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Moral Distress

One unit's recognition and mitigation of this problem

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Moral distress experienced by staff has been well documented in the intensive care work areas, but less described in oncology nursing. Factors that contribute to moral distress include ethical dilemmas, mismatched goals of care among patients and their families and providers, and perceptions of futility of care. This article describes recognizing the risk of moral distress in a newly formed medical-surgical oncology unit and steps taken to mitigate developing moral distress, illustrating that moral distress is present in oncology nursing and warrants further study.

AT A GLANCE

- Moral distress is a psychological disequilibrium between one's awareness of the morally appropriate action that a situation requires and the inability to act on it.
- The problem of moral distress threatens the integrity of healthcare providers and is reported by oncology nurses.
- Oncology advanced practice nurses can inform and implement moral distress mitigation strategies.

KEYWORDS
advanced practice nursing; moral distress; medical-surgical oncology; nursing burnout

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Moral distress in nurses was first described by philosopher Andrew Jameton (1984), who defined it as the psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires but cannot act on it. Subsequently, moral distress is recognized as an important problem that may threaten the integrity of healthcare providers (Allen et al., 2013). Moral distress has been noted by intensive care nurses and physicians but is reported to be significantly higher among nurses (Dodek et al., 2016; Hamric, Borchers, & Epstein, 2012). Based on the very nature of decision making in oncology practice, oncology nurses appear to be at risk for experiencing moral distress; however, little is known about the incidence or impact of moral distress in oncology nurses. This article describes an intervention to reduce the reported moral distress observed on a medical-surgical oncology inpatient unit.

Background

In 2017, the nursing leadership team of a community-based hospital decided to merge the medical oncology and surgical oncology nursing care units to establish one oncology-dedicated medical-surgical unit. This merger took place on the surgical unit. Surgical nursing staff who remained on the unit and newly graduated nurses hired to fill vacancies were all new to administering chemotherapy and caring for complex medical oncology patients. Because the unit's prior surgical oncology patients were discharged to their homes after brief surgical admissions, even the experienced surgical nurses lacked practice experience with the illness trajectory of the patient with cancer.

To prepare for this merger, the new unit's leadership team focused on training the new and surgical staff nurses about chemotherapy administration and providing didactic education regarding the care needs of complex medical oncology patients. Prior to the merger, the leadership team developed an eight-hour oncology boot camp for the educational components (Walden, 2018). In addition, nurses completed a chemotherapy administration test and were precepted in the ambulatory chemotherapy infusion center for a full-day, hands-on chemotherapy administration experience.

The oncology clinical nurse specialist (CNS), who is one of the current authors (S.D.B.), was available on the new unit during the first few weeks following the merger. This provided opportunities to guide review of chemotherapy orders, verify dose calculations, and check laboratory values to confirm chemotherapy parameters. The CNS role-modeled safe practices, including the second independent double-check and the use of personal protective equipment.

In the first few months after the merger, an unanticipated effect was observed: Nurses caring for dying patients were experiencing moral distress. Staff members voiced their apprehensions about futile care conveying false hope to patients and their families. The CNS recognized their concerns, identifying the underlying concept of moral distress, and discussed the observation with unit nursing leadership.