Moral Distress and COVID-19: Worlds Collide

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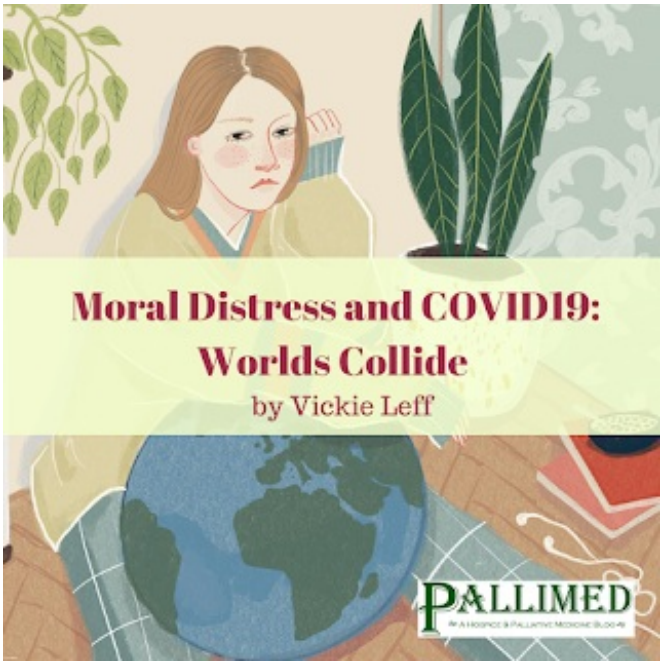

As a clinical social worker, I am often approached by my medical colleagues asking for support and a listening ear around difficult cases, understanding their own reactions, team dysfunction, and moral distress. In the middle of this COVID pandemic, Social Workers, Chaplains, Nurses, Physicians, Respiratory Therapists, Child Life Specialists, etc. are all likely experiencing an increase in moral distress. This is due to the necessary change of focus from "patient-centered" to "community -based" approach, and resource allocation issues such as PPE shortage, health inequities, visitation limitations.

A few years ago I wrote another article about Moral Distress. Things have changed since then, compounded by the pandemic. I would like to take a moment to focus on how we can manage these complicated, emotionally charged situations during this incredibly stressful time in which we are challenged about ability, time, strategies to deal with moral distress. Moral Distress challenges clinicians to speak out, work together, and tolerate ambivalence. We must embrace the discomfort in order to legitimize the occurrence and find solutions, especially during this pandemic, when the focus of providers can be easily pulled in many directions.

"You have to do everything to keep her breathing," the father of a 15 year old dying of a brain hemorrhage, said to me as the Palliative Care Social Worker. Hearing the panic and desperation in his voice while knowing she would not survive was distressing. Relaying the conversation to the bedside nurse and Resident amplified the distress, as they said what I was thinking: "There is no way she will survive, we have to take her off life support." Calming myself to be able to have a discussion about the ethics of the situation was challenging, but critical. I worried about whether advocating on behalf of the father would be interpreted as, "the social worker doesn't get it," and wondered if they would respect my opinion.

How can we help each other when faced with cases that cause us moral distress? What can our institutions do in response? How can we work as a team to deal with these issues when they arise?

We can remind ourselves that "When addressing moral distress, the aim is not to eradicate the phenomenon but rather to mitigate its negative effects, including preventing caregivers from feeling unable to provide compassionate patient-centered care, feeling withdrawn, unable to return to work or continue in their profession."

Evidence tells us there are many strategies that can help on the individual, team, and organizational level. It will take deliberate intention, institutional support, and commitment.

Individual Strategies:

Moral distress is not a failing of anyone's ability to cope with difficult cases, issues, or emotions. By definition, moral distress cannot be "fixed" with an individual effort. Collective action is needed. However, it is important to recognize when we are feeling the personal effects of distress: feelings of anger, frustration, powerlessness, isolation. Those red flags tell us we need to pay attention to what is happening in order to define interventions. Personal strategies raise a paradox. Moral distress is rooted in not being able to effect a change due to organizational barriers and policies that we cannot immediately change. This feeling of powerlessness can be personally immobilizing.

Key suggestions:
- Identify the moral distress issue (i.e. what is it about this situation that is bothering me so much? Is there an ethical question?)

- If you bring the issue to a group/team level, it can mitigate personal frustration and lead to solutions to help the pt/family and individuals. For instance, experiencing a lack of sufficient PPE can clearly create moral distress for individuals. Raising the issue with other colleagues, then bringing it to management collectively, can attend to the individual frustration. The team can begin to have discussions on a level that can affect possible change.

- Often staff will come to the clinical social worker with their case distress, needing support. We can help by differentiating between psychological stress, compassion fatigue, and moral distress – as the interventions vary. [See Sidebar]

- Accept that distress is a normal reaction to something that feels "out of sync," i.e. out of the ordinary for you. It is critical to not internalize or blame yourself. It isn't helpful to

pathologize your reactions.

- Ask your colleagues to take time and talk about concerns, opinions in order to find avenues for safe, effective solutions. There may be no answer to a morally distressing situation.

- Identify the resources that may be available in/by your workplace, such as your EAP and - those described below.

Institutional/Team Strategies: Moral Distress demands a collective response, between the active team and/or institution.

- Debriefings. These are scheduled or "on the fly" opportunities for colleagues from all disciplines to discuss a situation. Allowing for differing opinions and possible solutions will help. This process attends to the social isolation that accompanies moral distress.

- It allows for a safe space for those involved to voice their concerns.

- It works to create psychological safety

- It can serve to democratize medical culture.

- **Ethics Rounds**. Many situations evoking moral distress involve ethical issues. Scheduling routine ethics rounds while inviting interprofessional participation can help all of us understand complex issues, voice opinions, and create an atmosphere of safe discussion. If these kind of discussions aren't happening, and you are not empowered to schedule them yourself, then request them.

- **Deliberate Interprofessional meetings**. There is a lot of information about how to improve team functioning, which would of course add to the capability of teams to support members as they may experience moral distress. While there is evidence that physicians experience moral distress less than nurses and other bedside providers,4 involving all team

members works to create a more capable, healthy, team. Moral distress often gets played out between physician and nurses. We must be able to have these difficult conversations in a safe way to ensure all providers have a voice.

And Finally… stop using "Hero" language. If we exalt health care providers (ourselves) to this fantasy status, we deprive them (us) of the normalcy of stress-filled reactions, asking for assistance, de-legitimizing their (our) feelings of powerlessness. As we talk about disenfranchised grief, I believe using this language, during this time, disenfranchises moral distress.

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Editor's note: The CDC has excellent resources for managing anxiety during COVID-19 here.

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