Making Do During a Pandemic

Morally Distressing and Injurious Events

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The coronavirus disease (COVID-19) pandemic has placed nurses and other health care professionals in morally distressing situations related to personal safety, resource allocation, and family versus public care needs. *Making do*, referring to managing with insufficient means, has been the norm of pandemic testing and care. Health care professionals and essential employees at the sharp point of care and service have been required to pay the price associated with this new normal. Some have described these crushingly difficult circumstances as contributing to moral *injury*[1] and moral *distress.* Nurses, physicians, and other essential professionals are affirmatively responding to demands for their services while acknowledging that necessary clinical equipment and protective gear are unavailable in the quantities required for safe care delivery. These compelling concerns highlight the importance of fully appreciating the phenomena of moral distress and moral injury so as to better understand the reactions that this pandemic has evoked and will likely continue to trigger in nurses and other dedicated personnel. Recognizing the nature of morally distressing and injurious care experiences is a valuable first step in the planning and delivery of holistic care to assuage care providers' responses to the COVID-19 pandemic.

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Distinguishing moral stress from moral distress or moral injury is necessary to accurately appreciate the varying degree of nurses' and others' suffering related to these phenomena. Nurses and physicians are often challenged by ethical practice dilemmas that trigger moral stress.[2,3] Health care professionals anticipate such stressors and learn early in practice about the struggles associated with making practice decisions that involve conflicting ethical principles, including walking the thin line between doing good, avoiding harm, and advocating for patients' and families' well-being. Morally correct decisions are sometimes readily discerned by applying an established framework for ethical reasoning. At other times, the correct path is not apparent despite careful analysis. This type of moral stress is common and expected, although challenging and sometimes painful. There are often supports in place that can be prevailed upon to assist with particularly difficult decision-making, including consultations with ethicists and committee reviews to assist with objective determinations.

Moral stress differs from moral distress, a negative state of psychological imbalance experienced by nurses and other professionals when they are thwarted because of real or perceived institutional limitations from acting in a morally correct fashion.[4] Moral distress may be further differentiated by the initial feelings experienced when confronted by institutional or system barriers versus the reactive distress that these same people experience when they fail to act on their initial distress.[5] Published research findings describe some reactions to morally distressing care dilemmas as contributing to *never again* pledges associated with nurses' guilt and suffering following violation of deeply held moral tenets.[6] These pledges represent deep-seated vows that the nurse will never again respond to a similar event in like fashion or contribute to a comparable outcome.[6]

Moral distress is a topic of interest to nurse ethicists and researchers and it is recognized as a major problem in the nursing profession. It is also a reaction that is inconsistently addressed in nursing education programs, and as a result, nurses often lack effective strategies to identify feelings and manage distress.[2] Many nurses are poorly prepared during formal and continuing education experiences for the ethical reasoning and moral assertiveness required when confronting ethical dilemmas and this situation may be a contributing factor to moral distress.[2]

Evidence-based interventions are lacking; however, the phenomenon is increasingly better understood as a result of rich descriptive research. Evidence supports that initial moral distress is associated with frustration, anger, and worry. Nurses suffer from the belief that they have compromised their moral integrity when prevented by institutional barriers from doing what they know is the ethically correct act.[4] Published literature suggests that moral distress may significantly affect the providers' willingness to continue in practice or may affect job retention.[3]

Moral injury is unique from moral distress. Moral injury has its roots in war and was diagnosed in veterans harmed after perpetrating, failing to thwart, or witnessing acts that violated their deeply held moral convictions and expectations.[1,7] Physician experiences during the COVID-19 pandemic have been labeled as *moral injuries* to describe painful and powerful inner struggles experienced at work.[1] Some apply moral injury as a substitute for the more commonly used term "burnout,"[8] while others assert that moral injury is unique to wartime effects and it is inappropriate to repurpose this condition as the equivalent to burnout.[9] There is insufficient research to support a measurement of moral injury and until it is studied and operationalized, there is no way to realistically and accurately quantify the degree of injury or establish its prevalence, important measures necessary for establishing best practice interventions.[10] Potentially morally injurious experiences (PMIEs) experienced by combat veterans are recognized as associated with posttraumatic stress disorder, depression, and suicidal thoughts; however, this association is not clear in nonmilitary employment.[10]

The predominant concern as it relates to COVID-19 is not whether nurses and colleagues are morally distressed or morally injured but rather that either condition contributes to suffering and psychoemotional damage with short- and long-term consequences. Holistic care providers need to recognize the possibility of PMIEs or the occurrence of morally distressing events associated with care provision during heart-wrenching pandemic care encounters. Proactive efforts are needed to identify and meet the health needs of frontline health care workers and their families that will certainly manifest following this disaster.

Professional, government, and public information sources have presented rich descriptions of the COVID-19 pandemic as a war effort. Health care professionals have been delivering care under conditions likened to a battlefield. Triage sorting systems have been described as necessary for ventilator therapy rationing as a result of internationally inadequate equipment supplies. Nurses, physicians, and first responders have been rightly regaled as heroes for their determined and relentless fight against the "invisible enemy."

Health care professionals have publicly shared frustrations with inadequate to nonexistent personal protection equipment (PPE), including gloves, gowns, and N95 face masks. Twelve-hour shift assignments have been extended to exceedingly long periods of time without respite, contributing to exhaustion and, perhaps, higher vulnerability to care provider illness. Emotional trauma caused by dramatic death tallies, overwhelming care for the dead and dying and their families, as well as inadequate facilities for corpse storage have been worsened by necessary social distancing practices that require holding back from bedside vigils and funeral and religious services. COVID-19 testing inefficiencies and inadequacies have worsened the situation and increased risk across the board, particularly to those in health care environments.

Perhaps, most traumatic is the choice that direct care health professionals and essential staff have needed to make concerning personal and familial risks related to COVID-19 exposure. Providers across the world have died secondary to COVID-19. Many have shared via public platforms the agonizing choice between taking care of people who need health services versus potentially exposing loved ones to COVID-19, a heightened and likely risk during an era of care that is woefully and unconscionably short of reliable PPE.

The former chief medical officer for the New York State Office of Mental Health calls for the mental

health system to step up and provide crisis counseling to assist individuals and their families with their responses to the COVID-19 pandemic.[11] Crisis counseling is described as strength-based, anonymous, outreach-oriented, culturally attuned and focused on supporting rather than replacing existing support services.[11] These strategies are consistent with a holistic approach to responding to the aftermath of morally distressing or injurious events, including spiritual and faith-based approaches to support comfort and hope, and practical resource delivery such as food, housing, and transportation services. In the wake of the COVID-19 pandemic crisis, nurses and others will need time and encouragement for self-care. Crisis counseling and tangible support mechanisms will need to be devised and implemented. There will also need to be clear-sighted, proactive strategies based on quantifiable data for addressing future pandemics and international crises so that nurses and other essential providers and personnel are not again faced with *making do* within an inadequately planned, designed, and resourced system of care.

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