Moral injury in caring for patients with compromised autonomy: reconciling autonomy and vulnerability

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Introduction

- **Moral injury:** emotional and existential distress that occurs when taking part in or witnessing an activity that challenges and individual's moral beliefs (Dean, Talbot, and Dean 2019)
- Replacing the terms "burnout" and "compassion fatigue" for much of the burden placed on healthcare providers (Litam and Balkin 2020)
- A specific nidus for this moral injury amongst healthcare providers is the vulnerabilities of their patients
- **Vulnerability due to lacking mental capacity to make healthcare decisions is one such vulnerability.** In these cases, providers have a burden to make significant decisions on the patient's behalf.
- Because the healthcare provider can never know the full scope of the patient's holistic best interests, the physician is morally burdened in circumstances where she must act under conditions of uncertainty regarding the patient's interests, desires, and preferences. **This, we argue, makes the healthcare team vulnerable to moral injury.**

The case: James

- 80 year old male with dementia presenting to the emergency department with stroke that he is unlikely to survive
- Significant medical history includes that his dementia was rapidly progressive over the past three years making him fully dependent on his wife (who is at bedside) for activities of daily living. Additionally, he had a recent severe episode of diverticulitis requiring hospitalization which took the majority of his muscle mass. Since, he has been bed-bound, in constant delirium, and requiring assistance even for eating.
- Cindy has been his primary caretaker and exhausted her own retirement funds in doing so. Her heart breaks each time her husband mistakes her for a stranger breaking into their home.
- For James to have a chance at living until the end of the month, he would need an emergent craniotomy to decompress the lesion (a procedure with an extremely difficult and painful recovery period). The alternative would be to move forward with palliative care and hospice to make sure he is comfortable.
- James does not have any documented end of life preferences. Cindy requests that the team move forward with the emergent craniotomy.

Personal v relational autonomy

- **Personal autonomy:** humans as individual agents with the capacity to make informed decisions regarding medical care
    - Classic notion of autonomy in medical ethics
    - Criticized for ignoring the importance of socially embedded and interconnected nature of human decision-making
- **Relational autonomy:** decisions are supported and influenced by and individual's community or social support networks (Mackenzie and Stoljar 2000)
    - Allows for a patient's social embeddedness to to compensate for impaired autonomy
    - A loved one making a medical decision on behalf of the patient is not inherently inferior to the patient verbalizing the decision for themselves
    - When an individual does not have a community, this could be a source of vulnerability and impede them from making their ideal medical decision

Joseph Varon hugs a patient in the covid-19 intensive care unit during Thanksgiving at the United Memorial Medical Center in Houston. (Go Nakamura/Getty Images)

Vulnerability as a cross-cutting ethical dimension in moral injury

- **Vulnerability**: human susceptibility to being harmed, physically as well as psychologically, under particular circumstances
- Vulnerability viewed through the lens of relational autonomy allows consideration of the interconnected roles in a healthcare encounter (i.e. patient and physician, patient and partner, partner and physician). *Each of these individuals has vulnerabilities, and each of these relationships interacts with different sets of those vulnerabilities.*
- The patient is vulnerable to his poor state of health when interacting with his partner and the physician. He is also protected against some vulnerability because a member of his community is present.
- The physician is vulnerable to moral injury when interacting with the patient who cannot make decisions for himself.
- The partner is vulnerable to the burdens of complete caregiving and also to her devotion to the patient when attempting to make a decision on his behalf. She is also vulnerable because she does not have community support with her.
- The physician is again vulnerable to moral injury when moving forward with a procedure that has high risk and low reward in this instance because it is the partner's wishes.

Steps moving forwards

Protecting providers from moral injury:

- Balint groups (Roberts 2012)
- Encouraging and facilitating mental health counseling
- Including a relational view of autonomy as a part of medical ethics education to healthcare students

Decreasing the vulnerability of incapacitated patients:

- 5 Wishes and POLST: 2 forms of documenting wishes for end of life care
- Having these documents reduces the vulnerability of being exposed to unwanted medical treatment, or conversely, being denied wanted medical treatment due to incapacitation

Conclusions

Caring for patients going through suffering takes a toll on providers, thus making them vulnerable to moral injury. The vulnerability of the patient is inherently and intricately connected to the vulnerability of the provider, and vice versa. The highly relational nature of vulnerability, here examined in the context of moral injury, suggests that reducing vulnerabilities in patients and providers may have beneficial effects on others in such a relational care network.

In the end, more research and investigation must be done into the legitimacy, nature, and extent of the effects of moral injury, specifically regarding vulnerable patients. Are there particular factors that predispose providers to developing moral injury? Clinicians, patients, and caregivers alike will greatly benefit from finding answers.

References

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Disclosures

- none