Moral distress of oncology nurses and morally distressing situations in oncology units

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KEY WORDS

moral distress, nurses, oncology

ABSTRACT

Objective
The purpose of this study was to evaluate the intensity and frequency of moral distress and determine clinical situations leading to moral distress in oncology units. The study also examined the relationship between moral distress scores and demographic characteristics of oncology nurses.

Design
This descriptive study was performed between 25 January 2012 and 29 June 2013.

Setting
The study was conducted in the oncology units of eight training hospitals in Tehran, Iran.

Subjects
One hundred and forty eight nurses (131 females, 17 males; mean age 32.5 years; range 24 to 52 years) who had worked in oncology units of training hospitals in Tehran were included in the study.

Main outcome measure(s)
The main outcome measures included intensity and frequency of moral distress, which were assessed by the Moral Distress Scale – Revised (MDS-R).

Results
Most of the 148 nurses had high to moderate scores. Nurses had experienced higher moral distress when receiving informed consent forms from patients and asking patients to carry out physicians' order for unnecessary tests in patients' last stages of life.

Conclusion
Moral distress exists in oncology nurses and interventions will be developed and tested to decrease and prevent it.

INTRODUCTION

Nurses' actions and behaviours are influenced by their personal moral beliefs and ethical values. In addition they are taught and expected to adhere to the values of their profession (Momennasab et al 2015; Cohen and Erickson 2006). Every day nurses make great moral decisions in their workplace, but in practice they cannot always act according to their moral obligations. An unpleasant experience titled as 'moral distress' is one of the major issues that nurses are faced with (Wilkinson 1987; Jameton 1984). Jameton (1984) defines moral distress as a phenomenon in which one knows the right action to take, but is constrained from taking it. Moral distress experienced by nurses and other health care professionals depends on the environment of care (Pauly et al 2009; Hamric and Blackhall 2007; Corley et al 2005). With the increase of technology in health care, oncology nurses are often involved in ethical discussions regarding the best use of aggressive interventions for patients (Shepard 2010). Due to the physical and psychological stress that cancer patients are faced with, the oncology unit can be considered a challenging and unique setting for nurses (Wittenberg-Lyles et al 2014; Ekedahl and Wengstrom 2007). Findings of Rice et al (2008) indicated the level of moral distress in nurses caring for cancer patients is higher than the level of moral distress among other nurses. In Iran, much has been written about moral distress that Iranian critical care nurses experience. For example, the results of a study conducted by Shoorideh et al (2014) revealed that Iranian intensive care unit nurses suffered greatly from moral distress. Joolaee et al (2012) in their study conducted on nurses working in internal, surgical, intensive care, critical care units and the emergency rooms of medical and training centres of Tehran University of Medical Sciences found nurses suffered a moderate severity of moral distress. Based on a search of the databases in Iran using 'moral distress', 'nurses', and 'oncology' as keywords and also using the English equivalent of these keywords in databases it was concluded that moral distress in oncology wards in Iran has not been studied. If ethical issues remain unknown and unresolved in clinical contexts, they will lead to nurses instability, confusion, depression and finally end in a burnt-out and depleted workforce (Trautmann et al 2015; Hamaideh 2014; Shoorideh et al 2014; Cohen and Erickson 2006; Elpern et al 2005). Therefore, this cross-sectional study was designed and implemented with the following aims:

- assess the level of moral distress in nurses who work in oncology units at teaching hospitals in Tehran;
- identify clinical situations associated with significant moral distress; and
- evaluate possible associations among demographic characteristics of oncology nurses and the level of moral distress.

METHOD

Sample and setting

All nurses working in the oncology units of eight training hospitals in Tehran who met the criteria were included in this cross-sectional study. Participants had a Bachelor degree or higher; were employed in an adult oncology unit and had at least one years clinical experience in an oncology unit. Of the 156 eligible nurses 148 nurses participated in this study.

Procedures

Shahid Beheshti Medical Sciences University Research Ethics Board in Tehran approved this study. After coordinating with relevant hospitals, the researcher commenced collecting data in each hospital. Participants were assured their information would remain confidential before the questionnaires were distributed. Nurses were asked to participate by completing the questionnaires anonymously and returning them to a locked drop box placed in the units.

INSTRUMENTS

In order to collect data a questionnaire including demographics and MDS-R was used. Demographic information included age, gender, academic level and years of experience in oncology units. MDS-R measures moral distress intensity and frequency based on a five-point Likert scale from NEVER (zero) to DAILY (four) to measure frequency and NEVER (zero) to VERY HIGH (four) to measure intensity. A composite score for each item was calculated as the scores of moral distress intensity is multiplied by scores of moral distress frequency. Composite scores have a range of 0 – 16 and the total score has a range of 0 - 336. The scores of moral distress frequency and intensity of the total scale were classified into four categories: low (0-1), medium (1.01-2), high (2.01-3) and very high (3.01-4). The composite score was also classified into four categories: low (0-4), medium (4.01-8), high (8.01-12) and very high (12.01-16). A higher score indicates more moral distress.

Prior to use, official permission was obtained from Professor Hamric and the scale was translated into Farsi using a forward/backward method. Content validity was used to determine the validity of the instrument. The questionnaire was reviewed and evaluated by 10 faculty members of the Nursing and Midwifery Faculty at Shahid Beheshti University of Medical Sciences. Considering a score of 85% for content, all questionnaire items met the minimum requirements of validity. Using the Cronbach's alpha, reliability coefficient of the questionnaire was estimated at 0.88.

Data Analysis

In order to analyse the data, descriptive statistical methods were used to determine the level of moral distress. The appropriate correlation statistic was used to examine relationships among variables.

FINDINGS

In this study, 131 subjects (88.51%) were female and 17 (11.48%) were male. Participants ages ranged from 24 to 52 years; the mean age and the Standard Deviation were 32.5 and 5.8 respectively (see table 1).

Table 1: Sample Characteristics (n=148)

Characteristic	n
Age(years)	
20-29	62
30-39	73
40-49	11
50-59	2
Gender	
Female	131
Male	17
Experience in oncology (years)	
1-2	32
3-5	46
6-10	56
11-20	10
Greater than 20	4

Mean scores for items on the moral distress frequency scale ranged from 1.06 to 3.36, with an overall mean score of 2.13± 0.44 and Mean scores for items on the moral distress intensity scale ranged from 1.74 to 3.86, with an overall mean score of 2.08± 0.36. The two highest scoring items for moral distress frequency were '*Ignore situations in which patients have not been given adequate information to ensure informed consent*' (mean, 3.36± 0.61) and '*Carry out the physician's order for what I consider to be unnecessary tests and treatments*' (mean, 3.33± 0.71). The two highest scoring items for moral distress intensity were '*Work with nurses or other healthcare providers who are not as competent as the patient care requires*' (mean, 3.86± 1.12) and '*Provide care that does not relieve the patients suffering because the physician fears that increasing the dose of pain medication will cause death*' (mean 3.74 ± 1.11). Tables 2 and 3 show the top 10 detailed results for frequency and intensity.

The lowest scoring item for moral distress frequency was '*Increase the dose sedative/opiates for an unconscious patient that I believe could hasten the patients' death*' (mean 1.32 ± 1.1) and the lowest scoring item for moral distress intensity was '*Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it*' (mean, 1.50 ± 0.88).

Table 2: Moral Distress Scale items associated with top 10 items for frequency

Moral Distress Scale Items	Mean±SD
Ignore situations in which patients have not been given adequate information to ensure informed consent.	3.36 ± 0.61
Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	3.33 ± 0.71
Witness diminished patient care quality due to poor team communication.	3.01±1.04
Assist physician who, in my opinion, is providing incompetent care.	2.87 ± 1.13
Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	2.77 ± 1.14
Follow the physician's request not to discuss the patient's prognosis with the patient or family.	2.72 ± 0.87
Initiate extensive life-saving actions when I think they only prolong death.	2.61 ± 1.45
Witness medical students perform painful procedures on patients solely to increase their skill.	2.43 ± 1.25
Avoid taking action when I learn that a physician or nurse colleague has made a medical error and does not report it.	2.14 ± 0.43
Watch patient care suffer because of a lack of provider continuity.	2.12 ± 1.07

Table 3: Moral Distress Scale items associated with top 10 items for intensity

Moral Distress Scale Items	Mean±SD
Work with nurses or other healthcare providers who are not as competent as the patient care requires.	3.86 ± 1.12
Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death.	3.74 ± 1.11
Ignore situations in which patients have not been given adequate information to insure informed consent.	3.24 ± 0.9
Watch patient care suffer because of a lack of provider continuity.	3.18 ± 1.28
Witness diminished patient care quality due to poor team communication.	2.95±0.84
Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing.	2.93 ± 1.12
Increase the dose of sedatives/opiates for an unconscious patient that I believe could hasten the patient's death.	2.62 ± 1.13
Provide less than optimal care due to pressures from administrators or insurers to reduce costs.	2.55 ± 1.26
Be required to care for patients I do not feel qualified to care for.	2.30 ± 1.38
Witness healthcare providers giving "false hope" to the patient or family.	2.24 ± 1.18

Composite scores revealed situations, most associated with moral distress. The highest item score was '*Ignore situations in which patients have not been given adequate information to ensure informed consent*' (10.12 ± 3.02). Table 4 shows the top 10 detailed results for composite score.

Table 4: Moral Distress Scale items associated with highest levels of moral distress (composite score)

Moral Distress Scale Items	Mean±SD
Ignore situations in which patients have not been given adequate information to insure informed consent.	10.12 ± 3.02
Carry out the physician's orders for what I consider to be unnecessary tests and treatments.	9.38 ± 2.01
Witness diminished patient care quality due to poor team communication	9.01± 3.78
Provide care that does not relieve the patient's suffering because the physician fears that increasing the dose of pain medication will cause death	7.45 ± 3.47
Watch patient care suffer because of a lack of provider continuity	7.05 ± 2.84
Witness healthcare providers giving "false hope" to the patient or family	6.37 ± 3.69
Witness medical students perform painful procedures on patients solely to increase their skill.	6.15 ± 3.49
Take no action about an observed ethical issue because the involved staff member or someone in a position of authority requested that I do nothing	6.03 ± 3.60
Assist physician who, in my opinion, is providing incompetent care	4.73 ± 3.08
Work with nurses or other healthcare providers who are not as competent as the patient care requires.	4.42 ± 2.82

Demographic characteristics analysed in relation to the moral distress scores. Only years of experience in oncology unit were positively correlated with composite scores (p=0.01, r= 0.24) (see table 5).

Table 5: Correlation between demographic characteristics and moral distress frequency intensity composite

Characteristics	***Frequency***		***Intensity***		***Composite***	
	Correlation	P	Correlation	P	Correlation	P
Age	0.12	0.24	0.06	0.09	0.16	0.06
Experience in oncology	0.09	0.11	0.11	0.08	0.24	0. 01

DISCUSSION

In this study, mean score for moral distress was similar to scores found for critical care nurses in previous studies (Shoorideh et al 2014). In addition, mean score for moral distress was higher in this study than the scores found in other studies on oncology nurses (Sirilla 2014). Limitations in previous studies involving oncology nurses had participants from one institution (Sirilla 2014; Rice et al 2008). This study included oncology nurses from eight hospitals. Therefore the results can apply to oncology nurses in other hospitals.

According to this study the highest scores for frequency, intensity and level of oncology nurses' moral distress was related to receiving informed consent forms from patients, which demonstrated failure to be fully informed. Nurses in other studies also experienced high moral distress in such situations (Aft 2011; Lunardi et al 2009). As cancer patients need to undergo diagnostic and therapeutic procedures (Mobley et al 2007), and due to unknown and unexpected side effects of many diagnostic and therapeutic procedures in oncology wards (Ferrell 2006), it is necessary to obtain informed consent from patients before giving any treatment. However, it is also important to provide the patient with the necessary information about such diagnostic and therapeutic procedures before obtaining any consent. As patient education and emotional support in times of crisis and making medical decisions are among legal responsibilities of nurses, it is natural that nurses feel responsible for giving patients enough information to fill in consent forms. Patient's informed consent to undertake medical tests and to receive treatment is a patient's right (Grace and McLaughlin 2005).

Conducting unnecessary diagnostic and laboratory tests in clinical situations with 'futile care' (Mobley et al 2007) were sources of high moral distress in this study. Rice et al (2008), also report that futile care can also bring about high intensity and frequency for moral distress. In this area, Ferrell (2006), believes that nurses' moral distress issues which are associated with futile care and treatment have mostly been studied in the intensive care units. Having talked to oncology nurses Ferrell (2006) reached the conclusion it was necessary that futile care in oncology nursing be studied. According to the mean score of moral distress intensity in clinical situations of 'incompetent nurses or other health care providers, considering the important role of nurses in the care for cancer patients (Izumi et al 2010), research that identify factors leading to poor nursing care in oncology wards seems to be necessary. Pelton et al (2015) also indicated that incompetent nursing is one of the two main themes of situations leading to moral distress in surgical oncology unit.

In this study, the clinical situation in which the nurse observed a patient's suffering and pain as well as a failure to control the pain properly caused high moral distress in nurse. Maningo-Salinas (2010) and LeBaron et al (2014), also reported that failure to control the pain of the patient was among the situations with high moral distress for oncology nurses.

Positive correlation between experience in oncology and composite score was consistent with several studies (Shoorideh et al 2014; Rice et al 2008; Elpern et al 2005). However, Abbasi et al (2014) found that more experienced nurses experienced lower levels of moral distress.

LIMITATIONS OF THE STUDY

The only limitation of this study was nurses who work in oncology units of training hospitals in Tehran were busy and it took a long time to return the completed questionnaire.

CONCLUSION

According to the results of this study and the importance of reducing moral distress in clinical situations, moral distress in oncology nurses should be considered and addressed as a priority for further investigation. It seems interventions such as establishing Ethics Committees, and having nurses as members of such committees can improve discussion about clinical situations leading to moral distress, consultation, training, and proposing strategies for nurses to cope with moral distress. The results obtained in this study can be useful for nurse leaders, oncology nurses, managers of medical institutes, and education providers in order to propose strategies to cope with moral distress. This research will also be helpful in conducting studies on reducing or eradicating moral distress in oncology wards.

RECOMMENDATIONS

- Since moral distress reduces the quality of nursing care, it is necessary to identify clinical situations which lead to experiencing moral distress among nurses in order to increase the quality of nursing care.
- It is recommended that Ethics Committees be established and nurses be included on such committees to provide expertise about clinical situations which lead to moral distress.
- Head nurses should motivate and morally support their staff.
- Nurses should be trained and provided with strategies to cope with moral distress.

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