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Palliative Care Consultation Policy Change and Its Effect on Nurses' Moral Distress in an Academic Medical Center

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Moral distress affects workplace environment, burnout, employee retention, and patient safety. Palliative care is frequently involved in complex care for patients that may cause moral distress among staff. The goal of this study was to measure change in moral distress among nurses after implementation of a policy that allows nurses to consult palliative care. Before the policy change, data were gathered via email using the Moral Distress Scale-Revised. The scale was redistributed 6 months after implementation of the consult policy. Pre and post Moral Distress Scale-Revised results were analyzed. Qualitative thematic analyses of the nurses' comments were conducted. A significantly lower percentage of nurses reported providing care for a hopelessly ill patient frequently or very frequently (34.6% vs 23.1%, $P = .0397$) after the policy change. However, a significantly higher percentage of nurses postpolicy reported frequently or very frequently providing less-than-optimal care because of pressures from administrators/insurers (14.4% vs 21.1%, $P = .0378$), caring for patients they did not feel qualified to care for (5.3% vs 14.8%, $P = .0055$), and working with providers who were not competent to care for the patient (13.9% vs 26.9%, $P = .0059$). Themes from nurses' comments were inadequate staffing, communication, ethical concerns, and lack of education.

KEY WORDS

moral distress, palliative care

Moral distress is a well-known influence that affects workplace environment, employee retention, job satisfaction, and, ultimately, patient safety.[1,2] Previous studies have demonstrated the presence of moral distress in health care staff including nursing, pharmacy, respiratory therapy, social work, and administration.[3] However, moral distress was first described in the field of nursing, and it is known that nurses report higher levels of moral distress compared with their physician colleagues.[1] Moral distress is defined by Jameton[4] as occurring "when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action."

Jameton's initial definition of moral distress occurs when a nurse knows the morally correct action to take but feels constrained in some way to carry out that correct action. Fourie[5] argues to further expand the definition of moral distress to include 2 categories of distress: constraint, when it is clear what should be done in a situation, and "uncertainty-distress."[6] Uncertainty-distress is defined as those morally challenging cases when it is unclear as to the correct decision for the patient. Sirilla defines moral distress as knowing the right thing to do when policy constraints do not allow appropriate choices. Although the correct moral decision may not be clear, the nurse may still experience moral distress based on this expanded definition by Fourie.

Corley proposed that, when nurses' stated professional goals are opposed, it inevitably leads to moral distress. Corley claims that the stated goals of the profession are inherently ethical in nature: "to protect the patient from harm, to provide care that prevents complications, and to maintain a healing psychological environment for patients and families."[7] Literature suggests that, when nurses do not feel empowered to speak up on behalf of their patients and therefore remain silent, it results in not only moral distress but also patient harm.[2]

Studies have demonstrated that moral distress impacts nurses' consideration to leave a position.[3,8] In the current health care environment, neither hospitals nor employers

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can afford to have nurses leave their position because of moral distress. The 2017 National Healthcare Retention and RN Staffing Report[9] determined that the nursing turnover rate is down to 16.2% from 17.2% reported in 2016. The estimated cost of turnover for 1 bedside registered nurse ranges from $38 900 to $59 400. This equates to an annual loss of $5.13M to $7.86M for the average hospital. Despite most hospitals reporting that retention is a "key strategic imperative," less than half have demonstrated this in their operational practice and planning. It is reported that approximately 17.5% of new nurses will leave their first job within the first year and that high nursing turnover is an indicator of a poor workplace environment.[10] Studies suggest that workplace environment and ethical climate are negatively correlated with moral distress and those who report higher levels of moral distress are more likely to consider leaving their current position.[8]

Multiple studies demonstrate that nurses report high levels of moral distress when providing perceived futile care.[1,12,13] Futile medical care is the continued provision of medical care or treatment to a patient when there is no reasonable hope of a cure or benefit.

It is not uncommon that palliative care specialists treat patients with the previously stated conditions and are often asked to address code status, life support, and nutrition.

It has been reported that clinical team members with education in end-of-life care and pain management have higher levels of moral distress than those who do not have training in these areas, possibly because they are more aware of appropriate management.[8] The purpose of this study was to examine the relationship between allowing nurses to consult palliative care independent of the physician team and their moral distress as measured by the Moral Distress Scale-Revised (MDS-R), a previously validated tool.[13] We hypothesized that empowering nurses to independently consult palliative care would decrease moral distress surrounding complex medical care. Previously, this academic medical center allowed only a physician to consult palliative care. However, because nurses typically spend more time at the bedside, they may be more aware of patient and family needs than the physician team. The palliative care team was expected to communicate with the attending physician of record when a nursing consult was placed to ensure they were aware of the consult. The attending physician had the right to refuse the consult.

METHODS

This study was approved by the appropriate institutional review board on August 24, 2015. An MDS-R was sent by email to inpatient adult and pediatric nurses and internal medicine residents at our institution. All surveys were anonymous excluding unit description of where the individual worked. The focus of this article is the adult nurses (n = 2000) only.

All qualitative responses were compiled and reviewed by 2 independent reviewers who read and recorded themes for each response. Results were then compared between the 2 reviewers and adjudicated by an independent qualitative researcher.

This study took place from August 2015 to April 2016 at a 700-bed academic medical center located in the Southeastern United States. Round 1 survey distribution took place in September 2015; round 2 took place in March 2016. The 2-sample t test was used to compare the total MDS-R mean scores between rounds 1 and 2. We compared frequency of reported events from rounds 1 and 2 using the χ^2 test. All statistical analyses were performed in SAS 9.4. The consult policy change was enacted after the round 1 survey data collection. Although investigators anticipated a 10% to 20% response rate, the response rate was actually 10% for round 1 and 5% for round 2.

We were granted approval to use the MDS-R by Hamric. The MDS-R is a 21-item scale measuring nurses' moral distress levels. Two questions were included in the survey tool to assess intent to leave the current position or previous consideration to leave a position because of moral distress. A free-text comments section was added to the tool. The MDS-R survey was built and managed using the medical center REDCap secure Web application.

RESULTS

Both quantitative data and qualitative thematic data were collected and analyzed. Each of the 21 items was scored using a Likert scale (0-4) for frequency and level of disturbance. These were multiplied together to give a score of 0 to 336, with 0 indicating no moral distress and 336 indication the highest moral distress. Responses related to the frequency of events were then grouped into responses 0, 1, and 2, classified as "never" or "infrequently" occurring, and responses 3 and 4 considered as "frequently" or "very frequently" occurring. The frequency of reported events was then compared for round 1 versus round 2.

There was no statistical significance between rounds 1 and 2 MDS-R mean scores.

The frequency of events reported before and after policy change was significant for 4 MDS-R survey items:

1. Provision of less-than-optimal care (14.4% compared with 24.1%; $P = .0378$)
2. Continuation of care for a hopelessly ill patient (34.6% compared with 23.1%; $P = .0397$)
3. Caring for patients they did not feel qualified to care for (5.3% compared with 14.8%; $P = .0055$)
4. Working with other health care providers who were not competent to care for the patient (13.9% compared with 26.9%; $P = .0059$)

Of the adult nurses surveyed, 49.5% had considered leaving their current position or a previous position versus

55.1% after policy change ($P = .3491$). Twenty-two percent of the nurses before the policy change were actively considering leaving their position currently, versus 30.8% after policy change ($P = .0951$).

Although not statistically significant, 32.8% of the nurses reported witnessing health care providers giving "false hope" to a patient or family frequently or very frequently prepolicy versus 23.1% postpolicy ($P = .0786$). Before policy change, 5.3% of the nurses reported being asked to increase the dose of sedatives/opiates for an unconscious patient that they believed could hasten death frequently or very frequently versus only 0.9% after policy change ($P = .0535$).

Four major themes emerged from qualitative thematic analysis of the nurses' comments that contributed to moral distress: inadequate staffing, communication, ethical concerns, and lack of education.

INADEQUATE STAFFING

As described in previous studies, moral distress was reported because of chronic understaffing and therefore higher workload per nurse.[14] Nurses have previously reported feeling forced to provide care as quickly as possible leaving them with inadequate time to provide comprehensive care to their patients.[14] Nurses' comments support the findings that insufficient time hinders optimal patient care, communication, and patient safety.

> Nurses are so overworked that it is difficult to have time to talk to patients and families to assure full understanding of diagnosis.

> Poor staffing, leading to decreased emotional/personal support and care for the patient.

> Staffing problems. Made to pair extremely sick patients and increase nurses' work load causing unsafe situations.

One nurse's comments highlight the issues concerning retention of staff, which has been noted in the 2016 National Healthcare Retention and RN Staffing Report.[8]

> Understaffing of all ICUs at (this medical center) due to lack of an actual (floatpool) and lack of employee retention programs/incentives. If only upper management would pay attention to the high turnover rate (and) underlying issues.

COMMUNICATION

The overarching theme of communication identified subthemes of "truth-telling" and "limited freedom to talk to patients openly."

Truth-telling

Nurses reported feeling that physicians gave false hope to patients and their families or were not transparent about the benefits and burdens of certain treatment plans.

> Physicians disagreeing on patient viability and giving families false hope.

> When physicians continue treatment (chemotherapy, etc.) for a patient with poor prognosis/poor expected outcome and doing so greatly decreases their remaining quality of life without truly disclosing what the treatment will likely do to them.

Limited Freedom to Talk to Patients Openly

Previous studies have shown that nurses have higher levels of moral distress than did their physician colleagues, perceived their ethical environment as more negative, and were less satisfied with the care delivered in their unit compared with physicians.[4] Rainer[2] proposed that, when nurses feel powerless, the result is moral distress. Corley's theory supports this, stating that, when nurses do not speak up for their patients, the result is moral distress. In contrast, when nurses feel empowered and speak up, it fosters moral courage.[7]

> Nursing staff are not allowed to discuss code status, end of life options, and patient's opinion of continuing treatment vs. palliative care. Nursing waiting prolonged periods for MD team to discuss options with patient and thus causing patient days to weeks of unnecessary pain & discomfort.

EDUCATION

The nursing comments support that nursing staff feel hindered in attempts to provide symptom management and end-of-life care because of the lack of education among their physician colleagues concerning palliative care and symptom management.

> A patient with breast cancer and large pleural effusions who was dying alone and had no support system was having a lot of anxiety and the chief of the service would not give her anything because the patient "needs to learn how to cope."

> Patient not given adequate pain control because physicians are taught to fear pain medicine.

> Taking care of a palliative patient that needs changes in orders to keep the patient comfortable. Primary team uncomfortable changing (the) order, waits on palliative recommendations. This is a lengthy process. In the

meantime the patient is suffering when it is our job to provide them with comfort. I believe more effort should go into comfort measures for palliative patients.

ETHICS

Subthemes identified within ethics were "providing futile care" and "delay in consulting palliative care and/or ethics." Previous studies support the notion of moral distress especially surrounding perceived futile care, conflict over code status, nutrition, and life support.[11] The most common conflict among nurses occurs when palliative care is denied in the setting of aggressive care.[11] The comments hereinafter reveal that some nurses do not feel supported to consult ethics or palliative care.

We do not consult Palliative Care soon enough. It makes me so angry that some doctors think that we have to wait until the patient is hours away from death to consult Palliative. We need more resources and education for our doctors. We always have patients who have not needed to be kept alive for days because of poor family-to-MD communication. I'm taking care of a patient right now where the patient's family member is suffering more than necessary because GI Surgery and our Anesthesia team cannot agree and are telling the spouse different opinions. In my opinion I think nurses need more education on the issue as well.

MD not giving patient or family the whole prognosis of the patient until within 24 hours of the death of the patient. When nursing staff tried to get ethics involved was told to mind their business and stay out of the situation. Nursing staff having a lot emotional stress providing care for the patient.

DISCUSSION

This study examined the relationship between moral distress among nursing staff and the ability to consult palliative care independently of the physician team. Our results partially support our hypothesis that this policy change may decrease moral distress. It was noted that a significantly lower percentage of nurses after policy change reported frequent or very frequent, continued care for a hopelessly ill patient (34.6% vs 23.1%, $P = .0397$). Many studies have suggested that providing futile care provokes moral distress in nurses.[4,11] Notably, frequency of perceived futile care being provided decreased after the policy change. This may be associated with the policy change. We propose that, once palliative care is involved, the nurses may feel supported in their concerns about providing futile care to a hopelessly ill patient. Support from the palliative care team encouraging nurses to speak up concerning futile care may empower them and foster "moral courage," as Corley proposed.[7] This change may also be related to the campus-wide educational effort during the study period, promoting palliative and end-of-life care that was directed toward nurses and physicians.

Interestingly, it was noted that a significantly higher percentage of nurses reported caring for a patient they did not feel qualified to care for frequently or very frequently (5.3% vs 14.8%, $P = .0055$) after policy change. There was also a significant change in percentage of nurses who reported working with other health care providers who were not competent to care for the patient frequently or very frequently (13.9% vs 26.9%, $P = .0059$) postpolicy. These changes may suggest a higher level of moral distress among the nursing staff. Again, this may be due to the educational efforts put forth concerning symptom management and palliative care across the institution during this period. Consistent with previous studies, medical team members who were educated in pain management and end-of-life care reported higher moral distress.[8] As noted in the nurses' comments, inadequate staffing was also a perceived problem contributing to stress within the workplace, and it would not be surprising that inadequate staffing may further impact competent care being delivered.

Initially, it was hypothesized that empowering nurses to speak up and consult palliative care independently of the physician team would foster "moral courage" and therefore decrease moral distress.[7] However, there were instances when the attending physician of record refused the palliative care consult. The outcome of this was not measurable, but it is anticipated that this further silenced the nurse and may cause the nurse to hesitate in the future to speak up for a patient, thereby increasing moral distress.

The qualitative themes identified ultimately cause moral distress because they oppose the stated goals of nursing care, as Corley proposed.[7] Review of the comments reveals that patient comfort and safety continue to emerge as a priority, and when nurses feel hindered to provide this care, it causes moral distress.

There are many potential limitations of our study. It is unknown whether the same nurses filled out the survey rounds 1 and 2 because they were anonymous in nature. The results may have been skewed by the palliative care educational work that was ongoing during the study period. It is estimated that more than 50 hours of education were given campus-wide during the study period. In addition to educational efforts, the bandwidth of the palliative care team expanded. Between June and December 2015, the team grew to include a new medical director, a volunteer coordinator, a chaplain, a medical social worker, and an additional physician compared with the previous team that included 2 physicians and a full-time nurse practitioner.

CONCLUSION

Moral distress continues to be an issue that deserves attention because it impacts workplace environment, nursing retention, and, ultimately, patient safety.[1,2] Results of this study do not fully support the notion that allowing nurses to consult palliative care decreases moral distress. However, because many influencing factors were noted over the study period as limitations to this study, it is difficult to ascertain the impact of the policy change. Although not measured but noted by the palliative care team, moral distress increased among the nurses when the attending physician refused the consult, which was an unexpected complication of the study.

Previous studies have proposed that nurses' empowerment and ability to freely speak up on behalf of their patients are negatively correlated with moral distress.[2] The comments provided by nursing staff would support this position. The situations noted as causing moral distress were often when nurses felt hindered to speak freely to the patients and families about prognosis, need for palliative or ethics consult, expected outcomes of treatment, or the general plan of care.

Despite years of research on the subject of nurses' moral distress, limited solutions have been proposed to mitigate the effects. Because of the recognized impact of moral distress on burnout and patient care, a symposium including the John Hopkins Berman Institute of Bioethics, the Johns Hopkins School of Nursing, the *American Journal of Nursing*, and the *Journal of Christian Nursing* was held in 2016.[15] The members of the symposium developed consensus recommendations for addressing moral distress and building moral resilience among nurses. These initial recommendations aim to transform the outcome of moral distress to a more positive one, that being moral resilience. However, it is likely that moral distress will continue to impact nursing turnover rate, patient care, and workplace environment, and further studies concerning palliative care and the impact it has on nursing moral distress should be performed. Continued studies to ascertain methods to mitigate moral distress and decrease its effects on nurses are vital for nursing retention and high-quality patient care.

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