

# in multidisciplinary cancer care



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## Introduction

A variety of definitions concerning moral distress exist, but the common ground is that **moral distress (MD) arises when one knows the right thing to do, but certain constraints make it difficult or impossible to pursue, what is believed, the right course of action.**

Moral distress is, in a way, part of the job, certainly when working in oncology and having to deal with a complex and ethically challenging reality. But it is also a negative state of unpleasant psychological disequilibrium that can even lead to burnout and job leave.

The concept of moral distress is a relatively new phenomenon under investigation within health services, and has attracted much attention from a variety of disciplines, especially in nursing studies and in critical care. It was first described in 1984, but still remains rather neglected in the oncology field and among medical staff. Exploration is necessary to gain insight in how both nurses and doctors cope with MD in different types of oncology settings and how coping styles evolve throughout a career.

## Method

18 doctors (6 junior residents, 6 residents and 6 senior staff) and 18 nurses (6 having limited experience, 6 with medium and 6 with extensive experience) were interviewed about how and when they experience moral distress and how they cope. They were asked to describe 3 situations, in detail, in which they experienced MD.

Interviewees were working in 3 types of hospital wards of the Ghent University Hospital:

- Hospitalization ward **internal medicine** gastroenterology and medical oncology
- Gastrointestinal **surgery**
- **Day center** chemotherapy

1 respondent had to cancel the appointment last minute, so eventually **35 in-depth 1-hour semi-structured interviews** were conducted and typed out verbatim. Thematic analyses were performed using NVivo 10, after systematic discussion sessions leading to an inter-rater agreement.

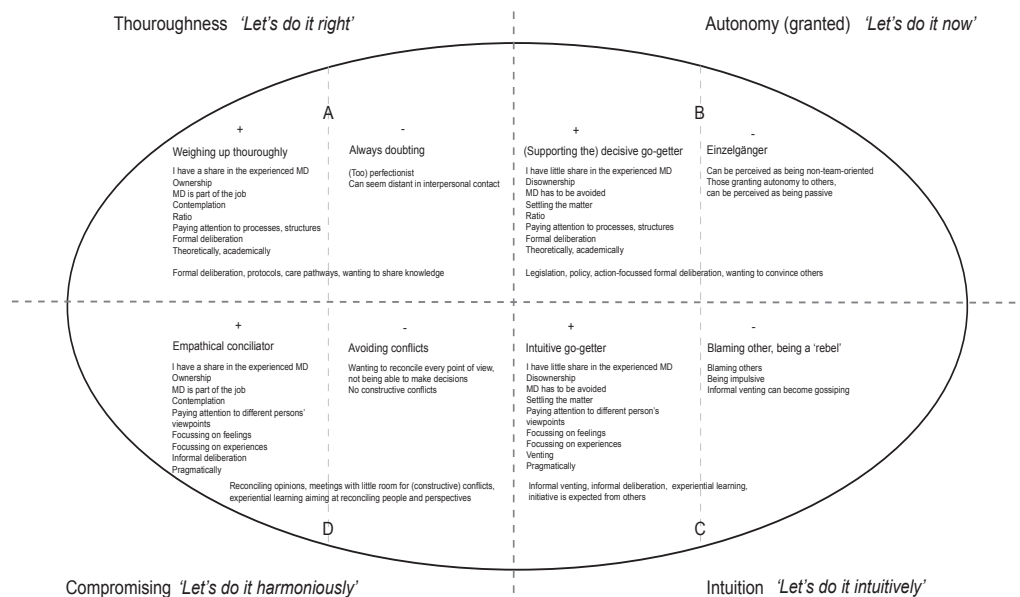
## Results: How do YOU handle Moral Distress?

4 dominant coping styles were found, based on 2 axes, conceived as two continuous axes:

1. A tendency to internalize MD (ownership) (x-axis, left segment) or externalize MD (disownership) (x-axis, right segment)
2. A tendency to focus on rational (y-axis, top segment) or experiential elements (y-axis, bottom segment)

Each coping style has its strong points (+) and pitfalls (-).

3 interviewees (2 internists, 1 surgeon) showed to dominantly express coping style A, 11 B (2 nurses Day Centre, 2 surgeons, 7 internists), 13 C (all nurses from the different setting types), 8 D (3 nurses and 5 doctors from the different setting types) (N=35). No distinct differences appeared based on experience levels. However, people appear to change coping style throughout a career or (try to) modify coping styles in accordance to a perceived team culture.



## Conclusions

MD is part of the day to day reality in multidisciplinary cancer care. 4 dominant coping styles are put forward. Each of the reported styles have strong features and pitfalls. Most people seem to be unaware of the way in which they, and team members, handle MD. Moreover, they express remarkable prejudices about other professions (e.g. nurses and junior residents doubt that senior staff members ever experience MD, surgeons think that internists suffer little MD and vice versa,...).

In this study, more doctors reported a mainly rational coping style when being confronted with MD, whereas nurses tended to focus more on feelings and experiences. However, coping is not a static construct: people do change their ways of handling MD, according to private or work-related experiences and perceived team culture.

Team leaders should be aware of this perceived team culture and should recognize their own and their team members' preferred coping style, resulting in a better mutual understanding, group cohesion, tools for more constructive team meetings and fitted training session (e.g. both focusing on theoretical topics and experiential learning).

MD can therefore be conceived as a challenging phenomenon in the ethically charged domain of oncology, leading to more introspection, team-reflection, creative answers, and higher job satisfaction.

Quantitative research could offer more insight in the validity of the presented model, also in non-academic (hospital) settings. Further research should zoom in more on leadership, team culture and team dynamics, especially in the complex process of ethical decision making.

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