

EDITORIAL

Limiting moral injury in healthcare professionals during the COVID-19 pandemic

Whilst many have focussed on the immediate physical health of the workforce [1] and maintaining their short-term well-being [2] the biggest long-term impact upon many doctors may well be from ‘moral injury’ created by difficult decisions made, high mortality, futility of treatment and moral/ethical dilemmas during the pandemic [3]. Treatment strategies for established moral injury are limited and identifying and supporting sufferers can be difficult due to their perception of having transgressed [4]. Whilst there is some role for post-decision support structures a preventative strategy is far more likely to be successful and rightly national guidance on managing workplace health focuses on this [5]. In this article we explore moral injury, what it is, how it develops and strategies to prevent its development focusing upon the current pandemic.

‘Moral injury’ arises from the ‘moral distress’ that individuals feel when constrained from doing what they believe is the right thing by external factors, such as resource availability. Moral distress upon moral distress, with limited time to process what has happened, reduces tolerance for further moral dilemmas. This build-up of ‘moral residue’, those niggling doubts about the finely balanced decisions made, can result in moral injury—Epstein and Hamric dubbed this the ‘crescendo effect’ [6]. This theory leads us to suggest three key preventative strategies: enhanced decision-making support with complex decisions shared; the provision of time and space for clinicians to ‘decompress’; and staff working consistently within the same team.

Decisions have different levels of complexity associated with them (Figure 1). Clinicians of all grades can make those towards the simpler end of the spectrum quickly, reliably and without significant psychological stress. As complexity increases, the need for involvement, either remotely or in person, of senior staff with both the experience and expertise to make decisions rises proportionally. More experienced clinicians are, in our view, more likely able to identify nuances between individual cases and may be better at decision-making towards the more complex end. The most complex decisions, like those around resource-constrained escalation to intensive care [7], which are less typical of usual practice and are highly morally distressing, will often occur during this pandemic. Whilst evidence in

this field is limited, we believe once decisions reach this point, nobody should be forced to make them alone. We suspect that sharing moral responsibility with other clinicians will help to reduce the intensity of dilemmas and the build-up of moral residue. This would fit with the well-established socio-psychological principles of diffusion of responsibility and moral disengagement. These are almost exclusively discussed for their extreme negative consequences but can also be adaptive, thus if applied effectively can reduce the emotional arousal of sensible decisions that are made within an appropriate clinical ethical framework [8]. Good practice is already to try to engage in shared decision-making with patients and their families [9] and we see no reason why this should not also extend to sharing the most difficult decisions as a team—we are not the first to suggest such an approach in critical care [10]. Where it is felt another opinion is needed, processes for rapid review of decisions should be available and there may be a role for local clinical ethics committees, their members or for lecturers in medical ethics in providing this.

The early evidence coming out of China suggests that healthcare professionals need and value time and a safe space to rest, and to be able to talk about their experiences, if they wish to do so [11]. We believe that a lack of time to process events is key to the build-up of moral residue and the development of moral injury. Thus, time to ‘decompress’ should reduce the risk. It should be recognized that repeated, long, intense shifts, and making decisions overnight, whilst being expected to work the next day, are not conducive to this. Rostering approaches need to better balance, and vary, the intensity of working environments for individuals [12]. Greater psychological flexibility, the key target of Acceptance and Commitment Therapy (ACT), appears to be linked to a reduction in psychological distress amongst caregivers and patients [13,14] and there have been some efforts to apply this to clinicians [15]. Of the principles of ACT, several would seem to be relevant and could be utilized pre-emptively to promote psychological good health—cognitive defusion with alternatives to rumination on events which can otherwise lead to concrete, but false, beliefs developing; acceptance of challenging situations and noticing the emotions that come with them; increasing contact with

5. National Institute for Health and Care Excellence. Workplace Health: Management Practices NICE Guideline [NG13]. 2015, updated 2016. <https://www.nice.org.uk/guidance/ng13> (1 April 20, date last accessed).
6. Epstein EG, Hamric AB. Moral distress, moral residue, and the crescendo effect. *J Clin Ethics* 2009;**20**:330–342.
7. Truog RD, Mitchell C, Daley GQ. The toughest triage—allocating ventilators in a pandemic. *N Engl J Med* 2020. doi:[10.1056/NEJMp2005689](https://doi.org/10.1056/NEJMp2005689).
8. Detert JR, Treviño LK, Sweitzer VL. Moral disengagement in ethical decision making: a study of antecedents and outcomes. *J Appl Psychol* 2008;**93**:374–391.
9. Kon AA, Davidson JE, Morrison W, Danis M, White DB; American College of Critical Care Medicine; American Thoracic Society. Shared decision making in ICUs: an American College of Critical Care Medicine and American Thoracic Society policy statement. *Crit Care Med* 2016;**44**:188–201.
10. van Soeren M, Miles A. The role of teams in resolving moral distress in intensive care unit decision-making. *Crit Care* 2003;**7**:217–218.
11. Chen Q, Liang M, Li Y *et al*. Mental health care for medical staff in China during the COVID-19 outbreak. *Lancet Psychiatry* 2020;**7**:e15–e16.
12. AoMRC ATDG. Plans Regarding Trainee Redeployment During the COVID-19 Pandemic. 2020. <https://www.aomrc.org.uk/trainee-doctors/> (31 March 2020, date last accessed).
13. McAteer G, Gillanders D. Investigating the role of psychological flexibility, masculine self-esteem and stoicism as predictors of psychological distress and quality of life in men living with prostate cancer. *Eur J Cancer Care (Engl)* 2019;**28**:e13097.
14. Sairanen E, Lappalainen P, Hiltunen A. Psychological inflexibility explains distress in parents whose children have chronic conditions. *PLoS One* 2018;**13**:e0201155.
15. Ramaci T, Bellini D, Presti G, Santisi G. Psychological flexibility and mindfulness as predictors of individual outcomes in hospital health workers. *Front Psychol* 2019;**10**:1302.
16. West M, Coia D. Caring for Doctors, Caring for Patients. GMC, 2019. https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf (31 March 2020, date last accessed).
17. Health and Safety Executive. Management Standards. <https://www.hse.gov.uk/stress/standards/index.htm> (29 March 2020, date last accessed).
18. Kinman G, Teoh K. What Could Make a Difference to the Mental Health of UK Doctors? A Review of the Research Evidence. Society of Occupational Medicine, 2018. https://www.som.org.uk/sites/som.org.uk/files/LTF_SOM_mental_health_of_doctors_0.pdf (31 March 2020, date last accessed).
19. Health and Safety Executive. Employer's Responsibilities. <https://www.hse.gov.uk/workers/employers.htm> (25 March 2020, date last accessed).