Pastoral Psychol (2013) 62:151–162
DOI 10.1007/s11089-012-0458-8

Resisting Moral Residue

Alina Bennett · Sheena M. Eagan Chamberlin

Published online: 26 June 2012
© Springer Science+Business Media, LLC 2012

Abstract This paper surveys contemporary scholarly conceptions of moral residue in order to demonstrate the fruitful inconsistencies contained in these various notions. Due to the fact that moral dilemmas are commonplace in the practice of medicine, patients and practitioners are uniquely situated to experience moral residue. The authors investigate two medical sites as case studies that demonstrate how a more capacious notion of moral residue can be useful for explaining ethical complexities: euthanasia on the battlefield and care of minors who are members of the Jehovah's Witness faith community. These case studies will be of particular interest to chaplains, pastoral theologians, and other relevant practitioners and intellectuals. Fruitfully cast against the illuminations of interdisciplinary scholars including Donald Capps, Lorraine Hardingham, and others, these cases are used as instructive discursive devices, shedding greater light on ideas put forth within the literature on this engaging and complex topic.

Keywords Moral residue · Military medicine · Jehovah's Witness · Ethics

Introduction

The works of medical humanities and bioethics scholars have been widely used in medical spaces by health care providers seeking both the cultivation of individually self-reflective practices and also to establish a communal base of knowledge regarding the often thorny ethical dimensions of such employment. One would be hard pressed to locate a more frequently used text than *Principles of Biomedical Ethics*, which is evidenced by the fact that at least one hospital ethics committee within the University of Texas Health Science Center is currently reading the famous book (Beauchamp and Childress 2009). Due to the fact that this text is so commonplace within clinician-centered teaching environments, it is of

A. Bennett (✉) · S. M. Eagan Chamberlin
Institute for the Medical Humanities, University of Texas Medical Branch, 301 University Blvd., Galveston, TX 77555-1311, USA
e-mail: ambennet@utmb.edu

critical import to understand the ways in which the text teaches providers about the ethics of caring for people in medical settings. In the most recent edition of their canonical text, philosophers Tom L. Beauchamp and James F. Childress discuss the distinctive character of moral dilemmas that result from competing or conflicting *prima facie* obligations. Namely, regardless of whether an agent chooses action *x* or action *y*, the agent's action will be considered simultaneously morally acceptable in certain respects and morally unacceptable in other respects (p. 11). Recognizing the inherent difficulty in such a task, the authors state: "We should discharge the obligation that, in the circumstances, we judge to override or to compromise what we would have been firmly obligated to perform were it not for the conflict" (p. 11). Although Beauchamp and Childress aim to discharge certain obligations, they acknowledge that overridden *prima facie* obligations do not simply go away, as "even the morally best action under many circumstances of conflict is regrettable and will leave a moral residue" (p. 16). Unfortunately, the twelve sentences dedicated to the topic fail to adequately address the intricacies of this complex concept. The few citations provided by the authors do not satisfy the inquisitive reader, thereby leaving more questions than answers: Does moral residue always entail regret? Is moral residue a necessary end point of all moral conflicts? Does moral residue merely occur in certain decisions and specific contexts?

In this paper, we attempt to flesh out a more capacious notion of moral residue through a two-pronged approach, first by way of a literature review and second by situating moral residue within two exemplary case studies. We will begin by surveying the literature in order to understand contemporary scholarly conceptions of moral residue. This literature review will serve to highlight the many inconsistencies encompassed within understandings of these notions as seen in the works of interdisciplinary thinkers such as Donald Capps, Lorraine Hardingham, Elizabeth Gingell Epstein, Anne Baile Hamric and Andrew Jameton. This paper will also employ case studies with the aim of gaining a richer understanding of the notion of moral distress and residue. The case studies will help to illuminate and further explicate the concepts discussed within the current published literature.

Surveying the field

We would be remiss not to mention the sister terms often found flanking moral residue, the two most prominent being "moral distress" and "moral dilemma." Generally moral residue is understood as arising from moral distress, which is the result of a moral agent being faced with moral dilemmas. This paper takes a deeply narrow approach by focusing on moral residue, but a brief explanation of the companion concepts will be useful given their linkages throughout the scholarly conversation. One of the consequences of such a tightly focused endeavor is that some stones will be left unturned. Beauchamp and Childress are not the only ones unwilling to tangle with moral residue; we found it to be by far the most under-researched of the three interrelated topics. In contrast, moral distress is by far the most researched concept and has been thoughtfully considered in nursing literature, which we explore below and further expand on by discussing it within one of the case studies.

Moral distress and moral dilemmas

According to nursing scholar Lorraine B. Hardingham (Hardingham 2004), moral distress arises when there is an inconsistency between one's beliefs and one's actions (p. 128).

Certain constraints in the situation prevent the agent from taking actions that they perceive to be morally ideal (Epstein and Hamric 2009). Thus, moral distress is the result of a perceived violation of one's core values and duties, while simultaneously being constrained from pursuing the ethically preferable course of action (p. 2).

Nursing scholars Elizabeth Gingell Epstein and Anne Baile Hamric endorse Andrew Jameton's notion that moral distress consists of two parts: initial distress and reactive distress (p. 1). Initial distress refers to the moral distress occurring at the time of the event or moral choice (i.e., as a situation unfolds), whereas reactive distress occurs after the situation that elicited moral distress ends and is carried forward into the agent's moral life. By formulating the concept of reactive distress is such a way, we as readers can see the connections between moral residue and reactive distress. Both involve unresolved feelings and obligations that are carried forward by the agent. Epstein and Hamric, whose interpretation of reactive distress is closely linked to moral residue, also share this opinion (p. 1).

The concept of moral dilemmas is almost always included in the discussion of moral residue and moral distress. Like the other concepts being investigated here, moral dilemmas have curious qualities that make them notoriously resistant to single, shored-up definitions. A deontologically grounded thinker following the work of Immanuel Kant might argue that moral dilemmas do not exist because there will always be a morally best action according to a matrix of maxims. Although Kant himself does not address moral dilemmas within his oeuvre, others, including Bernard Williams, W. D. Ross, and Thomas E. Hill, have mapped moral dilemmas and moral residue retroactively onto Kant's theories.

Hill (Hill 2002) argues that true moral dilemmas differ from "tragic cases" which are created by gaps in Kant's moral theory and that situations in which we cannot reason a resolution are based in one such gap not in a genuine moral dilemma (p. 8). When faced with two seemingly "wrong" choices, Kantians would say that because there are no moral dilemmas, an agent must simply wait for an as yet unseen resolution to reveal itself as the most reasonable option (p. 373). Hill continues in a Kantian vein, and he examines moral residue as a normative notion, focusing not on how people do or do not feel, but rather on how they should or should not feel. Rather than adhere to a specific philosophical tradition's conception of moral dilemma, we embrace a more pedestrian notion that points to the fact of indecision based on moral conflict. We apply this commonplace conception of moral dilemma in terms of the exploration of moral residue put forth here, focused most tightly on the affective dimension of moral residue. We privilege theorists who attend to emotional ways of knowing the world over other dimensions of experience stemming from rationality and thereby implicating duties and obligations which we find less helpful in terms of conceptualizing interprofessional ethics.

Moral residue

In their chapter entitled "Moral Residue," Canadian philosophers George C. Webster and Françoise E. Baylis introduce the concept of moral residue as it applies to the lives of clinical ethicists dealing with ethical problems of a moral nature (Webster and Baylis 2000). The authors offer a keen understanding of the serious nature of moral residue as

> …that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised. These times are usually very painful because they threaten or sometimes betray deeply held and cherished beliefs and values. They are usually also

> lasting and powerfully concentrated in our thoughts; hence the term moral *residue*. (p. 218)

For Webster and Baylis, moral residue develops because "serious moral compromise (this is, compromised integrity) irreversibly alters the self. One does not experience serious moral compromise and survive as the person once was" (p. 224). Unlike Beauchamp and Childress, who argue that moral residue can develop even if the choice of action is right, clear and uncontested, Webster and Baylis reserve moral residue for instances in which one has truly experienced alteration (Beauchamp and Childress 2009).

As an exemplar case, Webster and Baylis tell the story of a medical student who, after engaging in a morally compromising medical act, articulates feeling dirty and unclean as if something in the deepest reaches of herself had changed such that these new negative feelings would be with her forever (p. 224). This medical student was told by a faculty physician to perform a pelvic examination on an unconscious patient. For the student, this was an abhorrent act which left her feeling as if her soul had been violated. According to Webster and Baylis, this dramatic conceptualization of moral residue offers an indictment against the anemic conceptualizations articulated elsewhere and exposes the narrowness with which this fleshy, and perhaps frightening, experience is often theorized.

In the instance provided by Webster and Baylis, the imbalance of power caused complications for the medical student in that her integrity as a person and as a healer was compromised. It was compromised because she had been forced to make a choice that from her perspective was not a choice at all. It is this quality of un-choice to which Webster and Baylis's conception of moral residue hinges whereby an agent is in fact forced, or at least perceives themselves as forced, into making a specific choice due to the contextual complications and constraints.

An alternative perspective may be to consider this an example of a tragic capitulation to power through which one goes against one's "gut" in favor of acquiescing to the request of an authority figure. From this perspective, the student was choosing between various stronger and weaker moral obligations. For her as a healer, the stronger obligation was to the patient; however, for her as a student, perhaps the stronger obligation was to follow the instructions of her instructor.

There is a difference between being unable to choose between two equally strong moral obligations and making a choice that goes against one's "gut" decision due to the complications of the situation, thus resulting in the kind of moral residue pointed to by Webster and Baylis. Perhaps one of the most famous euphemistic crises of moral choice is seen in the motion picture *Sophie's Choice* (Pakula 1982). A "Sophie's choice" dilemma involves being forced to choose between two seemingly wrong choices of equally weighted value. The particular choice faced by Sophie in the film is to decide which of her two children to send to their death in the crematorium, the other being sent to the children's camp. When she exclaims that she is unable to choose, Sophie is informed that should she refuse, both will be sent to the crematorium. Rather than end both their lives, Sophie chooses to send the younger child, her daughter Eva, to the crematorium. Sophie is ultimately driven to suicide as a result of being unable to live with what we conceive of as the affective consequences of moral residue, having been forced to make this impossible choice between two morally equal choices.

We argue that a more robust understanding of moral residue will provide the common ground of connection between Webster and Baylis's concept of going against one's gut and being forced to decide between equally weighty choices as seen in *Sophie's Choice*. Moral residue can comprehensively include both of these conceptions because of its proper focus

on interiority. Perhaps moral residue's most salient quality is not the likeness of choices that facilitates the development of moral residue, but the internal experiences of those whose choices have resulted in moral residue. Perhaps we can only know that a choice will leave moral residue when moral residue develops.

There are certain limitations to this broader conception of moral residue, namely that one is unable to determine the likelihood of moral residue by mere assessment of the choices before them. Moral residue is necessarily ambiguous and not a helpful concept for one in search of the certainties implied by the language of "discharging obligations" and normatively proper feelings seen in the works of the deontologically inclined. Moral residue is weakly predictive because its true use lies in its descriptive strength regarding the affective dimensions of lived lives and will be explored in this paper through a discussion of two case examples.

Case one: battlefield euthanasia and moral distress

Euthanasia is defined as "a deliberate act undertaken by one person with the intention of ending the life of another to relieve or avert that person's suffering where that act is the cause of death" (Canadian Parliament 1995). Three commonly discussed types of euthanasia are: voluntary, involuntary, and non-voluntary (Canadian Parliament 1995). Voluntary euthanasia involves a patient who competently and persistently asks to have their life ended. On the other hand, involuntary euthanasia involves a patient whose life is ended against their explicit objections. Non-voluntary euthanasia occurs when a patient's life is ended while they are incompetent and unable to communicate their wishes, under the direction or upon the request of a health-care proxy or surrogate decision-maker. Although euthanasia on the battlefield could involve any of these three types of killing, we will be focusing on and discussing voluntary and non-voluntary euthanasia. The typical scenarios of discussions involving battlefield euthanasia take place during an emergency, when troops are retreating and unable to move their expectant patients, those whose injuries left them beyond the hope of military medicine.

Battlefield euthanasia has been a topic of military medicine since antiquity. In fact, requests of this nature can be traced as far back as biblical times (Swann 1987). Although U.S. military regulations do not condone euthanasia on the battlefield, discussion of this topic has persisted. For instance, CPT Steven W. Swann (U.S. Army) published an interesting, although fictional example of such a request in order to prompt discussion in his 1987 article on the topic (Swann 1987, 547). Beauchamp and Childress also mention a type of euthanasia *in extremis* in their work *Principle of Biomedical Ethics* (Beauchamp and Childress 2009, 33). While discussing ideas surrounding moral virtue, the authors cite Thomas Keneally's representation of a physician faced with the choice of euthanizing his patients or abandoning them to be tortured by the Nazi SS from the novel *Schindler's List* (p. 33). Beauchamp and Childress's discussion of *Schindler's List* reflects typical battlefield euthanasia cases as seen in the work of ethics scholar David L. Perry (Perry 2011). Although unaddressed by Perry, an important aspect of such cases is the element of forced choice where the moral agent is constrained by war and the approaching enemy, leaving very few options.

According to Hardingham, a moral dilemma may arise when an agent fails to do the right thing because of circumstances truly beyond their control (Hardingham 2004). Essentially, the agent is unable to do what's right because of context, despite recognizing the morally preferable course of action (p. 128). This constraint is undeniably present in the example of battlefield euthanasia. The morally ideal course of action would be to provide all the

necessary care required to give the patient a chance at surviving or to insure their evacuation to a safe location. However, the uncontrollable circumstances of war may make these options impossible.

In these extreme situations, a physician is left with three options. First, the physician can stay with these patients, providing palliative care, resulting in the physician's and the patient's capture or death. Second, the physician can leave; abandoning the patients without further treatment, or lastly, the physician can leave after euthanizing the expectant patients. The first option is the official position of the United States Military (Beam 2003). However, this position is predicated on the fact that the Geneva Conventions explicitly protect non-combatants (including medics, nurses, corpsmen and physicians) and the wounded from being killed or tortured (International Committee of the Red Cross 2011). However, in modern warfare these rules are not always upheld, rendering this option very problematic. By choosing to stay with the patient as their position is overtaken by enemy forces, the physician ensures their own capture as well as that of the patients, which could lead to the patients' torture and death. This first option also limits the medical corps' ability to care for future wounded soldiers due to the loss of medical personnel. With the second option, the physician abandons the current patients without treatment. These expectant patient-soldiers would continue to suffer as enemy troops or the Nazi SS (in Keneally's example) overtake their position, capture, and possibly kill them. This leaves only the final option: battlefield euthanasia.

Unfortunately, euthanasia involves killing patients and is ordinarily seen as incompatible with our current conception of professional and moral norms. Thus, this dilemma is not easily resolved; every choice is morally problematic. Although euthanasia is the best option (or the lesser of all available evils), it represents a constrained choice that was forced onto the agent and is not normally morally acceptable. Fitting Hardingham's conception of a moral dilemma, the agent is unable to do the morally best thing because of circumstances beyond their control, namely war (p. 128). This inability on the part of the agent to make a choice that is morally preferable is what leads to moral distress.

Case two: minor-age Jehovah's Witness patients and moral residue

The second and final case study is worthy of note and analysis due to the unique moral dilemmas involved in treating Jehovah's Witnesses (JW) patients. While the understanding of moral distress, as explicated in the previous case study, is undeniably present in the following case study, this case study narrows its focus to the moral residue of the agent involved in this type of morally distressing dilemma. JW patients present an interesting case in terms of moral residue because of the complicated ways in which the values and practices of medicine conflict with the values and practices of patients. Cases in which provider and patient wishes are misaligned may not be rare, but the unique challenges regarding the refusal of blood products by JW parents concerning the care of their children presents a fascinating example of the ways in which moral residue is implied yet absent from the discussion. Instead, a rights-based discussion concerning parental autonomy occupies the majority of works concerning such patients. We must first acknowledge that we were unable to locate a single source that discusses the concept of moral residue as it applies to JW patients. Having already established a robust notion of moral residue, we argue that despite its absence from our source documents, notions of moral residue undergird much of the scholarly conversation regarding these patients. A discussion of moral residue in this context will elucidate new conceptions of what tends to be a relatively one-sided conversation.

The Watchtower Bible and Tract Society is headquartered in Brooklyn, New York, and is the primary source of doctrinal guidance for the JW faith community. The concern regarding transfusions began in 1945 with Fred Franz, long-time member and "oracle" of the Society, although it was not published in church literature until the July 1, 1951, edition of the *Watchtower* which stated: "Any saving of life accomplished by transfusions is short-lived. And doing it in disobedience of God's commands could cost one eternal life" (Gruss 2003). Stemming from a number of Bible verses that discuss prohibitions against eating blood, the Watchtower Society argues that eating blood and getting a transfusion are the same by citing scientists' writings across the ages. The Watchtower Society still holds fast to this idea, saying that while living is precious, medical emergencies do not allow followers to ignore the Life-Giver's laws (Watchtower 2011a, Blood).

Concerning other medical procedures such as transplants, the Watchtower holds that "the conscience of some Witnesses permits them to accept organ transplants if done without blood," and much ado is simultaneously made about medical advances such as blood volume expanders and the imprecise science used to establish healthy versus unhealthy hematological levels (Watchtower 2011b, Quality). The Watchtower advocates both respect for autonomy and cooperation between patients and providers which includes mutually protecting documents such as preoperative agreements (Watchtower 2011a, Blood). Despite the hard-line stance regarding the refusal of transfused blood, the Watchtower makes room for individual choice, saying, "Ultimately, however, you, the patient or the parent, must decide. Why you? Because your (or your child's) body, life, ethics, and profoundly important relationship with God are involved" (Watchtower 2011a, Blood). Having provided a rough outline of the JW beliefs regarding transfusions, we will now address the ways in which the concept of moral residue can be fruitfully considered in situations involving JW patients.

Our concern regarding JW patients began with a case here at University of Texas Medical Branch. We were unsettled by the way in which providers were able to quickly secure a court order to transfuse a young child of JW parents. Thinking that such rapid actions left little time for discussion, figuring out each other's footings, and letting truth emerge through dialogue, we began feeling quite concerned that case law is all but settled when it comes to minor JW patients. Throughout our literature review of clinical ethics cases on the topic, we were unable to locate a single instance in which a judge refused to issue a court order for medical treatment of a minor-age patient of JW parents. The rationale cited for such actions is that the state has an interest in protecting children and advancing their *best* interests (Meadow 2010). This indicates the unobstructed way in which a child's welfare is narrowly conceived within medical parameters, as determined by medical professionals, and enforced through legal means.

This is not to say that there are no physicians who honor JW parental or late teenage (15–17) JW patient wishes regarding the use of blood products. Similarly, we imagine that there are a great number of physicians who work with JW parents and minor-age patients to come to consensus about the treatment plan because, as many clinical ethicists have said to me in reference to this project, there are Jehovah's Witnesses and then there are Jehovah's Witnesses. Underlying this comment is an implicit commitment to dialogue and the art of persuasion. It is concerning that this turn to the law is obscuring what may in fact be the most integral element in making medical decisions: the conversation. A turn to law in these instances is not strictly a foreclosing event. What gets animated because of the turn to law? And what role does moral residue play throughout this process?

In the example concerning the medical student, moral residue seems tethered to the aftershocks of the event. Though anxious and uncomfortable when instructed to perform and while performing the pelvic exam, the student's full experience of her*self* as compromised

took place through reflection after the fact. As the term implies, it is the residual aspect of a moral compromise that haunts the person. In the case of minor-age patients with JW parents, moral residue is simultaneously present and absent yet it motivates much of the action. Perhaps these instances of moral residue are best understood as powerful specters.

One of the most palatable specters concerns physician training. What is so troubling to physicians is the fact that they were trained to save lives, and their concerns about withholding treatment are consistently represented in JW cases but also within bioethics literature writ large. Physicians are disproportionally educated towards vitalist practices and protocols to such an extent that they lack competence in the possibilities of comfort care, which are relegated to the specialty of palliative care. Cure is so valuable that it may become the only goal towards which a physician works, even in situations when patients may wish or benefit from other types of care. We argue that this demonstrates a kind of avoidance of moral residue in which one's identity as a physician is unhinged because one betrays, so to speak, one's training to save lives.

Of course the question is up for debate in terms of whether or not lives are actually saved. In three Canadian cases, court orders were issued for transfusions in late-age minors (16/17 years) who refused treatment, and in all three cases the patients died. One particularly heart-wrenching piece mentioned only briefly how one of these patients, a 16-year-old girl with dysfunctional menstrual bleeding, had to be physically and chemically restrained throughout her 38 court-ordered yet not life-saving blood transfusions (Guichon and Mitchell 2006).

A nurse working with this patient said: "It became increasingly difficult to walk inter her room holding the IV tubing primed with blood and say, 'I'm sorry to do this to you'" (p. 658). This quote unmistakably demonstrates the kind of moral residue that originates in making a choice which is not really a choice at all, a point to which we will return. The nurse caring for this patient describes the kind of wearing down one experiences when one is repeatedly powerless in terms of making the choice they are making. As we discussed earlier, moral residue is involved in instances like these where people are forced into particular choices due to the contextual constraints of the situation.

It is significant that the nurse, not the physician, is discussing what we argue to be moral residue. This is an important dynamic to consider because health care is an inherently collective project. Though the physician may have sought the court order to avoid the effects of moral residue in terms of going against their training to save lives, it is the nurse who must implement the court order, an act that we argue is paramount to medical torture. This kind of transference of moral residue from the physician to the nurse is not critiqued within the text but is a familiar theme in much of the nursing literature, where it is framed instead as an issue of power. In terms of power, perhaps this nurse could have refused to participate or reported this as an ethics violation. Although we were unable to locate the details of this case, we imagine that these avenues were less available given the fact that a court order had already been issued, which indicates that perhaps the ethics route had already been taken.

This is not to say that physicians are able to avoid moral residue altogether. Perhaps this situation could be read as one in which the physicians go the legal route in order to transfer and thus take on the moral residue of the decision which previously lay with the parents. Removing the choice from the parents' hands may be considered an element of compassionate, holistic care for the parents now faced with a very difficult decision. Throughout much of the literature, JW parents of patients are represented as loving people who want the best for their children. Some are persuaded by physicians to allow treatments, some have the decision removed from them through legal means, and some successfully advocate for the

refusal of treatment resulting in the child's medical improvement or comfort care as the child dies. Regardless of the outcome, JW patients represent an example of the ways in which the practices of faith and the practices of healing are necessarily tethered. These cases force a kind of reckoning within medicine where the shortcomings of medical education are becoming unmistakably revealed.

One such shortcoming is laid out here by religious scholar Neil Pembroke, who locates it as an issue of compartmentalizing people. According to Pembroke, this is troubling because

> Human persons cannot be divided up into physical, emotional, and spiritual compartments. The human person relates to herself and to others in an integrated fashion, incorporating all the various facets of her personhood. When she becomes a patient, she experiences the suffering that is associated with her illness on a number of levels. (Pembroke 2008)

Pembroke argues that physicians should take spiritual histories in addition to the medically and socially centered histories they already take (p. 555). Rather than acquiring an in-depth understanding of the patient's spiritual life, the "aim is much more modest. Taking a spiritual history is largely an expression of a holistic concern. The physician wants to let the patient know that she is interested in much more than just his signs and symptoms" (p. 556).

For JW patients, a spiritual history is critical given the impact on treatment options, yet this is another area that has been similarly unaddressed in the clinical ethics case studies. However necessary and inspiring Pembroke's call to attend to a patient's spiritual as well as medical life, what is the benefit of gathering this information if the physician then ignores it in favor of treating "just the signs and symptoms"? The strength of the holistic approach is undercut by privileging the medical when conflict arises with the spiritual.

We argue that while the patient's spiritual health is disavowed in terms of it being the basis for decision making, perhaps it is a primary motivator for the physician. Because the physician's training has become so entwined to the notion of self, the good doctor becomes the one who continues to try life-saving measures. To undermine that training by allowing a JW minor-age patient to refuse transfusions would constitute an undermining of the self, thus resulting in the trappings of moral residue. Moving away from the JW example, we will return to the larger discussion of moral residue so as to further examine some of the ways in which these trappings have been intellectually explored.

Expanding moral residue

Within the scholarship on moral residue, the key component of transformation is largely present with particular concern that the involved agents describe themselves as giving up a part of their self or becoming a different kind of self. This notion of becoming is notably absent within theoretical frameworks that privilege a kind of calculated or measured approach and therefore seem badly suited for understanding thornier medical experiences that often facilitate moral residue.

Webster and Baylis resist this type of conceptual thinning and call for frameworks that account for what they call, the "experience of the ethical" which is colored by both moral uncertainty and moral distress (Webster and Baylis 2000). Epstein and Hamric argue that concessions or compromises of this nature should be understood as acts that entail yielding one's moral values (Epstein and Hamric 2009). The result of such experiences "is a loss of moral identity leading to moral residue that is lasting and powerful" (p. 3).

In their article, “Moral Distress, Moral Residue, and the Crescendo Effect,” University of Virginia nursing faculty Epstein and Hamric argue that health care providers suffer from being forced to take inauthentic actions such that each new morally distressing situation builds upon the previous, resulting in a kind of crescendo of personal crisis (p. 3). Working with staff of a neonatal intensive care unit, the authors find that moral residue differs from burnout or compassion fatigue in that it is specifically tethered to one’s experience of powerlessness in the morally distressing situation: “The repetitive nature of the situations and the perceived powerlessness that accompanies each situation may be caused by a wearing down of moral integrity rather than (or in addition to) the repeated experience of others’ dying” (p. 5).

Their qualitative work with seasoned and novice staff members demonstrates, as is discernible from the above quote, that a conscientious objection or even the choice to leave nursing may be the result of this chronic chipping away at one’s moral integrity even though actions of this sort are most often seen as a consequence of burnout. The authors cite the following examples demonstrating this phenomenon as moral residue and not burnout:

> “[Nurse asks]’Why are we doing this?’ And [the physician] said, ‘Because we can. That kind of thing really bothers me.’”
> “The situations where our ethics have not kept up with our technology.”
> “[Physician says]…in my heart of hearts, I think a lot of it is probably inappropriate and is harming the child and that bothers me a lot. But when you think that you’re fighting against the whole expectation of medicine…these interventions create a life of their own.” (p. 7)

An under-explored theme running throughout Epstein and Hamric’s work is the role of relationships in the building of moral residue. The quotes above demonstrate the consequences of power dynamics between doctors and nurses, the role of technology in extending life while simultaneously getting in the way of providing humane end-of-life care, and lastly, the role of a provider’s relationship with their patient being controlled by the legacy and traditions of medicine.

Rather than being forced to take inauthentic actions over and over again, we interpret Epstein and Hamric as advocating that providers remove themselves from situations that threaten their moral integrity in order to maintain the sound moral foundation necessary to do their work. The authors ultimately find that “healthcare professionals, insurers, patients, and healthcare systems must not assume that damaged moral integrity is an acceptable, natural consequence that must be borne by healthcare providers” (p. 11). Citing the difficulties of studying moral residue, the authors believe in the two-prong approach of, first, working to limit moral distress, and second, taking each other seriously after devastating events do occur; both are critical pieces towards moral progress (p. 11). In spite of a lack of verifiable studies of moral residue, the authors’ ethnographic and narrative evidence paints a persuasive picture of redemption for a notorious system known for devaluing relationship-building in healthcare settings.

Webster and Baylis’s and Epstein and Hamric’s respective conceptions of moral residue are not positioned within a single theoretical framework. The authors cite sources that resist such framing, including the work of environmental health ethicist Andrew Jameton and that of philosopher Charles Taylor, both of whom privilege knowledge gained from the everyday. By privileging work in which theory is necessarily tethered to the experiences of lived lives, Webster and Baylis refuse to engage in the normativizing that plagues less interdisciplinary work and thus offer a kind of closeness to the concept of moral residue that is plainly lacking from the work coming out of more isolated disciplinary traditions.

Coming from a similarly full-figured perspective and perhaps a bit closer to home, theologian-philosopher Donald Capps's work may provide a long view concerning the ways in which the course of one's career might encourage the development of moral residue. Although Capps is not specifically focused on medicine in *The Depleted Self: Sin in a Narcissistic Age*, his keen attention to human suffering can be generatively applied here since both the battlefield euthanasia and Jehovah's Witness examples stem from and came be contextualized within workers' lives. Capps argues that one's self becomes depleted in a variety of ways, including "when the individual comes up against, and is defeated by, the autonomy wielded by the institution…the blame lies with our bureaucratic institutions and the ideologues who have…turned a perfectly good concept—personal autonomy—into its opposite—social control—by causing individuals to be ashamed of their legitimate desire for personal freedom, the freedom to trust themselves" (Capps 1993, 144–145). His notion of autonomy as self-trust resonates with the exemplar cases because it is precisely this condition of going against one's self that seems to engender moral distress and residue. While this paper provided more of a concept analysis regarding moral residue, Capps's work is useful to think with and use as a spring board for new questions.

A truly inclusive analysis, more than what has been offered here, must attend to the ways that organizational and institutional values produce residual consequences for employees who conceive of medicine as a moral career. Expansive notions of moral residue are present within ethics literature and offer a more full and insightful explication of this notably complicated concept. Ethically thoughtful texts ought to form the backbone of clinical education because these types of carefully crafted works will provide essential insight for clinical people developing moral sensibilities appropriate to medical practices. The airing of the concept of moral residue is a useful project for a conversation about interprofessional ethics because of the uniquely social stresses that inform medical practices in the twenty-first century. Metaphors like salads and jigsaw puzzles pepper the literature on interprofessional ethics, thus underscoring the relational character of medicine where distinctly trained professionals work together towards the best care for their patient (Banks 2011, 285). While the importance of professional ethics is clearly evidenced in the relevant literature, debate continues as to the best way to train health care providers in terms of single-discipline versus interprofessional training (Caldicott and Braun 2011, 145). Because health care providers will ultimately be working in team-based environments, perhaps interprofessional thinking might be encouraged by jointly enrolling nursing, medical, and allied health professionals in mandatory-attendance ethics courses. Leaving preparation aside for the moment, recent contributions have pushed towards defining the boundaries of interprofessional ethics through the crafting of theoretical frameworks (Clark et al. 2007, 592). Although we appreciate Clark et al.'s call for conceptual clarity, this article is far less grand in scale and is intended to function at the level of exploration in terms of putting interprofessional ethics in conversation with moral residue. As far as we can discern, the area of moral residue has not been formally considered in terms of the implications for interprofessional ethics, and we hope to provide a wedge into that conversation.

Acknowledgments The authors would like to thank Dr. William J. Winslade for his ongoing support and tireless efforts throughout the many iterations of this work. The insights of the reviewers, in particular those of Dr. Nathan Carlin and Dr. Jeffrey Spike of the McGovern Center for Humanities and Ethics, have been provocative and so much appreciated. Our advisors Dr. Anne Hudson-Jones and Dr. Jason Glenn deserve a special thank you for their continued belief in us and our ideas.

References

Banks, S. (2011). Interprofessional ethics: A developing field? Notes from the ethics and social welfare conference. *Ethics and Social Welfare, 4*(3), 280–294.

Beam, T. E. (Ed.). (2003). Medical ethics on the battlefield: The crucible of military medical ethics. In *Military medical ethics*, vol. 2 (pp. 367–402). Falls Church, VA: U. S. Army Medical Department, Borden Institute.

Beauchamp, T. L., & Childress, J. F. (2009). *Principles of biomedical ethics* (6th ed.). New York: Oxford University Press.

Caldicott, C., & Braun, E. (2011). Should professional ethics education incorporate single-professional or interprofessional learning? *Advances in Health Sciences Education, 16*, 143–146.

Canadian Parliament. (1995). *The special senate committee on euthanasia and assisted suicide: Of life and death - final report* (chapter II: terminology). Ottowa: Parliament of Canada. Retrieved from http://www.parl.gc.ca/Content/SEN/Committee/351/euth/rep/lad-e.htm#ii.

Capps, D. (1993). *The depleted self: Sin in a narcissistic age*. Minneapolis: Fortress Press.

Clark, P. G., Cott, C., & Drinka, T. (2007). Theory and practice: A framework for understanding ethical issues in health care teams. *Journal of Interprofessional Care, 21*(6), 591–603.

Epstein, E. G., & Hamric, A. B. (2009). Moral distress, moral residue and the crescendo effect. *The Journal of Clinical Ethics, 20*(4), 330–342.

Gruss, E. C. (2003). *The four presidents of the Watch Tower Society (Jehovah's Witnesses): The men and the organization they created*. Longwood: Xulon Press.

Guichon, J., & Mitchell, I. (2006). Medical emergencies in children of orthodox Jehovah's Witness families: Three recent legal cases, ethical issues and proposals for management. *Paediatrics and Child Health, 11*(10), 655–658.

Hardingham, L. B. (2004). Integrity and moral residue: Nurses as participants in a moral community. *Nursing Philosophy, 5*(2), 127–134.

Hill, T. E., Jr. (2002). *Human welfare and moral worth: Kantian perspectives*. New York: Oxford University Press.

International Committee of the Red Cross. (2011). *The Geneva Conventions of 1949 and their additional protocols*. Geneva: Author. Retrieved from http://www.icrc.org/eng/war-and-law/treaties-customary-law/geneva-conventions/index.jsp.

Meadow, W. (2010). A premature infant with necrotizing enterocolitis whose parents are Jehovah's Witnesses. *Pediatrics, 126*(1), 151–155.

Pakula, A. (Producer and Director). (1982). *Sophie's choice* [Film]. Los Angeles: Universal Pictures.

Pembroke, N. F. (2008). Appropriate spiritual care by physicians: A theological perspective. *Journal of Religion and Health, 47*, 549–559.

Perry, D. L. (2011). *Battlefield euthanasia: Should military mercy killings be allowed?* San Diego, CA: International Society for Military Ethics National Meeting. Retrieved March 15, 2011, from http://isme.tamu.edu/ISME11/Perry-ISME2011.pdf.

Swann, S. W. (1987). Euthanasia on the battlefield. *Military Medicine, 152*(11), 545–549.

Watchtower. (2011a). Blood—vital for life. Watchtower: the official website of Jehovah's Witnesses. Retrieved from http://www.watchtower.org/e/hb/article_01.htm.

Watchtower. (2011b). Quality alternatives to transfusion. Watchtower: the official website of Jehovah's Witnesses. Retrieved from http://www.watchtower.org/e/hb/article_03.htm.

Webster, G., & Baylis, F. E. (2000). Moral residue. In S. B. Rubin & L. Zoloth (Eds.), *Margin of error: The ethics of mistakes in the practice of medicine*. Hagerstown: University Publishing Group.