Palliative and Supportive Care

Social injustice is moral suffering

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Editorial

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Our healthcare colleagues are suffering. The pandemic accelerated preexisting trends in burnout and professional dissatisfaction, compromising clinicians' abilities to self-preserve amid staff shortages and increasing numbers of seriously ill patients (Office of the Surgeon General 2022). Decades-long research points to the crucial role moral suffering plays in workforce sustainability and wellbeing. *Moral suffering* is "the anguish experienced in response to moral harms, wrongs or failures, and unrelieved moral stress" (Rushton 2018). In health systems' efforts to address the root causes of the burnout and attrition crises, they too often fail to appreciate one of its key drivers – social injustice, which, we argue, represents a deeply entrenched form of moral suffering.

Consider Allen, a Black man in his 30s currently living below the poverty line in a rural American town. Allen presents to the emergency department with progressive dyspnea and weight gain. Having experienced symptoms for months, he delayed seeking medical attention because he'd previously faced racial discrimination from inpatient hospice workers during his mother's end-of-life care years earlier. During his subsequent admission, he is diagnosed with hypertrophic cardiomyopathy and an ejection fraction of 10%. His shock and upset upon learning his diagnosis result in him being labeled by the clinical team as angry and aggressive, although the truth is Allen has struggled with uncontrolled anxiety for most of his life but has not had access to affordable mental health services.

Allen represents the human consequences of structural discrimination, with the health system mistrust, health service inadequacy, and racialized trauma that disproportionately and chronically stress the poorest populations and people of color. The barriers that Allen lives also strain health professionals to deliver equitable, person-centered care, and to achieve an ethically sound practice. Social injustice produces moral drudgery that the workforce must shoulder daily.

When Allen is readmitted months later with acute on chronic heart failure, he's unable to receive advanced heart failure therapies or be listed for transplant due to a history of non-adherence. He has severe pain due to lower leg non-healing ulcers. The palliative care consultant prescribes low-dose hydromorphone. On discharge, Allen cannot find a pharmacy near his home that will fill his prescription, nor are any of his outpatient clinicians willing to become his longitudinal prescriber. He lives outside the catchment area for local community-based palliative care agencies.

Social injustice permeates Allen's world and incites moral suffering in the clinicians seeking to partner in his care. When we, as those clinicians, are unable to ensure the equitable provision of high-quality services across structural divides, the experience intensely affronts the health professions' basic moral principles. As Allen's case reflects, racially and ethnically minoritized Americans experience morally unacceptable disparities in chronic pain treatment, leading to higher pain prevalence and substandard pain outcomes (Zajacova et al. 2022). Systemically embedded injustices also transcend borders and boundaries. For instance, despite international symptom management guidelines, populations in low- and middle-income countries consistently lack access to medically indicated opioids and other controlled essential medicines to mitigate health-related suffering in serious illness (Knaul et al. 2018). Worldwide, more than 61 million people live in opioid deserts without dignified evidence-based palliation because they – like Allen – are dehumanized through unjust social health determinants steeped in white supremacy. Clinicians who seek to uphold their moral obligations also suffer, albeit differently, as they go without the resources needed to alleviate the suffering before them.

Beyond the technicalities of medical care, social injustice invades even the most intimate moments of the human life. Ten months after his initial presentation, Allen suffers an unwitnessed cardiac arrest at his job. He is admitted to the critical care unit with a severe anoxic brain injury. He has no advance directives on file. Allen's same-sex spouse and surrogate decision-maker, Matthew (a Hispanic trans man) is at Allen's side. Although Allen has been estranged from his biological siblings – Teresa and Aaron – for years, the critical care team

incorrectly insists the family of origin are Allen's legal decision-makers and calls them to the hospital. The team guides Teresa and Aaron through goals of care discussions, culminating in the withdrawal of vasopressors and mechanical ventilation.

Teresa and Aaron do not wish to be with Allen at the end of his life, but also insist that Matthew be forced to leave the room. He is not "family." The critical care nurse, intensivist, and respiratory therapist – all of them strangers to Allen and all of them white – provide the technical expertise needed in Allen's final moments.

Allen dies alone.

Matthew is denied closure with his husband. He is given no bereavement care referral. Matthew is now vulnerable to prolonged grief symptoms and the associated negative outcomes, exacerbated by his already profound health risks as a trans gay man of color (National Academies of Sciences, Engineering, and Medicine 2020).

And what of the medical team's roles in this tragedy? When personal biases are empowered as valid components of medical decision-making, such as the rising number of state-level transgender treatment bans and anti-LGBTQ+ legislation (Human Rights Campaign 2023), the very foundation of "do no harm" is demolished. In this context, individual choice trumps both general normative ethics and the nature of common morality, threatening social stability, risking heightened societal permissiveness of intentional maleficence, and shattering heath professionals' obligation to their patients. When policy supports immoral and discriminatory behavior, moral violations are both weaponized and protected. Health professionals thus find themselves trapped in a system inexorably structured to perpetuate suffering. The center cannot hold.

Dr. Paul Farmer (2003) said, "The idea that some lives matter less is the root of all that is wrong with the world." This injustice is reinforced each time a human being like Allen is denied specialist palliative care in the face of a life-limiting illness or an immigrant seeking asylum is forcibly separated from their child and psychologically scarred for life. We see the 'root of all that is wrong with the world' each time a Black person is murdered by police; a member of the LGBTQ+ community is raped or bullied; a houseless person is discharged to the curb; or an Indigenous woman goes missing without legal ramifications or assistance. In health care, we are forced to reckon with the direct and indirect consequences of lives mattering less. Feeling powerless to make them matter more creates moral suffering.

We need system- and national level-policies to protect health professionals and the public, not only to provide mental health support for clinicians but also long-term structural interventions. Prioritizing patient, staff, and societal wellbeing over profits represents a critical first step. But it is insufficient. To truly foster new and antiracist structures we need transdisciplinary models to ensure inclusivity across professions and worldviews. Ensuring that all team members feel valued and experience a sense of belonging will help mitigate isolation and the vice of silence so many of us feel. Moral resilience can only grow in an environment calibrated to eradicate injustice.

Social injustice violates and debilitates our moral integrity as individuals (i.e., resulting in illness, distress, suicide) and as a workforce (i.e., leading to increased turnover, departure from the health professions). We are suffering and have become morally incapacitated. We need strategic action to heal and prevent further transgressions to the systemically marginalized, like Allen, his family, and his community. All hands on deck are required to mount a critical response and alleviate our collective burden of moral pain. Social injustice *is* moral suffering.

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