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ETHICS IN MEDICINE

Practical ethical challenges and moral distress among staff in a hospital COVID-19 screening service

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Abstract

The COVID-19 pandemic has led to unprecedented disruptions to established models of healthcare and healthcare delivery, creating a host of new ethical challenges for healthcare institutions, their leadership and their staff. Hospitals and other large organisations have an obligation to understand and recognise the downstream effects that highly unusual situations and professionally demanding policy may have on workers tasked with its implementation, in order to institute risk-mitigation strategies and provide additional support where required. In our experience, targeted ethics-based forums that provide a non-confrontational platform to discuss and explore the ethical dilemmas that may have arisen have been well received, and can also serve as useful and immediate feedback mechanisms to managers and leadership. Using two case illustrations, this article examines some of the ethical challenges and dilemmas faced by these staff, based on discussions of shared experience during a clinical ethics forum for the Screening Clinic staff at Austin Health, Melbourne, Victoria.

Introduction

The COVID-19 pandemic has led to unprecedented disruptions to established models of healthcare and healthcare delivery, creating a host of new ethical challenges for healthcare institutions, their leadership and their staff. Dynamic and rapidly evolving circumstances have required the immediate implementation of new policies and procedures aimed at minimising the transmission of COVID-19 to patients, their families and carers, and hospital staff.

Australia, with its relatively low prevalence of COVID-19 infection, has had a vastly different healthcare worker experience compared to much of the global workforce. Nevertheless, as Victoria entered its 'second wave' in July 2020 and metropolitan Melbourne was placed into lockdown, health services implemented new and rigorous regulations around public and staff screening and visitation, in particular the introduction of staff screening clinics and entry checkpoints, and significant changes to visitor policies. At the forefront of the implementation and enforcement of these hospital policies and procedures are the nurses, doctors, nursing students and medical students working in the screening clinics and at the screening checkpoints.

This article examines, using two case illustrations, some of the ethical challenges and dilemmas faced by these staff, based on discussions of shared experience during a clinical ethics forum for the Screening Clinic staff at Austin Health, Melbourne, Victoria.

Case 1: I want to visit my dying father…

It is August 2020, and Victoria is reporting hundreds of new cases of COVID-19 daily. Frank, 65, has been unwell with advanced cancer for some time, but has recently been feeling worse. Today, he collapsed at home and was rushed to hospital via ambulance, and has now been admitted to the palliative care ward. He has improved somewhat and is stable, but it is unlikely he will survive this admission; he is expected to die in the coming days to weeks. Sam, Frank's daughter, has not seen him since February, to protect him from any unnecessary risk of COVID-19. She has been updated on Frank's situation by her mum and has driven across town to visit. She is distraught, pleading and demanding to visit her father.

Jen is a final year nursing student who has been working at the hospital's screening checkpoint for the past

4 weeks, during which time she has seen many similar situations unfold. Jen has also had personal experience with the death of her own grandmother, and found spending time with her during her final weeks a source of significant comfort and closure to her and her family. As it is not expected that Frank is imminently dying, she knows that the hospital policy does not permit visitors in this circumstance, and that this policy is in place to protect both patients and staff. Jen must explain to Sam that her father's condition is not critical enough to permit a visitor at this time. However, seeing Sam's distress she cannot help but question whether she is doing the right thing.

Case 2: should I come in to work tomorrow?

It is now October, and new COVID-19 cases are becoming less frequent. Lisa, a nurse with 30 years' experience, is working a morning shift at the staff screening checkpoint as everyone arrives for their day's work. Lisa sees Bruce, a senior registrar with whom she has worked on the wards in previous years, skipping past the queue and trying to walk through without the mandatory check-in and mask-exchange required for every staff member as they enter the hospital. Lisa stops Bruce, and asks him to check-in and change his mask. Bruce does not recognise Lisa, and proceeds to berate her for interrupting his busy morning, coming right up to her face without his mask on to protest loudly. These experiences are becoming more frequent, sometimes several times in a shift. Lisa, who has an immunocompromised partner and two grandkids at home, wonders whether she needs to come to work every day to be treated like this.

Discussion

The cases above are hypothetical but based on the experiences discussed by Austin Health COVID-19 Screening Clinic staff at a clinical ethics education session. This forum was organised by the authors at the request of key COVID-19 clinic staff who, having attended a hospital Clinical Ethics Grand Round on moral distress related to novel scenarios created by COVID-19, recognised that clinic staff had faced and were continuing to face ethical dilemmas particular to their clinical roles and responsibilities, and that there had been no formal opportunities emotionally and intellectually to process their experiences. The session was delivered as a structured group reflection rather than a didactic lecture, which has been found to increase insight into ethical issues surrounding challenging situations,[1] and had three main objectives. First, to provide a forum for open discussion with colleagues to foster peer based learning and support through discussion of shared experiences.[1] Second, to highlight the ethical dilemmas faced by healthcare workers asked to enforce difficult policies that require the careful balancing of competing interests, including public health considerations which do not often feature prominently in many of the staff's daily work and ethical frameworks . Third, to equip staff with a better understanding of the sources of emotional and, more specifically, moral distress, and provide a framework for processing these experiences. The cases are two examples of many challenging situations and dilemmas faced by screening clinic staff. Other longstanding quandaries were also reported by screening clinic staff, including the challenges of providing care for colleagues, the difficulties of balancing research and clinical priorities and concerns about falling unwell at work or carrying an illness to family at home, all of which have been brought into renewed focus by the COVID-19 pandemic.

The pandemic has necessitated a shift of practice from 'patient-centred' ethics towards 'public health' ethics, where the needs of an individual patient and their family are subsumed by the needs of the wider public. This has disrupted many of the key tenets and practices of traditional nursing and medical care,[2] in particular patient- and family-centred care. Repeated exposure to ethically challenging situations can lead to moral distress, which may be experienced when individuals are faced with external circumstances or situations that conflict with their internal beliefs and values.[3]

In the first case, Jen is torn between her professional and personal obligation and desire to provide the best care for her patients, which is amplified by the emotionally laden situation of a dying person and their distressed relative, and the institutional, public requirement to protect the health of the community at large, creating tension between two competing moral goods. The dissonance between these competing needs as outlined, even when on balance an individual recognises the overarching need for policy in such a case, can often be experienced as moral regret.

In the first case, regarding visitor restrictions and terminally ill patients, usual (pre-pandemic) practice has been to allow family members' unrestricted access during a patient's last days of life, and is in line with Jen's professional and personal values and experience. Without this opportunity, Jen is aware of the distress caused to both the patient and their family, and has read enough accounts of family members separated from dying loved ones to recognise the lasting negative impact that this is likely to have on family members for years to come. However, Jen also recognises that, during a pandemic, particularly when community transmission is

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higher, visitors bring an increased risk of introducing infection to patients, other visitors and hospital staff.

Intellectually, Jen can understand the rationale of the policy, which aims to balance the competing moral goods of compassionate patient- and family-centred care and public health values and considerations aimed at safeguarding the health of staff, as well as minimising disruption to medical services from staff who are furloughed or unwell. However, accepting the reasoning behind the policy does not necessarily alleviate the discomfort or distress that Jen feels; the desire to provide patient- and family-centred care, and the strong human desire to be together at such times, is not able to be fulfilled due to constraints beyond her control.

In the second case, Lisa is confronted with a conflict between her duty to care, and obligations to her and her family's personal well-being. Duty 'to' care, in contrast to duty 'of' care (a legal obligation to provide a certain standard of care), refers to an ethical concept around a clinician's role-based responsibility to provide care, and includes all aspects of healthcare work. In Lisa's case, she has offered her service during a healthcare crisis with the knowledge that her job in the screening clinic puts her at higher risk of contracting COVID-19. Part of her work requires her to protect the institutional and public health by enforcing the screening protocols. Balancing healthcare workers' duty to care and their own personal safety during a pandemic or other health crisis has been the subject of much consideration,[4,5] particularly in international contexts where concerns have been raised about inadequate personal protective equipment.[6]

Lisa must also weigh her duty to care with her value as an individual, whose health and well-being is important, not only as a good in itself, but also because healthy staff are needed to provide ongoing patient care. Lisa's well-being, which includes not only her physical but also emotional health, will also be impacted by her family's safety. As the pandemic wears on, she has been exposed to, and has suffered from, behaviours not in line with her own moral values and expectations, such as those exhibited by Bruce. Misdirected aggression and disdain shown towards screening clinic staff by members of the public and, more concerningly, fellow healthcare workers, was discussed by several staff, with significant psychological and moral distress experienced as a result.

How an individual staff member responds to the above situations is by no means uniform. Staff encountering the same situation may have very different responses, ranging from no significant reaction to severe moral distress. For example, if Jen's view is that, on balance, the overarching need for policy in such a case makes sense to her, she may experience this as moral regret, which can be felt when there are competing, morally important choices, even when an individual is comfortable with the decision that has been made.[7] Alternatively, if Jen feels that the restrictions are too harsh, and disproportionate to the risk of infection, she may experience moral distress. Over time, if moral distress is repeated or left unchecked and unaddressed, it may lead to moral injury.

Moral injury has been reported in front-line staff during the COVID-19 pandemic,[8] and the obvious distress of families unable to visit sick patients cannot be overstated, but it is easy to overlook the workers at the intersection of organisational policy and its implementation, who must field the frustration directed towards the service, or the situation, as a whole. In our experience, as senior staff are required to quarantine or sent on furlough due to illness or exposure, it is frequently junior members of the nursing and medical workforce, including students, who are asked to shoulder this challenging responsibility. The effects of moral distress, regret and injury can be manifested both internally and externally, and can manifest as 'burnout' or other psychological sequelae.[9] This can be detrimental to both the individual worker and the wider organisation.[10]

Additionally, considerable emotional labour is often expected of healthcare staff, particularly nursing staff, during their interactions with patients, their families and other staff members,[11] including exemplification of organisational expectations of behaviour and emotionality in the workplace. This labour is often considered to be partly compensated by emotional rewards that workers experience as a result of performing these roles, such as gratitude and appreciation from patients and their families,[12] and the satisfaction experienced in having provided good emotional care. In the cases above, despite the considerable emotional work being asked of the Screening Clinic staff members, little in the way of appreciation can be expected in providing many of the requirements of this role, indeed high levels of patient and other staff member dissatisfaction may be experienced, compounding the psychological loading of working in these clinics. However, successful navigation of a morally distressing situation can lead to personal and professional growth, and an enhanced 'moral sensitivity'.[3,13]

Hospitals and other large organisations have an obligation to understand and recognise the downstream effects that highly unusual situations and professionally demanding policy may have on workers tasked with its implementation, in order to institute risk-mitigation strategies and provide additional support where required. In our experience, targeted ethics-based forums that provide a non-confrontational platform to discuss and explore the ethical dilemmas that may have

arisen have been well received, and can also serve as useful and immediate feedback mechanisms to managers and leadership, by allowing for the identification of specific areas of concern that can then be addressed. On reflecting on the forum, many staff indicated that this had been the first opportunity to reflect and think constructively about their experiences, in addition to the noting the solidarity developed by relating to and recognising shared experiences voiced by their colleagues. Such forums do not necessarily provide answers or solutions to these complex issues, but are valuable in providing a framework to explore and process ethical issues in order to address and alleviate moral distress, and protect against the moral injury that may otherwise result.

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References

1 Rasoal D, Skovdahl K, Gifford M, Kihlgren A. Clinical ethics support for healthcare personnel: an integrative literature review. *HEC Forum* 2017; **29**: 313–46.
2 Hossain F, Clatty A. Self-care strategies in response to nurses' moral injury during COVID-19 pandemic. *Nurs Ethics* 2020; **28**: 23–32.
3 Deschenes S, Gagnon M, Park T, Kunyk D. Moral distress: a concept clarification. *Nurs Ethics* 2020; **27**: 1127–46.
4 Dwyer J, Tsai DF. Developing the duty to treat: HIV, SARS, and the next epidemic. *J Med Ethics* 2008; **34**: 7–10.
5 McDougall RJ, Gillam L, Ko D, Holmes I, Delany C. Balancing health worker well-being and duty to care: an ethical approach to staff safety in COVID-19 and beyond. *J Med Ethics* 2021; **47**: 318–23.
6 Schuklenk U. What healthcare professionals owe us: why their duty to treat during a pandemic is contingent on personal protective equipment (PPE). *J Med Ethics* 2020; **46**: 432–5.
7 Gasdaglis K. Moral regret and moral feeling(s). *Inquiry* 2019; **64**: 424–52.
8 Williamson V, Murphy D, Greenberg N. COVID-19 and experiences of moral injury in front-line key workers. *Occup Med (Lond)* 2020; **70**: 317–9.
9 Kopacz MS, Ames D, Koenig HG. It's time to talk about physician burnout and moral injury. *Lancet Psychiatry* 2019; **6**: e28.
10 Burston AS, Tuckett AG. Moral distress in nursing: contributing factors, outcomes and interventions. *Nurs Ethics* 2013; **20**: 312–24.
11 Riley R, Weiss MC. A qualitative thematic review: emotional labour in healthcare settings. *J Adv Nurs* 2016; **72**: 6–17.
12 Bolton SC. Who cares? Offering emotion work as a 'gift' in the nursing labour process. *J Adv Nurs* 2000; **32**: 580–6.
13 McCarthy J, Deady R. Moral distress reconsidered. *Nurs Ethics* 2008; **15**: 254–62.