

Moral Stress Amongst
Healthcare Workers
During COVID-19:

A Guide to Moral Injury



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Introduction

This guide to moral injury during COVID-19 has been developed as a practical resource for healthcare workers and organisations to better understand the range of moral emotions arising from the COVID-19 pandemic and to develop organisational and individual strategies to mitigate risks of lasting harm.

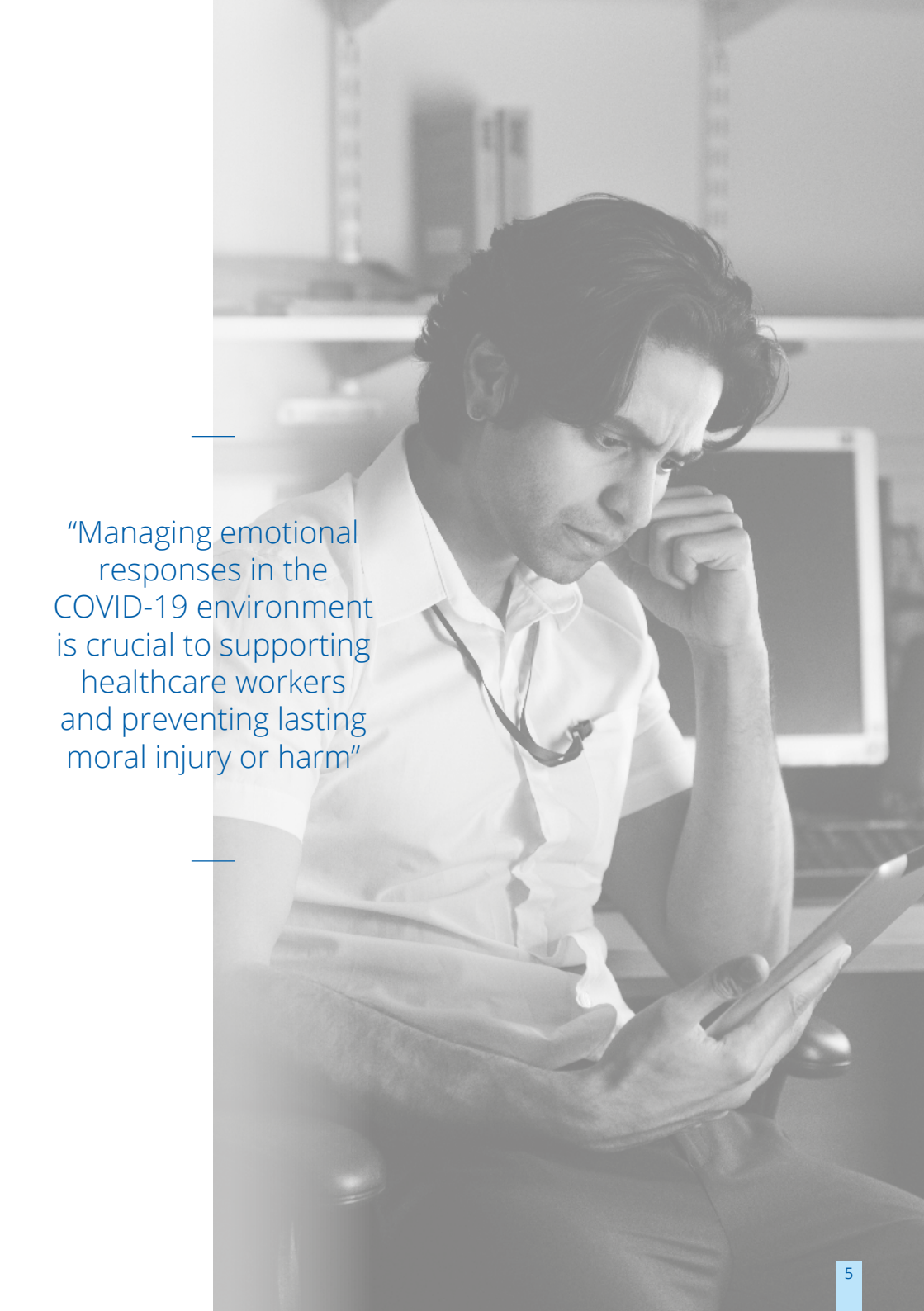
We encompass a broad definition of healthcare workers that includes medical, nursing and allied health staff, chaplains, peer supporters, and administrative staff with direct patient contact.

Since the onset of the COVID-19 pandemic, there has been a flood of articles, commentary and media published in regards to the mental health effects it has had on healthcare workers.^{1,2} In addition to basic emotional reactions such as fear, we've seen reports of a range of responses that involve moral emotions such as shame, guilt and demoralisation during both the COVID-19 pandemic and previous mass disease outbreaks.³ Moral emotions are those that are essentially social in nature and are linked to the interests of society or other people rather than just our own survival.⁴ They arise when our values or sense of right and wrong are challenged, and as such they are considered guardians of the moral order of society.⁵ When we feel that we've done something wrong ourselves, we may feel guilt, shame or embarrassment. When we feel that someone else has done something wrong, this gives rise

to moral emotions like contempt, anger or disgust. Moral emotions can also be positively valenced, and include emotions like pride, gratitude and compassion.⁴ When we seek to understand the emotional responses to COVID-19, and consider what we can do to support people, we need to have the full range of moral emotions in mind. Our approach reflects the importance of recognising the interaction between individual and environmental factors in understanding moral emotions and moral injury.

The term 'moral injury' has been linked to COVID-19.⁶⁻¹⁰ Moral injury lies at the extreme end of the range of harms that can result from events that involve moral stressors.¹¹ In the context of COVID-19 a severe moral stressor would be, for example, a healthcare worker having to, due to lack of resources, deny treatment to a patient they know will die without that treatment. This may give rise to reactions like anger and guilt, which if left unresolved may lead to moral injury. More common and less severe moral stressors would include, for example, being unable to provide optimal care to non COVID-19 patients, and concern about passing the virus on to loved ones. These moral stressors may give rise to a range of moral emotional responses, but are less likely to result in the enduring harm associated with moral injury.

In seeking to understand moral distress and moral injury in the context of COVID-19, we need to consider the range of potential moral stressors, and the range of emotional responses. Managing emotional responses in the COVID-19 environment is crucial to supporting healthcare workers and preventing lasting moral injury or harm.

A black and white photograph of a man with dark, wavy hair, wearing a white button-down shirt. He is sitting in an office, looking down at a tablet computer with a concerned or stressed expression. His right hand is resting on his chin, and his left hand is holding the tablet. In the background, there is a computer monitor and some office shelves. The overall mood is one of professional pressure or stress.

“Managing emotional responses in the COVID-19 environment is crucial to supporting healthcare workers and preventing lasting moral injury or harm”


What is moral injury?

Moral injury refers to the psychological, social and spiritual impact of events involving betrayal or transgression of one's own deeply held moral beliefs and values occurring in high stakes situations.^{12, 13}

The concept was developed in military settings where soldiers were returning from deployment having been involved in events that transgressed deeply held moral convictions. Soldiers suffered enduring harms to psychological, social and spiritual health as a result. There are two broad types of moral transgression events: moral transgressions that involve people doing or failing to do things themselves (deliberately or unwittingly); and being exposed directly or indirectly to transgressions on the part of someone else (betrayal, bearing witness to grave inhumanity).¹¹ Such events are called potentially morally injurious events in recognition that not everyone will respond in the same way to such events, just as in the trauma field there is recognition that individual responses to potentially traumatic events that involve threat to one's life or physical integrity vary.¹³

When a moral injury does occur, the range of outcomes are broad and can include: 1) feelings of guilt, shame, anger, sadness, anxiety and disgust; 2) intrapersonal outcomes including lowered self-esteem, high self-criticism, beliefs about being bad, damaged, unworthy or weak, and self-handicapping behaviours; 3) interpersonal outcomes including loss of faith in people, avoidance of intimacy and lack of trust in authority figures; and 4) existential and spiritual outcomes including loss of faith in previous religious beliefs, and no longer believing in a just world.¹⁴

“When a moral injury does occur, the range of outcomes are broad.”

A black and white photograph of a healthcare worker, possibly a nurse, sitting on the floor of a hospital hallway. The person is wearing scrubs and has a stethoscope around their neck. They are leaning against a wall, looking down with a distressed expression, resting their head on their hand. The hallway is brightly lit with overhead lights, and a handrail is visible on the wall to the left.

A continuum of moral stressors and associated harms

Moral injury reflects an enduring impact on an individual's self-image and world view, resulting from exposure to extreme moral stress.¹⁴

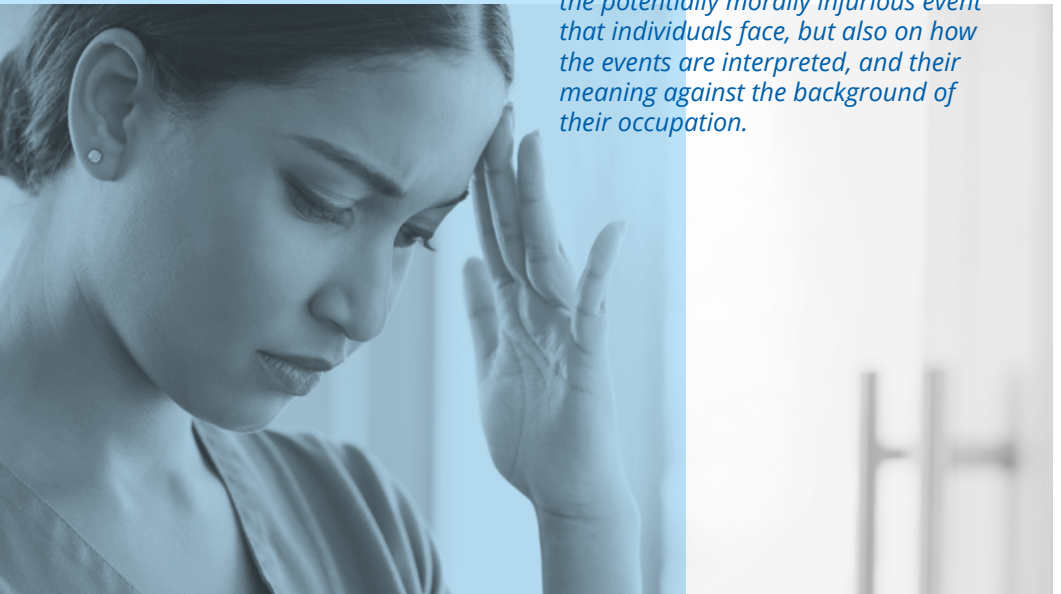
However, as noted above, morally injurious events are best understood as one extreme along a continuum of moral stressors, and moral injury as one extreme along a continuum of associated harms.

Litz & Kerig¹¹ outline a range of moral stressors that vary according to their potential psychological, social and spiritual harm and impairment. The least severe moral stressors occur frequently and are highly prevalent at a population level. These are termed moral challenges and are associated with minimal harm or impairment, which is characterised as moral frustration. Moral stressors with potential for moderate harm or impairment occur less frequently and are therefore less prevalent at a population level. These are termed moral stressors and their associated moderate level of harm or impairment is labelled as moral distress. Moral stressors with potential for the most extreme harm or impairment are rare and accordingly have a low population prevalence. These moral stressors are termed morally injurious events and the associated harm is termed a moral injury.

Thus, whilst all moral stressors violate a person's beliefs about what is right and just or wrong and unjust, and all give rise to moral emotions, their potential for enduring harm or impairment are a function of severity.

Moral injury in relation to healthcare

When the concept of moral injury is taken out of the military context and applied to a healthcare setting, it is likely that the professional context will have a bearing not only on the nature of the potentially morally injurious event that individuals face, but also on how the events are interpreted, and their meaning against the background of their occupation.



While both military service and healthcare are vocations individuals may choose for altruistic desires to 'help' others and have an impact, the difference with healthcare is the underlying assumption that it is the role of healthcare workers to heal and cause no harm.¹⁰

In the military context, moral injury may arise when a soldier has been forced to act against their deeply held moral beliefs, for example, failing to intervene to protect civilians because to do so would have been a breach of their rules of engagement.

In the healthcare context, the deeply held moral belief that can lead to moral injury if transgressed is the oath that healthcare providers take to put the needs of the patient first.¹⁵ When situations arise that do not allow healthcare workers to deliver care in the way they have been trained (that is, to help people and do no harm), this may be associated with moral and ethical dissonance.^{9, 10, 15-25} This dissonance could occur in a range of circumstances, including systemic problems within the healthcare system that impact patient care, threat of litigation influencing policies and practices, finances (hospital budgets), or demand exceeding capacity.

Beyond these issues, there are a number of events or situations that arise not uncommonly in the healthcare setting that have the potential to be morally challenging, stressful and possibly injurious. These include unintentional errors leading to injury or death, uncontrollable situational factors leading to injury or death (e.g., failure to find an organ donor for a patient), bearing witness to, or failing to prevent harm or death (e.g., the death of a child with cancer), and failure to meet patient needs.^{18, 22, 24, 26}

“When situations arise that do not allow healthcare workers to deliver care in the way they have been trained, this may be associated with moral and ethical dissonance.”

A continuum of moral stressors and associated harms

The full range of moral stressors has been seen around the world during the COVID-19 pandemic.

At the less severe end of the spectrum, many of us have experienced the moral challenge of witnessing the behaviour of other people that we consider wrong and work against the interests of society as a collective. Examples of morally challenging behaviours include the hoarding of food and toiletry basics and people flouting social distancing rules. Our emotional response to these behaviours may be frustration or even contempt for the other. These moral emotions are likely to be felt more keenly by those such as healthcare workers who are on the 'frontline' of the pandemic, and making personal sacrifices for the greater good, but they are still likely to be fleeting or relatively short-lived.

Some have experienced more severe moral stressors. For healthcare workers this may include being caught in the midst of a moral conflict between a preparedness to put oneself in harm's way to help others in need, and the natural desire to avoid infection for fear of the consequences for oneself or one's family. With the well documented shortages of personal protective equipment (PPE) internationally, the tension between self-preservation and the need to treat critically ill infectious patients may result in an ethical dilemma of whether or not to render aid.⁹ Workers have expressed fears about inadvertently spreading the disease to patients, friends, family and others.²⁷ Due to extensive quarantine requirements, some healthcare workers may be forced to quarantine when they are clearly needed at work, placing additional stress on their already stretched colleagues.²⁵ The requirement to quarantine from family for weeks at a time places additional stress on themselves and their family.

“These moral emotions are likely to be felt more keenly by those such as healthcare workers who are on the frontline of the pandemic.”

Even healthcare workers who are not on the frontline of treating COVID-19 patients have to deal with moral stressors when they face barriers to providing their usual standard of care. This may include:

- witnessing the suffering of patients arising from delays in non-essential medical procedures
- the need to discontinue face-to-face psychotherapy for patients with mental health concerns
- discharging clients earlier than recommended to avoid infection risk (e.g. mothers with newborns)
- avoiding human touch to limit risk of infection
- wearing of PPE (masks), which can adversely affect those who use facial cues to understand communication (e.g. elderly, those with disabilities).

Unfortunately, some healthcare workers have also become the target of hostility and aggression from members of the public, leading to recommendations not to wear uniforms or scrubs outside hospital.²⁸ Such moral stressors are likely to give rise to moral distress including anger and shame that may be more persistent and may even lead people to question their and others' fundamental values and beliefs.

In the context of COVID-19, therefore, many healthcare workers around the world are facing the type of severe moral stressors that would be considered potentially morally injurious events. A critical issue is the intersection between patient-centred clinical care and public-centred requirements which may be at odds. This may mean that individual patient needs have to be sacrificed for the greater public good.¹⁶ Severe moral stressors include: triaging patients for healthcare with implications for who gets what level of treatment in circumstances in which denial of treatment may result in the death of the patient; witnessing deaths of young and previously healthy individuals; preventing family members from being at the side of a dying relative; and having to follow clinical directions that the individual may feel are unethical.^{18, 29} In addition, many healthcare workers will be concerned that healthcare will be compromised for not only COVID-19 patients, but others needing to use the system.³⁰

Where these potentially morally injurious events lead to enduring psychological, social and spiritual harm, with adverse impacts on mental health, relationships and quality of life, we would say that a moral injury has been sustained.

Moral injury outcomes in COVID-19

Research and observations of moral injury associated with COVID-19 have identified a range of responses that are similar to moral injury outcomes reported in military populations.

Responses include moral emotions directed towards the self, such as guilt, anger, shame, remorse and disgust;^{15, 17, 20, 21, 24-26, 31} extreme negative self-attributions, demoralisation, self-condemnation, lack of self-forgiveness, and self-punishment; haunting memories or recollections; feelings of worthlessness, powerlessness or helplessness; loss of identity/role; and questioning of one's sense of self.^{21, 26} In circumstances when individuals have witnessed injustices and systemic failures, they also include moral emotions directed towards others, such as outrage, blame, disparaging thoughts about others, feelings of betrayal, loss of trust, and difficulty forgiving.²⁴

Individuals experiencing moral injury may also have impaired personal, social, and occupational functioning.^{17, 20, 24-26} This can include engaging in self-destructive behaviours and substance misuse. They may become socially withdrawn and avoidant, which is particularly problematic, as social support and opportunities to discuss and emotionally process potentially morally injurious experiences are critical. Individuals suffering moral injury may develop relationship problems, experience reduced empathy (again, particularly problematic in the healthcare setting), and show increased difficulties within the occupational context (e.g., difficulties coping with occupational stressors and authority figures).

They may also lose their sense of purpose or motivation, and come to question pre-existing religious beliefs or beliefs about the nature of humanity and the world. The development of moral injury has been identified as a risk factor for the development of mental health problems including posttraumatic stress disorder (PTSD), depression and anxiety,¹⁰ and associated problems such as insomnia, suicidal ideation and suicidal behaviour.³²

As the COVID-19 pandemic continues, with anticipation of new waves of infection, repeated exposure to potentially morally injurious events may also lead to symptoms of burnout including exhaustion, depression, and emotional numbing.^{19, 24, 33} The concept of burnout is well established, and has been a focus of extensive interest in the healthcare setting. More recently, burnout has been considered a form of moral fatigue or moral injury.^{15, 34, 35} This has led to burnout being reframed from a failure of resilience in coping with chronic workplace stressors, to the outcome of the inconsistency between the individual knowing what the patient needs but being unable to provide it due to constraints beyond their control. It has been suggested that when burnout is framed in this way, it may reduce the stigma associated with it and encourage help-seeking.^{22, 31} Other authors argue that workplace burnout itself may lead to moral injury via exhaustion, cynicism and reduced efficacy.^{19, 21, 33} Relatedly, it has

been noted that there is a fundamental inconsistency between the strong moral compass and values that drive a dissatisfied and burnt out worker to continue to work, and the reality that they won't be able to deliver what is needed due to flaws in the system or the extreme nature of the situation, such as in the current COVID-19 circumstances. This risks compounding the potential for moral injury.^{16, 25}

The development of moral injury has been identified as a risk factor for the development of mental health problems including PTSD, depression and anxiety, and associated problems such as insomnia, suicidal ideation and suicidal behaviour



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The flip side: Positive moral emotions during COVID-19

It is important to recognise that while some people exposed to moral stressors may experience significant distress and injury, others may experience posttraumatic growth, including improved psychological resilience, increased esteem, compassion, and engagement.^{17, 20}

A recent qualitative study of nurses caring for COVID-19 patients³⁶ found that while negative emotions were commonly experienced, these were accompanied over time by the emergence of positive factors including increased affection and gratitude, development of feelings of professional responsibility and competence, and self-reflection and insight.

A number of authors^{27, 37, 38} highlight the protective value of the vocational underpinnings of healthcare including a sense of service and purpose, a strong commitment to moral codes, justice and service to others, altruism and courage. These attributes may in fact be enhanced through facing adversity, where the appropriate system, team and individual supports are available.

While moral challenges and stressors are inevitable, focussing on the moral strength and courage that underpin healthcare service is of value. Moral strength underlies the capacity of healthcare workers to use compassion in their practice and make difficult and often complex decisions within high stakes environments with a steadiness, reliability and focus on the 'mission'.³⁷ Others discuss the idea of moral resilience among healthcare workers,²⁷ reflecting a buoyancy despite repeated adversity, and the sense that life is meaningful under every circumstance. Ways in which moral resilience may be fostered include helping staff to make meaning of morally laden situations in ways that reinforce their sense of purpose, fostering self-awareness, self-regulation, a sense of ethical competence and understanding, connection with others, and finding ways to celebrate even small or fleeting successes, and expressing gratitude.

A number of factors have been identified as supporting the wellbeing and motivation of healthcare workers. These include positive role models, supportive teams and appreciation from all levels of the organisation,³⁹ strong empathic leadership, camaraderie, feelings of effectiveness, and pride at making it through adversities.⁴⁰ In particular, experiencing adversity can highlight positive attributes of altruistic caretaking, compassion, personal sacrifice, and validation of existence.³⁹

Framework for the management of potentially morally injurious events in the workplace

The discussion of potential positive outcomes of the moral stressors associated with COVID-19 highlights the importance of healthcare organisations establishing a framework to guide their suite of preventative and early intervention structures to support healthcare workers.

Moral stressors are inherent in the COVID-19 environment and cannot be 'designed out' of the work. The onus is therefore on organisations to implement a preventative and early intervention approach which reduces risks and maximises protective factors, rather than simply to react to issues when they arise.

There are a range of risk factors which may increase the likelihood of moral distress or moral injury, including loss of life of vulnerable people, perceived lack of support from leadership, family/friends, and society; being unprepared psychologically; and being exposed to additional trauma.^{20, 41} A further complicating factor is that the moral and ethical nature of potentially morally injurious events means individuals may be reluctant to disclose or discuss them due to social or legal repercussions, increasing the likelihood that they may become a source of significant moral distress.²⁰

Although individual factors influence response to stressors of all kinds and adaptive coping is an important part of the approach, the literature consistently shows that individual factors are outweighed in their influence by the organisational and social context. The impact of inherent risks can be minimised by preparation, management of exposure, good job design, leadership and team cohesion.⁴² Furthermore, social support – both internal and external to the work environment – has consistently been shown to be a protective factor towards the development of posttraumatic and other mental health conditions.⁴³ Peer support in particular has been shown to be an important protective factor following trauma exposure.⁴⁴

A whole-of-organisation approach is therefore recommended as the best practice approach to managing potentially morally injurious events and mitigating the risk of moral injury in healthcare settings. This includes consideration of the role of managers and leaders, wellbeing support services (professional and peer), as well as individuals' own coping resources. It also includes consideration of how an individual or group is supported before, during and after the event or situation. This requires responses at the organisational, team and individual levels.⁴⁵



Organisational level considerations

The World Health Organization has issued guidance on how to support the mental health and psychosocial wellbeing of healthcare workers during the COVID-19 pandemic.⁴⁶

Key messages relate to: protection of workers from chronic stress to ensure they retain the capacity to fulfil their roles; provision of support to families of workers where necessary; good quality, accurate information; rotation of staff between high and low stress roles; partnering inexperienced staff with experienced workers; monitoring stress and enabling flexible schedules where possible; facilitating peer social support between workers; providing information about and facilitating access to psychological support; implementing these measures for managers/leaders and ensuring they are also able to seek support and role model these behaviours; encouraging a culture of self-care and positive coping strategies; and up-skilling the workforce with psychological first aid training.

It is important for institutions and workplaces to acknowledge the occupational stressors that healthcare workers may face such as physical strain, physical isolation, extreme fatigue (contributed to by shift work as well as wearing hot and uncomfortable PPE), constant awareness and vigilance, procedural pressures, tension between public health priorities and patient/family wishes/needs, and conflicting personal and professional demands.⁴⁷ In the context of COVID-19 a particular source of stress is the uncertainty that exists about the best way of treating the virus and alleviating symptoms. Open communication between colleagues and from leadership about what is known and unknown, helps take the burden off the individual's shoulders for treatment decisions, particularly those that prove ineffective. Another key consideration is optimal management of shiftwork to minimise fatigue amongst

healthcare workers. The optimal schedule for shift work is clockwise, with staff going from morning shift to afternoon shift to night shift and repeating the same cycle.⁴⁸

At a systems level, decision making on allocation of scarce resources should be supported with clear, transparent evidence-based guidance that reflects epidemiological data, consumer consultation and international experience. This may reduce the likelihood of moral injury by providing a clear guide for decision making.^{9, 16, 49} Furthermore, given the ethically and morally problematic nature of these decisions, it is recommended that workers outside of direct patient care make these decisions where possible, to reduce the moral and ethical burden of frontline workers.⁵⁰

Lessons learned from other large scale disasters such as 9/11 highlight the importance of monitoring levels of exposure to the trauma of the healthcare setting among healthcare workers.⁴¹ There is a risk of cumulative impact for those with high levels of exposure, so this should be managed and minimised as best as possible.

Individuals in healthcare roles often have positive attributes when faced with disasters, including a sense of duty to work and render assistance and a sense of custodianship of resources and healthcare provision. These positive attributes may be tempered by frustration with systems and institutions, therefore, where possible it is important that planning and decision making is undertaken collaboratively between administration and staff.^{40, 41, 51}

There are several recommendations for practical measures emerging from the literature. These include establishing peer support programs with the capacity to address moral injury and providing timely and easily accessible psychological support for frontline workers.^{52, 53} Given the nature of moral stressors, some staff may prefer religious or spiritual guidance that can be offered by chaplains.⁵⁴ This range of supports is well established within military and veteran services and may serve as an exemplar for moral injury arising in other contexts such as healthcare.

Informal community supports and services have been an increasing focus within care settings as they offer an opportunity to enhance existing care, with a person-centred focus. These supports often offer a recovery-oriented model of care in which individuals can draw on the experiences, support, and strengths of trained volunteers who have experienced similar circumstances and challenges.^{55, 56} These service providers require the same dedicated efforts and organisational supports as formal care settings in order to foster a psychologically safe environment for their dedicated staff members. However, informal community services often lack the funds and infrastructure required to support the mental wellbeing of their own workers.⁵⁷ It is imperative that these programs are provided with the necessary resources to support the health and safety of the individuals who provide care and services to so many.

Team level considerations

Research in the military has established that cohesive units with high morale have lower behavioural health problems regardless of combat exposure.⁵⁸



This research suggests that cohesive teams with high morale may be better able to protect their members from the adverse impacts of extreme moral stressors. This highlights the importance of preventative measures that focus not just on the psychological preparation of the individual, but on the cohesiveness and morale of the group.

In the trauma field there is good evidence that teams characterised by a strong sense of shared purpose and strong leadership have lower rates of mental health problems.⁵⁹ In the healthcare setting, managers, supervisors and team leaders can support staff through frank discussions about the moral and ethical challenges they will realistically face, including the possible social, emotional, cognitive and behavioural impacts. This requires open, empathic, leader-led, shared team discussions to enable explicit awareness and preparation for ethical dilemmas they may face. Leaders can also support staff and promote team cohesion through modelling and facilitating positive coping skills, and encouraging peer and social support.^{17, 20, 21, 29, 47, 60}

Team leaders are also critically important in helping staff make meaning of morally ambiguous situations and decisions.⁶¹ They can do this by taking the time to talk through a particular situation or event, acknowledging the moral dilemma, and reinforcing the value and importance of the work being undertaken. Where possible, it is helpful for team leaders to promote a positive or resilient narrative about potentially morally injurious events, and take responsibility for decisions and outcomes removing the onus from the individual worker.⁶¹ Team leaders can also give permission for staff to celebrate successes at work and acknowledge these.

In supporting their staff, team leaders should make available opportunities for rotation from high stress areas to low stress areas for periods of time. This assists those staff who do not want to identify that they are struggling emotionally, and more generally allows the staff member to 'regroup' before returning to a high stress area in the future, or to recognise that they need to stay in a lower stress area.

Team leaders should be aware of the potential for staff to avoid talking about moral stressors, and be prepared to reach out and proactively offer support rather than wait for staff to come forward. This may be difficult to do at work, and team leaders may consider calling team members on their day off. In offering support, team leaders should listen out for narratives, beliefs or statements that suggest an individual may be struggling with a sense of moral failure or guilt, and assist them to stay grounded and focus on aspects of the situation they can control, while acknowledging what they can't control. Providing acknowledgment and affirmation, and giving meaning to events in such a way that reduces feelings of powerlessness, helps to reinforce the 'mission' and a sense of purpose.^{21, 53, 60} Leaders are encouraged to arrange regular check-ins within teams, as well as support check-ins between peers and supervisors/managers.^{41, 53, 60} Leaders can also support staff by advising of available support and counselling services if needed.

The need to also support team leaders should not be forgotten. They may be reluctant to seek help by virtue of their position, and so should also be proactively offered and encouraged to access psychological support if needed, at the same time as they are encouraging others to do so.^{20, 40, 53, 60} Particular care should be taken to ensure that this can occur confidentially.

Individual level considerations

In addition to providing the right support at the organisation and team level, there are several ways in which individual healthcare workers can be supported in their ability to cope with the moral stressors associated with COVID-19.

Psychoeducation about moral stressors and moral injuries may be helpful in encouraging workers to make meaning out of their experiences rather than avoid, or dwell on moral emotions such as guilt or shame.¹⁷ In addition, there are a number of trauma-informed strategies to assist at an individual level. These include stress reduction activities such as mindfulness, meditation, exercise and breathing; engaging social support; building/promoting a resilient mindset (through acceptance and self-compassion); recognising traumatic or moral injury reactions, including avoidance, emotional numbing and shame; and encouraging early help-seeking.^{17, 24, 29, 47, 60}

Staff wellbeing should be promoted through support for workers to engage in positive self-care both within and outside of work. This includes maintaining social connections, eating well, exercising, having time out and getting sufficient rest. In the context of social distancing measures some of these self-care and coping mechanisms are more difficult to establish or maintain, so need to be actively facilitated.⁶² This could involve, for example, hosting a morning tea or team social event.

In addition to preventative interventions, consideration should be given to best practice approaches when a staff member appears to be struggling with moral stressors. This involves acknowledging the moral dilemma, and helping the individual to actively work

through and resolve any resulting moral conflict.⁶³ This could mean encouraging the individual to acknowledge their values, and accept the conflict inherent in the current situation, while ensuring that they continue to be guided in their future actions by their values. Further, based on the finding that the inability to make meaning out of potentially morally injurious events is associated with greater risk of PTSD, depression and suicidality, it is important to help the individual to make meaning of the experience.⁶⁴ This meaning-making may involve, for example, reflection on the event in a way that reinforces the mission and a sense of purpose in the activity, acknowledging the moral dilemmas, and reinforcing the principles that guide decision making in this context.⁶³ Also critical following exposure to a potentially morally injurious event are interventions that promote trust in leadership. For example, an open dialogue in which reasons for actions or decisions are explained, may mitigate against a sense of betrayal or injustice through consideration of the potential outcomes of alternative courses of action. Similarly, creating an environment that facilitates the acknowledgement of, and working through moral dilemmas, such as actions or inactions that have led to guilt or shame, may mitigate against shame-based anger and moral injury.

Beyond early interventions that can be implemented in the workplace, it is important to encourage and facilitate help-seeking, whether that be psychological or spiritual, if there are early indicators of distress following exposure to a potentially morally injurious event. Given the nature of moral emotions arising from potentially morally injurious events (for example, guilt and shame directed at oneself or contempt and anger directed at the other) it is not surprising that interventions



“Staff wellbeing should be promoted through support for workers to engage in positive self-care both within and outside of work. ”

that have been developed have a significant focus on forgiveness: self-forgiveness for things that the individual has done or failed to do themselves, and forgiveness of the other for events involving betrayal or moral transgression on the part of someone else.⁶⁵⁻⁶⁷ One such promising intervention is Adaptive Disclosure, a combination of cognitive behavioural therapy and compassion-based interventions that focus on forgiveness.⁶⁵ When moral injury is experienced alongside PTSD, evidence-based treatments for PTSD such as prolonged exposure and cognitive processing therapy should be carefully tailored to take into account the individual's experiences of moral injury.⁶⁸⁻⁷⁰



Summary and key points

The enormous pressure placed on the healthcare system in parts of the world most severely impacted by the COVID-19 pandemic has raised awareness internationally of the potential for moral injury amongst healthcare workers.

Moral injury can arise in circumstances where the individual does, or fails to do something that transgresses their deeply held moral beliefs. It can also arise when the individual feels betrayed in a high stakes situation or witnesses others behaving in ways that they feel are morally wrong. The impacts can be felt widely across psychological, social and spiritual domains and can be enduring. These sorts of events (potentially morally injurious events) and outcomes such as (moral injury) lie at one end of a continuum of moral stressors and moral impacts. During the COVID-19 pandemic we have seen a range of moral stressors, from mild to severe, and a range of outcomes, from fleeting moral emotions to enduring moral harm. We have also seen a range of positive moral emotions – compassion, pride and gratitude. No doubt, the impact of moral stressors experienced during the COVID-19 pandemic will continue to emerge for individuals as the demands of the pandemic reduce and they have time to reflect on what has occurred.

Support for healthcare staff in managing these stressors is critical if we are to avoid the most severe harms. This is a responsibility that is shared across all levels of an organisation.

What organisations can do

- Acknowledge the inherent moral stressors for healthcare workers during the COVID-19 pandemic.
- Promote a supportive culture within the workplace and arrange access to a range of support services for staff.
- Recognise the critical role of informal and volunteer service providers, and ensure sufficient resources to support the health and safety of these providers.
- Rotate staff between high and low stress roles.
- Establish evidence-based policies to guide ethically difficult decisions such as the allocation of scarce resources.
- Remove difficult ethical decisions from frontline workers.
- Arrange rosters for shift workers to follow the clock with a cycle of morning to afternoon to evening shifts.

What team leaders can do

- Provide strong leadership and establish cohesive teams with high morale.
- Be prepared to discuss moral and ethical challenges.
- Help team members make meaning of moral stressors.

- Model positive coping and encourage self-care and help-seeking as required.
- Celebrate successes – however small they may be.
- Arrange regular check-ins with staff to monitor wellbeing.
- Facilitate referral for further support or counselling if required.

What individuals can do

- Access psychoeducational material about moral stressors and moral injury.
- Undertake stress reduction activities such as relaxation therapy, mindfulness, or meditation.
- Attend to self-care through eating well, exercising, maintaining social connections, and getting sufficient rest.
- Support each other as colleagues who understand shared experiences.
- Seek professional support if you are feeling distressed or troubled by your experiences.

On a final note, we should not overlook the responsibility that needs to be shouldered across the community and the government, for how we treat our healthcare workers and the narratives that are created around the difficult choices they may have been forced to make. We unfortunately know all too well from the military, the power and enduring legacy of negative public opinion on those returning from war zones.⁷¹

We hope that government and public expressions of gratitude for the service and dedication of healthcare workers during the COVID-19 pandemic will continue, and will promote a sense of pride in the critical role that our healthcare workers have played.

References

- Chen, Q., et al., Mental health care for medical staff in China during the COVID-19 outbreak. *The Lancet Psychiatry*, 2020. 7(4): p. e15-e16.
- Lai, J., et al., Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Network Open*, 2020. 3(3): p. e203976.
- Gershon, R., et al., Experiences and psychosocial impact of West Africa ebola deployment on US health care volunteers. *PLoS Current*, 2016. 8.
- Haidt, J., The moral emotions, in *Handbook of affective sciences*, R.J. Davidson, K.R. Scherer, and H.H. Goldsmith, Editors. 2003, Oxford University Press: Oxford. p. 852-870.
- Tangney, J.P., J. Stuewig, and D.J. Mashek, Moral emotions and moral behavior. *Annual Review of Psychology*, 2007. 58: p. 345-72.
- Blake, H., et al., Mitigating the Psychological Impact of COVID-19 on Healthcare Workers: A Digital Learning Package. *International Journal of Environmental Research and Public Health*, 2020. 17.
- DiLallo, J., To maintain ethical medical practices, we must not underplay the vocational aspect of medicine. *The BMJ*, 2020. 368.
- Kalet, A., et al., Hearing the call of duty: what we must do to allow medical students to respond to the COVID-19 pandemic. *World Medical Journal*, 2020. 119(1): p. 6-7.
- Markwell, A., et al., Clinical and ethical challenges for emergency departments during communicable disease outbreaks: can lessons from Ebola Virus Disease be applied to the COVID-19 pandemic? *Emergency Medicine Australasia*, 2020.
- Williamson, V., S.A. Stevelink, and N. Greenberg, Occupational moral injury and mental health: systematic review and meta-analysis. *The British Journal of Psychiatry*, 2018. 212(6): p. 339-346.
- Litz, B.T. and P.K. Kerig, Introduction to the Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications. *Journal of Traumatic Stress*, 2019. 32(3): p. 341-349.
- Shay, J., *Achilles in Vietnam: Combat Trauma and the Undoing of Character*. 1994, New York: Scribner.
- Litz, B.T., et al., Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, 2009. 29(8): p. 695-706.
- Yeterian, J.D., et al., Defining and Measuring Moral Injury: Rationale, Design, and Preliminary Findings From the Moral Injury Outcome Scale Consortium. *Journal of Traumatic Stress*, 2019. 32(3): p. 363-372.
- Dean, W., S. Talbot, and A. Dean, Reframing Clinician Distress: Moral Injury Not Burnout. *Federal Practitioner*, 2019. 36(9): p. 400.
- Berlinger, N., et al., Ethical Framework for Health Care Institutions Responding to Novel Coronavirus SARS-CoV-2 (COVID-19): Guidelines for Institutional Ethics Services Responding to COVID-19 – Managing Uncertainty, Safeguarding Communities, Guiding Practice. 2020.
- Boback, A. Supporting the Mental Health of COVID-19 Healthcare Workers. 2020; Available from: <https://www.madinamerica.com/2020/04/supporting-mental-health-covid-19-healthcare-workers/>.
- Eisen, E. Moral injury and Covid-19: praying for the mental health of our frontline. 2020; Available from: <https://blogs.timesofisrael.com/moral-injury-and-covid-19-praying-for-the-mental-health-of-our-front-line/>.
- Garber, J., S. Brownlee, and V. Saini. What Do We Owe Doctors and Nurses? [Web page] 2020; April 10;[Available from: <https://www.zocalopublicsquare.org/2020/04/10/what-we-owe-doctors-nurses-frontline-responders-healthcare-covid-19-coronavirus-pandemic/ideas/essay/>].
- Greenberg, N., et al., Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ*, 2020. 368.
- Janssen, S. Moral Injury in Health Care and COVID-19. 2020; Available from: https://www.socialworktoday.com/archive/exc_040620.shtml.
- Knowles, M. Viewpoint: Physicians aren't burning out; they're suffering from 'moral injury' Integration & Physician Issues 2020 [cited 2020 30 April]; Available from: <https://www.beckershospitalreview.com/hospital-physician-relationships/brigham-and-women-s-surgeon-physicians-aren-t-burning-out-they-re-suffering-from-moral-injury.html>.
- Royal College of Psychiatrists, A statement from the Royal College of Psychiatrists on the roles and work of psychiatrists during the COVID-19 pandemic. 2020.
- UCSF Department of Psychiatry. Emotional Well-Being and Coping During COVID-19. 2020 2020; Available from: <https://psychiatry.ucsf.edu/coronavirus/coping>.
- Williamson, V., D. Murphy, and N. Greenberg, COVID-19 and experiences of moral injury in front-line key workers. *Occupational Medicine*, 2020.
- Centre for Addiction and Mental Health. Moral Injury. 2020; Available from: <https://www.camh.ca/en/camh-news-and-stories/moral-injury>.
- Mazanec, P., Ethical dilemmas facing nurses during the Coronavirus Crisis: Addressing moral distress.
- Nguyen, K., NSW nurses told not wear scrubs outside of hospital due to abuse over coronavirus fears. 2020.
- Omnia Health Insights. How to protect the wellbeing of healthcare staff in the COVID-19 crisis. 2020; Available from: <https://insights.omnia-health.com/coronavirus-updates/how-protect-wellbeing-healthcare-staff-covid-19-crisis>.
- Williamson, V., et al. Moral injury: Violating your ethical code can damage mental health – new research. 2019 [cited 2020 30 April]; Available from: <https://medicalxpress.com/news/2019-04-moral-injury-violating-ethical-code.html>.
- Kopacz, M.S., D. Ames, and H.G. Koenig, It's time to talk about physician burnout and moral injury. *Lancet Psychiatry*, 2019. 6(11): p. e28.
- Chew, N.W., et al., A Multinational, Multicentre Study on the Psychological Outcomes and Associated Physical Symptoms Amongst Healthcare Workers During COVID-19 Outbreak. *Brain, Behavior, and Immunity*, 2020.
- Garber, J. Moral injury: A systemic issue in medicine. 2019 [cited 2020 30 April]; Available from: <https://lowinstitute.org/moral-injury-a-systemic-issue-in-medicine/>.
- Canadian Institute for Health Information, COVID-19 and Global Human Health Resources. 2020.
- Chochinov, A. and R. Lim, On the Brink of Burnout: COVID-19 and the ER. 2020.

36. Sun, N., et al., A Qualitative Study on the Psychological Experience of Caregivers of COVID-19 Patients. *American Journal of Infection Control*, 2020.
37. Ulrich, C.M. and C. Grady, COVID-19 Resource: What Are Our Professional and Ethical Obligations to Patients and Ourselves?.
38. Ho, C.S., C.Y. Chee, and R.C. Ho, Mental health strategies to combat the psychological impact of COVID-19 beyond paranoia and panic. *Ann Acad Med Singapore*, 2020. 49(1): p. 1-3.
39. Spoorthy, M.S., Mental health problems faced by healthcare workers due to the COVID-19 pandemic-a review. *Asian Journal of Psychiatry*, 2020.
40. Sarner, M., Maintaining mental health in the time of coronavirus. *New Scientist*, 2020. 246(3279): p. 40-46.
41. DePiero, J., S. Lowe, and C. Katz, Lessons Learned from 9/11: Mental Health Perspectives on the COVID-19 Pandemic. *Psychiatry Research*, 2020: p. 113024.
42. Knaak, S., et al., Implementation, Uptake, and Culture Change: Results of a Key Informant Study of a Workplace Mental Health Training Program in Police Organizations in Canada. . *Canadian Journal of Psychiatry*, 2019. 64(1 supp).
43. Dimoff, J.K. and E.K. Kelloway, With a little help from my boss: The impact of workplace mental health training on leader behaviors and employee resource utilization. *Journal of Occupational Health Psychology*, 2019. 24(1): p. 4-19.
44. Jones, N., et al., Cohesion, leadership, mental health stigmatisation and perceived barriers to care in UK military personnel. *Journal of Mental Health*, 2018. 27(1).
45. Maben, J. and J. Bridges, Covid19: Supporting nurses' psychological and mental health. *Journal of Clinical Nursing*, 2020.
46. World Health Organization, Mental health and psychosocial considerations during the COVID-19 outbreak W.H. Organization, Editor. 2020.
47. US Department of Veterans Affairs. Managing Healthcare Workers' Stress Associated with the COVID-19 Virus Outbreak. 2020; Available from: https://www.ptsd.va.gov/covid/COVID_healthcare_workers.asp.
48. Burgess, P.A., Optimal shift duration and sequence: Recommended approach for short-term emergency response activations for public health and emergency management. *American Journal of Public Health*, 2007. 97(Suppl 1): p. S88-S92.
49. Boyd, M., RPS guidance on ethical, professional decision making in the Covid-19 Pandemic. 2020.
50. Emanuel, E.J., et al., Fair allocation of scarce medical resources in the time of Covid-19. 2020, *Mass Medical Soc*.
51. Van Bavel, J.J., et al., Using social and behavioural science to support COVID-19 pandemic response. 2020.
52. Hardacre, J. and F. Director, Psychological PPE: Survival Kit for Creating a Safer Culture in the Covid-19 context by Dr Jeanne Hardacre & Dr Alexander Margetts.
53. Hendin, A., et al., End-of-life care in the Emergency Department for the patient imminently dying of a highly transmissible acute respiratory infection (such as COVID-19). *Canadian Journal of Emergency Medicine*, 2020: p. 1-5.
54. Hodgson, T.J. and L.B. Carey, Moral Injury and Definitional Clarity: Betrayal, Spirituality and the Role of Chaplains. *Journal of Religion and Health*, 2017. 56: p. 1212-1228.
55. Miyamoto, Y. and T. Sono, Lessons from peer support among individuals with mental health difficulties: a review of the literature. *Clinical Practice and Epidemiology in Mental Health*, 2012. 8: p. 22-29.
56. Carey, L.B. and T.J. Hodgson, Chaplaincy, Spiritual Care and Moral Injury: Considerations Regarding Screening and Treatment. *Frontiers in Psychiatry*, 2018. 9: p. 619.
57. Wandersman, A. and P. Florin, Community interventions and effective prevention. *American Psychologist*, 2003. 58(6-7).
58. Wilk, J.E., et al., Unethical battlefield conduct reported by soldiers serving in the Iraq war. *The Journal of nervous and mental disease*, 2013. 201(4): p. 259-265.
59. Anderson, L., et al., Prospective associations of perceived unit cohesion with postdeployment mental health outcomes. *Depression and Anxiety*, 2019. 36(6): p. 511-521.
60. Morganstein, J.C., et al., Response to and Recovery from the COVID-19 Pandemic: What Will It Take? *Psychiatry*, 2020: p. 1-6.
61. Shanafelt, T., J. Ripp, and M. Trockel, Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. *Jama*, 2020.
62. Nobles, J., et al., The potential impact of COVID-19 on mental health outcomes and the implications for service solutions. 2020.
63. Zust, J. and S. Krauss, Force protection from moral injury: Three objectives from military leaders. *Joint Force Quarterly*, 2019. 92(1): p. 44-49.
64. Currier, J.M., J.M. Holland, and J. Malott, Moral Injury, Meaning Making, and Mental Health in Returning Veterans. *Journal of Clinical Psychology*, 2015. 71(3): p. 229-240.
65. Gray, M.J., et al., Adaptive Disclosure: An Open Trial of a Novel Exposure-Based Intervention for Service Members With Combat-Related Psychological Stress Injuries. *Behavior Therapy*, 2012. 43(2): p. 407-415.
66. Sherman, N., Recovering lost goodness: Shame, guilt, and self-empathy. *Psychoanalytic Psychology*, 2014. 31(2): p. 217-235.
67. Worthington, E.L. and D. Langberg, Religious considerations and self-forgiveness in treating complex trauma and moral injury in present and former soldiers. *Journal of Psychology and Theology*, 2012. 40(4): p. 274-288.
68. Gray, M.J., W.P. Nash, and B.T. Litz, When Self-Blame Is Rational and Appropriate: The Limited Utility of Socratic Questioning in the Context of Moral Injury: Commentary on Wachen et al. (2016). *Cognitive and Behavioral Practice*, 2017. 24(4): p. 383-387.
69. Smith, E.R., J.M. Duax, and S.A. Rauch, Perceived perpetration during traumatic events: Clinical suggestions from experts in prolonged exposure therapy. *Cognitive and Behavioral Practice*, 2013. 20: p. 461-470.
70. Wachen, J.S., K.A. Dondanville, and P.A. Resick, Correcting misperceptions about cognitive processing therapy to treat moral injury: A response to Gray and colleagues (this issue). *Cognitive and Behavioral Practice*, 2017. 24: p. 288-392.
71. Brooks, M.S., S.B. Laditka, and J.N. Laditka, Long-term effects of military service on mental health among veterans of the Vietnam war era. *Military Medicine*, 2008. 173(6): p. 570-575.

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