Moral Distress: A Consequence of Caring

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With the increase of technology in health care, oncology nurses often are involved in ethical discussions regarding the best use of aggressive interventions for patients. Conflicts between ethical principles and external forces can produce moral distress for oncology nurses caring for people with cancer. Moral distress can impact nurses in significant ways, including mental health and job satisfaction, and may impact care delivery. This article reviews the concept of moral distress and suggests interventions and future research to minimize its impact on nurses and patients.

Advances in medical technology, improved pharmaceutical agents, and new surgical and radiation therapy techniques have vastly improved the effectiveness of oncology care. Many cancers that formerly were considered fatal have become treatable and even curable. Advanced technologies also can support bodily functions during oncologic crises, improving survival. Pacemakers, implanted ports, and stem cell transplants are some examples of how technology has extended lives beyond what was possible in the recent past.

Oncology care has benefited immensely from advances in technology. Oncology nurses have been on the frontlines of many innovations—implementing research protocols, delivering new treatments, and managing technology. From the routine task of central line care to the extraordinary administration of cardio-pulmonary resuscitation, nurses are more involved in delivering the “technology” of health care.

However, medical technology also has resulted in the pervasive belief that death can be delayed and even avoided. Bioethicists, healthcare providers, and legislators often seem to be at odds regarding the ethical course of action in complex cases. Yet the ethical concerns of nurses often are not heard during such discussions.

Oncology nurses provide care over an extended period of time, within intimate proximity of patients. In addition, nurses often administer aggressive treatments. They witness the implications of life-prolonging interventions that may be at odds with the delivery of supportive care. How does providing this type of care impact oncology nurses dedicated to the principles of caring and compassion? Oncology nurses may suffer moral distress when witnessing the adverse effects of treatment, especially when the goals of care are compassionate rather than curative.

According to Jameton (1983), moral distress is “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). In a 2007 study, issues leading to moral distress included patients’ rights, just allocation of resources, and end-of-life care (Ulrich et al., 2007). For example, when a terminally ill patient is intubated, this may conflict with the goals of palliative care, and the nurse may experience moral distress. The question then becomes “Why am I doing this?”

Nursing is guided by ethical principles (American Nurses Association, 2001). Some bioethical principles such as beneficence, non-malefica, and autonomy may conflict with the use of aggressive medical technology. Beneficence is defined as actions that benefit the person, whereas non-malefica means that providers do no harm. The principle of autonomy includes respecting a patient’s right to self-determination.

Unfortunately, external forces may over-ride bioethical principles. Families, religious communities, and even political climates can impact the environment where healthcare decisions are made. Such forces can create an atmosphere in which providers feel coerced into forgoing or overlooking ethical principles and personal moral values, instead providing aggressive care, even when a prognosis is poor. The well-known Terry Schiavo case (2001–2005) is a good example of the political environment intervening in an ethically complex case. If a prognosis is poor and care is perceived as aggressive rather than palliative, providers may feel conflicted, even distressed, by their interventions.

Increasingly, nursing has sought to explore moral distress in health care. The Moral Distress Scale (MDS) is a tool designed to measure moral distress (Corley, Elswick, Gorman, & Clor, 2001). Another study described moral distress experienced by nurses witnessing care perceived as futile (Ferrell, 2006). Using both nursing narratives (N = 108) and a literature review, the study examined the impact of moral distress on nurses.

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Intensive care unit (ICU) nurses used words such as “torture,” “violence,” and “cruelty” when giving accounts of some treatments. The author concluded that delivering and witnessing such care elicited strong emotional responses and that nurses needed support in dealing with their emotions. Another study found a significant relationship between emotional exhaustion and morally distressing events related to care perceived as non-beneficial or futile (Meltzer & Huckabay, 2004). Even more alarming, some nurses who experienced moral distress had recurrent nightmares of clinical situations (Chambliss, 1996). Several other studies have identified the adverse effects of moral distress on retention and burnout (Corley et al., 2001; Meltzer & Huckabay, 2004). Moral distress impacts nurses emotionally, physically, and professionally and has implications outside the work setting.

Inpatient nurses may be more at risk for moral distress. Unlike physicians, inpatient nurses may not see patients after they are discharged from the hospital, but they do witness the suffering related to interventions during hospitalization. Sometimes patients survive health crises with good quality of life despite dismal prognosis during hospitalization. In one study, ICU nurses were more pessimistic than physicians (Frick, Uehlinger, & Zuercher Zenklusen, 2003). The nurses had considered withdrawing treatment for patients who ultimately recovered with good quality of life. Inpatient nurses may not have the opportunity to see the outcomes of their care, limiting their ability to have a fuller perspective of emotionally challenging cases.

The complexity of oncology care may require interventions at several levels to address moral distress. At the undergraduate level, nurse educators can prepare students for possible ethical dilemmas by exploring ethical principles and their application to nursing care, using case studies for discussion.

Newer nurses, upon entering oncology nursing, may have different needs. Oncology nurses frequently witness firsthand the ethical dilemmas arising from aggressive interventions, especially when a prognosis is poor. Delivering aggressive care may conflict with their ethical beliefs and their goal to alleviate suffering. Newer nurses may require support from colleagues and venues for discussion as they develop professionally in oncology nursing.

Ongoing programs are needed to acknowledge and lessen moral distress in oncology nurses. Support groups for nurses may facilitate discussion of difficult cases and provide support from colleagues to help reduce moral distress. Discussing the trauma of providing care contrary to nurses’ ethics may be cathartic for them and lessen the isolation often felt with moral distress. Rotation of difficult assignments may be helpful in decreasing the burden of moral distress for individual nurses working with complex patients. Cancer survivor days, when nurses can meet former patients, may allow nurses to see the outcomes of their care. Case studies, rounds, and in-service education programs may be useful in educating and supporting nurses and highlighting the ethical dilemmas inherent in oncology care.

Ethics committees, another venue for discussion, are created by hospitals to meet the requirements of the Joint Commission. Nurses should be included on such committees to provide a broader perspective on specific cases. Their input contributes to interdisciplinary communication among healthcare providers, ethicists, and representatives from the legal community. Committee members may discuss cases from multiple dimensions, including the goals of care, the ethical and legal implications of interventions, the potential adverse effects of treatment, and the wishes of patients and families.

Healthcare institutions should advocate that patients complete advanced care directives (ACDs), or “living wills.” ACDs provide a voice for compromised or unconsciousness patients and preserve their autonomy during health crises. They also provide healthcare providers with guidance when they are deciding on appropriate care, lessening the moral distress that may be experienced by providers during difficult cases.

Additionally, institutions should support healthcare providers during ethically complex cases. Fear of litigation or disciplinary action may result in moral distress in providers. Healthcare providers who adhere to ACDs despite pressures from families to pursue alternate courses should have administrative and legal support. In terminal situations, palliative care should be given equal consideration with aggressive care. The desires of patients or their surrogates in collaboration with the ethical guidelines of clinical practice should be respected and implemented, and ACDs should serve as the guidelines for decision-making.

Because of the complexity of care, clinical trials may be fertile ground for the development of moral distress in nurses. Although ongoing research to develop cancer treatments is essential, newer interventions, offered through clinical trials, may have adverse effects on patients, including diminished quality of life or even shortened life expectancy. Nurses may witness such cases and feel conflicted when administering prescribed medical interventions. Discussions regarding the perceived benefits and harms of newer treatments may require a team approach to ensure that patients are fully informed and providers respect their autonomy during decision-making.

Further research is needed to determine the prevalence and implications of moral distress in the oncology setting, its effect on nurse-patient relationships, and specific strategies to alleviate moral distress. The effects of moral dilemmas raise many questions that require further investigation (see Figure 1). Answers to the questions may direct interventions that acknowledge the occurrence of moral distress and mitigate its consequences.

The fact that nurses seek answers to complex ethical issues is evidence of the caring and compassion inherent in the

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**Figure 1. Moral Distress: Research Questions**

- What are the incidence and prevalence of moral distress in the oncology setting?
- Could moral distress have global effects on units traditionally involved in aggressive interventions and research care such as stem cell transplantation units and intensive care units?
- Can distress result in maladaptive behaviors in nurses, such as substance abuse and disruptive action?
- Does moral distress have negative effects on patient care?
- Does moral distress result in an emotional detachment from environment?
- Does the alienation that comes with technology contribute to moral distress?
nursing profession. Oncology nurses are impacted by the burden of moral distress, and it may impact the care they deliver to patients significantly. They need professional and administrative support as they pursue ethical discussions. Their voice in such discussions fosters a sense of empowerment, improves emotional well-being, and enhances job satisfaction. Nursing, a profession built on a strong ethical foundation, can surely address, acknowledge, and alleviate moral distress in those delivering care.

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