

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 cardiopulmonary 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-maleficence, and autonomy may conflict with the use of aggressive medical technology. Beneficence is defined as actions that benefit the person, whereas non-maleficence means that

providers do no harm. The principle of autonomy includes respecting a patient’s right to self-determination.

Unfortunately, external forces may override 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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