Coping With Moral Distress in Oncology Practice: Nurse and Physician Strategies

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Lievrouw completed the data collection. Lievrouw, Benoit, and Vanheule provided the analysis. All authors contributed to the conceptualization, design, and manuscript preparation.

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Purpose/Objectives: To explore variations in coping with moral distress among physicians and nurses in a university hospital oncology setting.

Research Approach: Qualitative interview study.

Setting: Internal medicine (gastroenterology and medical oncology), gastrointestinal surgery, and day clinic chemotherapy at Ghent University Hospital in Belgium.

Participants: 17 doctors and 18 nurses with varying experience levels, working in three different oncology hospital settings.

Methodologic Approach: Doctors and nurses were interviewed based on the critical incident technique. Analyses were performed using thematic analysis.

Findings: Moral distress lingered if it was accompanied by emotional distress. Four dominant ways of coping (thoroughness, autonomy, compromise, and intuition) emerged, which could be mapped on two perpendicular continuous axes: a tendency to internalize or externalize moral distress, and a tendency to focus on rational or experiential elements. Each of the ways of coping had strengths and weaknesses. Doctors reported a mainly rational coping style, whereas nurses tended to focus on feelings and experiences. However, people appeared to change their ways of handling moral distress depending on personal or work-related experiences and perceived team culture. Prejudices were expressed about other professions.

Conclusions: Moral distress is a challenging phenomenon in oncology. However, when managed well, it can lead to more introspection and team reflection, resulting in a better interpersonal understanding.

Interpretation: Team leaders should recognize their own and their team members' preferred method of coping and tailored support should be offered to ease emotional distress.

A range of definitions have emerged for moral distress (MD), leading to a concept that lacks conceptual precision (McCarthy & Deady, 2008). In 1984, Jameton stated, "Moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Raines (2000) adjusted this definition, stating that constraints can be more varied. Numerous studies have contributed by proposing internal and external barriers (e.g., fear of professional reprimands, lack of self-confidence, legal constraints, hospital policies) (Burston & Tuckett, 2013; Epstein & Hamric, 2009; Hamric, Davis, & Childress, 2006; Meltzer & Huckabay, 2004).

The psychological context of how MD takes shape (anger, frustration) usually is a key element when defining the concept (Repenshek, 2009). Kälvemark, Höglund, Hansson, Westerholm, and Arnetz (2004) connected MD to situations

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