others*" (1). This aspect concerns Campbell's "*perceived involvement*" (5), which we interpret entailing a moral responsibility, while "*moral transgression by others*" (1), we interpret as a distress due to others. However, in the original BMA definition, "others" are not used, instead a complicated explanation of moral transgression as "… *the feeling of unease stemming from situations where institutionally required behaviour does not align with moral principles*" (6). Here, we want to complement the authors for a good and broadened summary of just "*others*"!

Fourth, from here we will focus on moral stress, which we see as an important emotional reaction signalling a moral perception of what the ethical issue is in the patient situation. This is an important part of moral case deliberation (7) and possibility to ventilate this stress may prevent consequences as moral distress or injury.

Moral stress among surgeons

The authors have chosen to categorize according to the SEM. This is most understandable due to the heterogonous results in the articles in the review. However, we have made so bold as to try to extract what we interpret as moral stress, cutting across the levels of the SEM. Then, we also ventured to make a rough categorisation (see *Table 1*). These categories seem to partly comply with the author's favoured definition mentioned above. The first part "*the psychological unease*" (6) was difficult to trace. This is surprising as the title of the review signals emotions: "*To feel or not to feel*". We found a few signs in the summary table of the articles, which we interpret as "Sense of not living up to own moral ideals" (*Table 1*). The second part of the definition "*identify an ethically correct action to take but are constrained in their ability to take that action*" (6) can be traced in the following two categories: "Pressured to pursue life prolonging actions" and "Facing breakdown of relationships important for patient care" (*Table 1*). In the latter, we also see the third part including the authors' ending of "*by others*" of the BMA definition: "*witnessing the moral transgression by others*" (1).

The authors raise in the discussion that sources of moral distress should be context sensitively addressed. In our recent publication uncovering how moral reasoning was embodied in the vascular surgeons' everyday clinical practice, we see some correspondence with their experiences of moral stress in the present review. The vascular surgeons' moral reasoning encompassed "*a quest to relieve suffering and avoid harm*" (8). This seemed to entail a moral stress to struggle with authority for surgery for their frail patients with impaired decision-making capacity. They pondered on risky life prolonging procedures, whether they were meaningful for the patient and the intricate balance between what could be done surgically to relieve patient's suffering and the risk of harm (8). This has correspondence to our suggested category "Pressured to pursue life prolonging actions", but only regarding the issue of life prolonging actions. This reflects the paramount ethical issue reported in literature. But, what was absent in the vascular surgeons narratives, was the blaming of others, such as feeling pressured and facing breakdown in relationships. Furthermore, the vascular surgeons did not either express emotions of blaming oneself of not living up to own moral ideals. As above mentioned absence of emotions (except for findings in the summary table), corresponds with the lack of emotions in the vascular surgeons narratives.

In conclusion, there is a need to further explore the concept of moral distress related to other moral terms as well as the demarcation to psychology. Moral stress among surgeons seems to be about the core moral responsibility; to do good and avoid harm. However, the emotional part of surgeons' stress needs to be uncovered.

Table 1 A suggestion of categorization of moral stress extracted from the authors' result

Categories	Extracts of moral stress from different levels of SEM
Sense of not living up to own moral ideals (relates to psychological unease in the BMA definition)	"*felt their efforts were not enough according to their moral ideals*" (*Tab. 1* result summary)
	"*worried whether surgery aligned with patient goals*" (*Tab. 1* result summary)
	"*encountered ethical dilemmas leading to moral angst … expressed the need to feel safe to discuss these events openly*" (*Tab. 1* result summary)
	"*acting or witnessing actions that betrayed their morals*" (Individual level)
Pressured to pursue life prolonging actions (relates to constrained to take ethically correct action in the BMA definition)	"*to provide non-beneficial interventions*" (Environment)
	"*providing life prolonging intervention for terminally ill patients and pressure from others to drive care*" (Interpersonal level)
	"*confronting controversial values in American culture such as providing life extending interventions to facilitate family's emotional closure and extending life to facilitate organ donation*" (Community)
	"*initiate extensive life saving actions when I think they only prolong death*" (Interpersonal)
	"*pursuing care for fear of legal repercussions*" (Policy)
	"*following ethically discordant directions*" (Interpersonal level)
	"*having unclear or inconsistent goals of care*" (Interpersonal level)
Facing breakdown of relationships important for patient care (relates to constrained to take ethically correct action and witnessing moral transgression by others)	"*poor communication, both among team members and between the medical team and family*" (Interpersonal level)
	"*working alongside inadequately trained colleagues*" (Interpersonal level)
	"*disruptions to the doctor patient relationship*" (Policy)
	"*limits on family having access to loved ones during the pandemic, not offering surgery*" (Policy)
	"*excessive documentation resulting in impaired ability to care for patients*" (Policy)

SEM, Social Ecological Model; BMA, British Medical Association.

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Footnote

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