

Recognizing Moral Distress in the COVID-19 Pandemic: Lessons From Global Disaster Response

Bethany-Rose Daubman, MD^{1*}, Lynn Black, MD, MPH², Annekathryn Goodman, MD, MPH³

¹Division of Palliative Care and Geriatrics, MGH Global Health, Massachusetts General Hospital, Boston, Massachusetts; ²Department of Medicine, MGH Global Health, Massachusetts General Hospital, Boston, Massachusetts; ³Department of Obstetrics and Gynecology, MGH Global Health, Massachusetts General Hospital, Boston, Massachusetts.

Many US health care systems experienced a surge of critically ill corona virus disease 2019 (COVID-19) patients while lacking adequate resources to provide optimal care. Nurses, doctors, and other providers in the United States were confronted with having to implement crisis standards of care for the first time. The refrain “these are unprecedented times” was repeated to colleagues and patients. The demands and shortages of supplies are unique in recent history. As a result, many frontline responders have wrestled with moral distress, the feelings of distress experienced when forced to act—because of institutional or resource constraints—in a manner contrary to their beliefs.¹ However, for those medical professionals whose work includes being deployed on global disaster response teams or providing health-care in chronically low-resourced settings, navigating limitations of medicines, equipment, and personnel is a daily reality. We offer a framework for recognizing one’s own moral distress and that of one’s colleagues based on our experiences in global disaster response that may be helpful for clinicians during the COVID-19 pandemic.

A FRAMEWORK FOR MORAL DISTRESS

The intense and debilitating feelings of unexpected loss and helplessness faced by clinicians who are making challenging choices about medical interventions can be better understood by applying a theoretical framework that has the following three main stages in the evolution and response to moral distress: indignation, resignation, and acclimation. This framework can provide guidance to individuals experiencing distress during the COVID-19 pandemic and may also be beneficial in contextualizing interactions when working in teams or with referring providers.

Indignation

When working in a disaster setting, an initial period of indignation is common. The clinician is shocked and horrified by the conditions encountered, the severity of suffering, and a lack of resources with which they are unaccustomed. As we bear wit-

ness to the many healthcare providers who have fallen ill and died, we fear for our own safety in choosing to care for patients sick with COVID: “I’m risking my life caring for patients on the front lines, and it’s unacceptable that I’m not even being provided with adequate PPE!” Patients and families are suffering in ways we had previously thought our health system was capable of addressing: “How can I be a compassionate clinician when my patients are forced to die alone?!” It feels surreal and unacceptable that so many patients can die so quickly despite our heroic interventions and that we have very little control over their fate. We are unaccustomed to caring for so many dying patients at once. For example, during the peak of the pandemic in New York City, patients were dying at four times the city’s normal death rate.² Indignation may be compounded in settings where providers are not even equipped to deal with the aftermath of deaths, such as piling bodies into makeshift morgues:² “I feel powerless to prevent my patients’ deaths and horrified that many are dying alone and scared, and now I can’t even guarantee that their bodies will be cared for after death!” Additionally, during this pandemic, many of us are now facing issues of resource allocation that we had never imagined dealing with. “I took an oath to care for and protect my patients. How could I possibly tell a patient we have no more ventilators to put them on? Who makes the decision of which patients deserve to live or die?” With the realization that COVID-19 has been disproportionately affecting racial and ethnic minorities, concerns for systemic discrimination within our healthcare system may rightly lead to a deep indignation.³

Resignation

After the initial indignation stage, resignation often follows. “I guess I can’t fix healthcare in this new setting, and I was foolish for even trying.” Clinicians go through the motions and continue to care for patients but feel disillusioned. Part of the ongoing stress involves the concern that they aren’t making a difference. Lack of viral testing may breed further resignation: Clinicians are on the front lines caring for patients that they are not even sure are positive for COVID-19, they have no way of accessing antibody testing for themselves to be able to gauge their own personal risks, and when there is not enough testing being done on a larger scale, there may be a sense that, by continuing to work on the front lines, they are sticking their finger in the dike, without actually having data to inform when it is safe to reopen states and ease restrictions. The suffering of patients and families may feel overwhelming and insurmount-

*Corresponding Author: Bethany-Rose Daubman, MD; Email: bdaubman@mgm.harvard.edu; Telephone: 617-724-8121; Twitter: @bethanyrose_d.

Received: May 15, 2020; Revised: June 23, 2020; Accepted: July 5, 2020

© 2020 Society of Hospital Medicine DOI 10.12788/jhm.3499

able. “I know I have to comply with my hospital’s visitor restriction policies, but it’s hard to see my patients suffering alone and know there’s nothing I can do to help them.”

Acclimation

Acclimation follows the indignation and resignation stages. Even amid disasters, a productive rhythm develops as teams coalesce and are galvanized by a shared sense of purpose. Clinicians make meaning out of their role in the crisis and in the care of the patients they can help, despite often deep and significant obstacles. “There’s a lot of suffering and a lot that I may not be able to fix, but some that I can.” Clinicians that have been deployed to unfamiliar roles may start to habituate and even enjoy having responsibilities and challenges that are different from those they typically face. Innovation during a pandemic may feel empowering. “I’m committed to making sure my dying patients and their families can say goodbye however possible. Although it’s not ideal, I’ve been using technology for virtual communication and advocating for families to visit in person when possible.”

RECOGNIZING THE STAGES OF MORAL DISTRESS

One’s path of moral distress through a disaster may not be linear; one does not necessarily progress through the stages of indignation, resignation, and acclimation in a certain order or at a certain pace. Additionally, the stages can recur throughout the disaster. Being able to recognize these stages may prove useful for the duration of this pandemic while waves of providers are redeployed in new settings and experience fresh indignation, whereas others who have been in the trenches for some time may be more likely experiencing resignation or, hopefully, acclimation. The trajectory and duration of this pandemic in the United States remains unclear. While hot spots such as Seattle, New York, and Boston may be moving past their peak phase and acclimating to a “new normal,” there remain concerns that surges may recur in the fall and winter, which will undoubtedly lead battle-weary clinicians to experience the stages of moral distress anew and potentially compounding their distress.

MANAGING MORAL DISTRESS

An added complexity in this pandemic is that we, as clinicians, are both the victims and the healers. From the literature on disaster mental health, we know that emotional suffering is universal in affected populations.^{4,5} Unlike many disaster scenarios in which teams leave the safety and security of well-established and well-resourced practices to deploy and care for disaster victims in new, austere environments, we are also part of that affected population in this pandemic. Each day or night, we return to homes that, too, are infiltrated by this pandemic. Our ability to move through the indignation, resignation, and acclimation stages may be hindered and blocked by our home responsibilities, stressors, and supports. Having to reconcile working in COVID-affected hospitals (particularly if caring for critically ill colleagues) only to return home to young or immu-

nocompromised family members at night may place us in a state of indignation with its continued risk of burnout for the duration of this pandemic. Naming and acknowledging these painful challenges may allow self-compassion, self-forgiveness, and acceptance.

Though the primary focus of this article is to provide a framework to assist with the recognition of moral distress, it is important to address next steps once one recognizes someone is experiencing moral distress in this pandemic. Even outside of a disaster scenario, many clinicians feel obligated to put our patients’ needs before our own, and this sentiment is only heightened in a disaster scenario. It may feel unthinkable to call out sick or request a leave or reassignment during the pandemic. However, we are reminded that “the duty to serve is not endless.”⁶ Recognizing one’s own limits and reaching out to supervisors and mental health support before reaching one’s own limit is essential when experiencing moral distress.^{7,8}

Cultivating resilience is also recognized as a tool for managing moral distress.^{6,9} For harried frontline clinicians, this may be as simple as taking a few minutes each night to journal three good things that occurred during the day.¹⁰ Mindfulness-based stress reduction has also been found to decrease perceptions of moral distress,⁹ and many mindfulness programs (such as Headspace®, a mindfulness and meditation app¹¹) currently offer free membership to frontline providers during the pandemic. Mindfulness may be a particularly useful tool to leverage when one is stuck in the resignation phase and experiencing moral residue, described as a buildup of unresolved conflicts within the clinician that may crescendo with unresolved or inadequately resolved moral distress.^{6,12} Lastly, the American Association of Critical Care Nurses Ethics Workgroup developed the 4 A’s to Rise Above Moral Distress, which provides a framework of 4 concrete steps: ask appropriate questions, affirm your distress and your commitment to take care of yourself, assess or identify sources of your distress, and act or take action.¹³

Providers may experience moral distress in times of disaster. In applying this framework, we can gain self-insight and compassion, understand the types of moral distress our colleagues may be experiencing, and explore concrete tools for managing moral distress. Just as we confront the suffering of our COVID-positive patients, so too may we benefit from sitting with and naming our own suffering and moral distress.

Disclosures: The authors have nothing to disclose.

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