Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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How Could I Do Something So Wrong? Restirring concept of Moral Injury & healing within health care context of COVID-19 pandemic

Dear Editor,

Moral Injury (MI) is a well-established concept in combat settings wherein the psychiatrist Shay (1994) first observed that some Vietnam veterans did not suffer from Post-Traumatic Stress Disorder (PTSD) but a kind of wound defined as *"a betrayal of what's right"* by someone in authority in a high-stake situation resulting in perpetuating feelings of hopelessness, loss of faith on goodness of humanity and disenchantment. Though the current pandemic at the outset may appear like a different context, it has similarly exposed health care workers (HCWs) with innumerable moral and ethical dilemmas especially in a resource limited setting, which brings forth the direct relevance of the concept here.

Imagine a Health Care Worker (HCW) in a crowded COVID-19 emergency room perplexed at resolving the dilemma to provide the only available ventilator to one out of two critical patients. While the HCW knows that it had to be provided to patient with highest odds of survival and did so, it was hard not being able to offer the same to someone who needed it with equal urgency. It deeply bothered the HCW. Soon after the HCW found that both patients died, despite one of them receiving the optimal treatment. Now the HCW is overwhelmed with feelings of immense guilt, replaying the scenarios repeatedly in mind, anticipating all the possible choices that could have been made that might have lead to a different outcome. The HCW started thinking that the wrong decision-making led to death of the patients and soon this gets translated into blameful self-statements such as "*I am the reason for all the suffering*" "*My foolishness led to loss of lives*". To avoid dealing with this distress, the HCW immersed in work, distracted continuously, and avoided any lone time when these thoughts would have become unbearable. But the distress just followed the HCW everywhere and gradually it becomes overwhelming. The HCW tried calming oneself down with reasons like "*you did your best*", "*you followed the protocol*", the feelings of violation of deep moral values kept burdening the HCW with guilt and shame. The situation is precisely the context when MI perpetuates.

HCWs are exposed to such inevitable and unavoidable conundrum each day. For example, conflict between catering to increased demand versus reduced supply; less time for preparation versus very hard and quick decision making; knowing what's best versus providing whatever available; need to provide intensive care versus avoidance due to fear of infection among others. These challenging situations are called as Potentially Morally Injurious Events (PMIEs) or "situations perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations (Litz et al., 2009). It is important to note that just like presence of every trauma may not necessarily lead to PTSD, exposure to PMIEs may not automatically lead to MI rather causes wide range of biological, psychological, and social sequelae which has been argued in the literature as natural emotions people undergo when faced with PMIE. However, MI occurs when painful emotions and cognitions in response to PMIEs are avoided, or supressed altogether (Farnsworth et al., 2017) or when the cause of moral transgression is attributed on to global, internal character flaw and stable factors (Litz et al., 2009). As a result, HCWs undergoes a silent suffering which is often escaped by distraction, disenchantment (from work, people around or basic faith/spiritual beliefs), discontinuing self-care, which disrupts the valued-living of the HCW. In fact, the outward manifestation of MI in the form of withdrawal, sadness, crying spells, excessive fatigueness, often confuses people to consider MI as synonymous to "burnout" or "PTSD". However, while burnout is rooted in fatigueness associated with meeting demands of challenging situations at workplace, PTSD is rooted in fear of the reoccurrence of traumatic experiences manifested in the form of flashbacks, nightmares, hypervigilance or avoidance. MI in healthcare context is solely rooted in guilt related to experiencing simultaneous conflict between knowing what's the best care for the patient and being unable to provide it adequately due to constraints beyond one's control (Dean and Talbot, 2019). In the absence of these fine distinction of symptoms, the real distress never receives adequate treatment.

Most proponents of MI describes the space between exposure to PMIEs, initial emotional turmoil and Moral Injury sequel as a "opportunity space" for any active therapeutic work to begin. Literature on moral healing pathways comes from combat setting where one of the most widely accepted pathways discussed in the literature has been attributional pathways, within which, Norman et al. (2014) developed Trauma Informed Guilt reduction (TrIGR) model. It helped people to accurately appraise their non-adaptive guilt associated with trauma and to re-engage with their values in order to lead a more meaningful life. Acceptance and Commitment Therapy (ACT), refined further into ACT-MI has been another effective intervention that broadens the sense of self in people and helps them to unhook from blameful self-narratives, thereby, initiating a process of helping them connect more and more to their deeper core moral values. Similarly, Adaptive Disclosure (Litz et al., 2009) has been a well-known approach to address MI which helps people in accepting part of themselves that did or was subjected to immoral acts along with assisting clients in reclaiming and manifesting goodness and humanity in their day-to-day lives.

Recently, numerous novel recovery pathways has also been proposed within the health care context of the pandemic. One such research derives from teachings of the Bhagavad Gita where the moral distress of the warrior Arjuna was resolved by Lord Krishna through enchantment of four D concept, i.e., Detachment (from the outcome of action performed to the best of one's ability and circumstances), Duty (abiding by ethical and moral principles as much as possible), Doer-ship (where individual self are not only doers but instruments of higher power) and Dhyana or meditation (Menon et al., 2021). Another interesting

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philosophical perspective has been proposed by Akram (2021) who argues that adhering to core medical ethics (autonomy, beneficence, non-maleficence, and justice) is sometimes not enough especially at times of crisis like COVID-19 pandemic, where many decisions are based on resources availability than the ethical principles. Thus "utilitarian approach" should be adopted where consequences matter rather than the rules and hence places concept of good and bad before the idea of right and wrong. There have been suggestions in literature on engaging in "opposite action" to moral transgression resulting in significant reduction of shame as it provides enough evidences for each person's capacity for inherent goodness (Rizvi and Linehan, 2005). Further, Shale (2020) proposes "acknowledgement" as the core intervention element which includes acknowledging that there are universally shared norms and even if they are violated, it continuous to guide one's moral conduct.

Thus, literature has documented promising pathways to moral healing. However, most of them remain hypotheses awaiting systematic evaluation. The concept of MI needs to be focused as a mainstream theme in clinical care as well as research. This shall help ensure that an important dimension of the mental health care needs of the HCWs does no longer get unaddressed. Thank You!

Paper presentation from the current research

None.

Data sharing statement

Not Applicable.

CRediT authorship contribution statement

VC, **YPSB** and **RL** conceived the need for the article. **VC** and **YPSB** wrote the initial draft of the paper which was reviewed and edited further by RL. All authors read and approved the final manuscript and its further review.

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