

Moral Distress in Providers When Patients and Families Use Spiritual or Religious Language to Justify Treatment

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Goals for Today:

- ▶ Define moral distress
- ▶ Explore personal connections with moral distress using case study
- ▶ Discuss responses to religious or spiritual language used to justify treatment
- ▶ Practice AMEN tool for responding to miracle language

Defining Moral Distress

- ▶ Moral distress is the experience of cognitive-emotional dissonance that arises when one feels compelled to act contrary to one's moral requirements.

-Berger, "Moral Distress in Medical Education and Training", 2014.



Introducing Rosamie

Four Questions to Consider

As you care for this patient, what are you feeling?

What value/obligation/responsibility conflicts with some other value/obligation/responsibility?*

What practical things can you do to help this patient/family?

How comfortable are you feeling about the present medical course? Scale of 1-10, 10 being LEAST comfortable.

*Denise Dudzinski, *Moral Distress /Moral Courage*, 2018.

It's Not Just You

- ▶ A recent survey noted “the majority of physicians and nurses reported that the situations most responsible for their moral distress are (1) following families’ wishes to continue life support when the clinician believes it is not in the patient’s best interests and (2) initiating life-saving action that the clinician believes would only prolong death.”

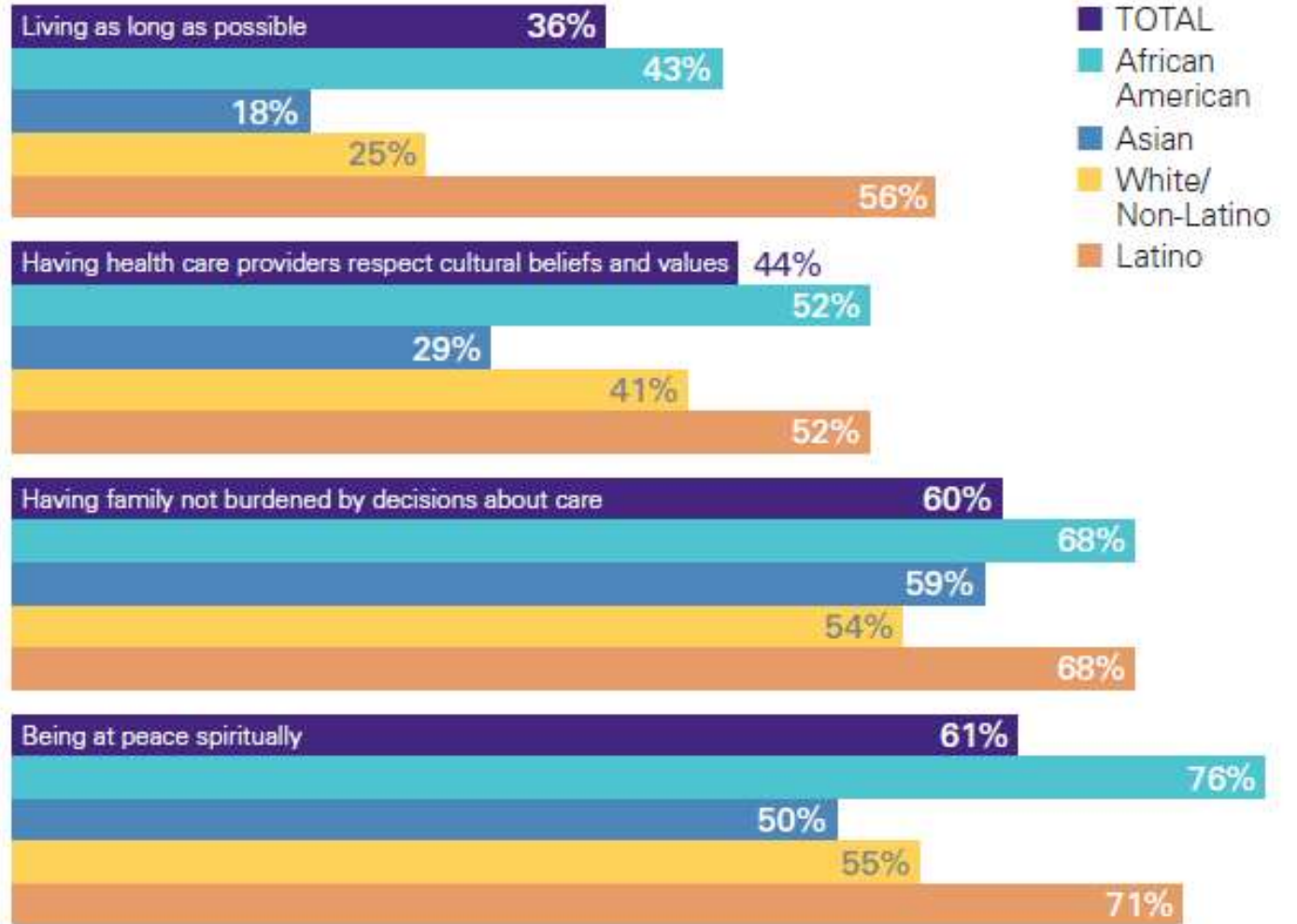
-Austin, Saylor, and Finley, 2016 Quoted in Heinze, et al 2017.

Moral Responsibility

- ▶ “I believe that no doctor should have to stand alone in making life or death decisions. In our current medical culture, one doctor makes most of the decisions for a given patient during a particular hospitalization. **But this, I believe, can simply be too much moral responsibility for one person to hold.**” –Zitter, “Extreme Measures,” 2017.

Why should clinicians care about patient & family religion and spirituality?

RATING FACTOR "EXTREMELY IMPORTANT"



Source: Californians' Attitudes Toward End-of-Life Issues, Lake Research Partners, 2011. Statewide survey of 1,669 adult Californians, including 393 respondents who have lost a loved one in the past 12 months.

Why should clinicians even care about this topic?

- ▶ In 40 GOC conversations:
 - ▶ 15 of 40- clinician responded to religious statements with statements about the medical plan, including terminal-event planning
 - ▶ 13 of 40- clinician responded to religious statements with empathetic statements
 - ▶ 11 of 40- clinician responded to religious statements with closed ended statements like ‘Mhmm” or “Okay”
 - ▶ 4 of 40 – clinician responded to religious statements with reassurance and emotional support

-Ernecoff, et al. 2015.

Understanding the Why

Why might patients and families voice a desire for treatment that does not align with medical opinion?

- ▶ “We are hoping for a miracle.”
- ▶ “He needs to die at an auspicious time.”
- ▶ “She needs to suffer to redeem her from her sins.”
- ▶ “Suffering will grant him a better place in heaven.”

Case Study

- ▶ 63 y/o Egyptian immigrant (with family) man who suffered a massive MI several months ago while visiting Egypt, only to have another arrest here in the States- both times he was resuscitated
- ▶ During one of his recurrent hospitalization, he had a ICD implanted due to decreased EF
- ▶ He was worked up for AHFT (transplant or LVAD) but not a candidate due to severe debility
- ▶ Now dobutamine dependent and having multiple ICD shocks at home for ventricular arrhythmias
- ▶ Multiple GOC discussions with patient and family, where family and pt continued to reiterate that within their belief system, suffering was okay
- ▶ Request to leave ICD on despite multiple shocks (~30 shocks)
- ▶ Family reluctant to allow for morphine
- ▶ Made DNAR by futility

Four Things a Clinician Can Do In Response to Spiritual and Religious Language:

1. Recognize your own bias*

- Your idea of a “good death” may look differently
- You may/may not use spirituality or religion to make sense of medical illness
- What if “ethically permissible” might look differently to the patient and family
 - Callaghan, 2018.

Four Things a Clinician Can Do In Response to Spiritual and Religious Language:

2. Be present to the emotional content in the room

- ▶ Sometimes people turn to spirituality as a way to make sense of the grief and loss they are in (recognize that grief is often in the room)
- ▶ Respond with empathic statements
- ▶ Validate the feelings being expressed

Four Things a Clinician Can Do In Response to Spiritual and Religious Language:

3. Get the spiritual care provider involved

- ▶ Spiritual Care Providers are trained to find grey areas within what might be seen as a very black and white belief system
- ▶ Spiritual Care Providers could be viewed as carrying an authority not assigned to any other discipline, allowing them to say something another clinician could not
- ▶ Involving Spiritual Care sends the message you have heard them and want to support their spiritual struggle
- ▶ Know how to introduce spiritual care as a resource

Four Things a Clinician Can Do In Response to Spiritual and Religious Language:

4. Use AMEN in Family Meetings

- ▶ Affirm the patient's belief
- ▶ Meet the patient or family member where they are
- ▶ Educate from your role as a medical provider
- ▶ No matter what; assure the patient and family you are committed to them

-Cooper, et al. 2014.

Questions?

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Thank you!

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