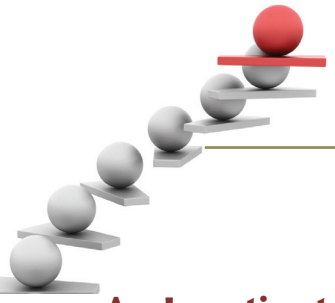

An Inpatient Surgical Oncology Unit's Experience With Moral Distress: Part I

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Have you ever walked onto an oncology unit and heard any of the following statements?

- "We do not have enough staffing to care for these complex patients."
- "There has to be something more we can do for his pain."
- "Why are we continuing aggressive treatment on this patient when you can clearly see he is dying?"
- "Administration does not support us, and they do not know what is happening on the unit."

All of these are examples of situations that may cause moral distress for an oncology nurse. Although moral distress has been variously defined and is a concept of continued study, it provides basic ideas that are helpful in framing some of the ethical challenges faced by oncology nurses.

Background

Jameton (1984) defined moral distress as knowing the correct thing to do when restrictions do not allow for appropriate ethical choices. Nurses are distressed not only when they are unable to do what they think is right (Schluter, Winch, Holzhauser, & Henderson, 2008; Sirilla, 2014), but also when they are unable to deliberate and determine the appropriate action in the first place. Table 1 presents some of the situations and constraints that contribute to moral distress and make the oncology nurse feel anxious, guilty, and frustrated (Epstein & Hamric, 2009). Conflicting emotions may lead the nurse to withdraw from the patient and his or her family (De Villers & DeVon, 2013; Sirilla, 2014; Varcoe, Pauly, Storch, Newton, & Makaroff, 2012). Oncology nurses need open communication with no barriers to be able to provide comprehensive quality care to their patients.

Results of moral distress may greatly affect healthcare systems. Patients with cancer and their families have great insight and are often aware of nurses' dissatisfaction, which may lead to decreased patient satisfaction, lack of communication, pain management issues, a lower quality of care, and increased length of stay (De Villers & DeVon, 2013; Huffman & Rittenmeyer, 2012; Robinson, 2010; Sirilla, 2014; Varcoe et al., 2012). In addition, healthcare professionals report a range of problems associated with moral distress (e.g., dissatisfaction leading to high turnover rates, burnout leading nurses to leave the profession altogether) (De Villers & DeVon, 2013; Epstein & Hamric, 2009; Varcoe et al., 2012). One study of oncology nurses revealed that, of the 14% who left their unit or hospital, half were considering leaving nursing entirely because of moral distress (Lazzarin, Biondi, & Di Mauro, 2012).

Given the increasing frequency of morally distressing events, oncology nurses are at particularly high risk for a phenomenon called the "crescendo effect" (Epstein & Hamric, 2009). This manifests when moral distress is left unresolved and its effects are compounded. The crescendo effect begins with one event causing acute moral distress. As the event passes, a lingering effect or residue remains with the nurse, forming a new higher baseline of distress. When the next morally distressing situation occurs, the effect may be greater because of the already elevated baseline remaining from previous experiences (Epstein & Hamric, 2009). For example, an oncology nurse may experience distress because of concerns regarding pain control in a dying patient. If this situation is not resolved, the nurse may harbor feelings of anxiety, guilt, and frustration. The next time a distressing situation occurs, he or she may feel greater distress partly because of the moral residue remaining from the previous experience. This escalation can also lead to increasingly severe symptoms of moral distress, emotional exhaustion, and a detachment from patient care. Nurses experiencing these symptoms have a higher probability of experiencing burnout and exiting the profession (Hamric, 2012). To avoid this effect, moral distress must be recognized in a timely manner, and interventions should be implemented to effectively resolve the situation.

The purpose of this article is to describe how an inpatient nursing team addressed ethical concerns and problems that occurred on a surgical oncology unit. The goal was to use existing knowledge about moral distress as a broad conceptual framework to elicit unit nurses' perspectives about problems on the unit.

Exploring the Problem

Those closest to a situation may be unaware of the external signs of distress. In this instance, the chief nursing officer (CNO) at Banner-University Medical Center in Tucson, Arizona, had heard staff repeatedly voicing their concerns

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about the lack of nurses on the unit, issues with patient care at the end of life, and their inability to provide adequate pain control to patients. The CNO brought these concerns to the unit's patient care manager, clinical nurse specialist, and nurse educator. This group decided to consult with a professor from the College of Nursing at the University of Arizona, which is affiliated with the medical center, who has extensive experience and expertise in nurse moral distress.

This group, of which the authors of the current article were a part, then reviewed various measures and conceptualizations of moral distress, along with the characteristics unique to the situation. A 15-item nurse moral distress clinical unit survey was developed to address specific issues on the surgical oncology unit in a way that was relevant and time effective for nurse respondents. The items, adapted from relevant literature, identified distinct and representative examples of situations of moral distress.

Nurses working on an inpatient unit that cares for patients in surgical oncology and overflow patients from the medicine and hospitalist teams were surveyed at two separate points in time. This provided two opportunities for nurses to participate, enriching the surveyors' overall understanding of the problem. Of the items that listed situations of moral distress, nurses were asked to rank those that most frequently occurred and those that were most morally distressing using a six-point Likert-type scale. An electronic method of surveying nurses was employed to provide an efficient, anonymous way for nurses to respond to the survey.

For the initial survey, 40 nurses were invited to participate, and 19 returned completed surveys. The majority of respondents were women, had earned a bachelor of science degree in nursing, and had between one and three years of work experience. Five of the respondents had worked less than one year as a nurse. Results from the first survey suggested that the situations or constraints that may contribute to moral distress are complex. In addition, addressing them may require approaches that focus not only on the unique experiences of nurses but also tackle systemwide issues that reach beyond individual nurses.

Table 1. Constraints That Contribute to Moral Distress

Constraints	Examples
Clinical circumstances	Delivering unnecessary care, prolonging the dying process with aggressive care, failing to obtain sufficient informed consent, working with less competent caregivers, using resources improperly, providing poor pain relief, offering false hope
External restrictions	Lacking adequate interprofessional communication, administrative support, and nursing involvement in decision making; having poor staffing and an increased turnover rate; compromising patient care because of a fear of litigation
Internal limitations	Having feelings of powerlessness and decreased knowledge, lacking the ability to identify ethical issues and be decisive

Note. Based on information from Hamric et al., 2012.

Table 2. Selected Results of Nurse Moral Distress Clinical Unit Surveys

Ranking	Most Frequently Occurring Situations	Most Morally Distressing Situations
Survey 1 (N = 19)		
1	Working with unsafe staffing levels	Working with a doctor who is incompetent
2	Following pain medication orders, although the medication will not control the patient's pain	Working with unsafe staffing levels
3	Working with a doctor who is incompetent	Carrying out a work assignment in which the nurse feels incompetent
4	Providing care on the doctor's orders and not in the best interest of the patient	Working with another nurse who is providing incompetent care
Survey 2 (N = 22)		
1	Following pain medication orders, although the medication will not control the patient's pain	Working with unsafe staffing levels
2	Working with unsafe staffing levels	Working with a doctor who is incompetent
3	Providing care that does not relieve suffering because the medication is inadequate	Providing care that does not relieve suffering because the medication is inadequate
4	Providing care on the doctor's orders and not in the best interest of the patient	Ignoring situations in which patients have not been given adequate information

Note. Survey 1 and Survey 2 were identical in content but were administered about one year apart. Both times, the surveys were completed by nurses working on the same surgical oncology unit at Banner-University Medical Center in Tucson, Arizona.

Following a significant turnover in nursing staff, the surveyors decided to readminister the original survey about one year after the first attempt to obtain additional information about nurse perspectives. This time, 22 out of 32 surveys were completed by nurses. The sample characteristics were similar to those from the previous survey. However, the surveyors do not know if the same individuals participated in both surveys. This overlap is acceptable because the surveyors were primarily interested in obtaining additional information to informally identify nurse concerns.

The top four most frequently occurring morally distressing situations and the top four most morally distressing situations, as selected by respondents to the first and second surveys, are shown in Table 2. The results from each survey shifted slightly in terms of order but retained similar themes. According to the surveys, respondents' two primary areas of concern were (a) inadequate staffing (i.e., unsafe staffing levels or incompetent staff) and (b) care that is inappropriate or ineffective.

Expanding Ideas About Moral Distress

The results from these clinical surveys support previous findings indicating that nurse moral distress is a significant beacon of major problems relevant to nurse well-being and the health and safety of patients. Moral distress is a significant issue in health care and particularly in oncology nursing. Oncology nurses can have significant insight into what is needed for clinically competent staffing and for appropriate treatment approaches. A growing area of literature on moral distress has explored the need for formally recognizing nurses as experts who must be included in the communications and decisions behind these patient care issues (Huffman & Rittenmeyer, 2012; Pavlish, Hellyer, Brown-Saltzman, Miers, & Squire, 2013).

A fuller understanding about moral distress likely extends beyond descriptions that typically focus on nurse inability to act ethically in a given situation. The problem of moral distress should motivate attention to deeper problems associated with a lack of communication and the failure to include nurses as equal and informed partners in the formal communications and deliberations regarding staffing and patient care treatments, which are vital to the well-being of patients.

Conclusion

The surveyors' approach to the problems that surfaced on an inpatient oncology unit recognized the value of the nurses' own perceptions about the issues. The findings led to new insights that can help others be all the more responsive to nurses' needs and the needs of the unit. Obtaining nurses' perceptions, as guided broadly by a survey specially designed for the unit, revealed themes that should be validated with nurses and then considered in planning strategies to address the problem. When moral distress continues, a crescendo effect in difficulties experienced by patient and nurse is likely. The second part of this article will describe approaches used to alleviate moral distress on this oncology unit and the challenges faced in fully addressing the complexity of factors that contribute to moral distress.

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