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Moral distress in oncology nurses: A qualitative study

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ABSTRACT

Purpose: Oncology nursing is a special field of practice containing many factors that cause moral distress. The purpose of this study was to explore the sources of moral distress in oncology nurses.

Methods: This qualitative phenomenological study was conducted with 14 oncology nurses. The mean interview duration was 30 min. Data were analyzed using qualitative inductive content analysis according to the methods of Corbin and Strauss.

Results: Four main themes were identified in the study. The first theme, related to the failure of quality of care, includes the failure to provide holistic care and competence problems (not feeling competent in oncology practice). The second theme includes biomedical ethical issues commonly observed in the field of oncology. The third theme includes treatment and care practices, consisting of futile treatments, lack of regulation for 'do not resuscitate' orders and decisions to limit life-prolonging treatment, limited informational authority of nurses, and problems related to educational practices on the patient. The final theme includes problems arising from the health care system and institution's management and the need for regulation to support ethical decisions.

Conclusion: Oncology nurses face ethical problems in providing the quality and continuity of care they desire. It is difficult to manage the problems, especially in the end-of-life period. In order to reduce and eliminate these difficulties, it is recommended to make administrative, institutional, legislative, and systemic arrangements.

1. Introduction

Ethical challenges are inherent to clinical practice in oncology (Neumann et al., 2019). In oncology practice, ethical issues are frequently raised in relation to the management of pain or painful treatments, the problem of maintaining quality of life, futile treatments, resuscitation efforts, gray areas in information sharing, end-of-life (EOL) care issues, the dying process, and the protection of patient dignity (Hamric, 2012; Tuca et al., 2021). Although regulations, ethical principles, professional ethical codes, and ethical guidelines provide a basis for carrying out their activities within an ethical framework, nurses can not always provide perfect solutions to all problems. The hierarchical structure of health care settings, the ethical perspectives of team members, and their individual values do not always align (McAndrew et al., 2011; McCarthy and Gastmans, 2015; Oh and Gastmans, 2015), legal and institutional policies, and limited resources may limit healthcare professionals in solving the ethical problem or implementing the solution (Hamric, 2012, 2014). Furthermore, even if healthcare professionals have an opinion about what is morally best and successfully do what they have decided, they are likely to feel that their moral integrity is compromised or flawed (Campbell et al., 2018).

Nurses who cannot cope with the complexity of the ethical situations they find themselves in or cannot implement the solution they believe to be correct are negatively affected by this situation; they experience disappointment and feel powerless (Rezaee et al., 2019). These experiences, referred to in the literature as "Moral Distress" are manifested by frustration, powerlessness, dissatisfaction, anger, emotional distancing, avoidance, and avoidance of contact with the patient and family (Meziane et al., 2018).

Jameton first described moral distress in 1980 as "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" (Jameton, 1984, p.6). Over time, the definition of moral distress has been expanded as "serious threat to an individual's moral integrity or inability to act on core values and obligations, or distress resulting from one's actions not achieving the desired outcome" (Hamric, 2014). The need to further expand the definition of moral distress, which has become increasingly focused and better understood since the day it was defined, is

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controversial. Campel et al. recommend defining moral distress as "one or more negative self-directed emotions or attitudes that arise in response to perceived involvement in a situation that one perceives as morally undesirable" (Rezaee et al., 2019). However, because it is more widely recognized and accepted, in this study Hamric et al. (2014)'s moral distress definition is based on.

The field of oncology nursing is a special area because it contains many factors that cause moral distress. However, studies on moral distress levels in oncology nurses are quite limited, and most of the literature consists of studies conducted in western societies (Morley et al., 2021; Mullin and Bogetz; 2018, Pergert et al., 2019). Further studies are needed to better understand the dynamics of moral distress in oncology that negatively impact healthcare professionals both individually and professionally (Marturano et al., 2020). Recognizing and understanding culture, health care system, and group dynamics will be an essential step in reducing moral distress. Moral distress is a challenging phenomenon in oncology, but the right interventions to properly identify moral distress sources can reduce moral distress experiences (Meziane et al., 2018; Neumann et al., 2019). Although moral distress has a negative perception, when moral distress is managed well, it can lead to more reflection, a better understanding of how the experience affects the team, and better interpersonal understanding, and it can reduce nurse turnover (Marturano et al., 2020). This study aimed to determine the sources of moral distress among oncology nurses in Turkey.

2. Methods

2.1. Design

This study, designed as a phenomenological descriptive qualitative type, was conducted using semi-structured one-to-one in-depth interviews, one of the qualitative research methods. This study was reported according to the checklist of Consolidated Criteria for Qualitative Studies (COREQ) (Tong et al., 2007).

2.2. Participants

The oncology nurses included in the sample of the study were reached through the Turkish Oncology Nursing Association. Clinical nurses who have been working actively in the oncology inpatient clinic for at least six months were invited to participate in the study. The research was conducted with 14 oncology nurses. After the researchers reached the participants, the in-depth interviews were conducted with each participant separately in a quiet room where they could be alone with the researcher, either in the hospital where the participants worked or in the researcher's office. The researcher [blinded] explained all study procedures before obtaining consent from the participants (Table 1). All procedures performed in this study with human participants were conducted in accordance with the ethical standards of the hospital and the Declaration of Helsinki.

Table 1
Characteristics of the participants.

Participant	Age	Gender	Professional experience (years)	Oncology experience (years)
K-1	30	Female	7	7
K-2	25	Female	2	2
K-3	38	Female	16	6
K-4	37	Female	14	4
K-5	44	Female	25	17
K-6	36	Female	14	8
K-7	35	Female	11	5
K-8	32	Female	10	9
K-9	32	Female	10	5
K-10	33	Female	10	10
K-11	39	Female	17	8
K-12	39	Female	18	12
K-13	34	Female	11	11
K-14	24	Female	2	2

2.3. Data collection

The research team consists of academics with practice experience and expertise in the field of nursing and medical ethics. Interviews were conducted by the researcher [AAÖ], and another researcher [MSK] took observational notes during the interviews. After identifying participants who met the inclusion criteria, the researcher [MSK] contacted them to schedule an interview. Prior to the interviews, the researcher [AAÖ] explained the purpose and design of the study. The researcher AAÖ was a female with a doctorate in psychiatric nursing and an assistant professor of psychiatric nursing at a university. The researcher AHK] was male, had a doctorate in medical ethics, and was an assistant professor of medical ethics at a university. The researcher MSK was male, a doctoral student in psychiatric nursing, and a research assistant in the psychiatric nursing department at a university. All researchers had training in qualitative research methods and experience in conducting research.

Data were collected face to face through in-depth interviews between 06/01/2020 and 01/10/2020 using a semi-structured questionnaire. After reading the relevant literature, the researchers developed a six-question semi-structured questionnaire, using their knowledge and field experience, questioning the experience of moral distress and its impact on the experience itself, the patient, and the institution. With the last interview, it was decided that data saturation had been reached (Corbin and Strauss, 2014), as no new relevant information could be identified, and the research was terminated.

Interviews were audio-recorded and lasted an average of 30 min. Observation notes were written immediately after each interview, and all interviews were transcribed. Interviews were not conducted again, and participants did not listen to the interviews again for interpretation.

2.4. Data analysis

The interviews were conducted and audio-recorded by the researching [blinded] author, and the observation notes of the researching [blinded] author were recorded and transcribed by the two authors. The interviews, audio recordings, and observation notes were transcribed and analyzed using the continuous comparative method proposed by Corbin and Strauss, which analyzes, organizes, and compares data to find similar characteristics (Corbin and Strauss, 2014). In order to capture different concepts and categories through the in-depth interview data, the interviews were conducted to the point of theoretical saturation, that is, to the point where similar content appeared repeatedly and no new categories emerged (Guba and Lincoln, 1989). During open coding, major themes and subthemes were identified and the relationships between them were determined through discussion and consensus-building among researchers. Four themes and 14 subthemes were identified in the study.

2.5. Rigor

This study's rigor was achieved by applying the criteria of readability, transferability, dependability, and conformability recommended by Guba et al. (Guba and Lincoln, 1989). Participants from six different institutions were included in the study. This provided very comprehensive information on the moral distress experiences of oncology nurses (Creswell et al., 2007). Data were used and transcribed without commentary and as direct quotes from the semi-structured interviews. In addition to the interviews, observation notes were also used in the data collection. The researchers determined the main themes and subthemes that should be clustered with similar ideas to ensure credibility and reliability. Inclusion/exclusion criteria and characteristics of participants, contexts, data collection, and analysis procedures were detailed

(Speziale et al., 2011). To minimize the risk of confirmation bias, researchers shared citations among themselves and reached consensus on the final version of the themes.

To ensure reliability, Brinkman and Kvale's (2015) guidelines were used. For ensuring member control, the interviewer checked participants' understanding during the interviews (Brinkman and Kvale, 2014). The findings were then summarized and discussed in relation to the transcripts to ensure that we captured the meanings expressed and intended by the participants. Finally, researchers shared comments with each other and reached consensus on the final version of the themes to minimize the risk of confirmation bias.

2.6. Ethical considerations

This study was conducted in accordance with the principles of the Declaration of Helsinki. Ethical approval was obtained from University Ethics Committee on Non-Invasive Clinical Research (GO19/1034) and written permission from Oncology Nursing Association to conduct the study. All written materials and audio copies are stored in encrypted form.

3. Results

Participants were on average 33.76 ± 5.26 years old. Participants' work experience was 11.46 ± 5.90 years, and their work experience in oncology clinics was 7.23.46 ± 3.90 years. All participants had undergraduate education and 6 had postgraduate education. The participants had undergraduate ethics training and no postgraduate ethics training. Table 2 groups the causes of moral distress of oncology nurses under four themes and 14 subthemes.

3.1. Failure to provide quality care

The first theme consists of the subthemes of not feeling competent in oncology practice, failure to provide holistic care, working with incompetent colleagues/physicians, and lack of team collaboration.

Due to the nature of oncology practice, difficulty working with a terminally ill patient, complicated treatment and care provided by nurses, dealing with complicated situations, and differences in theory and practice, oncology nurses do not feel competent in this area.

> "When I told the doctor about it, the patient was most likely already in the globe. However, my professional experience was not yet sufficient. When I saw the patient's pain, I later realized that a catheter needed to be placed, which the doctor did not do. The patient needed intensive care. I was very iii … … It has been a situation that made uncomfortable me and unforgotten (her voice trembled)."(K14)

The over workload, the shortage of nurses, the lack of inclusion of psychosocial care in the quality indicators and that it remains in the background for administrative reasons because it is not part of the control areas, the limited time and the fact that nurses have to work with healthcare professionals and equipment mean that holistic care is not possible.

> "Normally, we see 8 to 9 patients. I am assuming that 1 or 2 of these patients could have been critically ill patients requiring the conditions of an intensive care unit (ICU). Normally, a maximum of one nurse takes care of 3 patients in the ICU, but sometimes we can take care of those 3 patients plus other patients in the ward. Then you have to get your work done quickly. This means that the patient may want to talk to you, but you cannot make time for him/her. You can even answer the questions he/she asks with a gloss." (K2)

There are several factors in our health system that cause oncology nurses to think that they work with inadequate team members: nurses at different education levels work with the same duties, authorities, and

Table 2
Reasons for moral distress in oncology nurses.

THEME	SUB-THEME	OPEN CODE
Failure to provide quality care	Not feeling competent in oncology practice	Difficulty working with a terminally ill patient Difficulty in complex patient care Differences between theory and practice
	Failure to provide holistic care	Excessive workload The shortage of nurses Remaining psychosocial care in the background for administrative reasons Obligation to maintain care with limited resources
	Working with incompetent colleagues/physicians	Working with colleagues at different education levels and qualifications High nurse turnover Rotation of assistants working in the oncology clinic Working with physicians with different natures
	Lack of team collaboration	Intra-team conflict Lack of communication within the team Physician-dominated decision-making mechanisms Practices changing according to physician Teammates do not share the same values
Biomedical Ethical Issues	Neglect of patient autonomy	Failure to disclose diagnosis to the patient Patient's inability to participate in end-of-life decisions Adoption of routine procedures prior to patient decision making Regulations that ignore patient autonomy Leaving end-of-life decisions until the last moment
	Professional autonomy problem	Not being involved in the decision-making mechanisms Being the implementer of a decision in which he/she is not involved Limited informational authority Feeling compelled to follow a routine Inability to act as a patient advocate Regulations that threaten professional autonomy
	Justice problem	The use of blood and blood products on a dying patient Patient preference in the use of vital support devices Waste of limited resources on futile treatments Lack of standard implementation of institutional decisions
Treatment and care practices	Futile treatments	Prolonging death Disregard for human dignity Catastrophic health expenditures The problem of the benefit-burden balance
	Lack of regulation for DNR and DLT	Harm to the patient Increasing suffering Inability to achieve an honorable death Violation of professional autonomy Fear of being sued Violation of medical record integrity
	Limited informational authority	Being authority to inform in physicians

(*continued on next page*)

Table 2 (*continued*)

THEME	SUB-THEME	OPEN CODE
		Having to maintain empty hope
		Difficulty in informing a patient who does not know his or her diagnosis
		Failure to provide adequate information
	Educational practices on the patient	Practice by inexperienced healthcare professionals
		Practice by students
System-level root causes	Problems arising from the health care system	Lack of continuity in care
	Problems arising from institution management	Lack of institutional support for nurses when they are in trouble
		Lack of corporate policies
		Incompetent management through the appointment of unqualified managers
		Lack of openness of management (leaders) to feedback
	The need for regulation to support ethical decisions	Regulations that do not align with professional values (the lack of regulations to support ethical decision-making)

responsibilities, do not share common values, and there are qualitative differences in nursing and medical education, high nurse turnover in oncology clinics, management of oncology clinics with rotation of internal medicine residence.

"A mid-level senior medicine residence comes in during night shift and says, 'I am intubating now this patient.' Then the patient has been intubated for months; a decubitus ulcer is opening up … he/she is losing weight. Think of the last picture that patient relatives saw. When they open the patient's blanket and see his/her face after he/she has died, you are delivering to them a human who has dropped to 40 kg and who has gone from a beaming face to a completely uninspired face. So I do not think we have the right to do that."(K12)

As a result of these factors, the potential of team conflict, lack of communication within the team, physician-dominated decision-making mechanisms, and the expectation from nurses to do their practices according to physicians leads to the perception that there is no team collaboration.

3.2. Biomedical ethical issues

The second theme includes biomedical ethical issues common in oncology and consists of the subthemes neglect of patient autonomy, professional autonomy issues, and justice issues. Not disclose diagnosis to the patient (although it is rare), inability of the patient to participate in decisions about the treatment process and End of life (EOL), and adoption of routine procedures in some clinics prior to the patient's decision are included in participant statements.

"If his/her general condition deteriorates, we move him/her to the ICU. Here, for example, the patient is not in his/her own responsibility. Whatever is necessary for routine medical practice, that is the way we go. Anyway, I mean, this is the routine protocol for the management of this place. I do not want to, I do not want to go; that is not happening. I mean, this situation is explained to the patient or the patient's relatives. No matter what, there is always a legal intervention. That has to be communicated that there is a legal process; we can't leave it to the discretion of the individual. That is why the patient goes, even if he/she does not want to, and there are certain things." (K8)

Particularly in EOL care, regulations that ignore patient autonomy, leaving EOL decisions until the last moment, and the patient has moved on to a consciousness state that will not allow him to participate in decisions all lead to a neglect of patient autonomy.

"I think everyone has the right to make that decision if we explain the process properly. So I want the patient and his/her relatives to be brought to a capacity we can ask themselves how they want to end their life before it gets to such a bad process, with the information provided through training, rather than us making that decision." (K12)

The fact that nurses are not involved in the decision-making mechanisms but implement the decisions in which they are not involved, that they feel compelled to follow a routine with the influence of managers and colleagues, that the physician has the authority to inform the patient and family and nurses must inform in accordance with the physician's decision, and that they feel obligated to advocate for the patient but do not, as well as legal and institutional regulations that threaten professional autonomy, create problems for nurses' professional autonomy.

"I am in a big dilemma. The doctors decide. I do not decide, but because I am in it, it is a situation that I have to comply with, what I should or should not do. That is hard to accept." (K7)

The use of blood and blood products on a dying patient, patient preference in the use of vital support devices, lack of standard implementation of institutional decisions (overstretching of rules and practices within the facility by some professionals, managers and colleagues), waste of limited resources on futile treatments such as patient beds, workforce, time, medical equipment, drugs, etc., were grouped under the sub-theme of justice problem.

"We know that patients have died because their time of death has come, but we used blood and red cell suspension or platelet suspension at that time …. I think blood is a product taken from the human being and is hard to find; it must-have criteria to use. So we know he/she is with exitus while we put it on the patient, and it goes in both arms …. There may be other people who need it."(K4)

"Non-invasive ventilation is limited in our hospital; we have two mechanical ventilators in our clinic. While another patient had the device installed and needed it, it was removed from that patient and taken to the other patient because there was no one else in the hospital. The other patient was much older. I mean, yeah, we may not be able to do anything for the older patient, but at least it was being used by him at that moment." (K13)

3.3. Treatment and care practices

The third theme is treatment and care practices, which consists of the subthemes of futile treatments, lack of regulations for do not resuscitate (DNR) and decisions to limit life-prolonging treatment (DLT), nurses' limited informational authority, and educational practices on the patient. Participants expressed stunned at the notion that futile treatments prolong death, disregard human dignity, as well as cause catastrophic health care expenditures that harm both the patient's family and the national economy with the problem of the benefit-burden balance.

"There are very expensive drugs; the album is like that …. It means we give them to patients who may die an hour later, whom we predicted …. There must be some criteria. We feel bad. I also think that I have burdened the patient for nothing, because in the end-stages the patient's kidneys and liver stop functioning anymore and go into multi-organ failure." (K4)

"As long as you keep giving dopamine, yes, that heart will beat, the pulse will be monitored, these will be an externally given force that does not belong to him, but there is no urine output anyway, so believe me, the lack of urine output can cause the patient to weigh at

least 5 kg more in an hour than he is. His relatives see him in this state for a long period of time, and other patients and relatives of the other patients also witness this in the clinical setting." (K1)

The lack of legal regulation regarding DNR practice and the need for CPR practice in Turkey leads nurses to believe that they are harming the patient, increasing suffering, not achieving an honorable death, and in the case of CPR practice, violating professional autonomy. In the case of DNR use, fear of being sued and violation of medical record integrity leads to MORAL DİSTRES.

"I also often think that the patient suffers greatly. Whether or not the concept of DNR exists is a very ethical problem, but sometimes DNR should be. I wish that what we were doing was legal and we could do it legally." (K11)

Because physicians have informational authority, other reasons cited for moral distress are listed as follows: the nurse's inability to give the patient the information they think he/she needs, they have to maintain empty hope, the difficulty of giving the patient who does not know his/her every diagnosis the information he/she needs to manage the treatment processes, and the failure to be effectively informed to the patient by the physician or other health care professional.

"The patient has a lot of question marks in his head. He is wondering what is going to happen; most importantly, am I going to die? In other words, in this case, because the patient was not given the information he needed, I was in between. Sometimes I am obsessed with what I could do for patients even out of work hours." (K3)

Another reason of MORAL DİSTRES, voiced by participants, is that inexperienced nurses and students do practices on patients.

"For example, it can be like this, let's say the patient will get a Lumbar Puncture done. It's done by the internal medicine residency just to be able to learn it. But it is an unbearable procedure for the patient, a painful procedure. Sometimes the senior doctor comes; sometimes he does not." (K11)

3.4. System-level root causes

In the last theme, there are the subthemes of problems arising from the health care system, problems arising from institution management, and the need for regulation to support ethical decisions. Lack of continuity in care, lack of institutional support for nurses when they are in trouble, lack of corporate policies in some institutions, incompetent management through the appointment of unqualified managers, lack of openness of management (leaders) to feedback, and regulations that do not align with professional values (the lack of regulations to support ethical decision-making) are grouped under the theme of system-level causes.

"But sometimes it happens that you cannot decide for sure whether it is ethical or moral; that is just the way the laws are. That is how the institution works, but you do not feel comfortable while you're practicing." (K12)

"While we have tried so hard and put in so much effort, at least in good purpose. Then when you get into the legal dimension, it's bad when the job gets out of a little conscience dimension or professional dimension and into the legally defending aspect." (K7)

4. Discussion

This study, conducted in Turkey, investigated the sources of moral distress in oncology nurses. In addition to the commonly accepted moral distress resources in the literature, culture, health care system, and situations specific to nursing education and practice were also cited by participants as moral distress resources. Although almost all of the themes expressed by participants as causing moral distress are interrelated and intertwined, the study results are discussed in the context of the emergent themes to make the discussion more understandable.

The common goal of healthcare professionals in oncology clinics is to prolong life, improve quality of life, provide support to patients and their relatives, facilitate a dignified death, and alleviate care difficulties through team coordination and cooperation. Consistent with this goal, oncology nurses must be able to provide integration of physical, psychological, social, and spiritual care, as well as quality and continuous care (Puchalski et al., 2019; Macdonald et al., 2012; Rieger and Yarbro, 2003). In this study, nurses experienced moral distress because that they cannot perform these tasks because of limited resources and not feeling competent. The literature states that nurses cannot maintain quality care for reasons such as working with limited resources and few nurses, high turnover of nurses, and excessive workload, and for this reason they experience situations such as disregard for patient autonomy and inability to provide psychosocial care, and that these situations lead to moral distress (Rezaee et al., 2019). In the study by Pergert et al. the feeling of not being competent in the field and not being able to maintain continuity are the conditions that lead to moral distress (Pergert et al., 2019). McCarthy and Gastmans found a correlation between a high patient-to-nurse ratio and moral distress (McCarthy and Gastmans, 2015).

Nurses are in a unique position to maintain ethically appropriate practices in care and treatment practice. Nurses, who also have a role as patient advocates, also assume responsibilities as moral agents in their daily practice; in addition to protecting patients' dignity and respecting their autonomy, they also assume responsibility for supporting the flow of communication necessary for shared decision-making (Neumann et al., 2019). In our study, nurses cited situations in which patient autonomy was ignored, failure to protect professional autonomy, and failure to advocate for patients as reasons for moral distress. Witnessing a patient suffer and not being able to fulfill the role of patient advocate is known to cause high levels of moral distress (Mehlis et al., 2018). In such cases, patient autonomy becomes more important, and healthcare professionals can better manage moral distress if they feel that patient autonomy is respected in the process (Hamric, 2014). Fruet et al. (2019) found that failure to fulfill the role of patient advocate, denial of nursing's role as patient advocate, and disregard for patient autonomy were associated with high levels of moral distress (Fruet et al., 2019).

Another cause of moral distress, mentioned by the participants, is the problem of professional autonomy. We believe that the problem of nurses' professional autonomy in the current health care system in our country cannot be handled independently from the problem of patient autonomy. In two recent studies conducted in Turkey, critical processes such as EOL decisions were questioned. In these two studies, nurses or other health care team members are not mentioned during the participation process in decision making (Baykara et al., 2020; Kuvaki et al., 2014). In the study of Kuvaki et al., in 2014, it was concluded that only 30% of the physicians thought that the DNR decision should belong to the patient, while Baykara et al.'s study conducted in 2019 found the following: "Most ICU physicians did not want legalization of DNR and DNI orders, based solely on patient request" (Baykara et al., 2020). Physician-dominant decision mechanism, which is dominant in the health care system, and the lack of interdisciplinary and collaborative structures cause nurses' low participation in decision-making and intra-team conflict.

Furthermore, they are considered one of the sources of moral distress (Baykara et al., 2020; Mehlıs et al., 2018). Nurses' participation in decision-making varies by country (Dzeng et al., 2016). Although nurses are not involved in decision-making, they often take a tough role in implementing the decision and witness the patient's suffering and despair (Morley et al., 2021). Moreover, this situation leads them to have to use different procedures depending on the physician, be inadequately informed about the patient, have problems informing the

patient, and ignore the patient's autonomy. Nurses must be well informed and able to communicate sufficiently well with suffering patients, families in distress, and physicians to provide the care they are responsible for (Lokker et al., 2018).]. In the study by Rezaee et al. (2019), it was determined that inability to communicate honestly with the patient was the cause of moral distress (Rezaee et al., 2019). Comprehensive knowledge, clinical expertise, and the ability to make autonomous decisions based on evidence-based knowledge are hallmarks of professionalism. Thus, the problem of autonomy is associated with professional dissatisfaction, burnout, and intent to leave the job, whereas increased nursing autonomy is strongly associated with nurses' health and well-being and improved patient outcomes (Papathanassoglou et al., 2012). A positive correlation exists between autonomy and a collaborative approach and effective communication patterns within the healthcare team and a negative correlation between professional autonomy issues and moral distress (Fruet et al., 2019). In a setting such as oncology, where challenging decisions are made almost daily, achieving ethical practices can be accomplished by strengthening interprofessional communication and collaborative and interdisciplinary practices (Mehlis et al., 2018).

"Treatment and care practices" in oncology include issues that can be considered in the context of EOL care, such as futile treatment and DNR requests. It is well known that the EOL phase in oncology care includes important dynamics related to moral distress experiences (Statham and Marron, 2018). Examination of our study data shows that almost all of the themes identified as a source of moral distress are directly related to EOL care. Ethical challenges are common in EOL care (Gul et al., 2016; Iyilikci et al., 2004); the uncertainty of prognosis and the ethically permissible limits of treatment create confusion and conflict about the balance of benefits and burdens experienced by patients (Dzeng et al., 2016). In our study, these problems corresponded with futile treatment and lack of regulation of DNR.

"Futile" or "inappropriate" treatment is a well-known moral distress cause, but it is often not possible to make a clear judgment about whether a treatment is "futile" or "inappropriate" (Mullin and Bogetz, 2018). The delivery of what is considered "futile" treatment by one or more healthcare professionals, especially with an ineffective communication process, is among the causes of moral distress in oncology (Rezaee et al., 2019). In a qualitative study by Razeaa et al. (2019) in Iran, a Muslim society like Turkey and geographically close, nurses stated that providing futile treatments is a major financial burden for families who are economically weakened and have very limited financial resources, and cited futile treatments as a cause of moral distress (Rezaee et al., 2019). In our study, futile treatments, decisions to limit life-prolonging treatments (DLT) and the lack of regulation for DNR and the problem of justice were expressed as closely related. The use of blood and blood products on the dying patient is an apt example of the intersection of these themes. Blood and blood products have been given special status in nursing as "human-resources products" over other sources. The use of these products on the dying patient is cited as a cause of moral distress because it is seen as a limited resource and used to maintain empty hope. In a study by Mehlis et al. (2018) with oncologists and oncology nurses in Germany, the use of blood and blood products was assessed in the context of decisions to limit LPTs and was cited as a cause of moral distress (Mehlis et al., 2018). In Marturano et al.'s study of nurses in oncology, witnessing empty hope and futile treatment practices was shown to cause moral distress (Marturano et al., 2020).

In Turkey, there is no legal regulation for the use of DNR and DLT. It is known that there are other countries that do not have DNR and DLT regulations except Turkey (Olver and Eliott, 2016; Assarroudi et al., 2017). The lack of a specific law directly applicable to EOL care means that applying other non-specific laws to these cases in litigation leads to a range of divergent legal opinions and potential confusion. This issue is currently the subject of debate among lawyers in Turkey (Gul et al., 2016). In our country, in case of respiratory or cardiac arrest in the hospital, an "Code Blue" alarm is given and the health care team is expected to perform CPR. Although nurses and physicians are by no means advocates of CPR, they feel compelled to perform CPR because they fear litigation with patients' families and inadequacies in legal regulations (Gul et al., 2016; Kuvaki et al., 2014). DNR use in clinical practice has been demonstrated in several studies, although it has no legal backing (Gul et al., 2016; Kuvaki et al., 2014; Assarroudi et al., 2017). Nurses who participated in our study cited the lack of regulation for DNR as a reason for moral distress. When they use CPR, especially for terminal patients, they think that they are harming the patient, making them suffer, and cannot ensure an honorable death because they have to participate in an application where they are not involved in the decision-making process. Furthermore, their professional autonomy is damaged, and the care of patients who they think can benefit from their care is also interrupted. Again, nurses involved in DNR, that does not include them in the decision-making process; they are afraid of being sued and are in conflict with the principle of honesty. In cases where medical professionals think that they are prolonging death, they must use life-saving measures (Meziane et al., 2018), and a low concern for the patient's quality of life is also a common cause of moral distress (Campbell et al., 2018; Mehlis et al., 2018).

The present study's findings suggest that the institutional, legal and health care system needs to be regulated to prevent moral distress experiences. System-level root causes have an important place in the moral distress experiences of oncology nurses. Lack of professional boundaries, administrative problems, problems arising from the system, and problems caused by workload prevent nurses from practicing in an ethical context. Nurses find it difficult to transfer the ethical knowledge they have received in their professional training to their working lives (Kuvaki et al., 2014). Leaders' greater efforts to establish transparent rules and develop protocols to help nurses address and resolve ethical challenges can reduce moral distress (Rezaee et al., 2019). Developing and implementing these protocols and ethical guidelines can only be achieved by strengthening communication among nurses (Mehlis et al., 2018). The need for legal regulations that support the ethical decisions of healthcare professionals is another issue addressed in this study. Several recent studies in Turkey indicate this need (Gul et al., 2020; Kuvaki et al., 2014; Baykara et al., 2020) and other countries (Olver and Eliott, 2016; Assarroudi et al., 2017) indicate this need.

4.1. Limitations

The interviews of the research coincided with the pandemic period. Since both the interviewers and the researchers wore masks during the interview, some signals indicated by the participant's facial expressions were considered to be at risk of being overlooked. For this reason, the researchers conducted the interviews as two people, one researcher conducted the interview while the other researcher made observations.

5. Conclusıon

According to the results of the current study, nurses in oncology face difficulties in providing the desired quality and continuity of care due to ethical problems related to the need for futile treatment, non-participation in the decision-making process, and the lack of regulations for DNR and DLT; moreover, these difficulties are compounded by administrative, institutional, and systemic problems and lack of support. To support nurses deliver the desired quality of care, it is recommended that nurses' resources of moral distress be taken into account, that they be supported in enhancing their skills, that their working conditions be improved, and that systematic arrangements be made to ensure continuity in oncology care. In addition, legal arrangements which is required for respecting the rights of patients and their families should be made as soon as possible for DNR and DLT applications, which are particularly common in the terminal phase of life and are highlighted as a cause of high levels of moral distress experience.

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