



Moral Distress

When Others' Decisions Trouble Us

BY DONALD PATTHOFF, DDS, MAGD, AND DAVID OZAR, PHD

Longtime patient Evelyn Baker is in your chair. Her son, who brought her to this appointment, tells you that since her last visit two years ago she has moved into an assisted living facility because she "wasn't handling it very well alone." After her initial exam, necessary radiographs, and prophylaxis, you determine that her oral hygiene is still well-maintained. However, you also notice that the vibrant wit and personality that you and your staff came to know and love are almost gone.

You make special note of two small fractured restorations with soft carious lesions near the margins. Though you have time to repair them during this appointment, you are unsure whether your patient will understand. You ask her if you could consult with her son. "Yes, yes, ask him," she says.

Her son is invited into the operatory. You explain that although her oral hygiene is well-maintained, there are two small areas needing repair; you add that you could do the procedures right away. Before the son can answer, however, Baker says, "All I want is my usual cleaning; everything else feels fine."

"For goodness sake, Mother," the son says in a loud voice, "you've just had a cleaning. Get with the program!"

Unfortunately, dentists and their staff often are in the presence of other people's ethically questionable reactions and decisions, such as the one described. While some of these decisions are related to dental care, many involve managing a family relationship—but that does not make them any less uncomfortable for the dentist or staff. Effective communication and supportive relationships are major components of professionalism in the dental office, so it is understandable if the dentist and staff feel somehow involved in these kinds of troubling decisions.

Similarly difficult situations can arise when there is a child in the chair. Dentists and their staff deal with parents, guardians, friends, and others who scold, bribe, ridicule, or coerce children in the office. Such ways of relating to people undermine the caring relationships that dentists and their staff aim to develop, not only with each child and each elderly person, but also with every patient.

Sources of moral distress

Health care ethics literature has been paying increased attention to such situations among all kinds of health care providers, as this type of experience represents an ethically challenging situation. The literature now uses the expression

"moral distress" to refer to the anxiety a caregiver experiences when his or her own beliefs are at odds with another's actions, yet the caregiver is not in a position to prevent or correct those actions. He or she therefore must witness, often very close at hand, and possibly feel complicit in actions that he or she judges to be ethically mistaken.

The same kind of moral distress also occurs in settings where care is provided by several caregivers—like the typical dental office where a dentist, dental assistant, and dental hygienist work together to respond to patients' oral health needs. Suppose, for example, that the lead decision-maker in a caregiving team acts in a way that another member of the team judges to be ethically incorrect—either because it falls short of a standard of competent care or because it falls short in relating to the patient. Because of the hierarchical structure of the caregiving team, someone in a subordinate role may have no formal standing for inquiring about the ethics of such a decision; whether the lead decision-maker's decision was ethically well-founded or not, the decision almost certainly will not be discussed.

This does not necessarily mean that the caregiving team's hierarchical structure is inappropriate. In the case of dental offices, which are most often headed by a dentist, this structure is usually complemented by appropriate, and often informal, communication within the team. Such a structure is clearly the best one for providing patients with the highest-quality diagnoses, treatment recommendations, and treatments themselves. But hierarchical structures, in and of themselves, are *not* the most effective structures for addressing moral concerns, including moral distress.

Moral distress also can arise among members of a multi-dentist practice. This especially can occur if there is significant generational distance among the dentists. Additionally, if the practice is large enough that policies are determined routinely by a small executive group, moral distress can arise between the other dentists and that decision-making group. Here again, social and/or administrative hierarchies dictate many of the member dentists' relationships,

and understandably so. But if decisions with significant ethical importance are made only hierarchically, without an opportunity for respectful, inclusive discussion, the occasions for moral distress can multiply.

Dealing with moral distress

Moral distress situations can sap caregivers' energy and challenge the mutual respect and loyalty within caregiving teams and shared practices. As a result, these situations also can

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influence caregivers' ability to work for ideal patient care. There is no doubt a connection between repeated experiences of moral distress in practice and a sense of building emotional fatigue in practitioners—which the popular press inaccurately refers to as professional "burnout."

Therefore, we should consider which kind of structure is the most effective for addressing moral distress. We certainly are not going to diminish the ethical complexity of dental care in a world increasingly impacted by market and political forces that raise new challenges to maintaining professionalism in the dental office. It is well worth asking, however, what might be done to reduce the incidence of—or at least the intensity and negative consequences of—caregivers' moral distress in our dental offices and practices.

One positive step would be to make the ethical aspects of daily dental decision-making and group practice policy decisions more collegial—creating an environment and, if necessary, constructing specific settings in which all members of a caregiving team and all participants in a group practice can be included in discussing matters that are ethically complex or troubling. Each member needs to be aware and respectful of their possibly distinct contributions to the ethical thinking that a given patient, case, or policy issue requires.

It would help a lot, then, if there were more conversations about the ethical issues in difficult cases and policy decisions—honest and mutually respectful conversations aimed at putting all the relevant ethical considerations on the table so they can be weighed together by those involved. These need to involve a deliberate form of conversation designed to share ideas and concerns, and even differing points of view, when they are present. This is not the time to demonstrate

that one's own answer to the ethical question at hand is the only reasonable answer (or worse yet, that everyone else's ideas are clearly defective).

Beginning at home

Unfortunately, dental offices are impacted unavoidably by third-party payers' decisions regarding patient care and policy, as well as policy decisions from government agencies at every level. Add to that the growing force of computer management systems and standards organizations, as well as many other community agencies, services, and social media.

Dentists, correctly, often challenge the ethical adequacy of many of these decisions from the perspective of maintaining and improving patients' oral health. They do this by discussing these challenges with colleagues, friends, and representatives; by writing articles; and by bringing these challenges to their professional organizations.

We are far from constructing a forum, however, in which the direct providers of oral health care can represent their patients' interests fully and challenge those decisions they judge to be harmful to their patients. Even so, it would at least be helpful if our all too distant decision-makers at least would articulate the ethical thinking that leads them to imagine—if they do—that their decisions impacting the provision of oral health care are ethically sound.

This proposal may be, of course, little more than wishful thinking. But moral distress is real, and there is something that the oral health community can do about it. It can “begin at home”—in the dental offices and group practices where *AGD Impact* readers work.

We certainly are not proposing the elimination of the hierarchical structure of decision-making in patient care or the administration of large caregiving groups. We are proposing, though, that those with decision-making authority routinely recognize that each caregiver brings ethical life experiences and reflection to their caregiving. Each caregiver, therefore, can contribute to the

team or the group’s ethical thinking and therefore, either directly or indirectly, to the final decision that needs to be made.

If inclusive, respectful conversations like those described above were more common in dental offices and dental groups, fewer caregiving team members would feel the distress that comes when their ethical point of view is never even heard. Fewer would wonder about the ethical reasons, if any, behind the decisions of authorized decision-makers. None of them would have reason to believe that they, as thinking human beings with genuine ethical views, were considered unimportant in an important matter.

Of course, it is not only those with decision-making authority who would need to adjust in order to make ethical reflection in dental offices, and group practices, more inclusive and explicitly respectful of each person’s contributions. Everyone would need to change. Everyone would have to be willing to speak when such conversations take place, and everyone would have to learn, as a place to start, to be an acute, respectful listener to the others. In time, they would need to learn to be attentive to their own first responses in situations of moral distress. Do they, for example, express this distress by accusing others, in general or swooping accusations, of always being the cause or being incapable of learning or growing?

In other words, every member of every dental care team and every practitioner in a group practice would need to ask himself or herself: “As a member of this caregiving team and group, what could I do to contribute to this change? And, if I am the authorized decision-maker in some matter, what can I do to support and encourage respectful collaboration with those who report to me and whom I supervise?”♦

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