Editorial

Does thinking make it so?—what to make of the empirical evidence on moral distress amongst surgeons

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Last month I cared for a patient who came in after a gunshot wound to the head. The trauma alert paged out "*20yo male*, *GSW head*. *GCS 3*". When I first met him, he was rolling past me through the trauma bay doors. The typical team of emergency medical technicians (EMTs) and paramedics were escorting him in with monitoring devices and wires flying off his chest and hands. He came with the computer-generated moniker that is standard for all trauma centers, where the last name designates them as a trauma patient (my hospital uses "STAT" others use "trauma" or some such term) and then a randomly generated word, like a country or specific species of American pine tree, or a food (mostly some sort of noun I guess). I don't remember what his exact name was, but will call him "STAT, Dilemma" for these purposes.

On physical examination, he had two holes in his head, one on each side of his skull just near each ear, unequal pupils, and grey matter spattered on the gurney—ominous signs of a catastrophic brain injury. The diagnosis was secured with a computed tomography (CT) scan moments later. The neurosurgeons always evaluate these patients and tell us what we all already know, which is that this isn't something that can be fixed. They sometimes use the word "non-survivable" or some variant with the same meaning, which I always find a little funny, especially when it is posited as a diagnosis rather than a prediction. It is a minor detail for the patient, but profoundly important to the rest of us who must figure out what to do next, to make decisions about what to do with this imminently dying, but as-of-yet-still-alive human being.

For STAT, Dilemma, what made matters worse was that he came in alone, with no friends or family, and had no identification on him whatsoever. And in the ensuing 12 hours after his arrival, he lost all signs of brain function. An apnea test confirmed that he was dead. I declared the patient, whose real name was still unknown, dead. And we were all left standing there not knowing what to do. The social workers and law enforcement had still not found any family or friends and were only marginally confident that they knew his real name. But there we were, standing around a brain-dead patient, on a ventilator, vasopressors still infusing to keep a blood pressure necessary to confirm the brain death diagnosis we just completed. And additionally, I also knew that the organ procurement organization was aware of him and were evaluating his fitness as a donor. And as a 20-something, otherwise healthy person, I knew he was likely a good candidate. But to keep him on the ventilator and infusing meds, and taking up an intensive care unit (ICU) bed? There's no standard of care or algorithm or clinical guidance for these situations, which makes them distressing. But a decision has to be made nonetheless. After some deliberation, and discussion with a couple of my partners, and more than one call to the social worker to be sure we still did not have any contacts

for his patient, I landed on leaving him on the vent for 1 more hour. It seemed wrong to terminally extubate him without any family at his side and still with only his "STAT, Dilemma" name to identify him. The extra hour of ventilating a dead body in order to buy some time to find family or friends or anyone who just knew his name, even if it was arbitrary, felt acceptable, humane even. I would be lying if I told you I wasn't still a little irresolute about it as we extubated him an hour later with no one but us at his bedside.

I think this is moral distress. But I'm also not sure how much I care. The internal experience of psychological struggle is centered around an ethical question within the context of caring for a surgical patient which requires some sort of moral judgment to be made. This is a tautology as far as it's possible to see that the surgeon's job is inherently a job of solving ethical problems and applying moral judgment. The marriage of the two is what we call surgical judgement.

Until relatively recently, evaluating the moral life of a surgeon (or any physician for that matter) has been a job relegated to those of memoirs and personal essays. Richard Selzer, Atul Gawande, Oliver Sacks, Paul Kalinithi, and Abrahma Verghese come to mind (1-5). These are serious minds doing serious work. But the attempt of empirical research on this topic is relatively new. I don't remember ever having heard the term "moral distress" until I was well into my general surgery training. And while it seems that every surgical conference I attend nowadays has something to offer on the topic of moral distress—an abstract, an expert panel discussion, an invited lecture—I don't think that was the case even a couple of years ago. I like to attend these talks when I can. The panels and discussions on ethics and the moral life of surgeons offer a change of pace from the clinical outcomes research typical of these conferences. But I do have to admit that I am routinely left with the same question: what are we really talking about when we talk about "moral distress"? Millis *et al.* shine some light in this direction and give some credence for those of us who are a little confused on this increasingly discussed topic (6). Through a very well thought out study, expertly executed, and transparently written—"*To feel or not to feel*: *a scoping review and mixed-methods meta-synthesis of moral distress among surgeons*" comes to the most convincing and powerful finding that when we write about "moral distress" among surgeons, we're not all writing about the same thing.

Take into consideration that, according to a Web of Science search, there has been a 10-fold increase in articles published with the term "moral distress" situated somewhere in their titles (7). This should be cause for a concern when we think about how to use these data. Millis *et al.*'s findings need to be validated through the usual means of repeated studies done by others. But at the risk of falling victim to my own confirmation bias, these findings provide some justification for those of us who feel uneasy when the topic of "moral distress" comes up. What's more is that the incoherent use of the term in the literature should give pause for hospital systems and medical centers that have programmatic initiatives with the primary aim of managing moral distress among its caregivers. If we're not all sure that we mean when we say, "moral distress", then it may be best to clarify before moving forward.

To be sure, the practice of surgery comes with a special kind of moral weight. Bosk described this in his book "*Forgive and remember*: *managing medical failure*", where he observed the difference between the way an internist and a surgeon evaluate patient complications: where the internist asks "*what happened?*", the surgeon must ask "*what did you do?*" (8). This can be, in and of itself, distressing. This is most obvious for newly graduated, attending surgeons. The preceding years of training introduce the concepts of the expectations that come from these moral responsibilities but are impossible to carry completely until the day that the operative case is booked with your name on the board. That's Dr. So-and-So's patient. That's his patient. That's my patient. Coming to grips with this is a little like acclimating to an oxygen-poor environment. It can be done. Sometimes it's not pretty. But there's always a little suffering along the way. This is distressing. And it meets at least one of the number of definitions for "moral distress" that currently circulates in the literature. And if this is an example of moral distress, then what? Is it a problem? I'd suggest that its absence is more problematic than its presence. More to the point, isn't the new surgeon who feels none of this additional moral burden and "distress" more problematic? Intuitively the answer to this question is yes. But how do we characterize, study, or understand that without a uniform definition of moral distress.

Current literature, as Millis *et al.* summarize well, largely approaches the evaluation of moral distress as a problem that needs to be understood so it can be solved. A disease to be diagnosed and treated. And at first pass, moral distress sounds like a problem that needs to be solved. But the problem with the current empirical data on surgeons and moral distress is that the data is inaccurate

and imprecise and likely conflates ideas that need to be distinguished. A uniform acceptance of a definition for the term could go a long way to more precise conversations about moral distress. The value of those discussions will be determined by what is included and not included in that definition. If moral distress is to remain a term to diagnose a disease, then we will end up using it as such. This may be the detriment of understanding what's truly at hand here. Or even missing the possibility that not all that is distressing is bad.

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