Moral Distress and Relational Autonomy: MAiD

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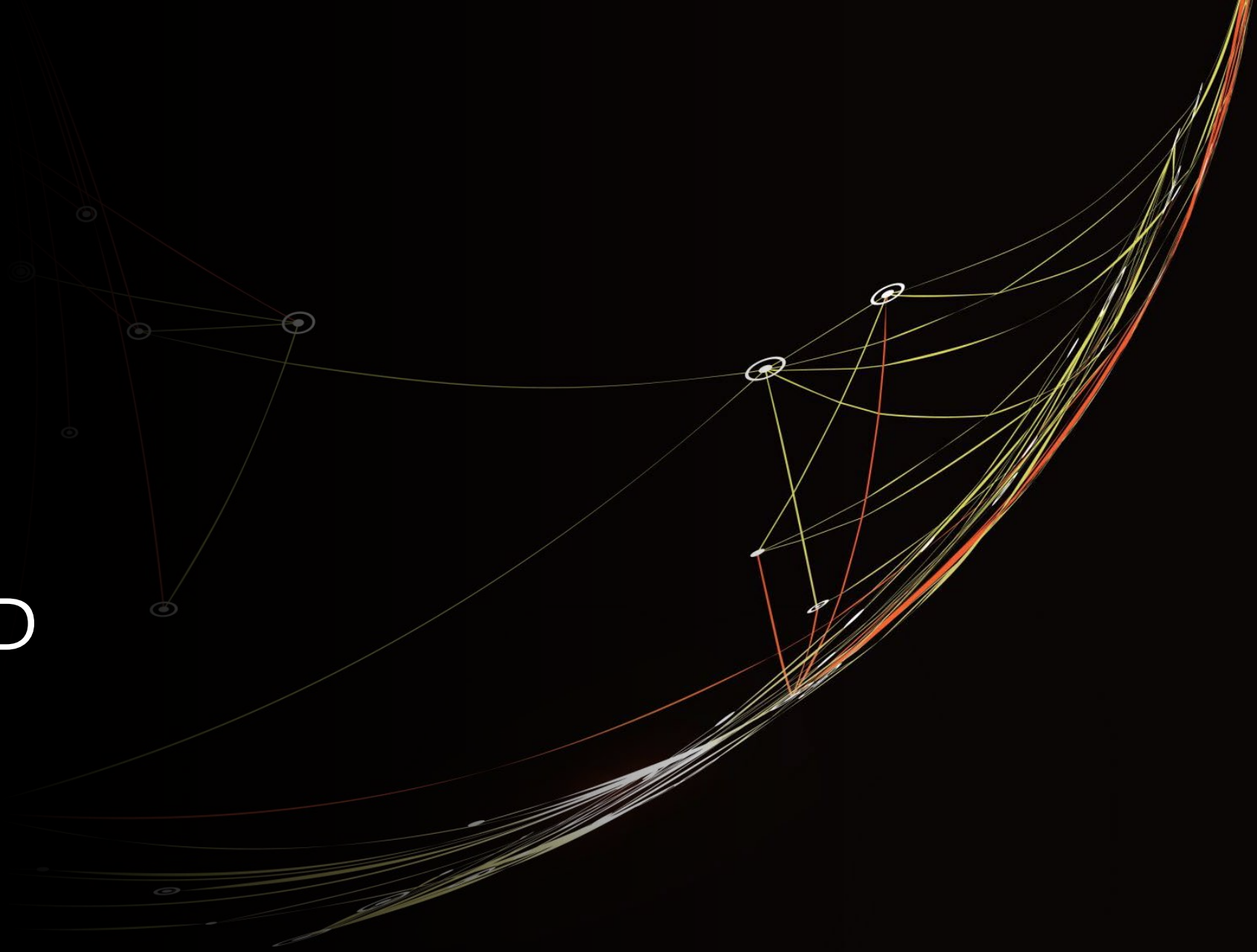


Abstract

Conscientious objection regarding the provision of medical assistance in dying (MAiD) is divisive. Discussion has tended to frame the issue in terms of the rights. However, a rights-based approach neglects the relational nature of conscience, and the impact that violating one's conscience has on the care one provides. Using MAiD as a case study, bioethicist Mary Heilman and I have suggested that what has been lacking in the discussion of conscientious objection thus far is a recognition and prioritizing of the relational nature of ethical decision-making in healthcare and the negative consequences of moral distress that occur when healthcare professionals find themselves in situations in which they feel they cannot provide what they consider to be excellent care. We propose that policies that respect the relational conscience could benefit our healthcare institutions by minimizing the negative impact of moral distress, improving communication among team members, and fostering a culture of ethical awareness. Constructive responses to moral distress including relational cultivation of moral resilience are urged.

The focus of my research on moral distress/injury

- Through an examination of MAiD as a Canadian case, bioethicist Heilman and I explored the relational nature of conscience, and the impact that violating one's conscience may have on the care one provides.
- Method: theoretical, bioethics case study

Moral Distress or Moral Injury or Moral Discomfort?

Moral injury is caused by "[p]erpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations"

(Litz BT, et al. 2009)

The term "moral injury" was first used in a military context but became used in the pandemic context mainly due to the need to consider triage, not provide adequate care due to limited resources, or to prevent people from being with loved ones.

Moral discomfort does not involve core values and is not as serious as moral distress/injury.

Moral distress may include moral uncertainty.

"Restricting the discourse to only combat works to continue the divide between the military and civilians; namely, moral injury is a *them* problem, not an *us* problem."

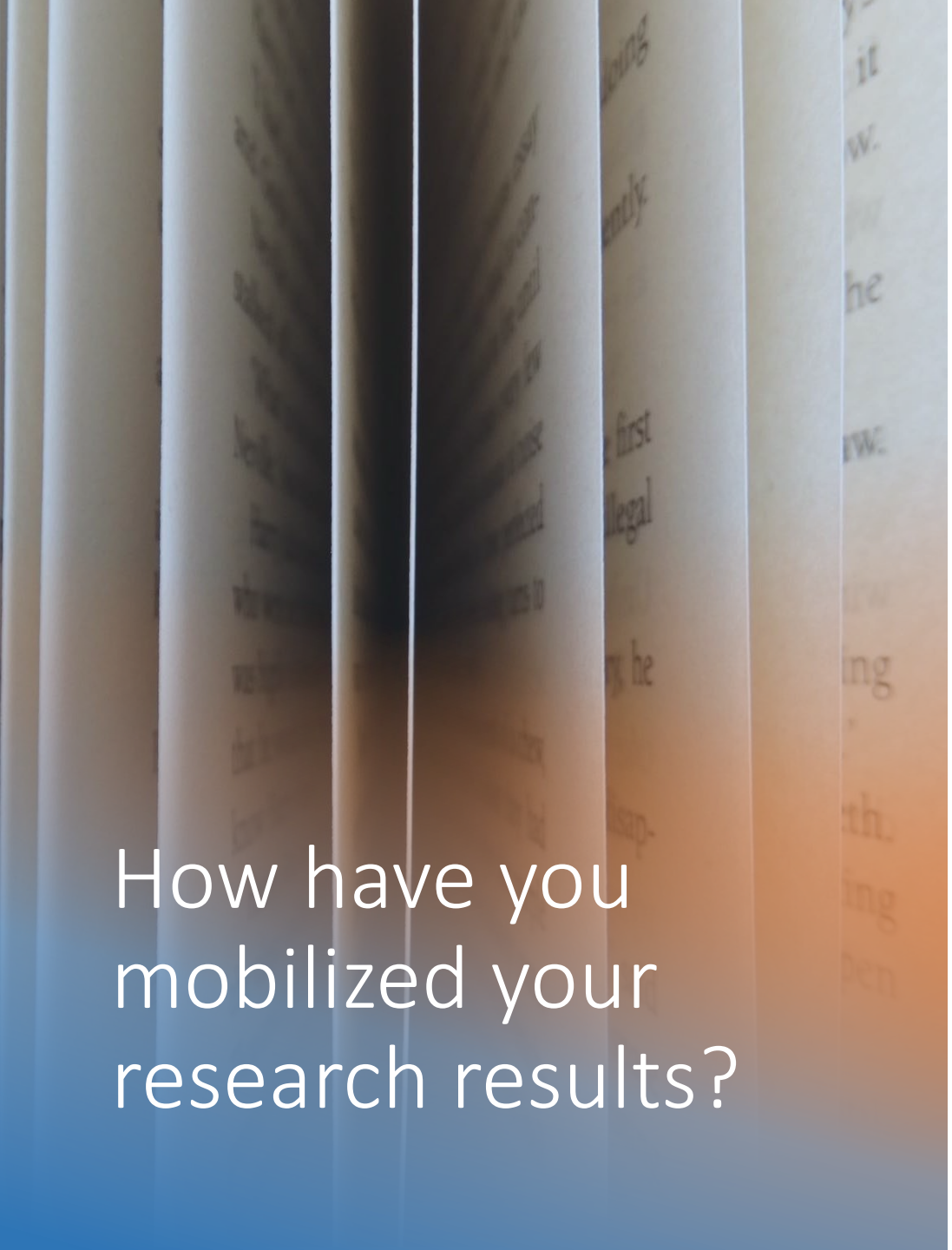
(Joshua T. Morris 2022)

Key Findings

- Discussion has tended to frame objections to MAiD in terms of the rights of the healthcare professional versus the rights of the patient. However, a rights-based approach neglects the relational nature of conscience, and the impact that violating one's conscience has on the care one provides.
- Respect individual autonomy must be understood in context of the relational nature of conscience if we are to minimize moral distress. Extreme individualism is a growing societal value.
- Communication is an ethical issue. Space to voice support & also conscientious objection is important. Dialogue can deepen understanding.
- Theory: Space for dialogue costs resources but so does moral distress.
- Effective referral is complicated and may cause moral distress.
- The provision of excellent care is a core healthcare value.
- In sum, policies that respect relational conscience could benefit our healthcare institutions by minimizing the negative impact of moral distress, improving communication among team members, and fostering a culture of ethical awareness. (see next slide)

The literature on moral distress shows that a system that respects the relational dimension of conscience would have three main benefits:

1. increased support of the psychological and spiritual wellbeing of health care professionals, minimizing the negative impacts of moral distress (ex. a sense of powerlessness, voicelessness, isolation, guilt, frustration, anger, exhaustion, depression, burnout, and career change); decreased sick leave rates and increased retention of clinicians.
2. the strengthening of teams. Research indicates that teams that clearly communicate their concerns on ethical issues provide fuller care for their patients. …since moral distress is relational and rooted partially in power and power imbalances, teams that communicate the factors that contribute to moral distress may be better able to address the power imbalances that often exacerbate these situations. A team that employs a routine method of communication provides its members with an opportunity to raise concerns regarding social, emotional, spiritual and physical dimensions of care before moral distress becomes unmanageable.
3. the development of a “culture of ethical awareness.”



How have you mobilized your research results?

- Publication in a well-regarded journal: *British Medical Journal—Journal of Medical Ethics*, 46/2: 123-127.
- Inclusion as a required reading in AGHE 802
- Referenced in presentations
- Nothing further

How could this knowledge be applied to long-term care?

- MAiD may be requested by some LTC residents and these requests may cause moral distress for some care providers if it contravenes a deeply held core value
- The importance of expanding beyond a rights based ethics narrative may become even more important in LTC because:
  - More vulnerable population: health, isolation, pandemics
  - Ageism
  - Scarce resources
  - Systemic marginalization
  - Importance of community

Ageism: relational autonomy+

EMILY LABER-WARREN, *Washington Post* August 2023:

- "Age bias doesn't show up only as discrimination or snarky birthday cards. One potent source of ageism comes from older people themselves…. Americans spent $5.4 billion in 2022 on anti-aging skin products, according to market research from Euromonitor International. Anti-age bias doesn't just sell anti-wrinkle creams. It affects how people think, feel and act."
- found that people who had internalized more positive age beliefs lived, on average, 7.5 years longer.
- Becca Levy's (author of Breaking the Age Code: How Your Beliefs About Aging Determine How Long & Well You Live) hypothesis, based on her research, is that internalized ageism worsens health through three mechanisms.
  - When you think decline is inevitable, you're less motivated to take your medicine, eat well and exercise.
  - Feeling bad about getting old can lower self-confidence, which can make people withdraw (one recent study, for example, found that internalized ageism made people want to retire early).
  - Negative emotions about aging can raise people's biological stress levels, putting them at risk for heart disease and stroke.

Moral Distress in Community Healthcare

Aim of this [qualitative] study [of 24 participants in southwestern Ontario] was to explore moral distress among community-based health and social care professionals working with older adults

Findings:

- human resource shortages and system challenges symptoms were associated with moral distress symptoms

-symptoms not as severe as those reported in acute care "study participants may have been able to cultivate moral resilience…through the positive reframing of adversity and therefore maintain their overall sense of moral integrity."

Webber, Trothen, Finlayson, and Norman. (2021). "Moral distress experienced by community service providers of home health and social care in Ontario, Canada." *Journal of Health and Social Care in the Community*.

What research questions still need to be answered?

- How do we promote respect (and understanding of) for relational autonomy in LTC as important to cultivating moral resilience?
- How best might we provide more education in ethics (as an antecedent to moral resilience)?
- How do the long-term retention rates of a healthcare system that supports conscientious objection (and/or differing core values) through increased dialogue compare with others that do not?
- Do effective referrals cause moral distress and, if so, are there ways to mitigate this distress through dialogue or other means? (underlying hopes or concerns about why MAiD – systemic issues such as ageism, existential angst,…)
- Why might symptoms of moral distress be more severe in acute care compared to moral distress symptoms among community-based health and social care professionals working with older adults? (Webber et al.)