Model distress in nursing in response to medical futility

Moral Distress in Nursing in Response to Medical Futility in the Geriatric Population at the End of Life Each day, in the life of a nurse, they deal with issues that address respect for life and doing what is ethically and morally right. Promoting the patient's self esteem and personal independence, and doing what is right and preventing harm are nursing care's utmost priorities. Since nursing is a centrally ethical profession, morals and values play an important role in making a nurse perceive that their work is more meaningful (Ferrell, 2006).

In Jameton's (1984) influential book, Nursing Practice the thical issues, he differentiates ethics from morals by contrasting professional versus personal values. According to Jameton (1984) professional values are set of rules that publicly state a profession's ethical beliefs, such as the Code for Nurses, while personal values are morals that a person strongly believes in. In short, ethics refers to the more professional and theoretical term, while morals are more personal and informal.

Mohammed and Peter (2009) defines medical futility as medical interventions and treatments that will unlikely result in any positive outcome and urther divides it into two categories: physiologic and qualitative. Physiological futility involves interventions that are unlikely to produce a specific medical outcome that will resolve symptoms nor prolong the patient's survival (Mohammed ; Peter, 2009). An example of physiologic futility is performing Cardiopulmonary Resuscitation (CPR) on a patient with a ruptured dissecting aneurysm.

Physiologic futility is often based on the clinician’s past experience, their colleague’s shared experience and based on statistical data that an intervention would have no desired ffect (Mohammed ; Peter, 2009). However, even with a given statistical data, collective analysis will not usually show that an intervention is 100% guaranteed ineffective, hence the issue of whether to terminate a treatment or not (Mohammed ; Peter, 2009).

Qualitative futility on the other hand, are situations that may violate the clinician’s sense of integrity, misuse of healthcare’s limited resources, and involve treatment that may be harmful rather than beneficial, when the goals of the patient and their decision maker are considered unreasonable (Mohammed ; Peter, 2009). An example of qualitative futility is the aggressive treatment of an end stage cancer patient that may disregard the patient’s pain and comfort. The patient would be in overwhelming amounts of discomfort with a likelihood of remission being zero.

According to Ferrell (2006) nurses are often placed in a difficult position being in the core of health organizations, direct contact with patients, and the dominance of medicine. When nurses are faced with situations that are against their values as a result of inappropriate medical treatment, nurses often experience moral distress (Ferrell, 2006). Moral distress in nursing arises when one recognizes the right thing to do, but is unable to act on it due to organizational constraints Oameton, 1984).

In an attempt to face such ethical dilemma, nurses will often choose to act as a patient ethical situation might do: the nurse recognizes the negative effects that their action might do, to avoid being reprimanded they will

therefore do nothing; a nurse may try to act as a patient advocate but will avoid direct confrontation with the physician by using communication strategies that will covertly get their point across; or a nurse ill strongly advocate for the patient and confront the physician.

Often times, according to Ferrell (2006), nurses are unsuccessful in their attempts to directly advocate for the patient. As a result, nurses feel hurt, powerless, anger and frustration which are all signs of moral distress (Ferrell, 2006). According to Pendry (2007), nurses will not verbalize that they are experiencing moral distress, but will instead report symptoms of sleeplessness, nausea, migraines and tearfulness. Moral distress in nursing is directly linked to burnout, as burnout is directly linked to the ursing shortage Oameton, 1984).

Since Jameton’s definition of moral distress in nurses, other researchers have expanded its meaning as failing to act appropriately from doing what is ethically right because of obstacles such as lack of institutional support, limitations due to institutional policy, medical dominance over nursing and fear of legal consequences which all results in psychological disequilibrium for the nurse (Pendry 2007). The issue of moral distress in nursing has long been lingering for over two decades, and despite the many studies and research, surprisingly many nurses are still unaware of ow this dilemma may manifest (Pendry, 2007).

Nurses experience role conflict when an institution or physicians have certain expectations that are against what the nurses think is providing optimal care (Pendry 2007). Nurses may view themselves as subordinates to the

management and physicians that they often feel powerless to act as an advocate for the patient and do what they believe is in the patient’s best interest. Pendry (2007), reports that some nurses are intimidated to act according to their values in the fear that it might be in disagreement with the physician’s values.

Nurses may also be burdened by the fact that they have to carry out orders or decisions made by another person (Pendry, 2007). Nurses often feel that aggressively treating patients that are unlikely to benefit from a procedure does not only put a patient in too much discomfort but also denies that person the right to palliative care (Pendry, 2007). According to Pendry (2007) end of life decision making, depending on how it is carried out, may affect a nurse’s morals. A nurse might experience moral distress if for example a patient is denied nutrition to hasten death.

On the other hand it is ore morally acceptable for some nurses to administer opiates ordered by physicians, to alleviate the patient’s suffering while secondarily hastening death In the nursing profession, one’s professional ethics is not a personal choice but rather an expected professional conduct that may be scrutinized by other professionals and even the public Oameton, 1984). Not to say the least, a professional’s work may be questioned for review using ethics criteria if they feel that the code of professional conduct has been violated Oameton, 1984).

Therefore professional ethics acts as a policy that represents their values as a result of debates ver issues that their profession has come across throughout their history Oameton, misrepresents their ethical conduct.

Jameton (1984) identifies 4 ethical principles in the nursing profession that keeps the patient's best interests the priority: trust, benefits, nurse-client relationship, and practical arts. An expectation among nurses is that every patient is treated with respect, and trust will not be abused.

A person's hospitalization makes them vulnerable and dependent on nurses. Nurses, as part of their code of ethics should maintain their patients trust by doing what is expected of them, doing no harm Oameton, 1984). While other professions owe duties because of certain benefits bestowed on them, nurses are discouraged from receiving gifts of money, power and status as a result of their service. Instead, they are encouraged to dedicate their time and skills doing public service and participating in supporting other hospitals and nursing schools Oameton, 1984).

Maintaining a mutually respectful nurse-client relationship is essential in the nursing profession. To achieve this, nurses are expected to exhibit fairness, honesty and mutual autonomy to their patients Oameton, 1984). Nursing as a practical arts means that their knowledge and skills are enhanced and practiced to stay competent and do good rather than harm Oameton, 1984). The end purpose ofa nurse's action is intended to benefit their patients, may it be immediate or distant.

An example of an immediate result would be a nurse giving their patient a back rub to promote comfort, while turning a patient every two hours to prevent pressure ulcers will not manifest results immediately, but rather overtime. In his book, Jameton (1984) questions if having a good moral character should be considered in the issue of ethical competence. Nurses

who have gained recognition, like Annie Goodrich during the 1890’s, are those who became involved with public health and have made an impact to the community Oameton, 1984).

It is therefore agreeable that nursing is a profession that extends beyond the bedside to the community. A nurse will not be scrutinized for their political efforts to do what is morally right to improve health. When a nurse’s private morals however conflicts with their professional life, the nurse is expected to disregard their own morals and act according to their professional ethics Oameton, 1984). An example would be a urse who has a history of being a battered wife, who ironically is assigned to take care ofa male inmate who is incarcerated for beating his wife.

The nurse is expected to put aside her private life and professionally take responsibility of that patient’s health as she would other patients. On the contrary, nurses may be unable to perform their duties well when their professional obligations interfere with their private sense of morality Oameton, 1984). For instance, a nurse who believes that abortion is morally wrong is not obligated to assist in abortion. In this case, nurses re encouraged to use their own Judgment in applying the principles of their practice Oameton, 1984). Nurses spend more time with patients compared to all healthcare personnel.

As a result, patients and their families tend to open up more to nurses rather than physicians because some patients feel that doctors do not have the time to listen to their concerns and are sometimes intimidated by their perceived power (Badger, 2005). Nurses are ideally forefront in assisting

patients and their families in issues the patient’s wishes come first. A patient owns their body and is the one who has to o through the consequences of a given intervention, thus giving them the right to decide as to which procedure they consider futile (Badger, 2005).

At the very least, patients should be given treatment options and choices that enables them to participate actively in decisions that will directly affect their life. However ideal this may sound, patients are seldom given enough authority to make decisions of whether a treatment will attain their desired outcome (Badger, 2005). There is a general belief that medical doctors are the experts in interpreting and analyzing medical data once it is collected.

Physicians are expected to be in the best osition to decide which treatment options would and would not benefit a patient. A doctor’s clinical Judgment, their knowledge, their authority and expertise makes some patients perceive that they know when a treatment should be deemed futile (Badger, 2005). When a treatment will unlikely cause any significant benefit, the physician has the duty to communicate to the patient and their family, in a compassionate approach, the rationale of withholding that treatment (Badger, 2005).

The media’s powerful influence raised the bar when it comes to the societys rising medical expectations. The world saw how public fgures, such as Lance Armstrong, attled their way out of a serious illness. Due to the rising societal expectations and fear of legal implications, healthcare professionals tend to participate in “ defensive medicine” defined as rendering all possible treatment to avoid being scrutinized as neglectful (Ferrell, 2006).

In general defensive medicine, although attributed to physicians, may compel the nurse’s participation to avoid legal implications (Ferrell, 2006). Paternalism is another controversial ethical issue in healthcare. Paternalism is defined by Jameton (1984) as another person deciding what is beneficial for the patient. According to Ferrell (2006), even clinicians run out of ideas when they have maximized the treatment options they could offer. When all else fails, the only treatment physicians could resort to is cardiopulmonary resuscitation.

The rule of thumb in healthcare is to give considerable thought in assessing the pros and cons of a treatment and to treat the person as a whole Oameton, 1984). Unfortunately, because of not having enough medical knowledge or having unrealistic expectations, patients and their families tend to entrust paternalism to their physicians, who in return may resort to defensive medicine to avoid conflict with he patient’s family (McCarthy & Deady, 2008).

In the study done by McCarthy & Deady (2008), aggressively treating terminally ill patients, setting unrealistic goals and ordering unnecessary tests, lack of support from the organization, and medical dominance all contribute to moral distress in nursing. The findings of their study also showed that of the 22 newly graduated nurse who participated in their research, 15% experienced moral distress, self-disappointment and doubt when they realized that the way they were practicing nursing was not how they had envisioned it to be (McCarthy & Deady, 2008).

In response to this, these nurses left the hospital, changed to another unit, blamed the institution and management, avoided interacting with patients, while some left the profession entirely (McCarthy & Deady, 2008). they found that it was challenging for nurses to decide how much information they should disclose to the patient and their families without stepping on the physician’s foot. Results of their study also showed that surgeons tend to pursue aggressive medical interventions while the nurses were more reluctant (TorJuul ; Sorlei, 2006).

The nurses who participated in this study shared a common view that most hysicians tend to treat a patient organ by organ and are reluctant to withdraw treatment which often times result to unnecessarily over treating the patient, prolonging their suffering and further decreasing their quality of life (TorJuul ; Sorlei, Nurses are molded and trained to provide consistent quality care for patients even if the care they provide does not move towards cure (Mobley, Rady, VerheiJde, Patel ; Larson, 2007).

As patients reach the end of life, the differences between the professional roles of the physician and the nurses widens as they may view futile are differently (Mobley et al. , 2007). The rate of moral distress in the critical care unit (CCU) is amplified as nurses witness technical advances in medicine that exposes the elderly to aggressive treatment before their death (Mobley et al. , 2007).

Among the 44 critical care nurses who responded in this study, 66-89% says they have witnessed and participated in futile care because the hospital wanted to steer clear from a lawsuit (Mobley et al. , 2007). In a study by

Zuzelo (2007), she collected clinical events that Registered Nurses perceived as futile and is associated to moral distress. Following the familys wishes in pursuing medical care to avoid a lawsuit ranked as the highest morally distressing situation (Zuzelo, 2007).

Other morally distressing situation reported by the participants include: carrying out unnecessary orders written by the physician, initiating life-saving action that prolongs suffering and death, witnessing medical students perform painful interventions on patients to acquire and improve their skills, and providing care that does not address comfort because the physician fears that administrating pain medications may hasten death (Zuzelo, 2007). According to Jameton (1984), it is imperative to recognize moral distress in an effort to retain nurses.

Aside from suggesting that nurses should be aware of their limitations, Jameton (1984) illustrated an approach in resolving ethical issues as follows: identifying the problem, gathering data, identifying options, thinking the ethical problem through, making a decision and acting and assessing Oameton, 1984). Identifying the problem involves recognizing the ethical issue and where the conflict arises. It is also important to know the people involved and how much time is needed to consider or resolve the issue Oameton, 1984).

Gathering data is investigating the situation that involves the history, present facts, views of the people involved, and the overall medical, nursing and social situation Oameton, 1984). Identifying options includes considering the course of action and the impact of each Oameton, 1984). For example, if

CPR is performed, is there a possibility of survival? Or if the patient is intubated, what are the chances that they could be weaned off the ventilator?

Thinking the ethical problem through involves bearing in mind the main beliefs of their professional ethics by considering basic values such as respect, aluing health, and equality Oameton, 1984). After considerable thought and valuing course of action is important to be able to handle subsequent situations more effectively Oameton, 1984). Nurses experiencing moral distress may develop disturbed self-concept related to compromised role performance (Carpenito-Moyet, 2006).

The nurse who unwillingly participates in futile treatment may question their role in care giving because they are acting against their values and morals. Assessing the related factors, offering support systems and encouraging stress management are important interventions to revent burnout (Badger, 2005). Nurses believe that sharing emotional reactions related to moral distress were best shared with another colleague who might have gone or witnessed a similar situation (Badger, 2005).

Nurses participating in futile care may also experience caregiver role strain related to unrealistic expectations for caregiver by others (Carpenito-Moyet, 2006). The nurse may manifest this by verbalizing feelings of guilt and inadequacy. To intervene and to avoid moral distress, the institution should make an active effort to resolve the ethical issue (Badger, 2005). The institution should also develop a systematic way of reviewing issues that lead to moral distress among nurses and take corrective action (Morris ;

Dracup, 2008). The society should not underrate how nurses value their profession.

All studies mentioned in this term paper show that nurses perceive they are unable to live up to their professional standards when their work does not reflect their values. End of life care and decision making, because of its uncertainties, puts the nurse in a difficult ethical situation. When health professionals fail to identify the need for palliative are during the last days of a person’s life, they may prolong the person’s suffering and death. Nurse advocacy may prevent futile care because they are aware of the issues involved in dying other than the patient’s physical needs.

Each person involved in the care of a dying person, including the family, should be left with the sense that they have done their best in caring for the patient. Members of the healthcare team should feel inspired from the lesson they have learned as a result of their involvement in the care of a dying person and hopefully motivate others to be more compassionate when dealing with death and dying. Rendering futile care does not only diminish the value of a person’s life, but also affects the growth of those participating in it both personally and professionally.