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COVID-19 Pandemic Guidance Document

MORAL INJURY DURING THE COVID-19 PANDEMIC

Prepared by the APA Committee on the Psychiatric Dimensions of Disaster and COVID-19

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The current global pandemic has created extreme and often excessive demands upon this country's healthcare system and specifically upon its healthcare workers. Front line workers are being confronted with demands for service not previously experienced in a non-combat environment. The scarcity of necessary equipment, the extent of severe disease in such a wide population, and the inadequate staffing necessitating extensive service hours are among the situations and decision-making dilemmas that are impacting healthcare workers to such a degree that "moral injury" is becoming an emerging consequence of this pandemic.

Moral injury in medicine "occurs when clinicians are ... expected, in the course of providing care, to make choices that transgress their longstanding, deeply held commitment to healing" [1]. Moral injury has been discussed as an occupational hazard in medicine before the COVID-19 pandemic [2], including in a recent project on developing moral resilience [3]. However, the current crisis has exposed the depth and breadth of moral injury's potential impact upon entire networks of healthcare workers.

Moral injury in COVID-19 may be related to, but is distinct from: 1) burnout, 2) adjustment disorders, 3) depression, 4) traumatic stress/PTSD, 5) moral injury in the military, and 6) moral distress. Moral injury may be a contributing factor to burnout, adjustment disorders, or depression, but they are not equivalent. The diagnosis of PTSD requires a qualifying exposure to a traumatic stressor, whereas experiencing a moral injury does not. Moral injury in the military has been addressed in a different population and particularly after deployment, and its lessons may not be generalizable to moral injury during COVID-19, which we are seeing acutely among healthcare workers. Finally, moral distress may be a precursor to moral injury, but the terms are not interchangeable. Previous literature [4] has noted that moral distress signals a need for systemic change because it is generated by systemic issues. Thus, moral distress can serve as a guide for healthcare improvement, and rapid systemic interventions to address moral distress may help to prevent and mitigate the impact of moral injury.

While not a mental disorder itself, moral injury undermines core capacities for well-being, including a sense of ongoing value-laden actions, competence to face and meet challenges, and feelings of belonging and meaning. Moral injury is associated with strong feelings of shame and guilt and with intense self-condemnation and a shattered core sense of self [5]. Clinical observations suggest that uncertainty in decision-making may increase the likelihood or intensity of moral injury.

In the context of a public health disaster such as the COVID-19 pandemic, acknowledgement of the need to transition from ordinary standards of care to crisis standards of care [6] can be both necessary and helpful to 1) provide a framework upon which to make difficult and ethically fraught decisions and 2) alleviate some of moral distress and indeed moral injury that may otherwise be experienced in the absence of such guidance. The pandemic forces us to confront challenging questions for which there are no clear answers, and to make "lose-lose" choices in which no one involved ends up feeling satisfied or even comfortable.

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That said, there is a significant role organizations and systems can play in mitigating the impact of moral injury on healthcare workers. As such, **in this document, we highlight the systemic contributors to moral injury during COVID-19 and propose systemic solutions.**

Circumstances that may lead to moral injury include but are not limited to the following:

1. Rationing of scarce healthcare resources (e.g., ventilators, PPE, and hospital/ICU beds).
2. Difficult triage decisions based on a patient's likelihood to benefit from or survive certain interventions (e.g., deciding which patient can access the last ventilator), especially when such decisions must be made rapidly and without a sound evidence base.
3. Healthcare workers' fears of infection and infecting their families that may influence their decision-making about the type, level, or rapidity of care provision in high-risk, super-spreading events.
4. Administrative and policy decisions that represent an organization's best efforts to respond to a disaster yet confront healthcare workers with impossible choices between suboptimal care for individual patients or families versus community protection and wellbeing (e.g., limitations on visitor access to patients with COVID-19).
5. Being barred from work (e.g., due to mild COVID-19 symptoms or after recovery from COVID-19) when colleagues and patients desperately need help.
6. Being unavailable to care for seriously ill patients who do not have COVID-19 and who need attention.

Addressing moral injury as experienced by healthcare workers in the context of an unprecedented crisis such as COVID-19 is essential to the well-being of our healthcare personnel. This might be addressed in a 3-tiered approach: 1) preventative interventions in the moral injury-prone workplace; 2) acknowledgment of and support for healthcare teams who are at risk for moral injury; and 3) ongoing efforts to identify and address moral injury in healthcare management and policy decision-making.

Tier 1 – Initial steps to reduce workplace risk for moral injury might include:

1. <u>Starting a conversation about moral injury.</u> Problems that remain unnamed cannot be addressed. The first step to mitigating the moral injury crisis in healthcare is to raise awareness that it exists—in everyday conversations between healthcare professionals, at organizational town halls, etc. The goal is to allow staff time to voice and consider the dilemmas we all face as we shift from ordinary to crisis standards of care, and to identify both individual and systemic ways of promoting resilience in this context.
2. <u>Educating healthcare workers about the potential risk for moral injury</u> arising from the many challenging situations associated with COVID-19 and the choices they must make in the course of providing care during this pandemic.
3. <u>Providing support for difficult decisions.</u> This may include ensuring that all decisions are optimally supported by supervising personnel and possibly creating methods by which morally

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challenging decisions might be made by more than one person. For example, healthcare systems should consider having decision-making processes in place for allocation of limited resources in contingency and crisis care scenarios; this would decrease the burden on individual healthcare workers. Crisis standards of care documents commonly address ways to share responsibility and pool information and expertise when making challenging decisions.

4. Assigning healthcare workers to consistent care teams (e.g., working the same shifts and having the same days off) in order to create a sense of unit cohesion and build a foundation of peer support based on shared experiences. This can be difficult to do when staff fall sick and/or are in short supply, but it is a worthy effort.

Tier 2 – Interventions during and after the exposure period might include:

1. Integrating discussions of decision-making dilemmas and moral injury into pre-existing educational group settings, such as grand rounds and team rounds, to decrease feelings of aloneness, encourage open discussion, and foster a supportive workplace culture.
2. Identifying individual as well as professional support systems that can brainstorm ways to ameliorate the negative impact of moral injury and making these support systems widely available and accessible for healthcare workers.
3. Scheduling regular virtual group meetings for healthcare workers to "check in" with each other as well as receive education and support, which include raising the topic of "moral injury" as appropriate.
4. Identifying resources to address the spiritual dimensions of moral injury (e.g. chaplaincy resources, expert guidance from faith leaders in the community).
5. Whenever possible, explicitly giving staff permission to take time off to recover from the psychological stress of working in a crisis setting. This time off would ideally be supported as paid leave, and employers should not discriminate between "mental health" sick days and sick days for other health reasons.
6. Ensuring prompt and easy access to ethics consultation. A public health disaster presents novel challenges that should be met with additional ethics support. In situations when it seems that any action may violate the core ethical principles of the healing professions, guidance from medical ethicists should be rapidly made available to healthcare team leaders and members. Continuous support and consultation should also be provided.
7. Providing access to palliative care consultation for patients who are in critical condition or dying, as palliative care teams are well-equipped in these cases to provide an additional layer of support in collaboration with staff, patients, and family. Palliative care resources should be expanded in public health disasters, which are defined in part by excess mortality.

Tier 3 – Measures to address the systems issues that lead to and exacerbate moral injury might include:

1. Empowering and encouraging healthcare workers to speak freely about the stressors they face and to advocate for their own health as well as that of their patients (e.g., an anonymous hotline to let healthcare workers voice their concerns without fear of reprisal). Leaders must be

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prepared to respond transparently and proactively to feedback. Front line workers should be encouraged to propose creative solutions to clinical and ethical challenges during the disaster.

2. Establishing and/or supporting an empowered Chief Wellness Officer or a healthcare worker well-being program, one of whose core directives should be to address moral injury in healthcare.
3. Ensuring that messaging and actions from leadership consistently reflect an understanding of moral injury and a genuine concern for the well-being of healthcare workers. Contradictory, inconsistent, or punitive messages and decisions undermine the morale of healthcare workers and may increase the risk of moral injury. In contrast, helpful messaging acknowledges that 1) hard choices are part of public health disasters and 2) careful thought and shared decision-making helps give providers a realistic understanding of options and impact.

Although, ideally, systems and situations would be designed in such a way that moral injury never occurs, this is not realistic. Some degree of moral distress is an inevitable consequence of mass-casualty disasters; to that extent, changes in policies and procedures cannot fully ameliorate the impact of witnessing excess human suffering as well as being forced to make decisions that pit irreconcilable values against each other. However, to the extent to which moral injury originates from, or is exacerbated by, systems-based problems, systems-based solutions will go a long way towards mitigating the impact of moral injury among healthcare workers. Such systems-based changes may include broad changes to both the culture of medicine and the way health care is practiced and managed in the modern era. These changes *should* be made in response to the current crisis. Furthermore, resources should be allocated to ensure that the changes withstand the test of time. This will require ongoing time, effort, and dedication on the part of individuals as well as organizations.

In the face of the current pandemic, which shows little hope of remitting over the short term, it is imperative—from a both a moral and a public health perspective—that leaders of healthcare organizations urgently address the reality of moral injury in their own healthcare systems. Further, every effort should be made to identify and create solutions which will allow healthcare workers to continue practicing medicine always guided by the core ethical principles to “first do no harm” and to “relieve pain and suffering.”

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REFERENCES

1. "What Is Moral Injury?" https://fixmoralinjury.org/what-is-moral-injury/. Accessed May 28, 2020.
2. Jameton A. Nursing practice: the ethical issues. Englewood Cliffs, NJ: Prentice Hall, 1984.
3. Rushton CH, Schoonover-Shoffner K, Kennedy SM (2017). Executive Summary: Transforming Moral Distress into Moral Resilience in Nursing. AJN: American Journal of Nursing, 117(2), 52-56.
4. Jameton A. What Moral Distress in Nursing History Could Suggest about the Future of Health Care. AMA Journal of Medical Ethics. Jun 2017. Available at: https://journalofethics.ama-assn.org/article/what-moral-distress-nursing-history-could-suggest-about-future-health-care/2017-06.
5. Smith-MacDonald LA, Morin JS, Brémault-Phillips S. Spiritual Dimensions of Moral Injury: Contributions of Mental Health Chaplains in the Canadian Armed Forces. Front Psychiatry. 2018;9:592. 2018 Nov 14. doi:10.3389/fpsyt.2018.00592.
6. The National Academies of Sciences, Engineering, and Medicine. "Rapid Expert Consultation on Crisis Standards of Care for the COVID-19 Pandemic." 2020 Mar 28. Available at: https://www.nap.edu/read/25765/chapter/1.

ADDITIONAL RESOURCES

1. The National Academy of Medicine's Action Collaborative on Clinician Well-Being and Resilience offers a wealth of actionable resources to support the development of well-being-focused programs and policies across sectors. Available at: https://nam.edu/initiatives/clinician-resilience-and-well-being/.
2. The Veterans Administration's National Center for PTSD maintains resources on moral injury in healthcare workers, which includes information specifically related to the COVID-19 pandemic. This website also has a section on self-care strategies (e.g., mobile apps that front line healthcare workers who have limited time for self-care may find useful). Available at: https://www.ptsd.va.gov/professional/treat/cooccurring/moral_injury_hcw.asp.

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