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Moral Injury: The Invisible Epidemic in COVID Health Care Workers

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Medicine is mourning 3 of our own during the past few weeks, cut down not by the virus, as too many others were, but by their own hands in the midst of the crisis. They signal death by suicide and the arrival of coronavirus disease 2019 (COVID-19) Curve 1.5—the surge of trauma, grief, and moral injury swelling during the pandemic response. If you are reading this for answers to your own emotional struggle, before you finish this piece please pick up the phone and call the Physician Support Line (888) 409-0141 or the National Suicide Prevention Lifeline (800) 273-8255.

To do their job, health care workers not only dress in personal protective equipment but also shield themselves with a protective emotional barrier so they can carry on in times of extreme stress. This is similar to soldiers in battle who arm themselves psychologically and try not to think about the carnage and death that surround them. Health care workers intensively caring for patients may not process the misery surrounding them until they have downtime, and that is where the danger is.

Long before COVID-19, physicians were considering a departure from the workforce at alarming rates. Almost half of our colleagues felt burned out last year. Large corporate medical groups bought small physician-run practices and then budgeted to the bone so that staffing, space, and supplies became tighter and tighter. We expressed our concerns for patient safety and increasing physician exhaustion within these new models, but by and large, the new paradigm was established, and physicians continued to persevere under pressure. Unfortunately, these "lean business principles" before COVID-19, suddenly became life threatening, without enough personal protective equipment or staff and equipment to care for our patients.

Yet, when the COVID-19 plague arrived before personal protective equipment, health care workers put on whatever they had and waded into the fray. It was as ugly as anything we imagined. We pushed aside our fear and frustration to focus on saving the patients in front of us; we kept our eyes open and our feelings closed.

As with soldiers in war, we know that as soon as we stop doing, we will start feeling. The deferred processing of grief and trauma and betrayal—for the patients we've lost, the tragedy we've witnessed, and the risks foisted on us by failures of organizational foresight—will threaten to overtake us. It is hard to know where we are safe.

Our institutions are worried about their own longevity. The river of revenue kept full by elective medical procedures has dried to a trickle. Ensuring basic physical safety is a daily struggle and a financial strain. Leadership, understandably, is distracted trying to ensure there are workplaces to return to after the pandemic emergency. Health care workers are facing pay cuts and furloughs while placing their lives on the line. Many are afraid to voice their fears lest they lose their jobs.

Health care workers have learned that vulnerability—saying, "I need help"—is yoked to shame, not courage. For physicians, especially, too many would rather die than submit to the trauma of admitting helplessness or weakness. There is no space in our organizations to be vulnerable.

The upheaval of the pandemic, which has upended so many norms, is an ideal opportunity to pivot our culture and our expectations. When the virus lets up, the biggest danger is in flipping a switch to "business as usual." The pull to get back to normal will be powerful because we all crave familiar routines, comforting rituals, a predictable future, and a bottom line in the black. The tendency will be to hurry away from the ugliness of COVID-19, but its ghosts already reside everywhere: in hastily built tents and closed-off corridors; in our enduring fear of close contact with our neighbors, friends, and colleagues; and in the public's fear of health care workers who have been "exposed" to the virus. We need time, energy, and intellectual capacity to make peace with those specters and recognize that this emotional processing won't adhere to a timeline or respond to a proscribed approach. Like everything else about COVID-19, the way out of it will be just as difficult and uncharted as the way in.

There are psychiatrists and psychologists who specialize in trauma and posttraumatic stress disorder, and the analysis of this situation is best left to them. There are also plenty of options to access free mindfulness and meditation programs, but you cannot meditate your way into wellness. Organizations and medical systems determine the bulk of our well-being by the policies set at the executive ranks. The compassionate, responsible action from hospitals is to put in place robust plans for supporting their workforce: true crisis teams that can respond to immediate needs; an ongoing, structured psychological crisis response; expanded employee assistance programs to anticipate increased need; memoranda of understanding with local organizations to accept overflow or ongoing care; and expanded support programs besides talking sessions, in which teams or individuals can come together to process their experience differently.

A commitment is needed from hospitals and organizations to provide staffing levels that allow lighter schedules in the coming months, giving time to process this grief, without consequent pay cuts. We implore leadership to pay attention and listen to what frontline workers say they need. Finally, we need an acknowledgement that going back to how health care was structured before is not an option. We have put our lives on the line to take care of patients. We need our organizations to have our backs now.

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