MORAL DISTRESS: SHOULD I SPEAK UP?

Haavi Morreim, JD, PhD
THE CONCEPT IS IN THE LITERATURE, BUT CURRENT VERSION(S) DON'T ENTIRELY CAPTURE WHAT'S GOING ON
TWO KINDS OF MORAL DISTRESS

• [1] Clash of "bedrock values" and "bedrock beliefs"
  – Your most basic beliefs and values collide with those of the person who will determine what will happen . . . and you feel helpless to convince that person of what you see as right

• [2] Conflict of interest
  – You can do what you believe is right, but at a (potentially) serious personal price
TYPE-1 SCENARIO

• ICU patient is quite certainly dying, and is probably suffering in the process
• The whole team believes that further aggressive support would be inhumane, pointless
• Family disagrees: "God will work a miracle! We insist that you do everything. Everything!!"
• The team deeply disagrees, but feel they have no viable way to resist – so they end up inflicting what they deem pointless suffering
TYPE-2 SCENARIO

• The patient was admitted to have graft surgery for vascular disease causing pain in her left leg after signing a proper informed consent.

• The leg was properly marked by the surgeon the night before, but somehow the surgical staff scheduled the procedure for the right leg. The surgeon did not catch the discrepancy, and operated on the right leg.

• Part-way through, a nurse recognized the error, whereupon the original procedure was then also done on the left leg.

• The attending surgeon then instructs the third-year surgery resident to tell the patient that both legs needed surgery, and to get an additional, retrospective consent form signed, for the right leg.
"MORAL DISTRESS"

• Concept introduced into nursing literature: Andrew Jameton, 1984

• Nurses initially the focus
  – Must implement medical orders not of their choosing
  – Spend more time at bedside, seeing decisions' consequences
  – Required (by law) to second-guess physicians' orders, decisions
  – Can experience negative repercussions when they question the questionable, as required to do
COMMON DEFINITIONS OF "MORAL DISTRESS"

• "You know the ethically appropriate action to take, but are unable to act upon it"
• [T]he ethically appropriate course of action is known but cannot be taken"
• "Moral distress occurs when clinicians are unable to translate their moral choices into moral action"
• " . . . acting against conscience . . . "
COMMON SCENARIOS

• End of life
  – Being expected to provide services with too much/too little heroics

• Professional competence
  – Being asked to implement incompetent plan of care
  – Being asked to provide services beyond one's competence

• Honesty
  – Being asked to provide (or not contest) false or inadequate information provided to patients, families
MORAL DISTRESS:
WELL BEYOND NURSING

• Students: subordinate to faculty, residents, administrators, nurses . . .
• Residents: subordinate to supervising residents, attendings, community physicians . . . nurses
• Physicians/faculty: taking over as attending, providing care for patients whose plan of care was set by predecessor in the rotation; covering for colleagues
TYPE 1: SOMETIMES MORAL DISTRESS FROM A CLASH OF BEDROCK VALUES, BELIEFS
BEDROCK VALUES, BELIEFS

• The BELIEFS ("is") on which other beliefs rest
• The VALUES ("ought/ought not" "good/bad") on which other values rest
• "I think X is true because of Y, and Y is true because of Z" can not go on, infinitely; at some point we must simply say "well, that's just the way it is, darn it!!"
BEDROCK BELIEFS

• One's concepts of how the world is put together, how things are organized
• Metaphysics, theology, religion
• Eg: "The fact that I survived that terrible wreck is proof that God is at work in my life, and that He has a purpose for me"
• Eg: "No, it's because you were incredibly lucky"
BEDROCK BELIEFS

• Try to disprove: "Everything that exists in the universe came into existence 5 minutes ago, complete with 'signs' of age" (Bertrand Russell)

• "But God would never do such a thing to us!!"

• Kierkegaard's "leap of faith" . . . but why leap? and why leap this direction rather than that one?
BEDROCK VALUES

• One's most basic views of what is right, wrong, good, bad

• E.g. "No one has the right to take his own life"
• E.g. "All people are created equal"
BEDROCK VALUES, BELIEFS:

CAN'T BE DEFENDED, CAN'T BE DEFEATED

THEY LIE BEYOND EMPIRICAL EVIDENCE, RATIONAL DISCUSSION
BEDROCK VALUES, BELIEFS:

ANY ATTEMPT TO DEFEND ONE'S OWN, OR TO DEFEAT ANOTHER'S, WILL BE INHERENTLY QUESTION-BEGGING
EXAMPLE: THE ABORTION DEBATE

- "A woman has the right to do what she wants with her own body!"
- "There are two bodies here – one inside the other!"
- "Human life begins as soon as there's a full set of chromosomes!"
- "That's true of every skin cell!"
EXAMPLES: END OF LIFE CASES

• "It's just wrong to inflict all these heroics on a patient who won't benefit"

• "Wait a minute – you're keeping her alive a while longer! What greater benefit can there possibly be?!!"
WHEN BEDROCK BELIEFS, VALUES CLASH:

the clash cannot be resolved either by empirical evidence or by rational discourse . . .
WHEN BEDROCK BELIEFS, VALUES CLASH:

It is the Ultimate Conflict –
Our strongest personal commitments, which can neither be defended nor defeated, in direct confrontation with someone else's
"In our church, every disagreement becomes a Holy War."

(spoken by a Chancellor in a Catholic Church diocese in Tennessee)
WHEN BEDROCK BELIEFS, VALUES CLASH:

... the result is anger, hostility, grief, frustration, burnout ... *

• *"Profoundly Diminished Life: The Casualties of Coercion"
ADDRESSING MORAL DISTRESS

• Common approaches: emotional assistance programs, grief counseling, other approaches to address the 'stress' part of 'moral distress' + avenues for determining whether/how to take action

• ADDITIONAL/ALTERNATIVE APPROACH

• Begins with: discern whether the conflict is actually a clash of BVs/BBs
MORAL DISTRESS: RULE-OUTS

• Type-1 Conflict may not be clash of BV/BBs – could be:
  – [a] Clinical/medical question
  – [b] Communication gaps, misfires
  – [c] Culture/etiquette
MORAL DISTRESS: RULE-OUTS

• [a] Clinical/medical question (can be highly contentious)

• Empirically resolvable, at least in principle: more data

• If not resolvable in fact, seek objective standards for identifying credible opinions

• If a given approach is credible, acquiescence may be uncomfortable but probably not morally defective

• If not credible, issue mainly concerns familiar questions about how to address substandard care
MORAL DISTRESS: RULE-OUTS

• [b] Communication gaps, misfires

• Important realm for communication skills
• Preventive measures: getting clear about potential problems before they flare up
Here's the first draft of an advance health care directive I wrote for you.

"Kill me if I have a headache. Kill me if I'm itchy. Kill me if I complain too much."

I might have some edits.

There's your complaining again!
MORAL DISTRESS: RULE-OUTS

- [c] Cultural differences

- A variety of manifestations, such as:
  - Religious differences
  - Ways of speaking, describing things
  - Grieving rituals
EVERYTHING COVERED BUT HER EYES, WHAT A CRUEL MALE-DOMINATED CULTURE!

NOTHING COVERED BUT HER EYES, WHAT A CRUEL MALE-DOMINATED CULTURE!
RECALL TYPE-2 SCENARIO

• The patient was admitted to have graft surgery for vascular disease causing pain in her left leg

• The leg was properly marked, but somehow the surgical staff scheduled the procedure for the right leg; the operated on the right leg

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TYPE-2 MORAL DISTRESS

• Standard description of moral distress: "You know the ethically appropriate action, but are unable to act upon it"

• Often, that's simply not true: one can do the right thing . . . but the question is, at what price to oneself

• Conflict of interest: obligation versus self-interest
ADDRESSING TYPE-2 MORAL DISTRESS

• Physicians as professionals – by definition – place patients' interests above their own
• Duty to efface self-interest: are there limits?

• On one hand: pointless self-sacrifice is often neither wise nor required (except: need for a symbolic stand)
• On the other hand: quickly deferring to minimal or fictitious risk is unprofessional
• Where direct action is impossible or unreasonable, intermediate actions may be the best choice (e.g. system-level improvements to avoid recurrence of the situation)
ADDRESSING TYPE-2 MORAL DISTRESS

• **SPECTRUM:**
  • Moral heroism
    – Heroism, by definition, is beyond the call of duty
  • Moral courage
    – Doing the right thing, even at risk or a clear price to oneself
  • Moral pragmatism
    – Intermediate options, where clearly right option poses unreasonably high price, but other options can address the issue somewhat, and/or reduce its likelihood in the future
  • Moral cowardice

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MORAL COURAGE

• "Moral courage is the courage to take action for moral reasons despite the risk of adverse consequences" (Aarne Vesilind)

• "Moral courage therefore involves deliberation or careful thought. Reflex action or dogmatic fanaticism do not involve moral courage because such impulsive actions are not based upon moral reasoning" (Douglas Walton)
COURAGE
With No Warning, House Republicans Vote to Hobble Independent Ethics Office

By ERIC LIPTON—JAN. 2, 2017

Representative Robert Goodlatte, Republican of Virginia, in 2014. Mr. Goodlatte announced on Monday that the House Republican Conference had approved a change to weaken the Office of Congressional Ethics.—T.J. Kirkpatrick/Getty Images
• The **fear of being judged** stops most people from developing their moral courage.

• What if you realized that **your worst critics are, in fact, your best teachers** when it comes to being successful and living with meaning?

• What would you do differently if you weren’t afraid to be blamed or shamed?

• Above all, how do you apply moral courage to building trust, and therefore healthy relationships, with patients, colleagues, family and beyond?
WHAT THE PATIENT NEEDS
MORAL COURAGE: PRACTICALITIES

• Not to be confused with moral dogmatism, arrogance, or blind certitude for personal convictions

• Yet still, by definition moral commitment means:
  – Right and wrong
  – Of utmost importance

• Best focus for "taking a stand" and exercising moral courage is usually a principle or value that is widely endorsed, e.g. in ethical codes or institutional policies
  – Not an idiosyncratic belief

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ADDRESSING TYPE-2 MORAL DISTRESS
SOME PRACTICAL CONSIDERATIONS

• Discern, as thoughtfully as possible:
  • Is the principle at stake embedded in a rule or professional ethics code, or an institutional policy?
  • How important is the principle, policy or rule?
    – Its value for patients, for professionals, for institution, for long- as well as short-term
ADDRESSING TYPE-2 MORAL DISTRESS

• Discern, as accurately as possible:

• **What is likely to be achieved** by a courageous act
  – Honoring professionalism can have long-term benefits
  – But sometimes, self-sacrifice is pointless even if valiant

• **Likely actual cost** of doing the right thing
  – Cost to the patient/family/institution/colleagues
  – Cost to oneself – e.g. a negative evaluation at end of rotation
  – Exaggeration is not helpful: "If I don't order this (needless) CT I'll get sued and lose my license"

• **Reasonable alternatives** to the obvious one(s)
ADDRESSING TYPE-2 MORAL DISTRESS

• Broaden the view:
• Confer with colleagues: "reality check" + ideas
• Look for collegial support, institutional and organizational support

• Build the support:
• For long-range integrity, create institutional mechanisms that support moral courage
COURAGE

Do one brave thing today... then run like hell.
ADDRESSING MORAL DISTRESS

• Where moral distress is genuinely at issue:

• Approach issues and persons with humility, respect
  – One's own views cannot be defended, nor others' views defeated
  – Such humility does not preclude genuine commitment

• Seek system-level solutions
  – Eg, continuity of providers so families can align with like-minded attendings, other providers
  – Eg, conscientious objection options (physicians have it, under TN HC Decisions Act, some other state laws)
DISCUSSION