Palliative Care: The Unexplored Frontier of Anesthesiology

In the Face of Suffering: Anesthesiologists' Moral Distress when Caring for Patients with Serious Illness

Lara India, MD Jason N. Batten, MD, MA

Imagine a patient presenting with a malignant bowel obstruction from metastatic colon cancer. She recently stopped chemotherapy due to frailty and worsening liver injury. Her oncologist recommended hospice care, which she declined. Now, she presents with severe abdominal discomfort and nausea for exploratory laparotomy. She states that the surgeon said she "needed" it and appears to have no qualms about proceeding with surgery. Her vital signs are abnormal – raising concern for sepsis – but stable, for now.

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Proceeding to the OR with this patient generates a unique discomfort for many anesthesiologists. While the ethical principle of autonomy defines patients' rights to make decisions regarding their medical care, upholding this ethical standard does not prevent the anesthesiologist from experiencing their own feelings of discomfort in providing such care. These feelings are increasingly recognized as a contributor to job dissatisfaction and burnout (*J Health Psychol* 2017;22:51-67). We've all experienced it in some way: the feeling when you know the right thing to do – from a moral and ethical standpoint – but are prevented from doing it. This particular type of discomfort is called moral distress (*JAMA* 2020;323:923-4).

Moral distress in anesthesiology

Moral distress occurs when a clinician is unable to act in accordance with their ethical beliefs due to external constraints. It differs from emotional distress and post-traumatic stress disorder because it directly links to a violation of ethical principles (*J Health Psychol* 2017;22:51-67; *JAMA* 2020;323:923-4; asamonitor.pub/3XsYXfX). In the example described, all clinicians caring for the patient must find a balance between the principles of autonomy and nonmaleficence (the ethical principle to *do no harm*). Proceeding with general anesthesia in a high-risk patient with a life-limiting condition could certainly be construed as *causing harm*. She could suffer a variety of major complications, all of which diminish her already-short prognosis. Even if the operation proceeds smoothly, her decision to decline hospice raises questions about her perception of her overall prognosis. Without insight into her understanding, many anesthesiologists would struggle to accept her decision to proceed with a large abdominal operation, especially one made while in active discomfort. While some patients might justifiably choose surgery, it is not obvious that this patient recognizes the difficulties associated with recovering from an exploratory laparotomy in the setting of incurable metastatic cancer. In this way, proceeding with surgery also raises concerns about violation of the patient's autonomy, as it is unclear whether she possesses the information necessary to make complex care decisions. Thus, the pressure that the anesthesiologist feels to continue with the emergent surgery generates moral distress in the face of potential, yet very real, ethical violations and harms to the patient.

The etiology of moral distress

Most studies exploring contributing factors to the development of moral distress come from nursing. However, one study which included nurses and physicians in critical care noted that moral distress occurred in both groups when clinicians felt compelled to provide aggressive treatment despite feeling such care was not justified (*Crit Care Med* 2007;35:422-9). Other clinical situations in which anesthesiologists risk experiencing moral distress were described earlier this year in the *ASA Monitor* article by Drs. Kussman and Brown (*ASA Monitor* 2024;88:e10-11).

An anesthesiologist's experience of moral distress is often mediated by the broader clinical environment – thus, systems-level factors must also be considered. Some of the systems-level factors identified through prior research that are relevant to anesthesiologists include lack of support from peers when caring for difficult patients, lack of respect from patients, and limited ability to collaborate with colleagues (*J Health Psychol* 2017;22:51-67). Notably, organizational environments differ in their propensity to generate moral distress. For example, individual hospitals vary in how supportive they are of clinician efforts to de-escalate potentially non-beneficial life-sustaining therapies (*JAMA Intern Med* 2023;183:839-48). Similarly, societal and cultural factors shape a clinician's experience of moral distress (*J Gen Intern Med* 2021;36:1890-7). When viewed from this vantage point, the OR environment in the United States may be particularly prone to generating moral distress among anesthesiologists due to an ever-increasing volume of surgeries, a progressively older and sicker patient population, and time pressures (*J Clin Monit Comput* 2012;26:329-35).

Importantly for anesthesiologists, lack of power also causes moral distress (*J Adv Nurs* 2013;69:415-24). Power, defined as "the information, support, professional resources, and opportunities needed to accomplish work," may be particularly scarce for anesthesiologists, who often enter a patient's care only when a procedure has already been offered to and accepted by the patient (*J Adv Nurs* 2013;69:415-24). When the surgical informed consent process occurs in a high-risk patient without their involvement, the anesthesiologist

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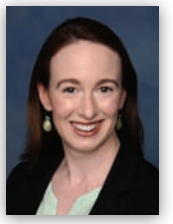

Lara India, MD
ASA Committee on Palliative Care, ASA Committee on Ethics, and Assistant Professor of Anesthesiology and Hospice and Palliative Medicine, Medical College of Wisconsin, Milwaukee, Wisconsin.

Jason N. Batten, MD, MA
Fellow in Critical Care Medicine and Adult Cardiothoracic Anesthesia, UCLA, Los Angeles, California.

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statements could be utilized to convey prognostic concern, not just to patients, but to the surgeon themselves:

*"I also **wish** for Ms. Y to have a successful cholecystectomy, while minimizing her risks from anesthesia. Unfortunately, her echo showed worsening pulmonary hypertension. I **worry** that a laparoscopic surgery would be higher risk for her than an open surgery. I **wonder** if the procedure could be done open, in order to decrease her OR time and avoid laparoscopic surgery. What do you think?"*

The primary tenet of palliative care is patient-focused support through excellence in symptom management and communication. The aim is for medical care to achieve a patient's goals while preserving what a patient values. For complex medical issues or psychosocial situations, specialty palliative care referral may be the best way to achieve this. For most situations, however, a clinician familiar with these tenets and tools can provide primary palliative care, such as when discussing a "prognosis" with patients, including what might happen as a result of a procedure. While becoming truly proficient in primary palliative care does require knowledge acquisition and skills practice, the work to acquire this proficiency can benefit periprocedural patients, their families, and the clinicians themselves. ■

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may feel obligated to proceed (*J Gen Intern Med* 2021;36:1890-7; *JAMA Surg* 2016;151:309-10).

Using perioperative goals-of-care discussions to reduce moral distress

Let's recall our hypothetical patient. For clinical situations like this one, a perioperative goals-of-care discussion may help limit moral distress for anesthesiologists. A patient's goals of care represent intentions of treatment during a particular episode of care. While our hypothetical patient most likely engaged in goals-of-care discussions throughout her cancer treatment, an additional discussion is needed in the preoperative setting because the patient's health status has changed, and a new treatment option – major surgery – has been introduced.

By eliciting the patient's goals within the context of the perioperative period, the anesthesiologist learns whether the patient's expectations align with realistic surgical outcomes. This information also clarifies whether the patient possesses the necessary information to make an autonomous decision about his/her medical care. Lastly, this conversation provides an opportunity for the anesthesiologist to discuss any ethical concerns with the patient.

Let's say our patient decides to pursue surgery with the goal of relieving pain. The anesthesiologist may have concerns about added pain in the immediate postoperative period from surgery, prolonged intubation, and reduced physical function due to immobility. Discussing the patient's goals and the anesthesiologist's concerns prior to surgery may decrease moral distress: At the end of the conversation, the anesthesiologist may come to feel as though they acted in concordance with, rather than in violation of, broadly accepted ethical principles.

Practical tips for perioperative goals-of-care discussions

Various frameworks for conducting goals-of-care discussions exist (asamonitor.pub/3zg3qJx; *J Oncol Pract* 2017;13:e844-e50). A key component of each involves the discussion leader expressing a desire to understand the patient's hopes for the future in the context of their illness. To gain this knowledge, anesthesiologists may use open-ended questions, such as asking how the patient envisions life following surgery. While answers will vary significantly, the anesthesiologist should evaluate whether the patient's expectations align with anticipated postoperative outcomes. If the anesthesiologist is uncertain of what expectations are reasonable, or if the patient's hopes for the future differ greatly from the likely outcomes, then the surgeon and possibly a palliative care specialist should be engaged for further conversation. Overall, increasing interdisciplinary discussions in complex clinical scenarios may alleviate moral distress for all involved parties (*JAMA Surg* 2016;151:309-10).

Systems-level interventions to prevent moral distress

While perioperative goals-of-care discussions can be carried out by individual anesthesiologists, systems-level interventions are required to prevent morally distressing situations from arising. While a full discussion of systems-level interventions is beyond the scope of this article, anesthesiologists should consider quality improvement efforts at their own institutions that identify and address the root causes of moral distress. Anesthesiologists can consider improving systems surrounding perioperative code status, completion of advance directive documents prior to planned major surgeries, and/or creation of preoperative optimization protocols for patients with serious illness (asamonitor.pub/4ggZHft). Forming a peer support program, providing access to individuals trained in psychological first aid, and/or implementing structured debriefs following unexpected outcomes provide outlets for anesthesiologists who may be suffering from moral distress (*Int J Environ Res Public Health* 2021;18:4594; *Cochrane Database Syst Rev* 2002;2:CD000560; *J Bioeth Inq* 2021;18:573-87).

Moral distress commonly occurs in anesthesiologists who care for seriously ill patients. Contributing factors include the feeling of providing care that may seem unwarranted, lack of support and respect from peers, patients, and hospital systems, and lack of power to decide if and when high-risk surgeries are offered. To mitigate this distress, anesthesiologists can improve their skills in conducting focused perioperative goals-of-care discussions. Such conversations provide anesthesiologists with insights into the patient's goals and expectations following surgery. If significant discrepancies between the patient's hopes and the likely realities are revealed, then more in-depth goals-of-care discussions with other stakeholders should be conducted. On top of these skills, anesthesiologists may also engage in systems-level quality improvement projects aimed at prevention of moral distress. Through partnership with our patients, surgeons, and other OR staff, we can create a healthier environment for all by limiting the frequency at which morally distressing situations occur and promoting strategies at both individual and systems levels for coping with them. ■