QUESTION

How does an oncology nurse increase moral resilience during a pandemic?

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As an oncology advanced practice nurse, I find myself asking, "How can I continue to provide the same level of competent, quality care while meeting the unique, holistic needs of this population leveraged with self-care during the COVID-19 pandemic?" In talking with colleagues, we find ourselves torn between providing fluid oncology care that is compassionate and comprehensive while managing our uncertainties with our family since the beginning of this pandemic. I practice in a state that is known nationally to have the worst rates of cancer-associated deaths and comorbidities, which predisposes patients to poor outcomes with COVID-19 (Centers for Disease Control and Prevention, 2020). Providers grasp that patients are at higher risk, yet patients with active cancer must be seen in person regularly and providers are tasked with how to protect them.

Since the beginning of the pandemic, I have feared that compassion and empathy are less expressed behind a mask and perhaps not perceived by the patients because of distancing. I am a provider who holds a hand, pats a shoulder, gives a side hug when needed, leans forward when listening or delivering results, and hugs when appropriate. However, since the early beginnings of the pandemic in the United States, my physical contact with patients has significantly decreased to remain at the very least a six-foot distance and limited to the physical examination to decrease exposure. I have found myself torn between the value of human touch when a patient reaches for a hug versus the potential ramifications of the hug because of possible exposure.

I recently saw a patient for whom I have been caring long-term who had just received results indicating the progression of her cancer. The visitor restriction policy did not allow for a family member to accompany the patient to the appointment. I sat six feet away from the patient to talk her through the next steps. She tearfully asked if she could overcome the travel restrictions in case of availability of a clinical trial and said, "Please don't give up on treating me. I want to keep fighting." One patient requested to cease cancer treatment for fear of contracting the virus while visiting. Another patient failed to report severe diarrhea because they "didn't want to be a bother," while thanking the oncology team for being available for them during this time. I have found myself pondering how compassion and empathy were perceived during these encounters and if there was something different that could have been done to convey this.

The answer lies in strategically increasing moral resilience to overcome moral distress associated with my practice as a person and as an advanced practice RN experiencing this pandemic. Nurses must build moral resilience by managing their own emotions and feelings before trying to help others. This requires having honest self-evaluation and awareness, practicing self-control in actions, and finding positive outlets to express feelings. Collaborative, innovative changes in practice involving multiple disciplines are required for shared decision making to protect all healthcare workers and patients with cancer. Nurses are tasked with ongoing communication with colleagues and administration if nurses feel they cannot provide adequate care because of personal or family needs during this time. The expression of compassion and empathy may be different than previous encounters, require more time, and be in a different format, but, most importantly, must be perceived by our patients with cancer.

RESOURCES

- **American Nurses Association**
  Considers nurses' ethics and response to the COVID-19 pandemic
  https://bit.ly/2F3goOi
- **Centers for Disease Control and Prevention**
  Provides information about coping with stress during a pandemic
  https://bit.ly/35h0FGt

REFERENCE

Centers for Disease Control and Prevention. (2020). Preliminary estimates of the prevalence of selected underlying health conditions among patients with coronavirus disease 2019—United States, February 12–March 28, 2020. *Morbidity and Mortality Weekly Report, 69*(13), 382–386. https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e2.htm

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