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# SOCIAL WORKERS' EXPERIENCE OF MORAL DISTRESS

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### Article abstract

When health care professionals know the right thing to do, but are prevented from doing so, they can suffer from moral distress. Although moral distress in nursing has been studied extensively, it has been a neglected topic with regard to the social work profession. This paper presents findings of a qualitative descriptive study on health care social workers' experiences of moral distress, focusing mainly on the situations that caused such moral distress. The effects of moral distress, the coping strategies these social workers used to deal with their experience and the common theme of "pushing the rules" are also presented. Finally, we offer recommendations, which were made by participants, to assist social workers with decreasing the effects of moral distress. By following these recommendations, social workers' experience of moral distress may decrease which will, in turn, positively affect the organizations for which they work and the patients they serve.

# SOCIAL WORKERS' EXPERIENCE OF MORAL DISTRESS

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**Abstract:** When health care professionals know the right thing to do, but are prevented from doing so, they can suffer from moral distress. Although moral distress in nursing has been studied extensively, it has been a neglected topic with regard to the social work profession. This paper presents findings of a qualitative descriptive study on health care social workers' experiences of moral distress, focusing mainly on the situations that caused such moral distress. The effects of moral distress, the coping strategies these social workers used to deal with their experience and the common theme of "pushing the rules" are also presented. Finally, we offer recommendations, which were made by participants, to assist social workers with decreasing the effects of moral distress. By following these recommendations, social workers' experience of moral distress may decrease which will, in turn, positively affect the organizations for which they work and the patients they serve.

**Keywords:** Social Worker, Moral Distress

**Abstr   :** Lorsque les professionnels de la sant   savent ce qu'il faut faire, mais qu'on les emp  che de le faire, ils peuvent souffrir de d  tresse morale. Bien que la d  tresse morale en soins infirmiers ait fait l'objet d'  tudes approfondies, elle a   t   n  glig  e en ce qui concerne la profession de

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travailleur social. Cet article présente les résultats d'une étude descriptive qualitative sur les expériences de détresse morale des travailleurs sociaux des soins de santé, en se concentrant principalement sur les situations qui ont causé une telle détresse morale. Les effets de la détresse morale, les stratégies d'adaptation utilisées par ces travailleurs sociaux pour faire face à leur expérience et le thème commun de « repousser les règles » sont également présentés. Enfin, nous offrons des recommandations, présentées par les participants, pour aider les travailleurs sociaux à réduire les effets de la détresse morale. En suivant ces recommandations, l'expérience de détresse morale des travailleurs sociaux peut diminuer, ce qui, à son tour, aura un effet positif sur les organismes pour lesquels ils travaillent et les patients qu'ils servent.

**Mots-clés :** Travail social, détresse morale

*ACCORDING TO THE CANADIAN ASSOCIATION* of Social Workers (2008), social workers' primary concern is the "social well-being of all people equally with attention to their physical, mental, and spiritual well-being" (CASW, p. 1). Social workers value helping people yet they are frequently blocked from doing so because of institutional constraints within their place of work and those of the organizations to which they refer people. These constraints can conflict with social workers' professional goals of helping people, as well as their Code of Ethics, as the constraints make it difficult, and sometimes impossible, to help patients obtain what they need. It is at these times of perceived inability to "do the right thing" for their patients that social workers may experience moral distress.

Andrew Jameton first coined the term *moral distress* after conducting a study on nurses and ethical dilemmas. According to Jameton (1984), moral distress "arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). He expanded his definition as follows:

The painful feelings and/or psychological disequilibrium that occur when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of institutional obstacles: lack of time, lack of supervisory support, exercise of medical power, institutional policy, or legal limits (Jameton, as cited in Corley, 2002, p. 636).

Moral distress is a phenomenon that has been extensively studied in nursing (Bruce, Miller & Zimmerman, 2015; Corley, Minick, Elswick & Jacobs, 2005; Kalvemark et al., 2015; Wilkinson, 1988; Winland-Brown, Chiarenza & Dobrin, 2010). These studies show the effects of moral distress are profound, not only for nurses, but for their patients and the organizations for which they work (Corley et al., 2005; Kalvemark,

Hoglund, Hansson, Westerholm & Arnetz, 2004; Spenceley et al., 2015; Wilkinson, 1988; Winland-Brown et al., 2010). For example, nurses reported symptoms of “frustration, sadness, psychological exhaustion, helplessness, suffering, distress, disappointment, depression and physical exhaustion” (Wiegand & Funk, 2012 p. 483) and stated “they lose their capacity for caring, avoid patient contact, and fail to give good physical care” (Rushton, 2006, p. 2) as a result of moral distress. Some nurses have also reported leaving their positions as a consequence of moral distress. For example, Winland-Brown et al. (2010) found that 22 % of nurses and 55.6 % of nurse practitioners had left a position due to moral distress (p. 9). Another study found that over a quarter of respondents wanted to quit their job, motivated to a large extent by the experience of moral distress (Spenceley et al., 2015).

At the time of this study, a literature review showed that while social workers have been included in some studies on moral distress (Ulrich, Hamric & Grady, 2010; Bruce et al., 2015, Dodek et al., 2016), only one study focussed uniquely on social workers and moral distress (Mänttärivan der Kuip, 2016). According to Weinberg (2009), one reason the concept of moral distress has not been studied in social workers is because “the outcomes of decisions in nursing are more dramatic and concrete – physical pain and death – whereas, in social work, the consequences are more often less tangible” (p. 143). Certainly, there is nothing more concrete than death, however, health care is not solely about life and death. Social workers are witness to many other dire situations that negatively impact a person’s life for which the social worker may have no solution. For example, being homeless with a severe illness and no income is very tangible. Therefore, Weinberg’s suggestion that this is the reason moral distress has not been explored with social workers seems implausible.

Weinberg (2009) also commented that the term “ethical dilemma” is used more often than “moral distress” to describe the difficulties social workers may face. A literature search using the terms “social workers and ethical dilemmas” generated many more results than “social workers and moral distress.” Ethical (moral) dilemmas involve situations where there are at least two viable options but picking one option negates the other option, for example, respecting a patient’s decision to live in unsafe conditions (autonomy) versus moving them against their will to a safer environment. Therefore, studying social workers’ experiences with ethical dilemmas does not increase our understanding of their experience with moral distress.

The only study we found on social workers and moral distress explored whether social welfare workers experienced moral distress due to insufficient resources (Mänttärivan der Kuip, 2016) and the results showed that of those who experienced moral distress, 42.4 % wanted to leave their jobs (Mänttärivan der Kuip, 2016). The respondents reported

frequently being unable to perform their role in a manner they would have liked and they were compelled to work in opposition to their professional moral code causing them moral distress (Mänttari-van der Kuip, 2016).

Moral distress is a personal experience; what causes moral distress for one health care provider might not be the same for another. As Epstein and Delgado (2010) wrote, "Because values and obligations are perceived differently by various members of the health care team, moral distress is an experience of the individual rather than an experience of the situation" (p. 4). Therefore, even though nurses and social workers share a common goal of helping people, their experiences of moral distress may be different, making it inappropriate to assume that what nurses report as causes and effects of moral distress in their work would be the same for social workers.

Studying social workers and their experience of moral distress contributes to an understanding of this phenomenon in disciplines other than nursing (Pauly, Varcoe, & Storch, 2012). Furthermore, social workers' experience of moral distress is worthy of attention, not only because few studies have been undertaken, but because knowing its cause, as well as the support structures that could help lessen it, will help address this issue before the impact to the individual social worker, and the profession as a whole, become irreparable.

In this paper we report on a qualitative study that explored the causes of moral distress for health care social workers. The effects of the distress are summarized, as well as the supports the participants used to cope with their feelings of moral distress. A discussion regarding the findings that the participants often "pushed the rules" in order to avoid constraints that caused them moral distress is presented. Finally, we offer recommendations, which were made by participants, to assist social workers with decreasing the effects of moral distress.

## **Method**

### *Qualitative Description*

This study used Qualitative Description (QD) to explore the causes of moral distress for health care social workers and how the distress affected them. According to Sandelowski (2000), "Qualitative Description is especially amenable to obtaining straight and largely unadorned (i.e., minimally theorized or otherwise transformed or spun) answers to questions of special relevance to practitioners and policy makers" (p. 337). The aim of QD is to report the findings directly and provide a description of the participants' experiences in their own language (Neergaard, Olesen, Anderson & Sondergaard, 2009).

*Participant Selection*

Social workers representing a variety of health care departments, and who had extensive experience working in health care, were purposely selected in order to provide a diversity of perspectives. Ten social workers were sent a recruitment email message from the Social Work Professional Practice Leader describing the purpose of the study and all ten agreed to participate in the study. The participants (nine females and one male) worked in a variety of health care departments, including Home Care, Supportive Living, Community Health, as well as inpatient and outpatient units in Calgary's four hospitals, including the Alberta Children's Hospital. Given their lengthy experience, the social workers were able to reflect on their many working years to describe occasions when they had experienced moral distress. The number of years the participants had each worked as a social worker ranged from seven to 38 years, with the average being 19.5 years. Of the ten participants, nine had obtained a Master's degree in Social Work.

*Interviews*

Data were collected through semi-structured interviews, which were conducted in private, one-on-one settings. Interviews commenced with participants being provided with Andrew Jameton's (1984) definitions of moral distress (mentioned previously in this paper). Participants were asked to speak freely about their experience with moral distress. Prompts were used when participants were unable to think of experiences of moral distress, as well as to assist in participants' reports of the effects of such distress and the supports they used to deal with moral distress. For example, participants may have been asked, "Have you ever experienced moral distress when you have tried to help a patient access a support you knew they needed but the patient was denied the support due to qualifying restrictions?". Or, "Do you believe you suffer any physical or emotional symptoms as a result of moral distress?". Participants were directly asked if they had ever left a position, or considered leaving a position, due to their experience of moral distress.

*Data Analysis*

Data collection and data analysis occurred simultaneously with data analysis starting after the first interview. The specific quotes (data) from each interview were coded into three pre-determined research themes: causes of moral distress; effects of moral distress; and supports for moral distress. The terminology and codes were then examined to create the sub-themes for each main research theme. Consistent with the methods of Sandelowski, we counted the number of times a sub-theme was mentioned

by each participant to determine which sub-themes were reported the most (Sandelowski, 2000).

### *Ethics Considerations*

Ethics approval was received from the University of Calgary Conjoint Health Research Ethics Board (REB15-3059). All participants signed a consent form that included information about the purpose of the study, what their participation involved, and the anticipated benefits and risks to them. All participants were assured their confidentiality and privacy would be protected through data security provisions and their experiences would be represented in presentations and publications with pseudonyms. They were informed they could withdraw from the study at any point during the interview and up to the point where their data had been analyzed (within one week of the interview). No participant withdrew from the study.

## **Findings**

### *Causes of Moral Distress*

While all participants acknowledged experiencing moral distress, they reported its frequency as varying from rarely to daily, with most participants stating they experienced it a couple of times per month. Causes of moral distress generally fell into one of four participant-generated sub-themes: *other health care professionals*; *caseloads*; *external resources*; and *internal rules*. These sub-themes are described below.

*Other health care professionals.* Other health care professionals (professionals who were part of the participants' interdisciplinary teams or who worked in another department or agency) were the most frequently reported causes of moral distress. Two commonly expressed issues were the other health care professionals' (HCPs) unrealistic expectations regarding the participants' ability to see all the patients referred to them within a short time frame and/or their ability to secure external resources for patients. As Mary said, other HCPs often expected that "you are going to immediately see all the patients who have been referred to you and you are going to solve the problem right away and they can go home." She stated further, "And when you can't and people [other HCPs] aren't happy with that, that's hard for social workers also... you can't meet the expectation even though you would like to." Claudia stated, "There is a huge amount of pressure on my shoulders to fix this situation, whatever it may be, because we want the best outcome for the patient." Sheila commented that when a social worker is unable to meet the expectations of other health care professionals "I think that can often be misconstrued that you are ineffective; that you're incompetent at what you are doing."

In addition, half of the participants stated they were frequently asked to do things that did not fall within their scope of practice (such

as capacity assessments), or that were not appropriate, such as finding a patient's lost dentures. Participants suggested these inappropriate requests arose because other HCPs did not understand the professional role of social workers. The participants also suggested that social workers are often given tasks that other HCPs do not want to do (for example, complete forms). Moral distress arose in these situations because the inappropriate requests required time from social workers, limiting their ability to assist patients and provide services within their professional mandate. In addition, moral distress arose because the participants sometimes believed that if they did not do the inappropriate task, such as find dentures, the patient would possibly suffer (for example, replacing dentures can be very costly and time consuming).

Being told by other HCPs not to assist certain patients was also a source of moral distress for half the participants. For example, Claudia reported she had been told not to do external advocating for a specific patient population. She said, "I was asking myself why am I even here?... I have never experienced anything so utterly ridiculous." She stated that what she was asked not to do was such a core aspect of her responsibilities that she did not think she could continue to work under that request. As another example, Jane mentioned her manager asked her, "Why are you counselling those brain injury people? They don't understand counselling." The manager told her to focus on the patients' financial concerns only. Mary reported being told by a doctor to stop helping a particular patient because the doctor felt she was doing too much for the patient.

The manner in which HCPs treated patients was also a frequently reported cause of moral distress for most participants. Participants spoke of situations where patients were inappropriately judged and these judgements negatively affected the care the patient received.

For example, Robyn described a situation where she tried to enrol her patient in a brain injury rehabilitation program but was told the patient would not be accepted. Robyn stated, "I remember clearly the conversation, like 'what do you mean she can't go to rehab because she was a sex-trade worker?' I don't get it." The participants also stated they experienced moral distress when other HCPs did not respect patient autonomy.

*Caseloads.* A second sub-theme identified as a cause of moral distress was the frequent reporting of unmanageably high caseloads. Eight participants in the current study stated that the inadequate number of social workers required them to triage their patients based on patient need for housing and income, which meant they often did not have time to see all patients referred to them, or to address other concerns such as a patient's emotional issues. As Jill stated:



You're not able to do a lot of that advocacy work because the referrals just keep coming in, right? And how do you manage that in an effective way to be able to advocate for your client and be able to feel good about the work you do each day so that you don't have that moral distress that comes up that interferes with your own personal life and your own personal well-being?

*External resources.* The third sub-theme identified in the participant descriptions as a cause of moral distress was the constraints imposed by the agencies ("External Resources") to which the participants referred their patients. Such constraints prevented access to resources patients needed and often consisted of strict eligibility criteria or a lack of availability. For example, Jill spoke of some hospices' rules that made people with addiction issues ineligible for hospice care, and of addiction treatment facilities that did not accept people with mental health issues. Marnie stated, "I definitely experience some distress when I have to send people away saying 'These are the avenues, for one reason or another you don't fit into them.'"

Four participants also spoke of patients dying as result of external agencies refusing to accept patients they referred to them. For example, Karrie spoke of a patient's death that she attributed to an external agency refusing to assist a patient and his family. She said:

The doctor and the social worker said to Child Welfare 'This mom is telling us, like saying, she cannot take this child home, she is not coping' and Child Welfare released the child to the mom's care and the child came [back] and died in this unit a month later [as a result of injuries his mother inflicted on him].

*Internal rules.* The fourth sub-theme arose from descriptions participants gave of situations where the rules in their own place of work ("Internal Rules") caused them moral distress. For example, participants who worked in in-patient departments frequently spoke of moral distress when patients were discharged because they were "medically cleared," however, the patients' other needs, such as income, housing, and general emotional support, had not been addressed. As Robyn stated, "Social issues don't keep people in hospital, which leads to a 'Well, what am I doing here then?'" Seven participants suggested a social work consultation might have prevented patients from further hospital admissions so it was hard for them to understand why these patients were discharged before seeing a social worker. Participants offered other examples of internal rules that caused moral distress including being forbidden to assist family members of patients or prevented from sending email messages to patients and their families to facilitate communication.

*Pushing the Rules*

Many participants spoke of how they would not follow an internal rule if they thought doing so was in their patient's best interest. Their "disobedience" allowed them to do what they perceived as the "right thing" for their patients. For example, Jane would communicate with patients' families who did not live in the city by email, which was against workplace policy. She said, "I just do it, you know, I just don't care" because she believed, "We are here to serve the client and their families and to best communicate with them."

Similarly, the participants spoke of the efforts they undertook to fight the constraints that stopped their patients from getting the resources they needed, even if it meant "pushing the rules" or "going in the back door." For example, Linda did not disclose a patient's well managed mental health diagnosis on a housing application because she knew that if she wrote "schizophrenia" on the application, the patient would likely not have been accepted. Linda stated, "I don't adhere to rules, really. You know, if I can help somebody and go through the back door [a figure of speech], then I will do it." Linda further stated, "it's about the patient really. It's not about the organization" but she added, "I would never jeopardize my job." Robyn said she would decide whether to push the rules by asking herself:

Do I have a valid reason, a valid rationale, for the approach that I am taking in this situation? And I specifically don't do things that are wrong, right? If I know that something is wrong, I am going to try and figure out another way. I am not going to do the wrong thing purposefully. Nothing that would be against my personal values, or values and ethics as a social worker, right?

Mary spoke of when she advocated for a patient to move into a long-term care facility closer to where the patient's husband lived, rather than the one to which she had been assigned that was 100 kilometers away. She said, "So I did everything in my power, and I didn't always follow the rules to the letter and I actually was willing to get my hand slapped because I couldn't see this happen." When asked if she feared she would get reprimanded for this, her response was:

So yeah, I was concerned, but in my heart, I knew what was right. And I think that for social workers, the dilemma is, in your heart you know this is the right thing to do but the system does not allow that to happen but where you come from a place of advocacy, you come from a place of care and support to the patient and family and it's all about that and so that's why, I think, we make those decisions to not follow the rules.

Sometimes, when the participants recognized they advocated more for some patients than for other patients by “pushing the rules” or “going in through the back door,” they experienced moral distress. More specifically, they thought it was not right that they provided inequitable assistance to their patients. For example, Robyn stated, “And sometimes it’s hard to make sense of that in your mind of why am I doing things differently for this person, but sometimes you just do.”

### *Effects of Moral Distress*

The second main research theme related to how moral distress affected the participants, as well as how these effects subsequently affected their interactions with patients and the organization they worked for.

The most reported effects of moral distress by far were exhaustion and sleep disturbances. Some participants reported feeling so exhausted from the emotions involved in morally distressing situations that they would go straight to bed when they returned home from work. Most participants reported they had difficulty falling or staying asleep because they could not stop thinking about specific instances that had caused them moral distress. Other than exhaustion, participants did not report any other physical health symptom. Participants also reported experiencing emotional responses, such as anger, frustration, disappointment, and sadness as a result of moral distress. For example, Robyn stated:

The emotion I have most common with moral distress is anger and frustration. When I am ‘going against the norm’ and advocating hard because I feel strongly about something, it is frustrating to be unsupported by staff and the larger system and makes me question my role here.

Several participants suggested that the effects of moral distress negatively affected their self-esteem in that they experienced “self-doubt” when they were unable to secure resources for a patient. Most participants stated their feelings of moral distress affected their family and personal lives. For example, Mary said, “I’ve come home and I just don’t want to talk to anybody.” Claudia stated, “I think I’ve withdrawn as a person because that’s typically how I deal with stress.”

The participants in this study were aware that moral distress affected their interactions with patients, most commonly in the manner of distancing themselves from the patients and not advocating as much as they typically would. For example, Claudia stated, “I was definitely more reticent” as a result of moral distress. Sheila stated, “You don’t have time to be empathetic.” Finally, seven study participants stated they had considered leaving a position and five reported they had left a position due to moral distress. Participants who reported leaving a position had done so because they believed they had been unable to fulfill their professional role competently and effectively due to various constraints.

*Supports for Moral Distress*

The third theme related to how participants managed or coped with their experience of moral distress. By far, the most commonly reported supports used by participants were their team members and peers. However, most participants said they had limited time to access peer support due to caseload demands. Tom stated, "I need to be talking to people who are familiar with the situation because if you bring in an outsider, I'm not sure that they fully understand even what you are referring to." Most participants shared this sentiment, which is why they rarely used formal supports such as Employee Assistance Programs or Ethics Consultation Services. According to Karrie, she would not access the EAP because the counsellors often don't have frontline experience and their advice "just comes across as cookie-cutter crap."

Six participants stated their self-care, both physical (exercise, meditation) and emotional (attitude and perspective) also helped to alleviate the effects of moral distress. For example, Claudia said, "I still insist on coming to work every day with optimism." Karrie stated, "I am genuinely proud to be a social worker. I get to make someone's life fractionally better in their worst possible nightmare." Furthermore, all participants acknowledged that their number of years working as a social worker helped to alleviate the frequency with which they experienced moral distress. According to Marnie, "Age and wisdom and learning to accept and let go" helps to keep her moral distress to a minimum. Having "healthy boundaries" and "learning to say no" (to inappropriate requests, for example) were ways participants dealt with HCPs whose expectations and demands could cause them moral distress.

**Discussion**

Although this study has a very small sample size, the results show that social workers experience moral distress and this distress affects them personally as well as their patients and the organizations they represent. Participants reported that the health care professionals for whom they worked were the most frequent cause of their moral distress. The participants spoke of being told by other HCPs to do things outside of their scope of practice or to complete tasks that were otherwise inappropriate. Participants also reported some HCPs told them to not do certain things—things participants deemed as integral to their role as social workers. They attributed these types of situations to some HCPs' not clearly understanding the professional role of social workers. Some participants suggested some HCPs assigned them tasks simply because they did not want to do the task themselves. Confidence and experience enabled the participants to speak up when they perceived their role was misunderstood.

Participants also spoke of experiencing moral distress when they witnessed their patients receiving inappropriate treatment or unfair judgements by other HCPs. Given the Canadian Association of Social Workers' (CASW) Code of Ethics (2005) that mandates all social workers to "Advocate for fair and equitable access to public service and benefits" (p. 5), as well as to "Oppose prejudice and discrimination against any person" (p. 5), it is easy to see why participants were upset when they perceived their patients received inappropriate treatment by others. However, social workers can find it difficult to challenge those who display such disrespectful behaviour because, often, it comes from individuals who may be in a higher position of power (e.g. physicians).

Nurses have also described experiencing moral distress resulting from other HCPs' interactions with patients (Bruce et al., 2015; Mukherjee, Brashier, Savage & Kirschner, 2009; Oliver, 2013; Spenceley et al., 2015; Wilkinson, 1988). For example, Wilkinson found that one of the most common situations that caused moral distress for nurses was the "incompetent/inadequate treatment by a physician" (p. 20). Regarding the latter, Wilkinson (1988) referred to the nurses' feelings as "moral outrage" and stated:

Nurses do not clearly separate the feelings that occur as a result of actions they, themselves, do or do not take from those actions which occur because someone else (physicians, students, other nurses, etc.) performs an action the nurse believes to be immoral... and while nurses do not participate in the act, they are powerless to stop it. They then experience the same feelings and effects that occur in moral distress (p. 24).

Given that many organizations experience budget limitations and staffing shortages, it should be no surprise that participants expressed that their high caseloads contributed greatly to their experience of moral distress. Most participants said they did not have enough time to "do the right thing" for all their patients according to their professional and personal values. High caseloads have been commonly reported as causing moral distress in nursing as well (Corley, Elswick, Gorman, & Clor, 2001). Participants reported eligibility criteria and availability of external resources, as well as the internal rules of their workplaces, were other reported causes of moral distress.

Many participants spoke of "pushing the rules" or "going in through the back door" when they were met with some type of constraint to get their patients the assistance and/or resources they needed. Participants reported doing this even if they were told not to assist a patient, either overtly by another HCP or because of internal rules. They also "bent" or withheld information so their patients would meet eligibility criteria for resources. This high level of advocacy was the participants' attempts to

*combat* the constraints that caused them moral distress. (Given that many of the participants used phrases such as “get your fighting gloves on,” “rally the troops,” and “get ready for a battle,” the term “combat” is an appropriate term to describe their efforts.)

In doing what they believed was the right thing for their patients, even if they were disobeying the rules, the participants were demonstrating what has been described as *moral courage*. According to LaSala and Bjarnason (2010):

Nurses who consistently practice with moral courage base their decisions to act upon the ethical principle of beneficence (doing good for others) along with internal motivation predicated on virtues, values, and standards that they believe uphold what is right, regardless of personal risk (p. 1).

Nurses also recount similar situations in which they do not adhere to rules. For instance, when there was discord between the organizational rules and what nurses perceived as the right thing to do for their patients, the rules were often broken to favour the patient (Kalvemark et al., 2004). Jameton (1993) suggested that nurses make a moral judgement to determine what they are going to do when their organizational rules constrain them from helping their patients. Similarly, Wienberg and Taylor (2014) suggested social workers use their judgement of what is best for their patients when they push, or break, the rules of their organization and described such social workers as being “rogue.” Weinberg and Taylor (2014) stated that many of the participants in their study “had, as a common aim, the good of the client as the underlying value that motivated them to be more ‘relaxed’ about the rules” (p. 78) and that the “proliferation of rules by the very fact of their tangle and contradictions promotes rogue behavior” (p. 84). Certainly, some participants in the current study discussed using their judgement to weigh the benefits (for the patient versus the organization) of pushing the rules and, if the outcome favoured the patient, then the participant would typically proceed.

The Canadian Association of Social Workers’ (CASW) Guidelines for Ethical Practice (2005) and the Alberta College of Social Workers’ (ACSW) Standards of Practice (2013) seem to support social workers “pushing the rules.” For example, the CASW Guidelines for Ethical Practice state, “Social workers take all reasonable steps to uphold their ethical values and responsibilities even though employers’ policies or official orders may not be compatible with its provision” (CASW, Guidelines, 2005, p. 16). The ACSW Standards of Practice (2013) state, “If an employer/supervisor demands that a social worker act in a manner contrary to the Social Work Code of Ethics or Standards of Practice, the social worker is expected to apply professional judgement in deciding what action to take” (p. 34).

As mentioned previously, the participants in this study spoke of applying their professional judgement to decide whether to “push the rules,” as suggested by these Standards of Practice.

Fine and Teram’s (2013) paper explored the overt and covert ways in which social workers may react when they disagree with their organizations’ rules. An overt manner of reacting is to directly confront the organization to try and effect change. Covert actions are less obvious and can be exemplified by the examples presented by the participants in the current study, such as withholding a mental health diagnosis on a housing application. Fine and Teram (2013) suggested that thinking about such actions in advance can give rise to feelings of moral distress. The participants in the current study said they were mindful they would get reprimanded for “pushing the rules,” however, they felt they were doing “the right thing” for their patients and they could justify this belief if they indeed were reprimanded. They did not express that “pushing the rules” caused them moral distress but that it allowed them to get around constraints that caused them moral distress. The thing that did cause them moral distress was their inequitable support for some patients. They questioned themselves as to why they would “push the rules” to advocate more for some patients over others.

Similar to LaSala and Bjarnason’s description of moral courage, Fine and Teram (2013) argue that “both covert and overt actions ought to be considered heroic in light of what appears to be timidity on the part of many social workers to act against their perceived moral injustice in the work places” (p. 1312). Arguably, the participants in the current study were “heroic” and demonstrated “moral courage” when they went above and beyond to get their patients the assistance they required, despite knowing they could “lose my job” or be “reprimanded” for doing so. Unquestionably, Mary’s patient (for whom the doctor said Mary was doing too much) recognized her efforts when she said, “I will never forget you, you’ve made the impossible possible. You’ve helped me rebuild my soul.”

## **Recommendations**

All participants in this study reported they had experienced moral distress multiple times throughout their careers. Given that participants reported moral distress affected not only themselves but also their patients and the organizations they represented, moral distress must be addressed to minimize these effects. Not addressing the stress related to moral distress can result in moral wounds that cause harm to those who bear them and which can harm careers, particularly when such incidences are experienced on an ongoing basis (Epstein & Delgado, 2010). Participants were asked to make recommendations regarding supports that would help them, and their colleagues, to experience less moral distress and to deal with its consequence more effectively.



Given that many participants reported a significant cause of moral distress pertained to inappropriate or unrealistic requests made by other HCPs, organizations and social workers should educate other HCPs on the role of social workers and their guiding Code of Ethics. Organizations should also ensure that managers are informed of the causes and effects of moral distress so they are better able to support their staff members who experience moral distress. Furthermore, because high caseloads were reported to be a significant cause of moral distress, health care departments should advocate to their upper management for funding to ensure a sufficient ratio of social workers to patients. This would allow social workers to fulfill their professional role effectively and also allow patients to have equitable access to the specialized services provided by social workers.

Social work education programs should include training on the causes and effects of moral distress to help social workers learn to recognize when they, and their colleagues, are experiencing moral distress. Such recognition could prepare social workers to take the necessary steps in addressing the effects of moral distress before such effects become detrimental to the individual and the profession as a whole.

Finally, managers should encourage social workers to participate in regularly scheduled, peer support meetings and recognize that such time “away from the job” is time well spent as it may prevent social workers who are unable to cope with their moral distress on their own from taking sick leave or leaving their jobs. Most participants acknowledged their peers as their biggest source of support, yet many stated they rarely had time to seek such support. The participants said it was important to them to discuss their experiences of moral distress with colleagues familiar with their experience and that regularly scheduled peer support meetings would facilitate this occurrence. Participants also suggested organizations assign a Social Work Clinical Lead (or access to clinical supervision) to each department that employs social workers to support them when needed. Such access would give social workers the opportunity to speak with someone familiar with their responsibilities and values—something the participants felt would be useful in helping them deal with the moral distress they often encounter while trying to fulfil their important and demanding roles as social workers.

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