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MORAL DISTRESS IN HEALTHCARE PROFESSIONALS

Joan Bertran Muñoz, Francisco José Cambra Lasaosa,
Joan Carrera i Carrera, Montse Esquerda Aresté,
Marc Illa Mestre, David Lorenzo Izquierdo & Helena Roig Carrera

Abstract: The COVID-19 pandemic has generated, because of its disruptive, exceptional and sudden character, great changes in the care, planning and organization of healthcare systems, bringing about scenarios for which nobody was prepared, especially healthcare professionals. In these scenarios, moral distress, affecting mainly healthcare professionals, makes its appearance. The goal of this article is to analyse and describe the roots of moral distress, the areas in which it has appeared during the pandemic and, lastly, to offer a proposal to fight against it.

Keywords: *Moral distress, Healthcare, COVID-19, Pandemic, Resilience*

The COVID-19 pandemic has brought a radical change to our societies, at a global scale. But this impact, especially in healthcare, has been so sudden that in a few days, not even weeks, a structural reorganization of how we practice medical care has been required.

One of the most important effects of this impact is the "moral distress" in healthcare professionals. The aim of this paper is to analyse the concept "moral distress" and its causes in the context of this pandemic. To this end, the authors rely on empirical data (both qualitative and quantitative),

taken from personal experience and scientific literature. The approach to the concept and these data are based on a philosophical methodology.

Most healthcare professionals have been trained and have practised in a particular assistance framework, in an environment with high availability of both diagnostic and therapeutic means and an adequate technical training, but with little training on distributing scarce resources, handling social problems or bad news communication.

This quick and abrupt change in the practice framework of the medical profession, without time to get prepared for it, and with the need to take on enormous challenges in patient care, can entail a high emotional and ethical cost for the healthcare professionals.

The risk in mental health due to physical (longer work shifts, high volume of case-load, difficulties in maintaining control over this load), cognitive (new approaches, infrequent presentations of the disease, lack of efficacy of treatments) or emotional (limit situations) overload has been broadly described (Shanafelt *et al.*, 2020). But it is important to recognize that there are also situations that can lead to high moral distress or even moral residue (moral injury).

The concept "moral distress" can be described as moral "anguish" or moral suffering. Although it already existed as an ethical and anthropological reality, its definition originally comes from the field of nursing. It was first defined by A. Jameton in 1984 in his Ethics manual *Nursing practice: The ethical issues*. According to Jameton (1984: 6), moral distress consists of the suffering of a professional caused by not being able to fulfil an action which s/he considers ethically correct due to institutional limitations or restrictions.

In the 90s, the concept was the object of profound debates (and it still is). Since then, the concept has expanded its meaning, so that the scientific community has considered that moral distress can also occur in other healthcare professionals, not just nurses (Corley, 2002). Some authors claim that, in addition to the stated definition – which they consider narrow or restricted – a broader definition could be given, such as: "a psychological response to hard/challenging ethical situations" (Fourie, 2015 and 2017). We consider the narrow definition to be more useful and representative of the distress phenomenon, as it better shows its essence and cause: the fact that a good action cannot be performed by the individual. This fact is not expressed in the broader definition.

It must be pointed out that, *sensu stricto*, moral distress does not refer to cases of moral dilemma or uncertainty. In this situation, the in-

dividual is not faced to an unavoidable decision in which s/he is unsure about which option is ethically correct (moral uncertainty), nor with a decision between two goods, values or principles in conflict (moral dilemma). In a situation of moral distress, the individual (the nurse, the doctor) knows or thinks that s/he knows which moral option is the best one, but s/he cannot carry it out due to external, structural or institutional limitations.

These limitations may be caused by bureaucratic, administrative, economic or human factors, such as obedience to orders that are considered unfair (in the case of nurses, students or residents). The management of scarce resources could also be a source of moral distress, for instance, when a doctor cannot use a respirator for a patient who needs it because the distribution criteria of the medical team or the hospital do not allow it. Other examples could be when a nurse is forced to participate in the application of a treatment that s/he considers to be futile or disproportionate, or when there is family or social pressure to carry out a treatment that is not indicated.

Other sources of moral distress are difficulties in communication with the patient, his/her family or the team, which can generate situations of limited comprehension of the situation, or positions in the diagnostic process, prognosis or treatment that are not clearly controversial but which question the proposals of a given professional, without openly posing an ethical dilemma.

The consequence of moral distress is "moral residue" (also called "moral injury"). This is the psychological impact (or "psychological trace", we could say) that occurs in the individual when s/he transgresses his/her own ethical or moral code, either by action or omission (Epstein and Delgado, 2010). This concept comes from the military sphere (Greenberget *et al.*, 2020; Litz *et al.*, 2009), more related to traumatic experiences, and is related to mental disorders such as post-traumatic stress syndrome or depression. Associated negative feelings are closely tied to guilt and shame.

Moral distress is a problem related to conscience, with its roots in the relationship between the conscience of an individual and his/her social and professional environment. The conscience, generically considered, is the faculty or the act of judging the morality of a particular action (Rodríguez, 1998: 288). When judging or evaluating an action, the conscience can be in a situation of rectitude/truth or of error, depending on the truth of the principles and information from which the individual starts. It can

also be in a situation of certainty or uncertainty (insecurity), depending on the degree of certainty about the rightness/wrongness of a particular action. Moral distress arises from a situation in which the individual conscience is upright/true (knows the principles and the adequate information) and certain (experiences security in the moral evaluation of the action).

Moral distress carries a high emotional burden which can come with anxiety, helplessness, wrath and frustration, and even physical symptomatology. It is also related to worse work quality, higher degree of professional burnout or even job abandonment.

Moral distress appears when the conscience of a healthcare professional indicates him that an action is good and should be performed but, due to external limitations, s/he cannot make it and s/he ends up taking another action, which may be less beneficial for the patient or even maleficent (in a higher or lesser degree).

What should be done in these cases? How should the professional act? There is no answer capable of covering the entire casuistry, but the following criteria about the difference between preventing acting for good and forcing one to act wrongly may be useful. Spaemann states in his book *Ethics: Fundamental Questions* (2007: 104) that society (or a group or a person with authority) can, for various and proportionate reasons, prevent an individual from acting according to what s/he considers to be right; that is, the individual can be prevented from following his/her conscience, avoiding his/her acting, but s/he cannot be asked to perform an action that goes against his/her conscience, an action that his/her conscience considers malefic. Since maleficence admits degrees, the situation can then reach a moment in which the degree of maleficence of an action is such, according to the conscience of an individual, that s/he chooses to refuse to perform that action, that is, s/he opts for the conscientious objection (which, unlike disobedience, consists strictly in not acting).

MORAL DISTRESS IN HEALTHCARE PROFESSIONALS DURING THE COVID-19 PANDEMIC

During the COVID-19 pandemic, the large number of cases appearing in a short period of time and their severity, extreme in some cases, has greatly conditioned the response of health systems and their professionals.

In the clinical settings, most of these changes, without prior preparation of healthcare professionals, can be a source of emotional and ethical-moral distress.

Therefore, the medical practise framework has presented an important change in a very short period: from a "postmodern" western medicine, with abundant means, to a "medicine of catastrophe and survival."

It is important to keep in mind that this change has occurred without preparing the professionals and without a careful planning, so it has required an "along the way" adjustment of the care provided, with all the risks that this entails.

Various situations have posed a great challenge to professionals who have had to face the pandemic and have undoubtedly suffered a significant burden of moral distress. Some of the clearly identified areas which have incurred into moral distress are:

– **Risk of infection:** The fast epidemic expansion of the virus and the lack of defensive means for professionals (the so-called Personal Protection Equipment - PPE) meant that healthcare professionals had to endure a higher risk of infection.
  This risk generated a logical fear that in most cases was overcame by the sacrifice and moral high ground of the professionals who managed to put the patient care above other considerations.
  The fear of contagion and its consequences were not exclusive on a personal level, but the possibility also appeared of transmitting the infection to their families and loved ones, which led many professionals to prefer to isolate themselves while the epidemic situation continued and reside in their hospitals or other establishments.
  This self-isolation of healthcare professionals from their families was an added difficulty to their emotional overload, since they lost part of their support system, i.e. family and social life at a time when precisely these networks were most required.
– **Lack of knowledge about the disease:** The care provided to patients has been imbued, from the start, with a significant degree of uncertainty, since COVID-19 is a new and unknown disease, of which the overall time of experience of all health professionals is only a few months, in many cases only a few weeks. Its way of contagion, clinical evolution, complications, response to different treatments or vital support were all unknown, and practically diagnostic and therapeutic protocols have been carried out in real time, and they

have been constantly changing in the light of the new findings, that is day by day. There has been an exercise, never before carried out to this date, of collaboration among professionals from various institutions and from all the affected countries, who have pooled their knowledge to face the situation.

Undoubtedly, work has been carried out in a context of high uncertainty that has inevitably generated significant moral distress among professionals, with contradictory information regarding specific therapeutic approaches (use of corticosteroids, anticoagulation) or multiple publications (some in pre-print format) about the effectiveness of some specific treatments (chloroquine, azithromycin, remdesivir).

The credibility of the new information on the disease has been a source of concern, in order to identify and differentiate scientifically correct works from incomplete ones, pre-prints or even fake news.

It is estimated that from January to mid-May 2020, 20,000 articles have been published in reference scientific journals (Brainard, 2020), and practically all scientific journals have published openly.

This tsunami of publications has hindered the direct work of professionals, often generating confusion and associated doubts about the quality of publications, retractions included (Mahase, 2020). Speed has not helped obtain quality publications, thus increasing uncertainty. It is also necessary to point out that the lack of professionals has made the collaboration of all those available unavoidable, forcing some of them to take care of COVID-19 patients even when this is far away from their area of expertise. The lack of specialization is an added challenge, as many professionals may experience feelings of guilt as they do not consider themselves sufficiently prepared.

– **Lack of therapeutic means. Prioritization:** There has been a clear lack of means to care for affected patients, fundamentally for the most severe cases, tributary of life support treatments.

The shortage of means has forced the use of utilitarian criteria, assigning the scarce resources to those patients with the greatest chance of cure. The prioritization of patients can pose an emotional and ethical overload on the professionals, that is difficult to bear.

Traditionally, the principle of justice has been very difficult to apply in the field of direct healthcare, although justice is part of daily routine clinical decision-making. Parker and Mirzaali (2020) say:

Deciding which patient should take the last remaining Intensive Care Unit bed is a decision for doctors. Rationing and making tough decisions are not unfamiliar; however, doctors' approach to moral decision-making tends to be deontological in nature. Medicine takes place within discrete interactions between individuals. By this very fact of the doctor-patient relationship, doctors often set aside questions of the greater good emphasising patient-centeredness, the needs of the person in front of them and putting that patient's interests first. Being the predominant way in which doctors interact with their patients, not to mention the way that the General Medical Council admonishes doctors to act, these values are placed at the core of what it means to be a good doctor. Indeed, these moral values are the heart of practicing medicine and a significant part of a doctor's moral identity. This is principally a different way of thinking about ethics and the doctor-patient relationship, rather than utilitarian ways of thinking.

Patient prioritization has been a difficult issue. Professionals dedicated to a specific service are used to deciding which patient can benefit more and better from their specialized service. There are assessment scales and decision algorithms that facilitate the thorny task, which is usually shared with the healthcare team. The enormous clinical pressure has meant that less time has been available for making these decisions. Besides, shift work has changed the "usual team" with which each professional used to make decisions, with the incorporation of specialists from other disciplines, who are not specifically used to act in an environment of superspecialization. All of that has increased the possibility of moral distress for all the involved professionals. The response to this situation, when possible, has been given by the Clinical Ethics Committees.

In this sense, we would like to point out the importance of documents and guides with agreed criteria to facilitate decision making in prioritizing patients, including, for example, the document "Ethical recommendations for making difficult decisions in Intensive Care Units in the exceptional situation of crisis due to the COVID-19 pandemic: rapid review and experts consensus." This document was agreed by 18 Spanish scientific societies. It should be noted, in addition to the broad participation and representativeness, that this document was published in mid-March, when there was still no other guide or protocol available.

– **End of life, death in loneliness:** The pre-COVID society had a complicated and ambivalent relationship with the end of life,

marked by the taboo of death. Therefore, during the pandemic, death has also been concealed, to the extent that there is still controversy about the number of deceased and the place where their death has occurred.

Many deaths have occurred in solitude, either at home, in hospitals or in nursing homes. The death situation in nursing homes or in hospitals, whether acute or intermediate care, without the company of their loved ones, has been a dramatic experience for many professionals who have had to care for patients in these circumstances. In these cases, professionals have accompanied these patients, holding hands and being close to them until the end. Thanks to technology, they have also facilitated remote communication with family members, either by videoconference or by bringing the phone closer to the patient's ear so that they could hear the voice of their closest family members.

These professionals have been shocked by the need to accompany dying patients because the relatives have not dared to come, they have lacked information, or it was simply prohibited by the current regulations at the centre. Other professionals have experienced the moral crisis of the family member who has come to accompany the dying person, and the fear of contracting the infection and transmitting it to those who are at home has made him give up.

The impossibility of seeing the body has also entailed distress for the family. Some centres have let a farewell at a distance by visualizing the moment of death, depending on its protocols. In general, there have been many restrictions at the time of transportation of the body from the hospital to the mortuary.

The limitation of therapeutic effort has also influenced the care of patients affected by COVID-19, since it has been necessary to set the level of intervention in unknown patients and with a difficulty to access clinical history. Also, there have been difficulties in communication with the patients due to their clinical situation and with the family due to communication barriers, and lack of time, due to the clinical pressure, to thoroughly review the shared medical history and other documents. These problems generate uncertainty when making decisions, due to the concern of evaluating the patient's prognosis based on the available data, without assuring that we are missing any relevant data to understand the patient's situation.

An added stressor is the typical very fast fatal course in some patients. They are patients who begin with a certain respiratory distress and, in a matter of minutes, practically enter in agony. Regarding these patients, health professionals experienced a feeling of helplessness due to the difficulties of predicting their evolution and not being able to act to change the outcome.

But the most important problem has been information to the patients and their family. It has been difficult to inform some patients because they were already at a very advanced stage or because there was no longer any possibility of communication. Difficulties in communication with the family have come from remote contact and the limitations that this entails. Communication by phone or by other technologies lack closeness and, above all, entail a difficulty of perceiving the impact that the information has on recipient.

On many occasions it has become difficult to stagger and adapt the information. In a first and sometimes unique contact it has been necessary to establish communication, assess the degree of knowledge of the situation by the family member and graduate relevant information about the situation, foreseeable evolution, unfortunate prognosis, and on some occasions, also the fatal outcome. All this in a single session and remotely.

– **Attention to the elderly in residential institutions:** Care in old people's homes environment has by itself a series of differential characteristics that have become much more prominent during the COVID-19 pandemic. Healthcare facilities in nursing homes are usually limited and need support from other healthcare levels. During the pandemic, other health services that normally provide support and assume health problems have also been overwhelmed.

Therefore, new problems have arisen and already existing structural problems have worsened. Indirect and organizational support and consultation with professionals from the nursing homes have also been compromised.

For this reason, the professionals of the nursing homes have been overwhelmed by the same constraints as other professionals but with the addition of the lack of updated knowledge on this topic and the difficulty of access to updating, limited resources such as personal protective equipment (PPE) or diagnostic tests, lack of treatments such as oxygen, the impossibility of referral in many cases, and having to assume end-of-life situations with little prepara-

tion, which generally are referred to other specialized centres or to palliative care external support.

These are some of the extraordinary sources of moral distress in the old people's homes context that must also be considered at the end of life. There has been a lack of time and possibility to coordinate and collaborate from a distance with a team of experts in palliative care. It has also been difficult, partly for this same reason, to obtain some specific tools, such as subcutaneous peristaltic or mechanical infusers, which allow subcutaneous medication to be administered every 24 hours, but which are only available by palliative teams, and even so by not all of them.

In this particular pandemic, particularly in the first month, there was a break in stocks of two drugs that are widely used for sedation in palliative care: midazolam and haloperidol. The problem was that these drugs are also used for Intensive Care Units sedation, with high demand these days. The manufacturing of the laboratories was directed mainly to the hospitals and there was a real shortage in the pharmacies that supply the nursing homes.

The stressful situation, also on a moral level, was caused by the fact that some professionals who made the difficult decision to sedate their patient did not find advice to do so, did not have the necessary clinical material and did not have the drugs that usually appear in the sedation guidelines.

– **Lack of care of other patients:** The attention devoted to patients with COVID-19 has caused that patients suffering from other diseases have clearly received suboptimal care; diagnostic tests and surgical interventions were postponed; evolutionary controls, non-existent; transplant programs, frozen. These events have also generated significant moral distress in those professionals who had to care for them and who have experienced the helplessness of not being able to do the right thing. The massive and unplanned deployment of telemedicine as an emergency solution has also been an added challenge.

MANAGING MORAL DISTRESS AND LOOKING TO THE FUTURE

Just as dealing with physical or emotional overload will require specific strategies, it would be important to recognize and properly manage

the moral distress generated by the pandemic. Ethics, both in its reflexive and in its deliberative aspect, can contribute strategies that facilitate the management of moral distress.

Moral distress requires, in the first place, to be recognized as such, that is, people must be able to put words to the lived situation. Narrative is essential for the healthcare professional in the sense that, although a same situation has been gone through, no two experiences are the same. Each person, according to his life experience, will interpret differently and may present a higher or lower degree of moral anguish.

Besides recognizing it, ethics can help identify the values underlying the decisions made. In the case of the pandemic, the main sources of moral distress would be related to structural causes with scarce resources or means. In this case, it is crucial to be able to clarify which values have been injured in the decisions taken and situations lived, also identifying any possible alternatives to these situations.

Spronck *et al.* (2020), quoting Martha Nussbaum, speak about how it would be important to distinguish between situations that can be solved through a cost-benefit analysis and those that involve deciding what to give up. This last one would refer to the "tragic question" and would include those moral choices that people are forced to make.

They refer to it as "tragic" because the available options are accompanied by inevitable moral objections. In this sense, we should be aware that, in a situation like the pandemic, there were no ideal or even acceptable options available, and that the one chosen whas the one that at the specific moment and situation could seem the least bad option.

It is important not only to know how to identify the ethical conflicts and the underlying values, but also the emotional response they generate, which will also be highly individualized. Emotional validation is an understanding and acceptance of one's emotional experience, and it is essential to develop coping strategies appropriate to emotional distress.

Narratives play a key role in emotional expression and validation. Putting harm into words and narratives could help to uncover and elaborate the pain involved in the moral dilemma (Spronck *et al.*, 2020). Thorne *et al.* (2018) describe

> how this story telling seems to play an important role in the sense-making process, particularly around working out culpability when the professionals were left feeling morally compromised because, in their own opinion, they had not fully enacted their duty in relation to beneficence and nonmaleficence. In

the context of narrating a clinical scenario, the study participant inherently engages the interviewer in appreciating why a particular clinical case would have been so distressing from their perspective, often reliving the emotionality of the situation and finding a philosophical context within which to place it.

And beyond validation it will be necessary to foster coping strategies for all that has been experienced, which will help generate resilience. Rosenberg (2020) commented on the need to "cultivate" resilience as an active process that requires a deliberate effort, not as a trait or characteristic that some people possess and others do not. Resilience would require, therefore, to be able to activate internal or external resources which this author identifies as resilient strategies, whether individual, communitary or existential. At the same time, the following reflection can be made: on an ethical level, and given the exceptional circumstance caused by the pandemic, it has been seen that a strictly procedural, dialogical and deontological ethics is not enough to provide quality healthcare. Thus, from Rosenberg's proposal, the following contribution can be generated: the recovery and vindication of an ethics of virtue (which is always acquired) can be a complement of the prevailing ethics in the world of clinical ethics. Where the pause and the weighing of procedural ethics are difficult to practice, know-how and professional and personal virtues can heal these difficulties.

Recognizing distress, naming it, identifying ethical conflicts and underlying values, deliberating on them, helping emotional validation and helping to cultivate resilience, are some of the key points where ethics can help to respond to moral distress.

Rosenberg (2020) said that:

When (people) get far enough past an adversity to look back with perspective, they appraise it. They consider its effects on their lives and identities, and (sometimes only with prompting) they reflect on the skills they leveraged or developed, the actions they took, the lessons they learned, and the reasons they kept (or keep) going (p.817).

If health professionals can overcome the distress that the pandemic has caused, they will be able to assess it, to consider how it has affected both their personal and professional lives, what skills they have gained and what they have learned from it.

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Joan Bertran Muñoz
Institut Borja de Bioètica, Universitat Ramon Llull
Hospital Sant Rafael Germanes Hospitalàries, Barcelona
jbertran@ibb.url.edu

Francisco José Cambra Lasaosa
Institut Borja de Bioètica, Universitat Ramon Llull
Hospital Sant Joan de Déu, Esplugues de Llobregat
Fjcambra@sjdhospitalbarcelona

Joan Carrera i Carrera
Institut Borja de Bioètica, Universitat Ramon Llull
joan.carrera@esade.edu

Montse Esquerda Aresté
Institut Borja de Bioètica, Universitat Ramon Llull
Sant Joan de Déu, Terres de Lleida
mesquerda@ibb.url.edu

Marc Illa Mestre
Institut Borja de Bioètica, Universitat Ramon Llull
millam@ibb.url.edu

David Lorenzo Izquierdo
Institut Borja de Bioètica, Universitat Ramon Llull
Campus Docent Sant Joan de Déu, Universitat de Barcelona
dlorenzo@santjoandedeu.edu.es

Helena Roig Carrera
Institut Borja de Bioètica, Universitat Ramon Llull
hroig@ibb.url.edu