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Ethics Grand Rounds:

**Biomedical Ethics Considerations
Stemming from Limb Loss/Difference care
and Prosthetic Enablement**

**University of Texas Southwestern Medical Center
April 11th, 2018**

Physical Medicine & Rehabilitation

**VANDERBILT  UNIVERSITY
MEDICAL CENTER**

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Ethics Grand Rounds:

**Intentionality and Professionalism
at the Limits of Knowledge and of Knowing**

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A talk in 3 parts:

- Ethical considerations stemming from Limb Loss/Difference Care and Prosthetic Enablement**
- Metacognitive considerations to the Bioethics consult**
- Operationalizing Bioethics support for modern healthcare delivery (-specific topics-)**

Bioethics surrounding Limb Loss/Difference Care

In 1997, Robert Smith, a Scottish surgeon, is approached by a man with an unusual request.

After consultation with psychiatrists, Smith performed the amputation. 2.5 years later the patient reported that his life had been transformed for the better. A second patient also reported been satisfied with his amputation.

Smith was scheduled to perform further amputations of healthy limbs when the story broke in the media. Predictably, there was a public outcry, and Smith's hospital instructed him to cease performing such operations. As of 2005, no hospitals offered healthy limb amputations.

Bioethics surrounding Limb Loss/Difference Care

Would-be amputees – or “wannabes”, as they refer to themselves –appear to number in the thousands.

- 1) Body Dysmorphic Disorder (BDD), a condition in which the individual believes that a part of their body is diseased or exceedingly ugly.
- 2) Apotemnophilia: some wannabes have a sexual attraction to amputees or to being an amputee. (vs. acrotomophilia / “devotees”).
- 3) Body Integrity Identity Disorder (BIID), also known as Amputee Identity Disorder (AID). The body fails to conform to the subjective experience of itself.

Bioethics surrounding Limb Loss/Difference Care

Autonomy: -(setting the bar)-

Capacity? (belief system vs. decision-making / vs. cosmetic or gender-reassignment surgery)

Informed, autonomous desires ought to be given serious weight.

Harm Minimization:

Whether wannabes are correct in thinking that their disorder requires surgery or not, a significant proportion of them will persist in their desire for amputation, even in the face of repeated refusals, and will go on to take matters into their own hands...

Establishing Capacity: Know what you are dealing with ... qualify BDD vs delusional state (e.g. paranoid schizophrenic) vs “BIID,” in establishing capacity.

Bioethics surrounding Limb Loss/Difference Care

The body fails to conform to the subjective experience of itself.

In 2008, Brang et al did a preliminary study (n=2) that explored skin conductance response (SCR) to pinprick above and below the line of desired amputation. They noted increased SCRs were found for stimuli that contacted the limb selectively below the line of desired (amputation) demarcation.

In 2011 McGeoch et al used magnetoencephalography (MEG) (n=4), in conjunction with a tactile stimulation task, to explore activity of parietal areas. Findings revealed altered activity in the right parietal lobe. The authors concluded that apotemnophilia/BIID should be termed “**xenomelia**” and should be included within the right parietal lobe syndromes related to body representation.

Bioethics surrounding Limb Loss/Difference Care

The body fails to conform to the subjective experience of itself.

In 2012, Aoyama et al tested (n=5) [Points of Subjective Simultaneity \(PSS\)](#), finding individuals with BIID to more distal stimuli (in the “to-be-amputated limb”) [as occurring first](#). Contrastingly, PSS should be in favor of proximal body parts, due to faster neural transmission times. [They argued that this confirms that the desire to amputate a healthy limb is a parietal lobe syndrome](#), as their subjects had no sensory impairments that could explain the results.

In 2013 Hilti et al (n=13) reported [structural differences](#) between control subjects and individuals with BIID, [in the right superior parietal lobe \(SPL\) – the right primary and secondary somatosensory cortices, and in the anterior insula](#).

In 2013, Van Dijk et al reported an [fMRI study](#) (n=5) involving tactile stimulation and a motor execution, [noting different responsivity in the somatosensory network](#).

Bioethics surrounding Limb Loss/Difference Care

The body fails to conform to the subjective experience of itself.

From the starting label “apotemnophilia”, authors have turned to “BIID” and, very recently, have moved to “**xenomelia**”.

At present, it can only be concluded **that some neurostructural or/and neurofunctional differences exist** between individuals who seek to amputate a healthy limb and those who do not. **Further, individuals with this condition show psychiatric comorbidities during their lifetime, even though not sufficient to explain their desire.** Finally, some clinical features, such as the age at onset, the presence/absence of sexual arousal for amputation and amputees, pretending behaviors, and the lateralization of the desire appear to be crucial to understanding this condition.

Bioethics surrounding Limb Loss/Difference Care

The body fails to conform to the subjective experience of itself.

In conclusion, the 37 years of study of this desire to be disabled have brought to light a still secretive condition (but possibly not-so-rare, considering the increasing numbers of individuals included in the studies), which appears challenging to understand, even using state-of-the-art technologies.

Much more effort is needed to find a solution and, finally, a treatment for the distress these individuals experience.

This still-obscure condition needs a multidisciplinary approach to go beyond the “simple” clinical/experimental frame, **and requires a much more complex model that also includes social and ethical aspects.**

Bioethics surrounding Limb Loss/Difference Care

A paraplegic (SCI) patient requests an elective bilateral transfemoral (i.e. above-knee) amputation, for intractably debilitating spasticity.

Bioethics surrounding Limb Loss/Difference Care

CASE REPORT

Elective bilateral above the knee amputation in T4-complete spinal cord injury: a case report

MS Jaffe

Department of Physical Medicine and Rehabilitation, Kaiser Permanente, San Diego, CA, USA

Study design: This case study outlines an individual with a T4 complete level injury with Ashworth scale grade 4 spasticity of the lower extremities.

Objective: To discuss a treatment option for this individual with spinal cord injury (SCI) who had a variety of functional impairments, disabilities, and medical complications based on his level of injury.

Setting: The department of physical medicine and rehabilitation at Kaiser Permanente in San Diego, California.

Methods: The patient's lower extremity spasticity contributed to pressure ulcers of his hips and feet as well as comfort and functional issues with his instrumental activities of daily living (ADLs). After failing medical therapies to control spasticity, and much discussion, bilateral above the knee amputations were performed.

Results: The patient had resolution of his SCI medical complications and a marked improvement in his quality of life.

Conclusion: This case study discusses a treatment option for a SCI-complete patient whose lower extremities had become detrimental to his function and general well being.

Spinal Cord (2008) 46, 585–587; doi:10.1038/sc.2008.58; published online 3 June 2008

LETTER TO THE EDITOR

Elective bilateral cord injury: a cas

Firstly, such an amputation for spasticity in paraplegic patients has been described. Krause quoted by Borchard *et al.* (1919)¹ described the double amputation to prevent pressure sores developing on useless limbs to a German meeting of spinal injury consultants. The participants did not agree with this procedure and in particular, Krukenberg opposed this. This work was quoted by Silver (2003).²

This operation was again described in Ludwig Guttmann's textbook when he reviewed the situation in 1973.

Not very long ago surgeons (Lindenberg, 1953; Street, 1958; Chase and White, 1959; Felix, 1959) performed amputations on patients with transverse lesions of the spinal cord as a preventive measure to the development of pressure sores, or these operations were carried out indiscriminately in paraplegics suffering from sores in the paralysed limbs which could have been healed by adequate conservative or surgical treatment or even on the grounds, that without their 'useless' legs, they will be more mobile. During the Second World War, the writer saw such mutilated victims, amongst them a tetraplegic, who had a bilateral amputation above the knees performed some time after his injury.³

Guttmann was strongly opposed to this procedure.

Jaffe twice postulates that no cases have been described earlier. Cases have been recorded in the German, British and North American literature and quoted in two textbooks.

Complete spinal

Secondly, Jaffe says that on presentation, he changed the patients' medication and carried out magnetic resonance imaging.

In a case of intractable spasticity, it is vital that the patient is seen by a multidisciplinary team involving physiotherapists, doctors, occupational therapists and surgeons to eliminate the spastogenic factors and assess if the spasticity can be alleviated.

No one has a monopoly of knowledge, and having obtained the advice of a psychiatrist, surely it would have been prudent at the very least to have had a conference with a more experienced colleague well versed in treating patients with spinal injury.

Jaffe says

Over the course of 8 weeks, the patient and I had long discussions regarding the benefits and alternatives to surgery. We discussed the shift in the centre of gravity, wheelchair seating and so on.

What does 'and so on' mean? Does it include the aforementioned multidisciplinary approach?

Jaffe says that his publication is meant to outline the working relationship regarding treatment options between the clinician and the patient.

This course of treatment is at variance with the accepted principles of treating a patient with spinal injury. The patient was not exposed to traditional treatment.

The surgical approach is graduated with deafferentation, rhizotomy and dorsal root entry zone procedure and if these procedures fail, then an amputation procedure developed by Foerster or even a total lumbosacral root section and the alcohol injection of the spastic patient to resume

The absence of such a unified approach is contrary to the fundamental principles of treatment of paraplegic patients. Before such a drastic procedure as an amputation, it is mandatory that a psychiatrist assesses the patient.

Bioethics surrounding Limb Loss/Difference Care

Emerging Technologies



Bioethics surrounding Limb Loss/Difference Care

Emerging Technologies

OSSEOINTEGRATION



Bioethics surrounding Limb Loss/Difference Care

Emerging Technologies

OSSEOINTEGRATION

Exclusion criteria / Contraindications:

Diabetes Mellitus

Vasculopathy

Psychiatric disorders

Ongoing chemotherapy or corticosteroids

Pregnancy / lactation

Patient non-compliance

Incapacity / Institutional custody

Ethical Consideration(s):

- Are patients given all the options?
- Are patients being appropriately consented?

What is the ethical and responsible thing to do when emerging technologies have a high foreseeable potential risk for adverse events?





Bioethics stemming from Prosthetic Enablement

Let's define ENABLEMENT

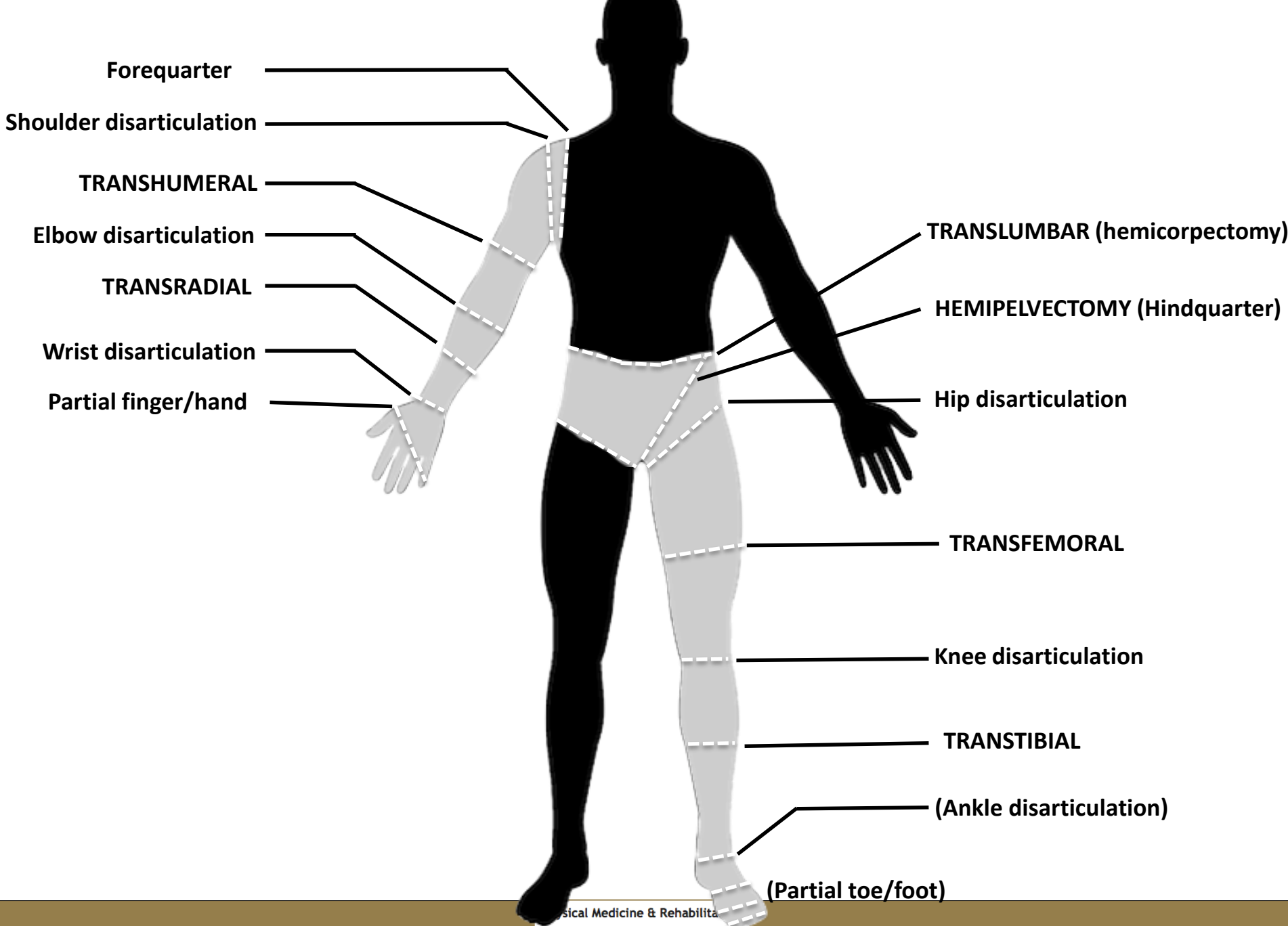
Treatment Model vs. Enablement Model

Participation		Construc-tion					
		LEVEL OF OUTCOME					
		Body Structure	Body Function	Activity	Participation		
LEVEL OF TREATMENT	Body Structure	Serial casting					
	Body Function		Progressive resistance exercises				
	Activity			Wheelchair			
	Participation				Employer training		
Body Stru	tendon length	elasticity	tendon length	radialis tendon length	tendon length	capsule size	

Limb loss/difference has many causes:

- Congenital limb difference/absence
- Trauma
- Dysvascular conditions (PAD, PVD, DVT, etc)
- Complication from medical comorbidities (e.g. diabetes, neuropathies, etc.)
- Burns / Frostbite
- Toxins
- Infection
- Cancer

Limb loss can affect anyone, at any time, during the lifespan



Forequarter

Shoulder disarticulation

TRANSHUMERAL

Elbow disarticulation

TRANSRADIAL

Wrist disarticulation

Partial finger/hand

TRANSLUMBAR (hemicorpectomy)

HEMIPELVECTOMY (Hindquarter)

Hip disarticulation

TRANSFEMORAL

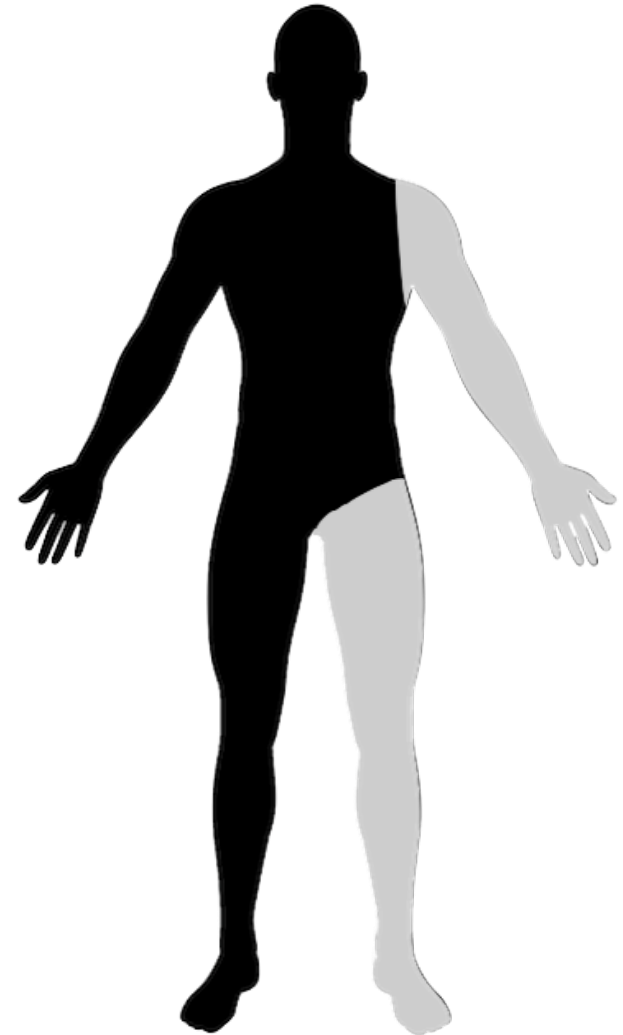
Knee disarticulation

TRANSTIBIAL

(Ankle disarticulation)

(Partial toe/foot)

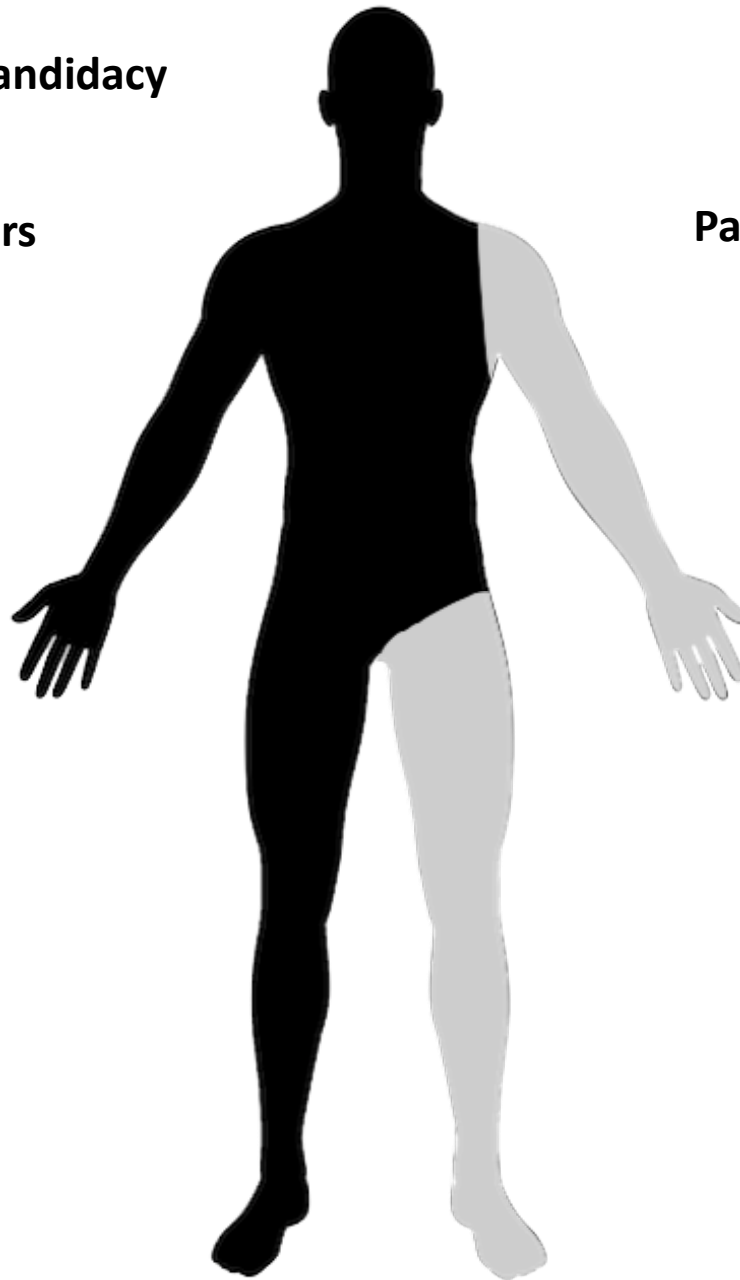
We have a heterogeneous patient population with very diverse abilities and needs, that are **constantly evolving**.



Evaluation of prosthetic candidacy and enablement

Patient intrinsic parameters


- Cognition
- Impairments (NEU/MSK/CARD/PULM/VASC)
- Medications
- Behaviors
- Psychometrics
- Biomechanics
- Energetics



Patient extrinsic parameters

- Socket fitting
- Suspension efficacy
- Prosthesis alignment, and component performance
- Environment
- Vocational or functional expectations

Prosthetic performance vs. enablement

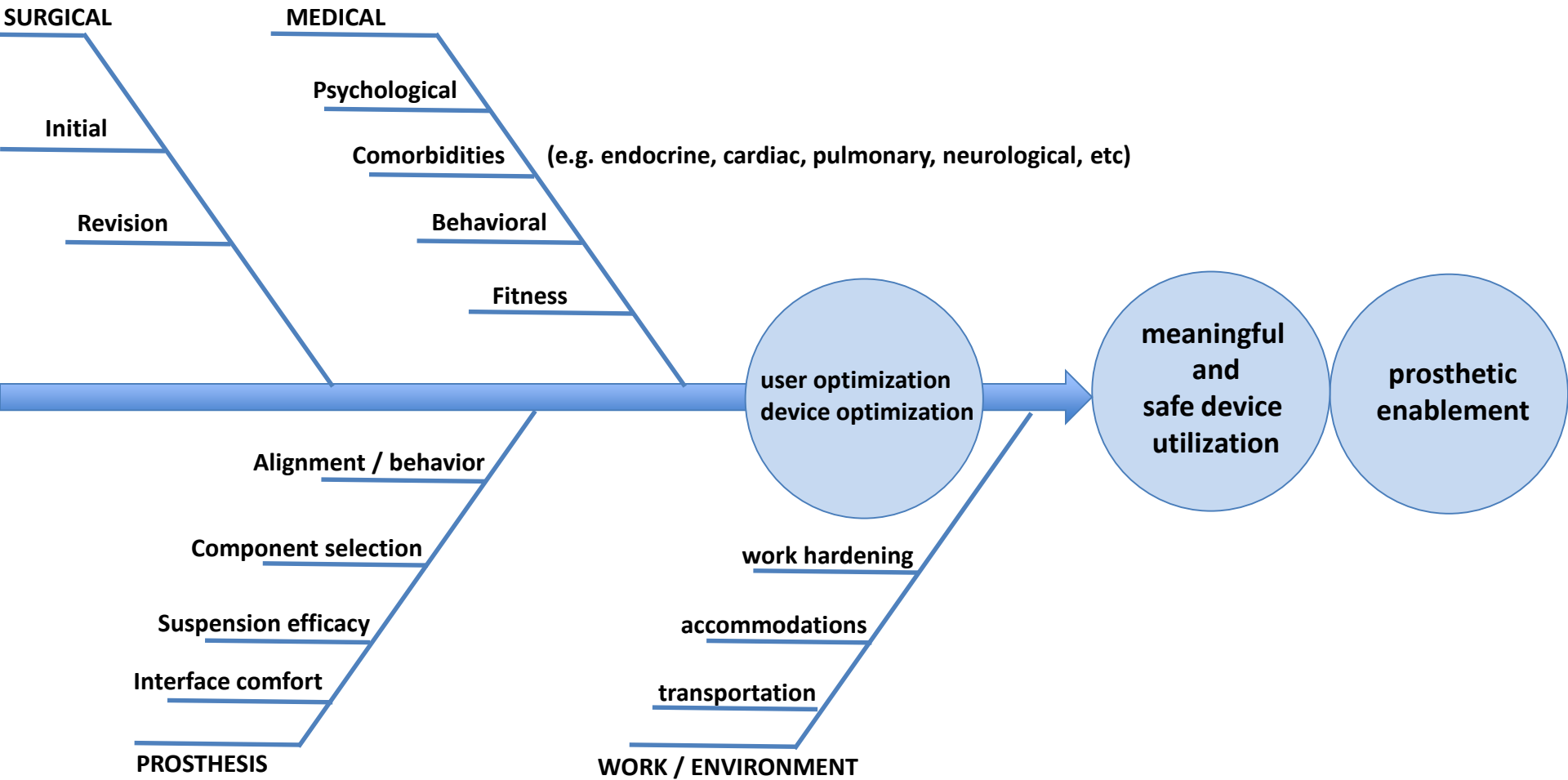


**user optimization
device optimization**

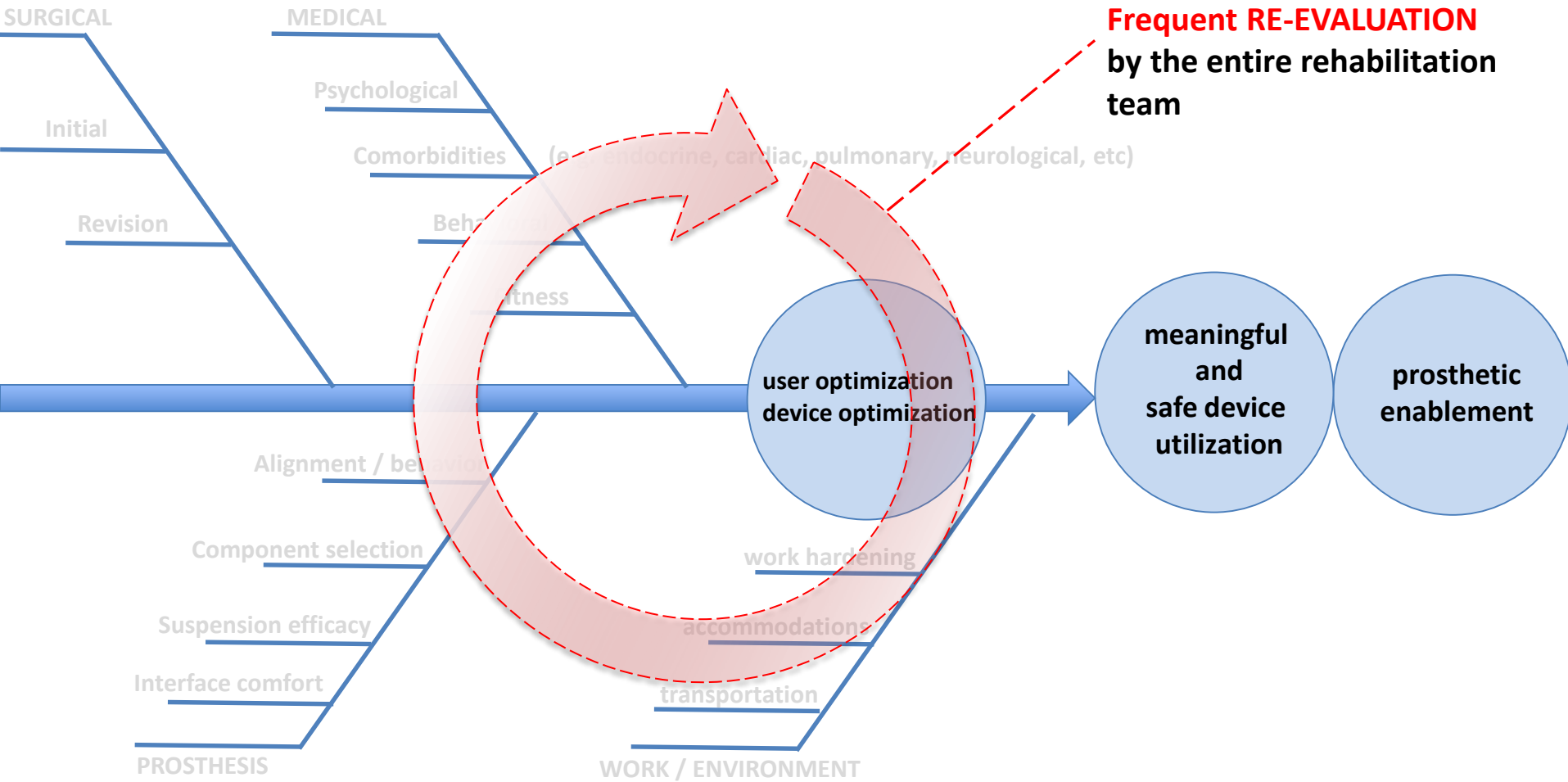
**meaningful
and
safe device
utilization**

**prosthetic
enablement**

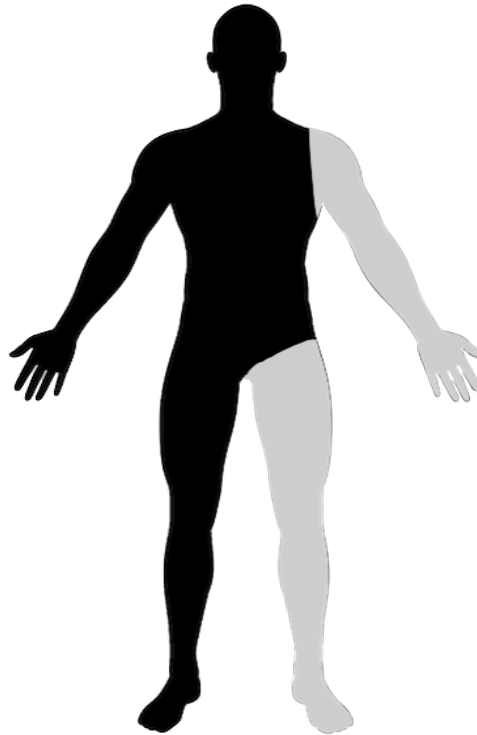
Prosthetic performance vs. enablement



Prosthetic performance vs. enablement



Looking beyond the device ...



Multifaceted contributions of overall health, mental/social wellbeing, and vocational/activity participation comprise major pillars of limb restoration enablement.

Bioethics stemming from Prosthetic Enablement

Existing attitudes and practices surrounding Limb Salvage

The typical patient with PAD/PVD, DM, HTN, HLD, CAD that gets a diabetic foot ulcer, or the trauma patient with significant functional debility in the salvaged limb.

“Preserve as much of a limb as possible ...”

We commit patients to:

- multiple procedures ... (pain, financial cost)
- compounded functional debility ...
- loss of connection (vocational/social/recreational/personal and interpersonal relationships) for years at a time ...
- distressed psychodynamic life narrative

...all because we don't want to have a “difficult” conversation

Bioethics stemming from Prosthetic Enablement

“I wish I would have done this years ago ...”

“I wish **they** would have done this years ago ...”

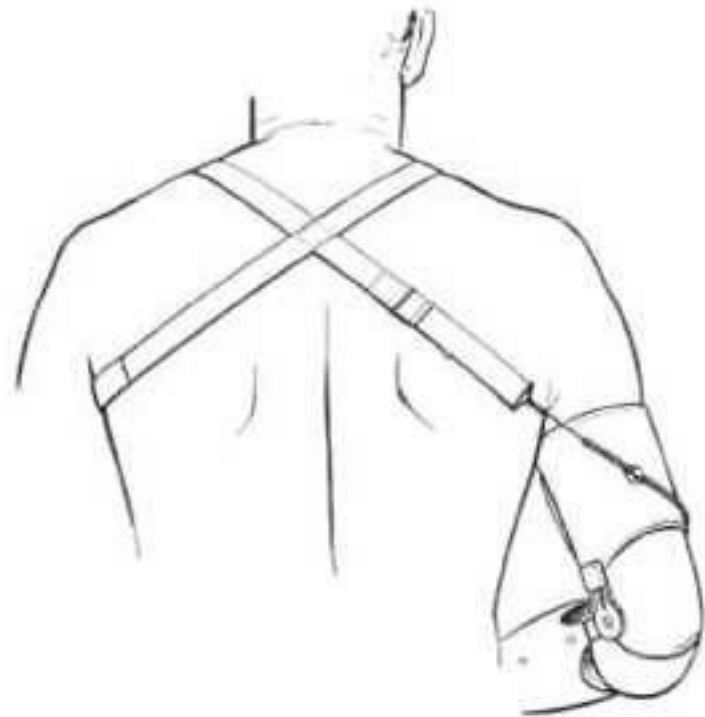
Bioethics stemming from Prosthetic Enablement

Existing attitudes / subculture / practices :

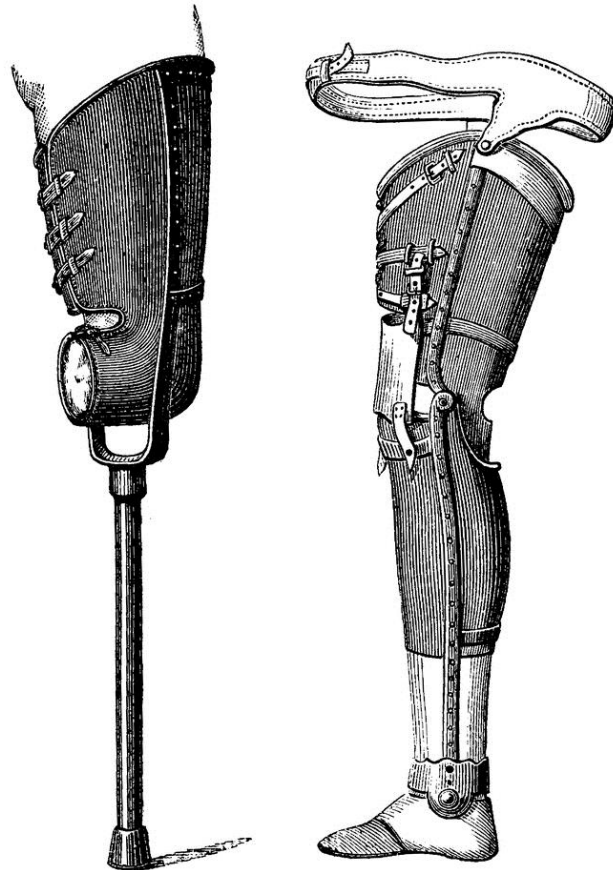
No discussion surrounding potentially warranted / enabling amputations (as a therapeutic alternative treatment).















Do we have a moral obligation to at least be educating PROVIDERS and certain PATIENTS about the benefits of prosthetic enablement?

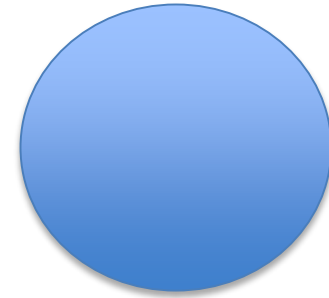
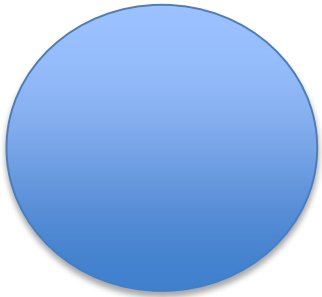
Part 2:

Metacognitive considerations to the Bioethics consult

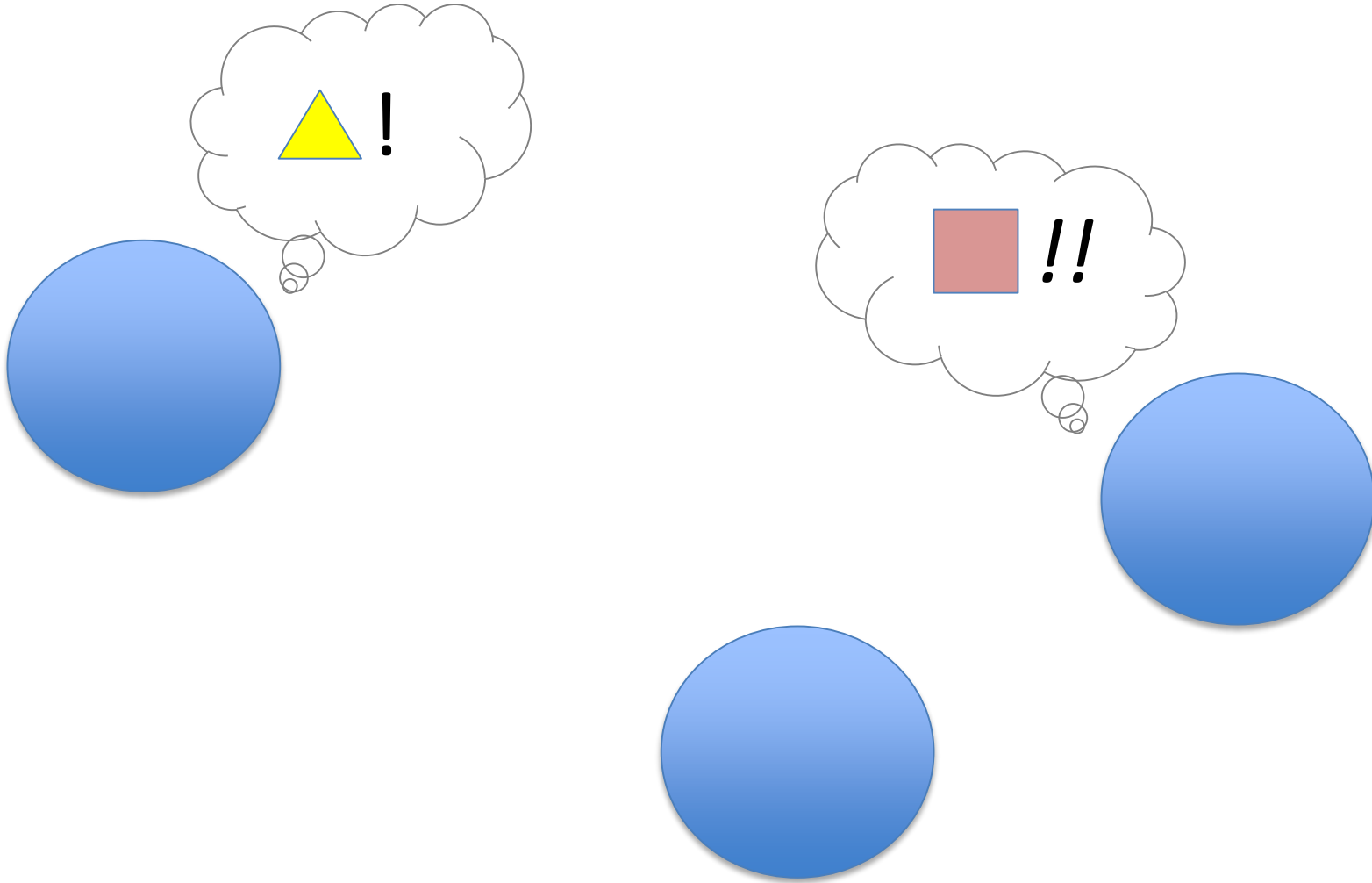
What is the highest notion / virtue / ideal in legal science?

Hint: it is not “Justice” or “Fairness”

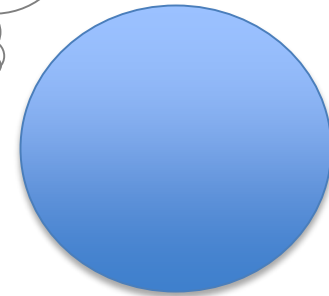
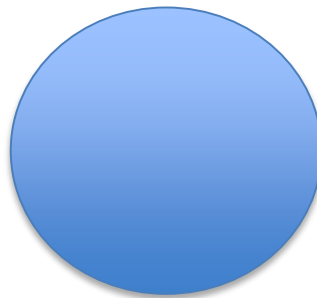
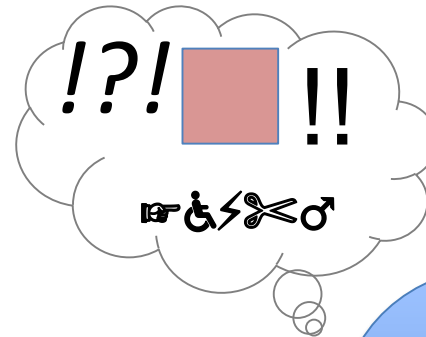
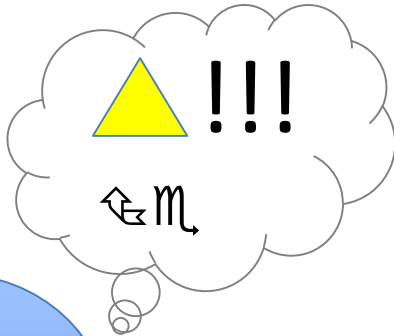
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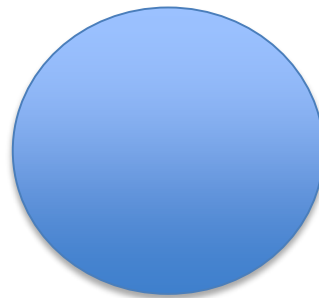
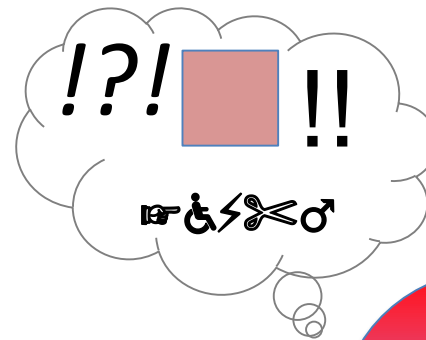
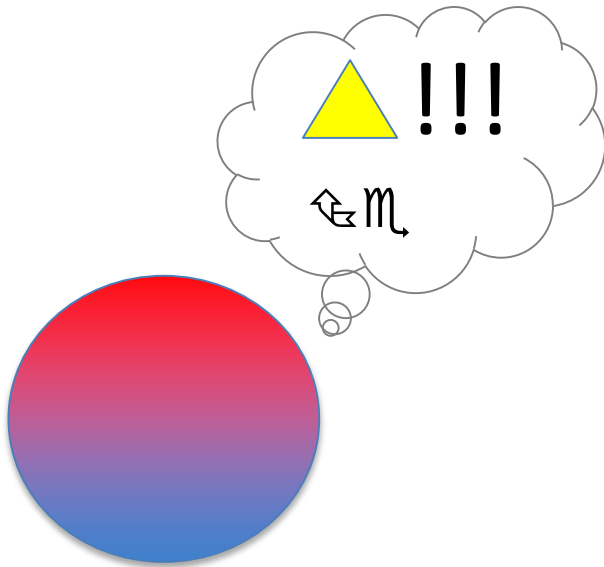
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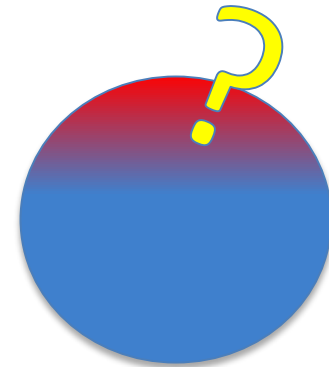
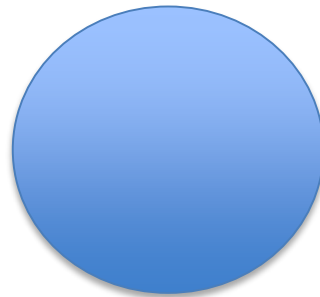
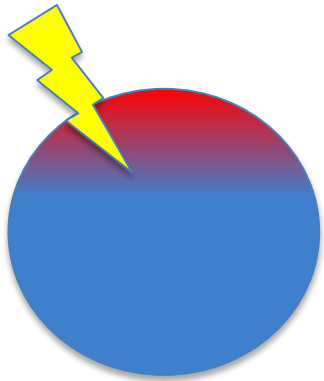
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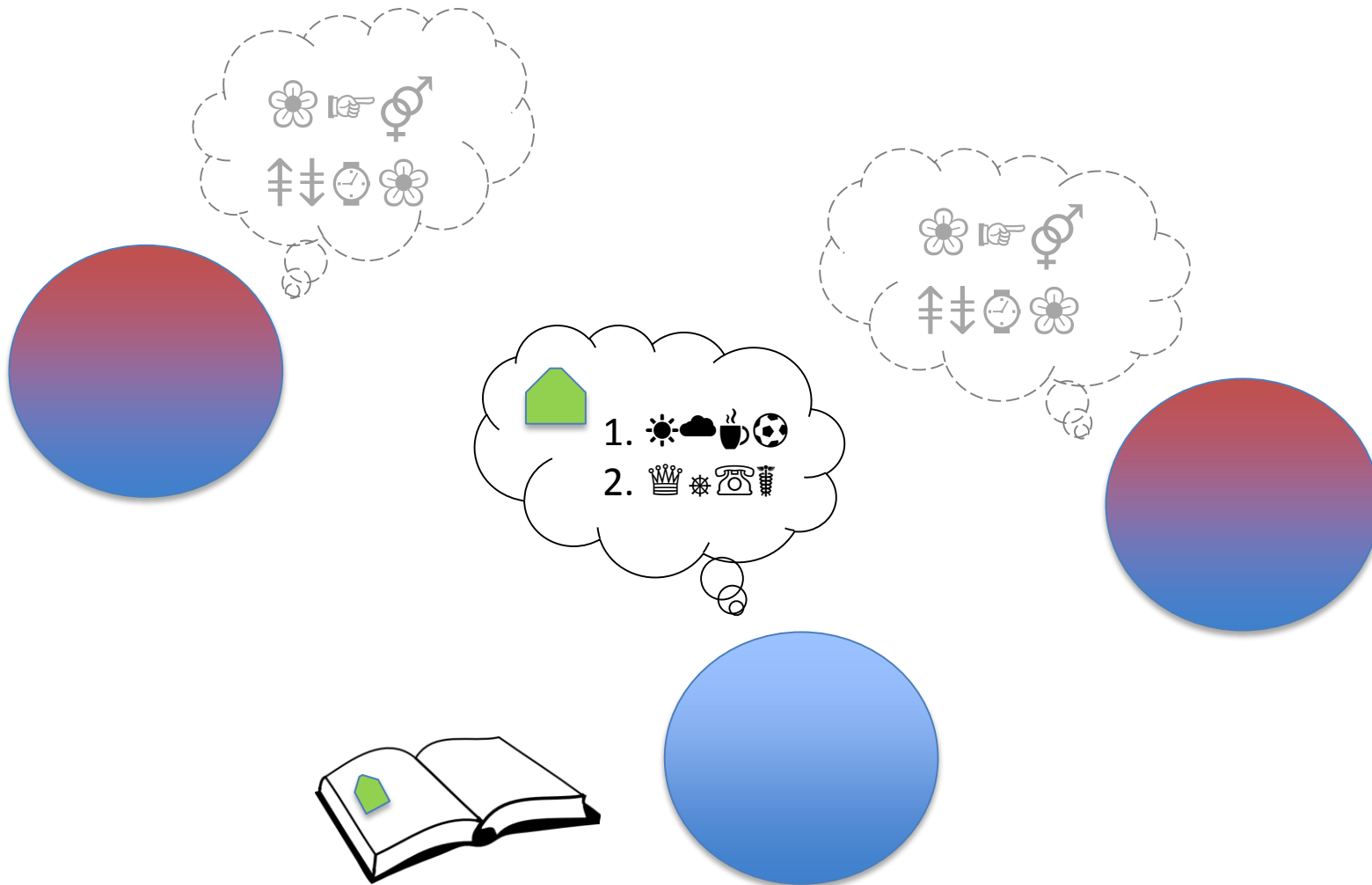
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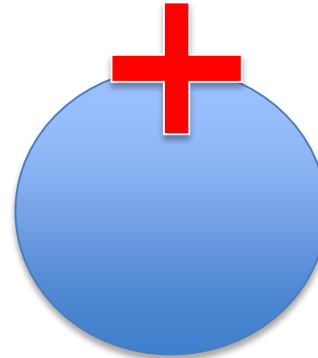
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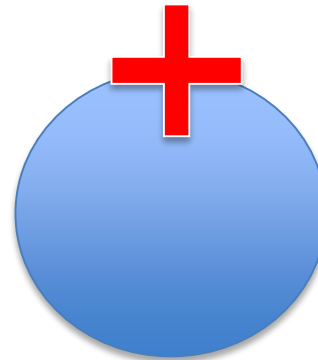
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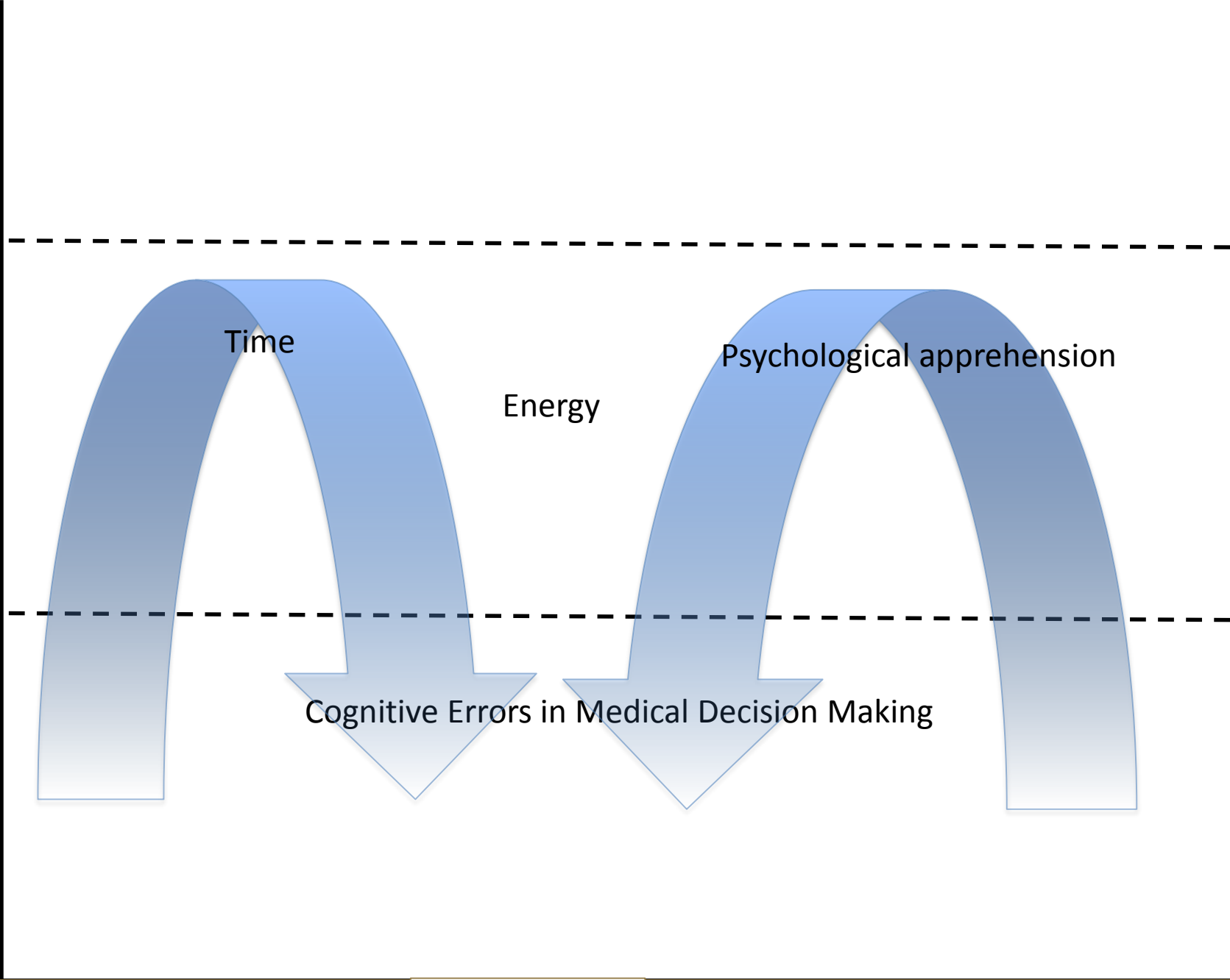


1. Quaternary level service
2. Practical and moral imperatives:
 - must know (CME)
 - must teach
 - must do best to not influence decision (respect for autonomy)

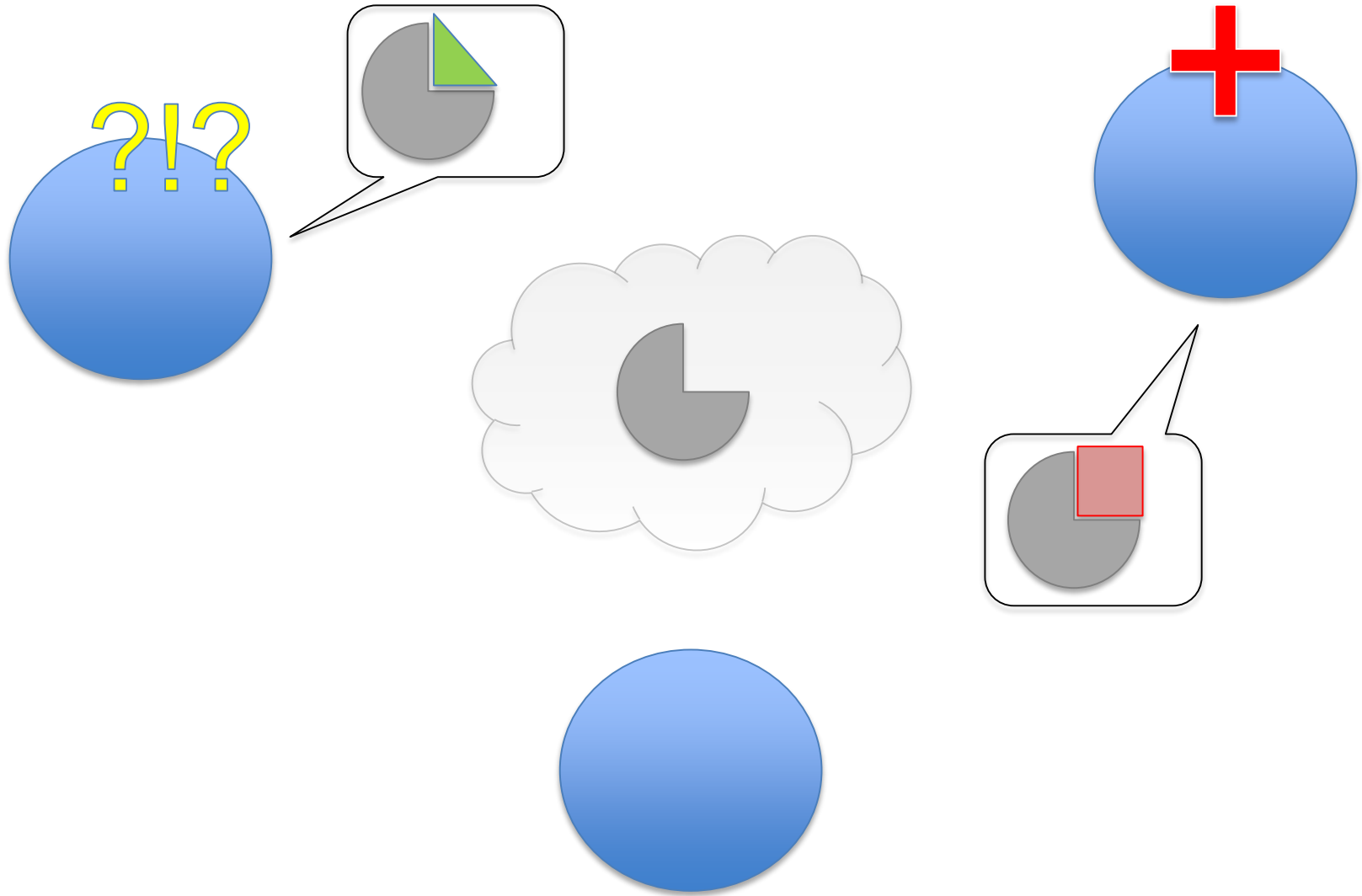
Distress

MORAL

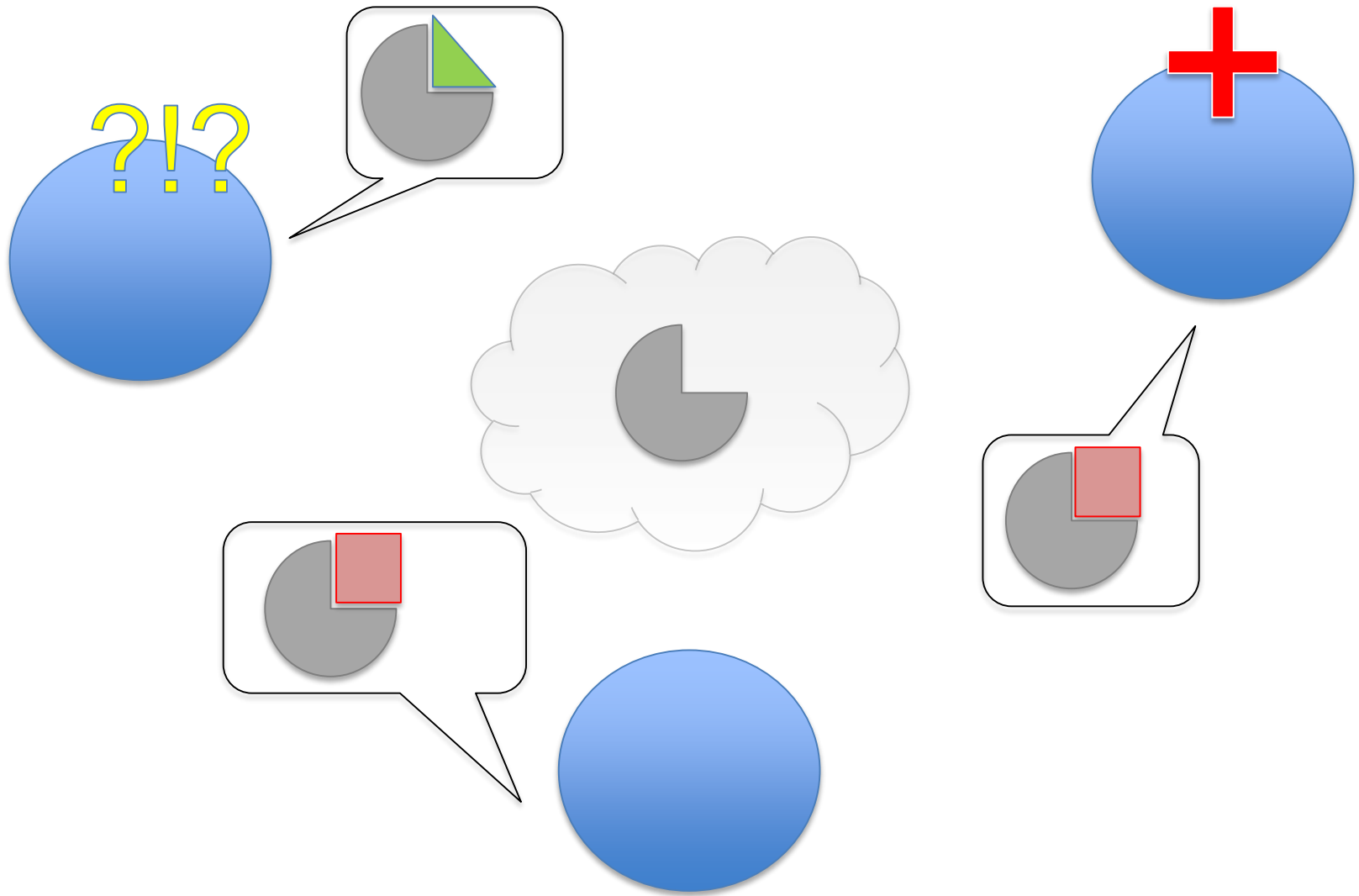
Certainty



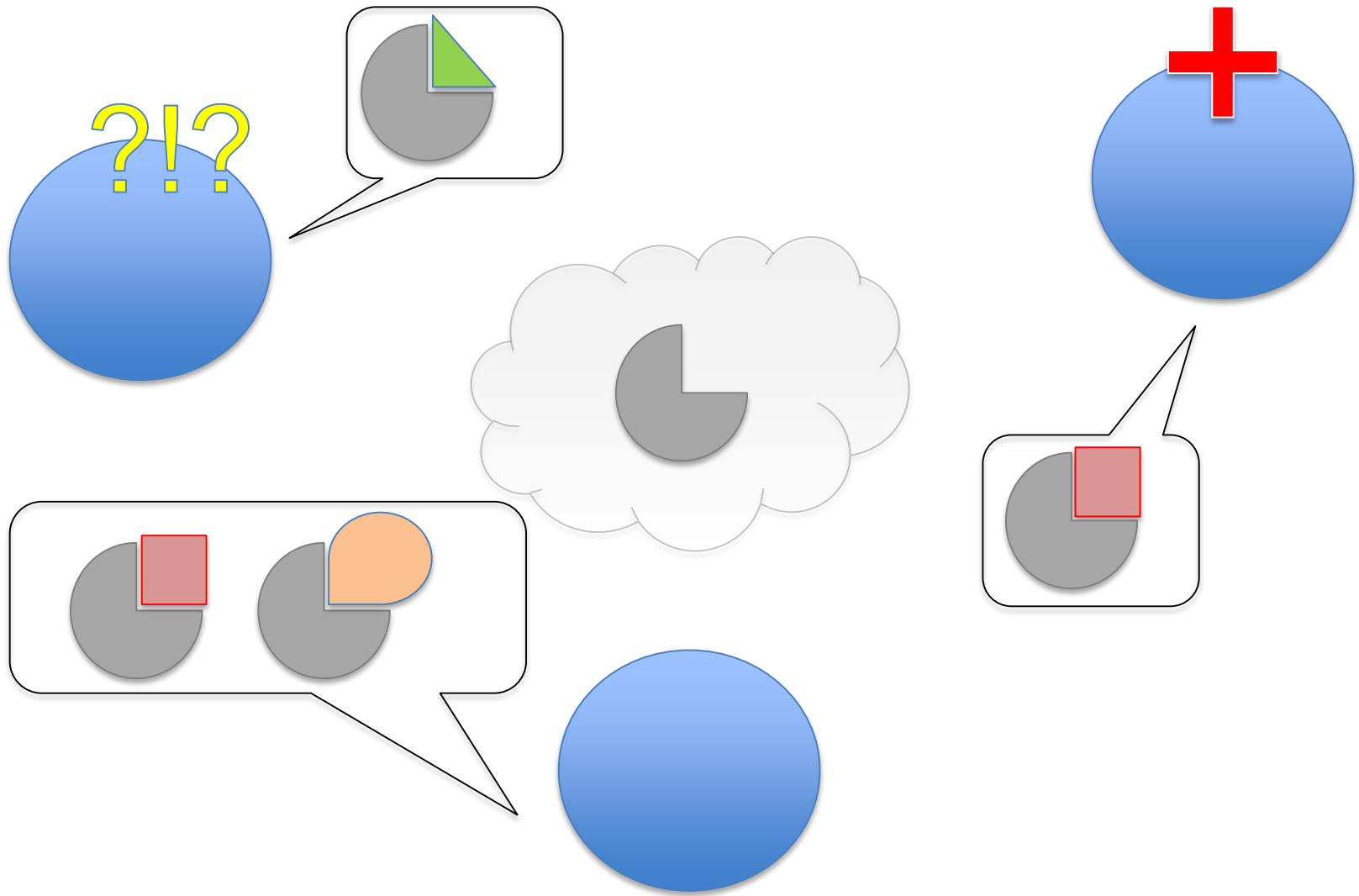
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The Bioethics Consult:

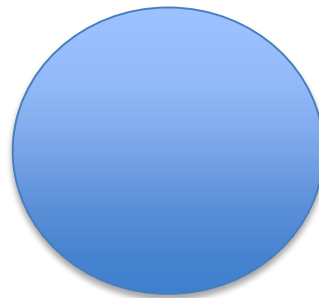
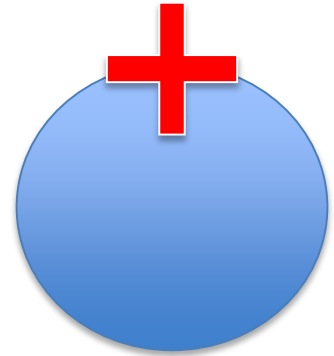
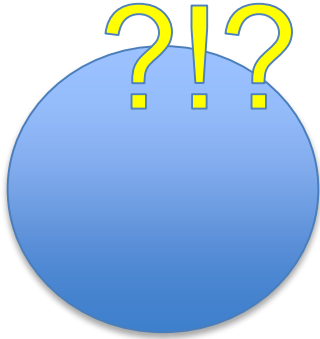


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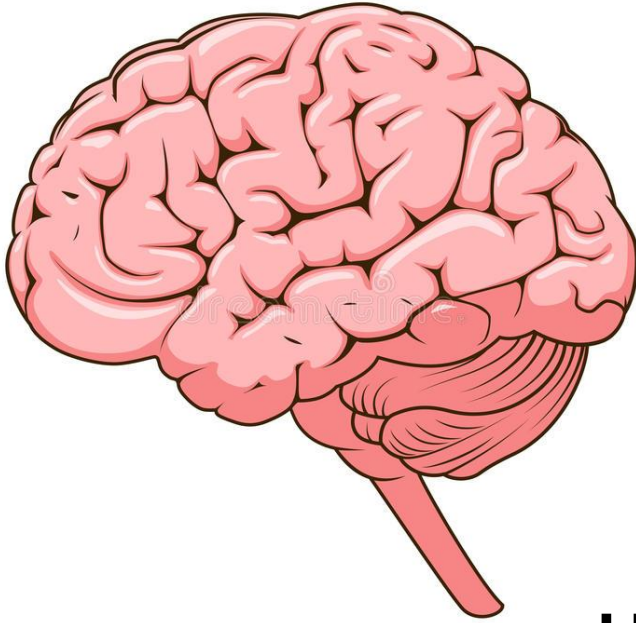


In sublimity of soul
there is no contagion...

The Bioethics Consult:



All morality should
be sympathy



a biological
augmented
reality machine

... which is fairly
error-prone in its higher level
deliberations ...

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1. Zwaan L, Singh H.

Diagnosis (Berl). 2015 Jun;2(2):97-103. Epub 2015 Mar 12.

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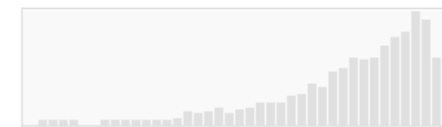
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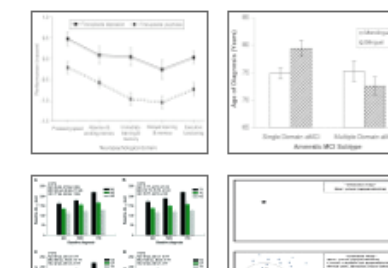
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J Dent Educ. 2018 Apr;82(4):340-348. doi: 10.21815/JDE.018.037.
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2. Morel Swols D, Tekin M.
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3. Koyama A, Ohtake Y, Yasuda K, Sakai K, Sakamoto R, Matsuoka H, Okumi H, Yasuda T.
Biopsychosoc Med. 2018 Mar 13;12:4. doi: 10.1186/s13030-018-0122-3. eCollection 2018.
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The Importance of Cognitive Errors in Diagnosis and Strategies to Minimize Them

Pat Croskerry, MD, PhD

ABSTRACT

In the area of patient safety, recent attention has focused on diagnostic error. The reduction of diagnostic error is an important goal because of its associated morbidity and potential preventability. A critical subset of diagnostic errors arises through cognitive errors, especially those associated with failures in perception, failed heuristics, and biases; collectively, these have been referred to as *cognitive dispositions to respond* (CDRs). Historically, models of decision-making have given insufficient attention to the contribution of such biases, and there has been a prevailing pessimism against improving cognitive performance through debiasing techniques. Recent work has catalogued the major cognitive biases in medicine; the author lists these and describes

a number of strategies for reducing them ("cognitive debiasing"). Principle among them is metacognition, a reflective approach to problem solving that involves stepping back from the immediate problem to examine and reflect on the thinking process. Further research effort should be directed at a full and complete description and analysis of CDRs in the context of medicine and the development of techniques for avoiding their associated adverse outcomes. Considerable potential exists for reducing cognitive diagnostic errors with this approach. The author provides an extensive list of CDRs and a list of strategies to reduce diagnostic errors.

Acad. Med. 2003;78:775–780.

33 Major Cognitive Dispositions to Respond (CDRs) That May Lead to Diagnostic Error

- Aggregate bias:** when physicians believe that aggregated data, such as those used to develop clinical practice guidelines, do not apply to individual patients (especially their own), they are invoking the *aggregate fallacy*. The belief that their patients are atypical or somehow exceptional may lead to
- Search satisfying:** reflects the universal tendency to call off a search once something is found. Comorbidities, second foreign bodies, other fractures, and coingestants in poisoning may all be missed. Also, if the search yields nothing, diagnosticians should satisfy themselves that they have been looking in the right place.
- Vertical line failure:** routine, repetitive tasks often lead to *thinking in silos*—predictable, orthodox styles that emphasize economy, efficacy, and utility. Though often rewarded, the approach carries the inherent penalty of inflexibility. In contrast, lateral thinking styles create opportunities for diagnosing the unexpected, rare, or esoteric. An effective lateral thinking strategy is simply to pose the question: “What else might this be?”
- Visceral bias:** the influence of affective sources of error on decision-making has been widely underestimated. Visceral arousal leads to poor decisions. *Countertransference*, both negative and positive feelings toward patients, may result in diagnoses being missed. Some attribution phenomena (*fundamental attribution error*) may have their origin in countertransference.
- Yin-Yang out:** when patients have been subjected to exhaustive and unavailing diagnostic investigations, they are said to have been worked up the Yin-Yang. The *Yin-Yang out* is the tendency to believe that nothing further can be done to throw light on the dark place where, and if, any definitive diagnosis resides for the patient, i.e., the physician is let out of further diagnostic effort. This may prove ultimately to be true, but to adopt the strategy at the outset is fraught with the chance of a variety of errors.
- Unpacking principle:** failure to elicit all relevant information (unpacking) in establishing a differential diagnosis may result in significant possibilities being missed. The more specific a description of an illness that is received, the more likely the event is judged to exist. If patients are allowed to limit their history-giving, or physicians otherwise limit their history-taking, unspecified possibilities may be discounted.
- Psych-out error:** psychiatric patients appear to be particularly vulnerable to the CDRs described in this list and to other errors in their management, some of which may exacerbate their condition. They appear especially vulnerable to *fundamental attribution error*. In particular, comorbid medical conditions may be overlooked or minimized. A variant of psych-out error occurs when serious medical conditions (e.g., hypoxia, delirium, metabolic abnormalities, CNS infections, head injury) are misdiagnosed as psychiatric conditions.
- Representativeness restraint:** the representativeness heuristic drives the diagnostician toward looking for prototypical manifestations of disease: “If it looks like a duck, walks like a duck, quacks like a duck, then it is a duck.” Yet restraining decision-making along these pattern-recognition lines leads to atypical variants being missed.

Cognitive Debiasing Strategies to Reduce Diagnostic Error*

Strategy	Mechanism/Action
Develop insight/awareness	Provide detailed descriptions and thorough characterizations of known cognitive biases, together with multiple clinical examples illustrating their adverse effects on decision-making and diagnosis formulation.
Consider alternatives	Establish forced consideration of alternative possibilities e.g., the generation and working through of a differential diagnosis. Encourage routinely asking the question: What else might this be?
Metacognition	Train for a reflective approach to problem solving: stepping back from the immediate problem to examine and reflect on the thinking process.
Decrease reliance on memory	Improve the accuracy of judgments through cognitive aids: mnemonics, clinical practice guidelines, algorithms, hand-held computers.
Specific training	Identify specific flaws and biases in thinking and provide directed training to overcome them: e.g., instruction in fundamental rules of probability, distinguishing correlation from causation, basic Bayesian probability theory.

Simulation	Develop mental rehearsal, "cognitive walkthrough" strategies for specific clinical scenarios to allow cognitive biases to be made and their consequences to be observed. Construct clinical training videos contrasting incorrect (biased) approaches with the correct (debiased) approach.
Cognitive forcing strategies	Develop generic and specific strategies to avoid predictable bias in particular clinical situations.
Make task easier	Provide more information about the specific problem to reduce task difficulty and ambiguity. Make available rapid access to concise, clear, well-organized information.
Minimize time pressures	Provide adequate time for quality decision-making.
Accountability	Establish clear accountability and follow-up for decisions made.
Feedback	Provide as rapid and reliable feedback as possible to decision makers so that errors are immediately appreciated, understood, and corrected, resulting in better calibration of decision makers. ²⁶

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Camb Q Healthc Ethics. 2014 Oct;23(4):386-96. doi: 10.1017/S0963180114000061. Epub 2014 Jul 17.

The ethical imperative to think about thinking - diagnostics, metacognition, and medical professionalism.

Stark M, Fins JJ.

Abstract

While the medical ethics literature has well explored the harm to patients, families, and the integrity of the profession in failing to disclose medical errors once they occur, less often addressed are the moral and professional obligations to take all available steps to prevent errors and harm in the first instance. As an expanding body of scholarship further elucidates the causes of medical error, including the considerable extent to which medical errors, particularly in diagnostics, may be attributable to cognitive sources, insufficient progress in systematically evaluating and implementing suggested strategies for improving critical thinking skills and medical judgment is of mounting concern. Continued failure to address pervasive thinking errors in medical decisionmaking imperils patient safety and professionalism, as well as beneficence and nonmaleficence, fairness and justice. We maintain that self-reflective and metacognitive refinement of critical thinking should not be construed as optional but rather should be considered an integral part of medical education, a codified tenet of professionalism, and by extension, a moral and professional duty.

PMID: 25033249 [PubMed - indexed for MEDLINE]

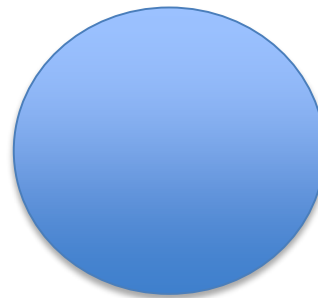
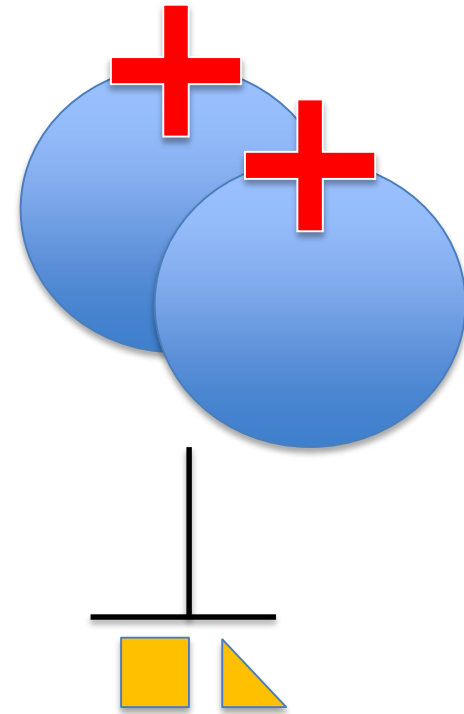
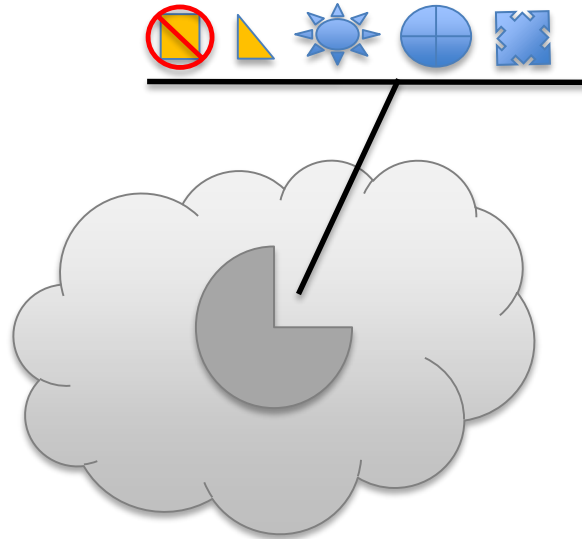
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Operationalizing Bioethics support for modern healthcare delivery

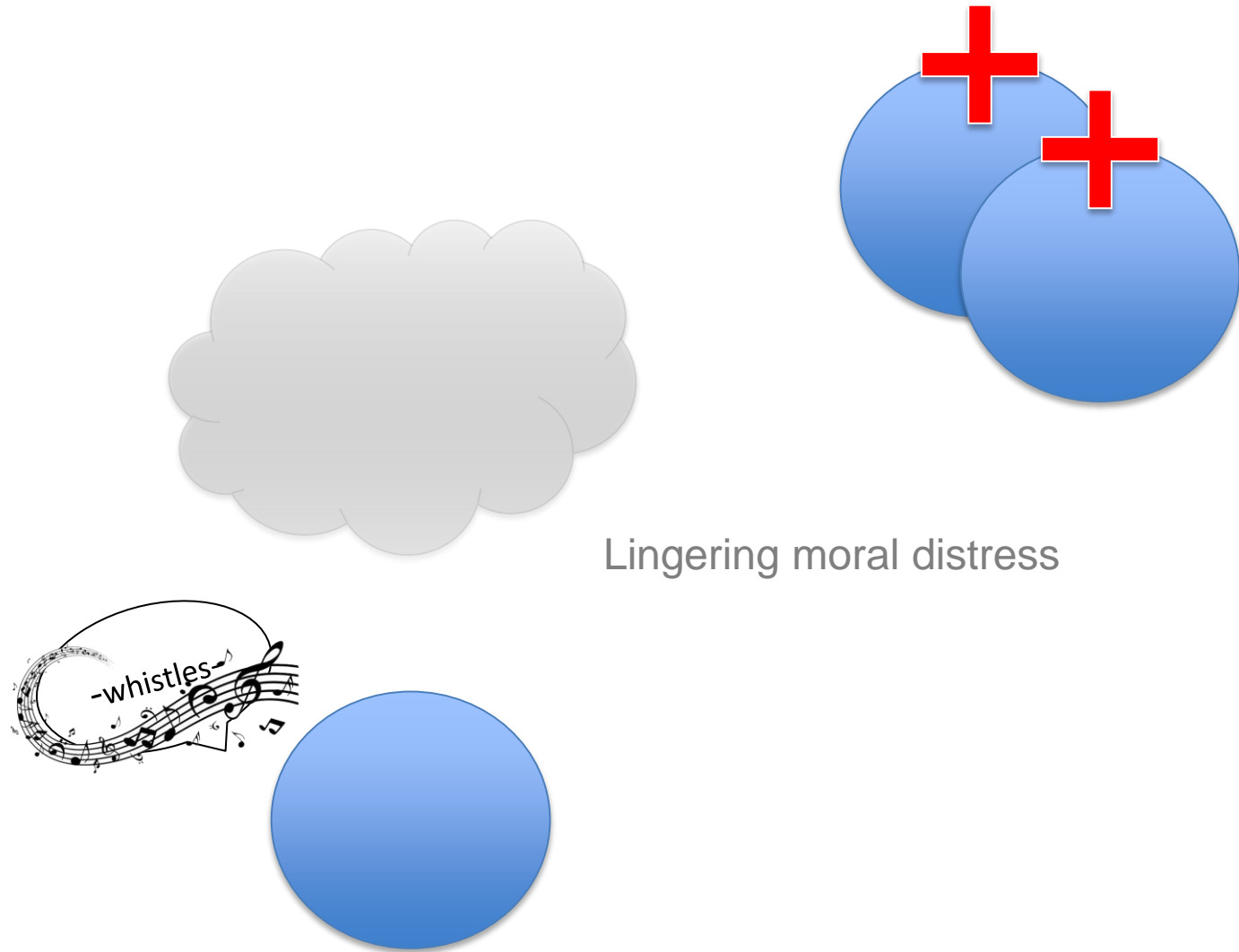


**A(n operationalized) consensus of conduct
relating to the delivery of medical care.**

The Bioethics Consult:



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Ethical Legal Feature

Moral Distress in Rehabilitation

Guest Discussants: Michael M. Green, DO, Mark R. Wicclair, PhD, Lucia D. Wocial, PhD, RN

Guest Editor: Andy Kondrat, PhD

Feature Editor: Debjani Mukherjee, PhD

Feature Editor Introduction

About a dozen years ago, I took the lead on surveying clinical and nonclinical staff members at the Rehabilitation Institute of Chicago (now the Shirley Ryan AbilityLab) about their perceived moral distress [1]. My colleagues and I asked, "We are interested in learning about the issues that create a sense of moral distress in your daily professional life. What types of situations are troubling for you because of your beliefs about what is right and wrong? What is troubling to you because of conflicts of values?" The results were published in this *Journal* in 2009 and for many years the data guided the priorities and focus of our ethics initiatives.

The literature on moral distress has continued to grow since then and is relevant for all of us working in health care. For this column, I have invited Andy Kondrat, PhD, to be a guest editor. Dr Kondrat's

doctoral dissertation in Philosophy was titled "Moral Distress and the Health Care Organization," and he has continued to immerse himself in the theoretical, interpersonal, and institutional aspects of this topic through his research, observation, and practice. He has been working as a Bioethicist at the Shirley Ryan AbilityLab for several years and will be joining the faculty of the Center for Healthcare Ethics at Cedars-Sinai Medical Center in Los Angeles in July 2017. As always, I welcome suggestions and comments about the Ethical Legal column and can be reached at dmukherjee@sralab.org.

Reference

1. Mukherjee D, Brashler R, Savage T, Kirschner K. Moral distress in rehabilitation professionals: Results from a hospital ethics survey. *PM R* 2009;1:450-458.

Moral distress was first defined by Andrew Jameton in 1984 as occurring “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action”

A recent definition states that moral distress “occurs when providers believe that they are being involuntarily complicit in acting unethically they are doing something that they believe to be morally wrong but have little power to act differently or to change the situation.”

Moral distress, when allowed to grow and compound over time, comes with a host of detrimental effects on clinicians, health care organizations, and patient care.

Moral distress eventually can lead to professional burnout and thus has an effect on the health care team, as communication and collaboration among team members become strained. These effects, in turn, directly affect patient care. For example, in one study morally distressed nurses were found to “lose their capacity for caring, avoid patient contact, and fail to give good physical care; they physically withdraw from the bedside, barely meeting the patient’s needs”

[...] frequent episodes can have significant effects on the health of an organization or institution, subtly warping its culture.

As I progressed in my training, I had other experiences of moral distress. Although I was aware of the negative reactions I was experiencing, I struggled to understand and articulate their nature and source. And, despite the ubiquity of these situations, **I found that my training program did not explicitly address these experiences.**

I also found that **the rehabilitation team itself lacked both the ability to name the experience as well as the vocabulary to discuss it.**

Clinical care is ineradicably ethical and, thus, moral distress is inevitable.

Ensuring clinicians learn about this concept and acquire a vocabulary to think about and discuss their experiences of moral distress with colleagues is the first step to mitigating it.

– Michael Green, DO (Univ. of Utah)

“Physiatrists practice in institutional settings [...] that require them to compromise professional standards or provide less than optimal care. Moral distress also can result when physiatrists observe colleagues and staff provide less than-optimal care due to institutional constraints and obstacles. The limitations imposed by third-party payors can be another significant source of moral distress. As its definition indicates, moral distress typically is associated with a sense of powerlessness - a perception that one is unable to do the right thing or to refrain from doing the wrong thing. Hence, **moral distress can be experienced as diminished moral agency.**

[...] managing moral distress and conscientious objection call for different approaches.

Facilities may decrease moral distress by **promoting a culture that encourages moral dialogue and reduces the sense of loss of moral agency.** Concurrently, facilities may decide to manage moral distress by **establishing mechanisms to identify and correct significant moral deficiencies.** For example, facilities might implement a process to enable practitioners to report concerns that give rise to moral distress to a designated individual or body (eg, a medical director or committee) without risking reprisals or disciplinary action."

- Mark Wicclair, PhD (West Virginia Univ. and Univ. of Pitt.)

“At its core, moral distress is an experience with emotional, psychological, and physiological components rooted in a person’s understanding of professional responsibilities.

[...] the extended length of stay in rehabilitation, relative to acute care, and its resulting deeper interactions with patients and families can blur professional and personal boundaries, putting physical medicine and rehabilitation clinicians at risk for a particular, and complicated, form of moral distress.

[...] long-term relationships complicate our sense of responsibility and cause us to have an inflated sense of duty when it comes to moral agency, thus leading us to think we have failed our duties when, in fact, external constraints are to blame.

[...] it is not uncommon for them to be celebrated for going above and beyond the normal standard of behavior (ie, boundary crossing) to meet a patient’s needs. This may set a precedent for a standard that is in reality a boundary violation (outside the zone of helpfulness), yet somehow providers who do less than this supererogatory standard may feel they are failing to meet their obligations to the patient (and thus not doing what is right).”

- Lucia D. Wocial, PhD, RN (Indiana Univ. School of Nursing)

The BIOETHICS department/effort has a distinct opportunity and (arguably) responsibility to serve as the institutional consciousness.

Argue for more MONEY / ASSETS for the following operations/actions:

- Build redundancy/operational reserve (recruit bioethicists)
- Proactively create a(n inter)national network of experts
- Commit bioethicists to a proactive solicitation of information on topics (update every 2 years)
- Disseminate bioethics considerations to other departments (in-service education), and to the IRBs. (Be a catalyst for conversations ... even difficult ones). Utilize the network for specialty-specific content dissemination
- Help your colleagues avoid burnout and moral distress

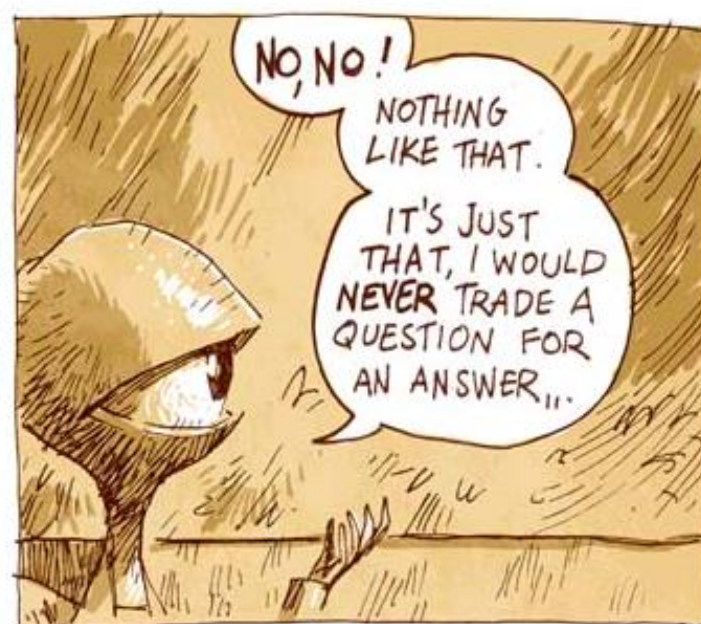


Never give up an interesting question,
just because someone has offered up
a
convenient answer...

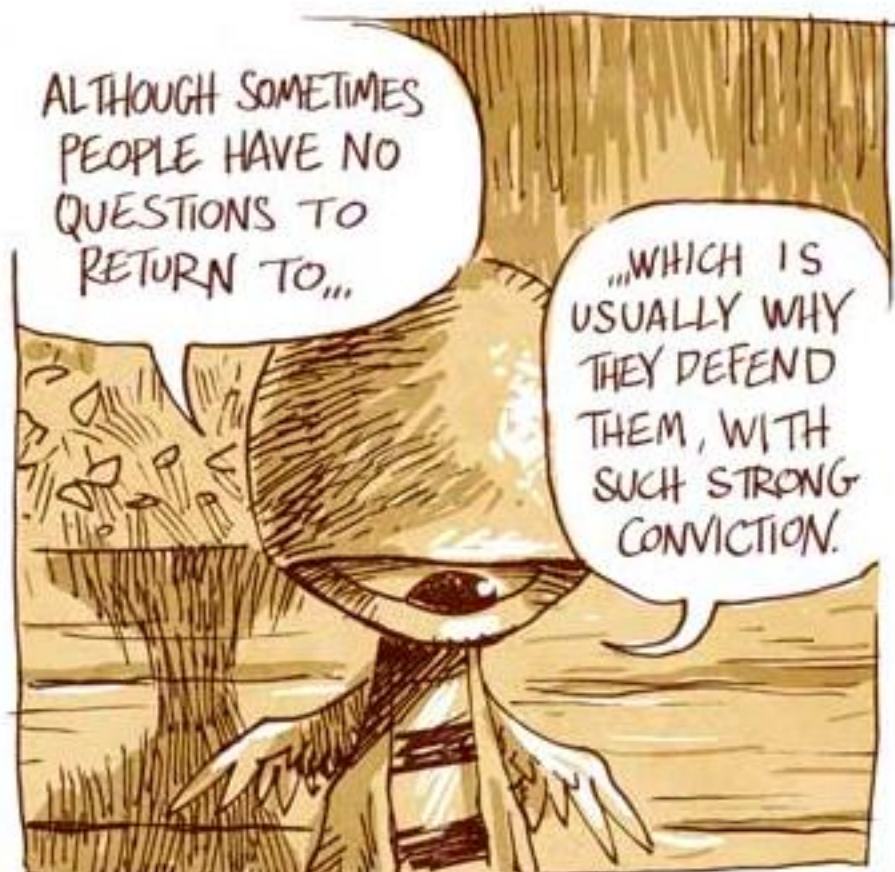
















From:





Thank you for this wonderful opportunity!

I remain, humbly, at your service ...

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IS HARM TO A PROSTHETIC LIMB PROPERTY DAMAGE OR A PERSONAL INJURY?

POSTED ON FEBRUARY 21, 2017 BY HUTCHISON & STOY

Currently, the law treats damage to prosthetic limbs just like any other type of property damage. This concept can be illustrated through an example. If an individual's prosthetic limbs were destroyed after a car accident, current law would treat damage to the prosthetic limb just like damage to a car.

This likely means that the victim would be able to recover the cost of the limb. Proponents of changing the law to consider damage to a prosthetic as a personal injury believe that the damages that individuals receive under the property damage regime do not adequately demonstrate the victim's reliance on the prosthetic limb. This is because monetary policy limits on property damage are often much lower than personal injury policy limits.