INSTITUTE TO ENHANCE PALLIATIVE CARE

PALLIATIVE CARE CASE OF THE MONTH

Working Through Moral Distress

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Case: Mrs. L was a 95 year old woman who was admitted to the acute care hospital from her nursing home with decreased mental status. She was found to have pneumonia, and though her infection improved with antibiotics, her mental status did not recover and she continued to be only slightly responsive to her family, unable to eat or interact On the sixth day of Mrs. L's hospitalization, palliative medicine was consulted to help the family with decision-making. By the time the palliative care consultant saw the patient, a temporary feeding tube had been placed, and the family had reached consensus on a trial of artificial feeding to give her a chance to regain strength, though they acknowledged that her prognosis was poor.

The next day, the patient was still unable to communicate, but was moaning and grimacing. She repeatedly tried to cough weakly to clear the copious secretions in her upper airway. The palliative care consultant recommended low doses of intravenous morphine to treat pain and shortness of breath, with a medication to clear secretions. However, Mrs. L's attending physician was concerned that treating pain with opioids would cause respiratory depression and lead to Mrs. L's death. The next night, the bedside nurse charted several times that Mrs. L was screaming, but they were only able to give her Tylenol for pain; she required wrist restraints to prevent her from pulling out her feeding tube. The palliative care physician was haunted by the image of the dying 95 year old woman, tied down and denied treatment for her suffering.

Discussion: Moral distress occurs when the clinician knows the appropriate action to take, but is unable to carry it out, and feels forced to give care contrary to her values. It is more often described in the nursing literature, but is beginning to come to the awareness of physicians as well. Moral distress often occurs in end-of-life situations when the decision is made to provide aggressive life-sustaining treatments that are felt to put excessive burden on patients and families.

Clinicians who see patients at the end of life may be particularly vulnerable to moral distress. For those of us who serve as consultants, our involvement in a case is at the discretion of the attending physician. In cases such as Mrs. L's, we feel constrained by our role as advisors to the consulting physicians and the expectation of professional courtesy towards other physicians' decisions. When we serve as attending physicians ourselves, our ability to relieve patient suffering may be limited by the family's preference that every possible life-sustaining measure be taken.

Moral distress is also a common problem in the nursing field, particularly critical care nursing. For clinicians in any of these roles, moral distress arises when the system or other people interfere with our ability to relieve a dying patient's suffering.

In the nursing literature, moral distress has been shown to contribute to decreased job satisfaction and to burnout. The American Academy of Critical Care Nurses recommends addressing moral distress with a four-step process:

Ask: You may not even be aware that you are suffering from moral distress. Signs of moral distress may include physical illnesses, poor sleep, and fatigue; addictive behaviors; disconnection with family or community; and either over-involvement or disengagement from patients and families.

Affirm: Validate the distress by discussing these feelings and perceptions with others. Make a commitment to caring for yourself by addressing moral distress.

Assess: Identify sources of your distress, and rate its severity. Determine your readiness to act, and what impact your action would have on professional relationships, patients, and families.

Act: Identify appropriate sources of support, reduce the risks of taking action when possible, and maximize your strengths. Then you may decide to act to address a specific source of distress in your work environment.

In Mrs. L's case, the consultant discussed the case with the interdisciplinary team, receiving support for her concerns. Despite fear of negative repercussions from the primary service, she called the patient's son herself and gently explained the signs of suffering that Mrs. L was showing. He agreed that his mother should have low-dose morphine. The primary team added this order without any expressed objections to the consultant stepping over her boundaries. Mrs. L died a few days later.

References:

1. Weissman, D. Moral distress in palliative care. Journal of Palliative Medicine. October 2009, 12(10): 865-866.

2. The American Association of Critical Care Nurses. The 4 A's for managing moral distress. http://www.aacn.org/WD/Practice/Docs/4As_to_Rise_Above_Moral_Distress.pdf

For palliative care consultations please contact the *Palliative Care Program at PUH/MUH*, 647-7243, beeper 8511, *Shadyside Dept. of Medical Ethics and Palliative Care*, beeper 412-647-7243 pager # 8513 or call 412-623-3008, *Perioperative/ Trauma Pain* 647-7243, beeper 7246, *UPCI Cancer Pain Service*, beeper 644 –1724, *Interventional Pain* 784-4000, *Magee Women's Hospital, beeper 412-647-7243 pager #: 8510, VA Palliative Care Program, 688-6178, beeper 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore*, and Children's page 958-3844. With comments about "Case of the Month" call David Barnard at 647-5701.