Moral Distress

Using mindfulness-based stress reduction interventions to decrease nurse perceptions of distress

Elizabeth A. Vaclavik, DNP, RN, OCN®, NEA-BC, Beth A. Staffileno, PhD, FAHA, and Elizabeth Carlson, PhD, RN

BACKGROUND: Studies have shown that the moral distress experienced by nurses affects patient outcomes and staff engagement.

OBJECTIVES: The purpose of this quality improvement initiative was to implement a process for staff to cope with moral distress.

METHODS: The 21-item Moral Distress Scale–Revised (MDS-R) was administered pre- and postintervention to a sample of 56 oncology nurses to assess moral distress and whether it was alleviated with the use of mindfulness interventions. Chi-square analysis compared the frequency of morally distressing situations.

FINDINGS: Moral distress was identified, with the finding that mindfulness interventions decreased nurse perceptions of distress. Healthcare providers offering a false sense of hope was the most frequently reported situation. Postintervention MDS-R survey results reflected a decrease in frequency of distress.

KEYWORDS
moral distress; mindfulness; false hope; mindfulness-based stress reduction

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ONCOLOGY NURSES ARE FACED DAILY WITH A BARRAGE of ethical and moral dilemmas that affect the work environment and can lead to moral distress. According to Jameton (1993), moral distress occurs when a nurse performs duties that are contrary to what he or she believes is appropriate but feels powerless to change those actions. This distress may be caused by internal constraints (e.g., lack of knowledge or support), external constraints (e.g., staffing or supply issues), clinical constraints (e.g., provision of care perceived as futile), or observations of others giving a false sense of hope (Elpern, Covert, & Kleinpell, 2005; Sirilla, 2014). The uncertainty and sometimes futility of treatment, as well as the emotional impact of caring for patients experiencing life-threatening diseases, leads to moral distress, which has a negative impact on nurses' physiologic and psychological well-being (Elpern et al., 2005; Lawrence, 2011; Whitehead, Herbertson, Hamric, Epstein, & Fisher, 2015).

Several descriptive studies have shown a correlation between moral distress and patient outcomes, satisfaction, and staff engagement (Elpern et al., 2005; Lawrence, 2011; Whitehead et al., 2015). Nurses experiencing moral distress are at increased risk for burnout, emotional exhaustion, and physical illness (Lawrence, 2011; Rushton, Batcheller, Schroeder, & Donohue, 2015; Whitehead et al., 2015). In addition, this distress often leads nurses to seek out different work environments, such as outpatient clinics, or leave nursing altogether (Giarelli, Denigris, Fisher, Maley, & Nolan, 2016).

The impact of moral distress is multifaceted, and it has become a national workforce priority. The American Association of Critical-Care Nurses (2016) urges hospital administration and individual nurses to work on creating a healthy work environment. Causes and manifestations of moral distress vary by practice setting (Epstein & Hamric, 2009, Lievrouw et al., 2016). A study by Elpern et al. (2005) identified significant moral distress among nurses in critical care units as a result of nurses believing that the treatments they were providing to patients were futile. Sirilla (2014) found that nurses on inpatient medical units experienced less distress than nurses on hematology/oncology or critical care units. A study by Bohnenkamp, Pelton, Reed, and Rishel (2015) that involved administration of a moral distress survey to staff on an inpatient oncology unit determined that a crescendo effect of distress may occur. After the first distressing event dissipates, a residual effect remains with the nurse, creating a lower threshold for future stressful situations. Consequently, the next distressing event will lead to a higher level of moral distress.

A review of the literature provides evidence of the negative consequences that moral distress has on nurses when working with patients every day