



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

Susan Bohnenkamp, RN, MS, ACNS-BC, CCM, Nicole Pelton, RN, BSN, Pamela G. Reed, PhD, RN, FAAN, and Cindy J. Rishel, PhD, RN, OCN®

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

ONF, 42(3), 308–310.

doi: 10.1188/15.ONF308-310