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Using the Theories of Caring to Support Co-Workers and Reduce Moral Distress during a Pandemic

Jennifer Solomon*

Department in the School of Arts and Sciences, St George's University, Grenada, West Indies

ABSTRACT:

Caring is felt to be the central theme underlying nursing. Moreover caring involves being present and mindful of whatever is needed at the time. In relation to this, moral distress where the concept of having adverse feelings that arise when one knows the morally correct response to a situation but cannot act accordingly is not unusual to nurses (Jameton, 1984). Defined as moral distress and separate from emotional distress this undermines the ability to care and can lead to burn out (Wiegand & Funk; 2012). Recently, the nature and intensity of patient care many nurses faced during the pandemic has led to an awareness and interest in moral distress. Although contributing factors and negative outcomes to the individual, profession and institution have been discussed in the literature, there is a paucity of literature and theoretical understanding of supportive measures to negate moral distress from the field of nursing.

Using a reflective and personal account of experiencing moral distress and engaging in purposeful caring of colleagues this article aims to provide a better understanding of the concept of moral distress and caring in nursing. The construct of caring remains critical to the nursing profession perhaps even more so now than in the past. By exploring associated nursing theories from Jean Watson and Kristen Swanson, this article aims to illuminate and expand the knowledge base on how to mitigate moral distress through caring actions. These nursing theories can frame supportive nursing actions thus decreasing moral distress and illustrating the interrelations of nursing theory and the practice of compassionate nursing.

KEYWORDS: Nursing, Moral Distress, Caring theory, Kristen Swanson, Jean Watson

INTRODUCTION

Caring is an accepted characteristic in nursing, according to Jean Watson caring is the essence of nursing (Watson, 2007, 2011). The concept has been threaded throughout the profession, however, some nursing proponents fear that it is no longer a central theme and has become superseded as the busy, overworked nurse finds themselves in a technologically dominated setting experiencing moral distress and burnout (McGrath, 2008). Caring in nursing occurs through two primary domains, one as an act of caring for another person when s/he is unable to care for themselves. Second, and the context of concern here, is the adjective of being a caring nurse displaying actions of compassion, kindness, and concern not just to patients but to each other. It is argued that the nurse stays genuine to themselves, a committed and devoted health care professional who assumes a position to create an environment not only conducive to patient healing but extended to fellow co-workers (Watson, 2007). Such attributes have captured the very essence of how nurses effectively implement their practice to contribute significantly to a positive and compassionate working environment and express care to fellow workers (Beckstrand, et al. 2009). However, during this pandemic, the erosion of compassion and ability to care for our co-workers is felt and reported (El Ghaziri, et al, 2021; Urban, et al. 2021). Moral distress was revisited in this context, as nurses were unable to act as advocates or had to compromise patient care due to lack of resources, practicing within crisis standards or delivering aggressive care to patients who would not benefit. Prior to COVID literature suggests that families are not satisfied with end-of-life care in the ICU (Intensive Care Unit) and that nurses also are often dissatisfied and distressed in providing end-of-life care (Blazeviciene, et al. 2020). In the authors experience and in the context of nursing during a pandemic, this was compounded by no or limited contact with families in the ICU and the increased frequency of having to deliver end-of-life care without time to recuperate. This loss of integrity and moral distress was reported as the complex needs and numbers of the COVID-19 patients increased (El Ghaziri, et al, 2021; Urban, et al. 2021). Moreover, outcomes such as incivility, horizontal violence or workplace bullying

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*Correspondence regarding this article should be directed to: jsolomon@sgu.edu

are a symptom of a lack of care for our co-workers often felt by a level of powerlessness. It is important to note that the effects of moral distress on nurses are systemic; that is, they affect their entire being. As well as feeling desensitized many describe losing their self-worth, distress affecting their personal relationships, feelings of depression, and clinical symptoms such as heart palpitations, diarrhea, and headaches (Silverman, et al. 2021).

NURSING THEORIES: The legitimacy of any profession is built on its ability to generate and apply theory (Johnson, 1974). Theories are mental patterns or constructs created to help understand and find meaning from our experience, organize and articulate our knowledge, and ask questions, leading to new insights (Roy, 2018). In general, nursing theory describes and explains the phenomena of interest to nursing in a systematic way to provide understanding for use in nursing practice and research. However, historically, this has been problematic, with nurses not recognizing or valuing the unique contribution and body of knowledge they bring, or perceiving that theories have no place by the bedside or everyday nursing (McCrae, 2012). In revisiting existing nursing

theories, there is the possibility of enhancing the practice and development of the profession as it responds to the challenges of a continually evolving clinical environment- in this case, the phenomenon of caring in nursing to combat moral distress (Birch, et al. 2020). During the pandemic, the author volunteered in an ICU. To understand the role of caring and being present for colleagues, the author undertook an exploration of nursing theories related to caring and here presents a personal account.

UNDERSTANDING THE AUTHOR'S EXPERIENCE OF CARING THROUGH NURSING THEORIES

On reflection, my awareness of the desperate situation many nurses faced motivated me to assist my colleagues. Using my own experience, I identified that caring and altruism were motivational and key in the decision-making process.

Encountering both Watson's and Swanson's discussion that caring is grounded on a set of universal humanistic, altruistic values appealed to me. Watson's (2007) theory gave me an insight as to the 'why', while (Swanson, 1991) illustrated the 'how' Watson's (2007) theory included kindness, empathy, concern, and love for self and others in these values, pertinent to easily identified by nurses. Watson, (2007) states that these altruistic values arise from commitments to and satisfaction from 'receiving through giving'. Personally, I felt great gratification in being able to assist my colleagues and, although tired, left each day exhilarated. Additionally, I identified with Watson's view that caring for others promotes self-actualization on both a personal and professional level and is a mutually beneficial experience.

Swanson's (1991) theory of caring provided me with a meaningful structure within which to care for those with whom I volunteered. (Swanson's, 1991) five caring behaviors of knowing, being with, doing for, enabling, and maintaining belief can serve as the road map when working in challenging conditions where moral distress may occur in the nursing context. Each component will be explored related to my experiences.

Swanson (1991:163) described knowing as 'striving to understand an event as it has meaning in the life of the other'. As a volunteer in an unfamiliar unit, I felt it important to know my colleagues and to hear their stories so I could support them effectively. I listened as they recounted their experiences in the first wave and their sense of inadequacy and fear for themselves and families. Moreover 'being with' encompasses being emotionally present; I wanted to understand what the nurses, patients and families had been going through so I could better meet their needs. The nurses were emotionally drained from the strain of working under the first and second wave of the pandemic. I was able to support them by being with them. They had given so much to those who they were caring for that it left them depleted (Nolte, et al. 2017). Swanson (1991: 164) characterized 'doing for' as 'comforting, anticipating and being protective of other's needs'. Although I was volunteering as a nurse in an ICU, my goal was to offer support to my colleagues, through small protective acts such as making tea, enabling a bathroom break, or ensuring someone got lunch (Yeung, et al. 2018). I was constantly humbled by the 'thank you' as none of these measures went unnoticed. However, I became aware of the emotional toll their experiences had on my colleagues, recognized compassion fatigue, moral distress, and witnessed situations where moral distress was felt collectively (Nolte et al, 2017).

Swanson's (1991: 164) fourth caring behavior, 'enabling', with the purpose of 'facilitating the other's capacity to grow' encompassed my ability to teach and support those nurses who were unfamiliar with working in an ICU. With my ICU experience and years of service, I felt able to assist those who had been seconded from other wards. For those nurses unaccustomed to the monitors and pumps, or overwhelmed by the critical nature of the patients, I felt able to encourage and give confidence (Thoits PA, et al. 2001); allowing them time to ask questions and helping them feel capable. I witnessed such caring acts among the permanent ICU staff, which, despite being responsible for four patients with two support nurses, were committed to teach, give feedback, and thoroughly explaining the process and rationale of proning a patient, for example (Guérin, et al. 2020) those seconded felt more relaxed, able to perform and feel a valued member of the team. Lastly, Swanson (1991: 163) defined the fifth caring behavior as 'maintaining belief' or "maintaining a hope-filled attitude and going the distance". I was able to maintain optimism and faith in the abilities of the team I had joined. I believed everyone was delivering the best

care they could under extraordinary circumstances, and we would all go the distance together. I made a purposeful effort in volunteering to model an appropriate level of optimism and positive attitude. I felt this could help those who were feeling overwhelmed and burdened by the loss felt by so many. As discussed by (Wanzer, et al. 2005), humor was used by many as a stress-relieving strategy. I sought out ways to bring humor to the workplace, seeing and feeling the benefits of the sound of laughter. The nurses celebrated the accomplishments of their patients and colleagues. I intentionally circulated these accomplishments and good news to lift spirits and give hope. As the effects of the successful vaccine program impacted admissions and there was news of a 'road map' out of the pandemic, nurses felt more positive, feeling the end was in sight.

CONCLUSION

As a nurse volunteer the author reviewed the work of two nursing theorists (Watson, 2007; Swanson, 1991) who offered a framework to explain caring in the nursing context to reduce the effects of moral distress. (Watson, 2007) believed that human care and caring is the moral ideal of nursing. Furthermore, the transpersonal caring relationship through connection was played out in the author's volunteer experience. This personal account illustrated the transformative experience of caring for colleagues as described by (Watson, 2007; Swanson's, 1991) theory of caring provides an ideal framework within which to understand the caring and meaningful relationships the author formed with the permanent ICU staff. The author used (Swanson's, 1991) five caring processes to support my colleagues during this devastating pandemic second wave. The strategies discussed in this article serve as an exemplar for nurses to cultivate caring and supportive relationships with other nurses as they work in extreme situations such as ICU. However, such strategies can also be used to the benefit of many other nursing settings.

REFERENCES

Beckstrand, RL, Moore, J., Callister, L., & Bond, AE. (2009). Oncology nurses' perceptions of obstacles and supportive behaviors at the end of life. *Oncol Nurs Forum*, 36(4), 446-453.

Blaževičienė, A., Laurs, L. & Newland, J.A. (2020). Attitudes of registered nurses about the end – of – life care in multi-profile hospitals: a cross sectional survey. *BMC Palliat Care,* 19, 131

Birch S, Dorosz EJ. (2020). Getting involved: a practical approach to deployment as a nurse or health care professional volunteer. In: Goodhue CJ, Blake N (eds). *Nurs Manage pediatr disaster*. Cham, Springer, 389-403.

El Ghaziri, M, Johnson, S, Purpora, C, Simons, S, & Taylor, R. (2021). Registered nurses' experiences with incivility during the early phase of COVID-19 pandemic: Results of a multi-state survey. *Workplace Health Saf*, 70(3),148-160.

Fee E, Garofalo ME. (2010). Florence nightingale and the Crimean war. *Am J Public Health, 100*(9), 1591.

Guérin C, Albert RK, Beitler J, Gattinoni, L, Jaber, S, Marini, JJ, et al. (2020). Prone position in ARDS patients: why, when, how and for whom. *Intensive Care Med*, *46*(12), 2385-2396.

Jameton, A. (1984). Nursing practice: The ethical issues. Englewood Cliffs: Prentice-Hall.331.

Johnson DE. (1974). Development of theory: a requisite for nursing as a primary health profession. *Nurs Res, 23*(5):372–377

Kahana E, Bhatta T, Lovegreen LD, Kahana B, Midlarsky E. (2013). Altruism, helping, and volunteering: pathways to well-being in late life. *J Aging Health, 25*(1):159-187.

McCrae N. (2012). Whither Nursing Models? The value of nursing theory in the context of evidence-based practice and multidisciplinary health care. *J Adv Nurs, 68*(1):222–229.

McGrath, M. (2008). The challenges of caring in a technological environment: critical care nurses' experiences. *J Clin Nurs*, *17*(8), 1096-1104.

Nolte AGW, Downing C, Temane A, Hastings-Tolsma M. (2017). Compassion fatigue in nurses: a metasynthesis. *J Clin Nurs, 26*(23-24), 4364–4378.

Roy C. (2018). Key issues in nursing theory: Developments, challenges, and future directions. *Nurs Res, 67*(2):81–92.

Silverman, HJ, Kheirbek, RE., Moscou-Jackson, G., & Day, J. (2021). Moral distress in nurses caring for patients with Covid-19. *Nurs Ethics*, *28*(7-8), 1137-1164.

Swanson KM. (1991). Empirical development of a middle range theory of caring. *Nurs Res, 40*(3):161–165.

Thoits PA, Hewitt LN. (2001). Volunteer work and well-being. *J Health Soc Behav, 42*(2), 115–131.

Urban, RW, Smith, JG, Wilson, ST, & Cipher, DJ. (2021). Relationships among stress, resilience, and incivility in undergraduate nursing students and faculty during the COVID-19 pandemic: Policy implications for nurse leaders. *J Prof Nurs*, *37*(6), 1063-1070.

Wanzer M, Booth-Butterfield M, Booth-Butterfield S. (2005). 'If we didn't use humor, we'd cry': humorous coping communication in healthcare settings. *J Health Commun, 10*(2), 105–125.

Watson, J. (2011). Human caring science. Jones & Bartlett Publishers.

Watson J. (2007). Watson's theory of human caring and subjective living experiences: carative factors/caritas processes as a disciplinary guide to the professional nursing practice. *Texto e Contexto Enfermagem, 16*(1), 129–135.

Wiegand DL and Funk M. (2012). Consequences of clinical situations that cause critical care nurses to experience moral distress. *Nurs Ethics, 19*(4), 479-487.

Yeung JWK, Zhang Z, Kim TY. (2018). Volunteering and health benefits in general adults: cumulative effects and forms. *BMC Public Health*, *18*(1), 8.