Chapter 3
COVID-19 and Moral Distress/Moral Anguish Therapeutic Support for Healthcare Workers in Acute Care: Our Voice

Victoria L. Cerone

Introduction

In the midst of the novel coronavirus disease (COVID-19) pandemic (WHO 2020), healthcare workers (HWs) worldwide are at the forefront of a war against the viral enemy. As with all wars, the COVID-19 battle has claimed mass casualties. Reported by the Johns Hopkins Coronavirus Resource Center (2020), as of July 18, 2020, there were 14,107,052 confirmed cases worldwide and 602,657 deaths. In the United States, there were 3,677,453 confirmed cases and 140,888 deaths. HWs in hospital facilities’ acute care areas—including physicians, nurses, social workers, dieticians, chaplains, pharmacists, physical and occupational therapists, and varied support workers—are caring for the medical needs of these patients against the backdrop of their own fear of exposure. Also, with the increase of people presenting to acute care, HWs are concerned about having adequate resources to treat COVID-19 patients and those with other conditions (Moench 2020; White and Lo 2020). Thus, the COVID-19 crisis is a time of acute shared trauma for HWs and the communities they serve.

Where HWs treat patients undergoing life-altering events, the HWs are commonly at risk for traumatic workplace experiences of moral distress and moral anguish (MDA). Jameton (1984) offered the first definition of moral distress in the nursing literature. He described moral distress as occurring when a nurse experiences a painful feeling of knowing the right thing to do but encountering constraints (e.g., organizational policies) that make this course nearly impossible to pursue. In Corley (2002) the effect of MDA on nurses is examined as to how it correlates with organizational support or lack thereof. Unlike moral distress, which refers more
narrowly to an individual’s emotions in response to institutional constraints, moral anguish encompasses interpersonal reactions to a specific patient interaction. Included in MDA are one’s own value-laden standards of behavior or beliefs concerning what is and is not acceptable to do and the emotional and existential conflict that can occur in attempting to reconcile these standards with organizational guidelines of patient care.

The potential is high for the COVID-19 pandemic to increase MDA among HWs. They are working during an enormously stressful time, enduring high mortality rates alongside unusual isolation, as acute facilities have restricted social interaction between colleagues and visitors for patients in an effort to contain the spread of the virus. This chapter examines how MDA is being experienced by HWs since the arrival of COVID-19. It highlights therapeutic approaches that may serve to mitigate their distress and build resilience, allowing them to continue the work.

Moral Distress and Moral Anguish

Figley (1995) describes a parallel phenomenon in which a clinician experiences secondary trauma when treating traumatized people. The emotional stress on the clinician may manifest in symptoms of “compassion fatigue,” including the responses “sadness, depression, sleeplessness, and gen anxiety…” (pg. 16). MDA encompasses emotional responses common to compassion fatigue and other syndromes: burnout and post-traumatic stress disorder (Hamric 2014). MDA responses include physical exhaustion, gastrointestinal issues, headaches, insomnia, nightmares, anger, frustration, anxiety, depression, depersonalization, and loss of personal fulfillment (Dalmolin et al. 2012). HWs working in the high-stress environment of a pandemic are at high risk for psychological distress with responses in accord with MDA, including fight or flight response, anxiety, panic attacks, post-traumatic stress, depression, and others (Cai et al. 2020; Mecca 2017; U.S. Department of Veterans Affairs National Center for PTSD- NCPTSD 2020). Dr. Spoorthy (2020) of the Department of Psychiatry at Jawaharlal Nehru Medical College, Wardha, India, conducted a review of six current studies (Cai et al. 2020; Kang et al. 2020; Lai et al. 2020; Liang et al. 2020; Mohindra et al. 2020; Xiao et al. 2020) looking at mental health problems HWs may confront during the COVID-19 pandemic. All six studies found data which suggest health sector work during COVID-19 could be an independent risk factor for disturbances of emotional stress (e.g., depression, anxiety, and insomnia). The participants of the studies were identified as physicians, nurses, and other/allied healthcare workers. Although social workers were not specifically identified as research participants, in acute care, they are included as primary members of the medical teams providing care. Therefore, social workers working with patients with COVID-19 are subject to the same risk of moral distress as their colleagues. Also, where work involves such physical and emotional distress, social workers, as all HWs, may feel a loss of job satisfaction, making them more likely to abandon the job and the profession (Nathaniel 2002). Significant rates of
attrition may result in lower standards of care and other possible issues related to the care and safety of patients (Corley 2002).

MDA occurs across health professions but can occur for different reasons and to different degrees depending on circumstances. At an 825-bed medical center in Virginia, Whitehead et al. (2015) found evidence of moral distress among many healthcare professionals (n = 592): nurses, social workers, physicians, dieticians, chaplains, pharmacists, and physical and occupational therapists. The study utilized the 21-item Moral Distress Scale-Revised (MDS-R) (Hamric et al. 2012) and a shortened measure of Olson’s Hospital Ethical Climate Survey (HECS-S) (Olson 1998). Findings from the study showed that nurses had the highest levels of MD. Further, Whitehead et al. (2015) found that “watching patient care suffer due to lack of provider continuity” (p. 117) was a top cause of moral distress across the professions. Pressure from insurers to reduce costs was often reported as a root cause for moral distress by non-ICU workers but less so by ICU workers. Whitehead et al. (2015) further noted that “continuing to care for a hopelessly ill patient when no one will make a decision to withdraw support” (p. 122) was a common source of moral distress for ICU workers.

Dalmolin et al. (2012) synthesized scientific literature over the prior 10 years and looked at moral distress in nurses and the similarities between this phenomenon and burnout. The review found that signs/symptoms of moral distress experienced by nurses included physical and emotional dimensions which affected their lives and the lives of those they cared for in their organizations.

What Does MDA Look Like During the COVID-19 Crisis?

Ms. M1 is an 84-year-old female who was admitted to the hospital intensive care unit (ICU) for fever and shortness of breath. While in the ICU, she tested positive for COVID-19 and her symptoms worsened. Her course was complicated by pneumonia, cardiac arrhythmia, persistent fevers, and ventilator dependency. Years prior to admission, Ms. M had been diagnosed with sugar diabetes which she controlled with medication. She was an active person, living alone since the death of her spouse 10 years prior. She enjoyed spending time with her three adult children and several grandchildren. During her 35-day course of treatment, her medical status improved, which included being weaned off the ventilator, supported by a high level of oxygen via a nasal cannulation. The HWs, an interdisciplinary team including physicians, social workers, and RNs, and her family were cautiously optimistic her condition would continue to improve. Unfortunately, while Ms. M remained in hospital, her eldest daughter was stricken with COVID-19 and admitted to another acute facility. Sadly, Ms. M’s daughter passed away from the virus. The family struggled with

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1All names and other personal identifiers of this case have been changed to protect privacy and confidentiality.
whether to tell Ms. M, concerned that doing so would risk her relapsing. Ms. M had noticed her eldest child missing from video chats, however, and eventually the family, unable to hide their overwhelming grief, told her. With this news the family’s worst fears were realized: Ms. M’s medical status declined. She seemed to lose the will to live, and within days of the news, she died.

**MDA Challenges**

The HWs treating Ms. M faced several MDA challenges as a result of the organization’s no visitation policy. Every day during normal circumstances, HWs witness how the power of touch, in something as simple as a hug from a caring person at the bedside, addresses the patient’s need for human connection and soothing. Winnicott (1953) believed that as babies, humans have transitional self-regulating abilities directed toward finding objects to meet their needs, e.g., a mother’s voice for soothing. Bowlby (1969) developed attachment theory, which deepened the understanding of the need for people to feel and stay connected to others. The presence of family caregivers at the bedside often reinforces a feeling of caring human connection, which in turn may strengthen a patient’s resilience to endure often laborious or agonizing treatments and their chances of survival and return to normal life.

To help cope with Ms. M’s and her family’s feelings of isolation, the social worker and RNs treating her implemented video chats with a cell phone and laptop. This was difficult for the patient as she was not familiar with screen chat and just wanted to see her children in person. It was extremely difficult for the family, who wanted to be with her. The situation was stressful and MDA inducing for the HWs, who understood the organization’s reasoning in forbidding visitors to help curb the spread of the virus but felt helpless to provide the time and level of support needed by Ms. M and all of their patients.

It is a primary social work tenet that a person’s self-determination and autonomy should be facilitated wherever possible. However, as has been the case with many patients stricken with this sudden and debilitating illness, prior to COVID, Ms. M had not discussed with her family her wishes regarding her medical care should she become critically ill. As her symptoms worsened, she deferred to her family to discuss with the HWs her goals of care and treatment plan. The HWs struggled with identifying via video chats the family’s physical cues to facilitate a comfort level in such discussions. For example, during in-person discussions, the social worker may respond to moments of apparent distress by pausing, touching a shoulder, or providing other simple gestures of comfort and understanding. These can make discussions much smoother when serious concerns are being addressed, such as the futility of sustained treatments in which the burdens may outweigh the benefits (e.g., painful tests, prolonged intubation, tube feeding). During video discussions such gestures were difficult or impossible. Meanwhile, the family and the HWs struggled with wanting Ms. M to recover, while understanding her poor prognosis and seemingly diminished wishes to prolong her life after the death of her child. After several
meetings the family began to accept her poor prognosis, eventually transitioning to comfort care.

The HWs felt Ms. M and her family were robbed of their time to be physically together to support and comfort each other during the most sorrowful time of their lives. The social worker L consoled the patient and family, working to bear witness to, and therapeutically hold, their fear and anxiety. L facilitated between the medical team and family a person-centered experience that involved empathic listening and validation of their feelings as they processed their anticipatory grief. After Ms. M died, the family thanked all of the HWs for their care. They were most grateful to L for her frequent calls to listen to their concerns and update them as to how Ms. M was physically and emotionally enduring.

The HWs shared their compassion and distress with the process. Each from their own perspectives, members of this interdisciplinary group struggled with MDA; their compassion caused them distress in witnessing Ms. M’s hospitalization, grief, and death and the grief of her family. Due to the intense needs of all their patients coping with the challenges of treatment, they had minimal time to discuss their distress among themselves. L questioned her role in the process, wondering how, or even whether, SWs can effectively intervene and assist in the processing of anticipatory loss/grief in a setting of isolation. She noted that isolation was a factor not only for patients separated from their families but also for HWs who felt deprived of normal levels of support from colleagues, since all were guarded with masks, gowns, gloves, and social distancing policies. For her own self-care and to soothe her distress, L listened to classical music from her country of origin. The music, which her mother used to play for her, reminded her of happier times as a child, and this brought comfort to her and strengthened her resolve to continue the work. However, it was also bittersweet, as her mother had died years earlier and the comforting music reignited L’s grief.

**Professional Perspectives and MDA Challenges**

HWs are collectively taught and work from a perspective of historical knowledge within mission-driven organizations. Physicians, social workers, nurses, and other hospital HWs practice with a medicalized lens of themselves and their patients. The disciplines work as teams in a structured fashion, a collective body working to stabilize symptoms and discharge patients. Structured methodology is practiced to reduce suffering and to make room for the next patient. It gives universality to the discipline, in effect saying “We are all in this together, aware of what others are doing for a focused outcome.” The structure normalizes events which are not everyday occurrences in an individual’s life. Under normal circumstances, this allows HWs to proceed with a semblance of certainty and regularity, even when patients and their families are feeling disoriented and unsure.

However, with the advent of COVID-19, I and my fellow HWs have been reminded of how wildly unpredictable illness can be. In contrast with everyday
illnesses, a pandemic is largely unknown to HWs as it is to the general population, and they must often improvise and learn how to respond as they go along, all while facing a surging number of cases. It is thus a powerful lesson in how life and death do not always follow a delineated path. The story of COVID-19 is more than the numbers, and it is not finished. It is still being created in narratives being authored and shared by all involved, especially the HWs, patients, and their loved ones. It is not sanitized but messy with tears of regret and thoughts for the future.

In the midst of caring for patients with COVID-19, HWs are enduring a shared trauma, or “experiences of clinicians exposed to the same community trauma as their clients” (Tosone et al. 2012, p. 231). I, along with my colleagues, the patients, and their caregivers, fear the virus and suffer isolation from loved ones because of it. Patients and caregivers are unable to physically be with each other; when HWs go home, many are isolated as they practice social distancing from spouses, children, parents, and friends out of fear of spreading the virus. Many have sent their families away to less affected areas. Others who live alone are unable to see their parents, sisters, brothers, nieces, and nephews because their work in the hospital makes them high-risk visitors. Many are making life and death decisions for their own loved ones with COVID-19 or other critical illness while caring for patients. They, too, are being robbed of precious time with their loved ones due to no-visitor policies.

This tragic chapter in history must be explored and understood in terms of shared trauma (Tosone 2011). In its dual reality of isolation and universality, it facilitates a particular way of understanding the human experience. During the COVID-19 crisis, I have worked with varied medical services and with both patients and caregivers, all undergoing their unique experiences but all experiencing forms of loss. All long for the chance to be with their loved ones, rest, administer self-care, and inform themselves while and contemplating medical goals of care and treatment options. During this time, I lost a loved one from an illness unrelated to COVID-19. The organizational policy of no visitors heightened my feelings of moral distress as it robbed us of our time together. After a few days of prohibited visitation, I was allowed to visit and was thankful for this. But, as was the case for my patients, visitors were restricted to one, so I was alone with no friends or family support at bedside.

My loved one died, and although my grief is at times unbearable, I find some comfort in being part of a new shared reality which many in the world will have to overcome and in the knowledge that, with my colleagues, I am being forced to forge a new reality. I question: How am I going to do my work? How will I and my work be different because of the pandemic and its protocols? Will I be able to provide a holding environment, especially when I don’t even know what I have left to give? How do I keep my personal experiences and feelings separate from my patients’? How do I share my experience, adding life and practice wisdom but not blurring the lines between my experience and those of my patients?

I do this work with benevolent intentions of helping others. However, there is a reciprocity in provider-patient interactions, a natural back-and-forth that must be managed. When I am feeling I might share too much, I return to early-learned social
work basics: start where the client is; and if in doubt, ask yourself why. I find these basics give me some distance, a moment to pause, and reestablish focus on the work at hand. The following section of this chapter outlines therapeutic strategies which have helped me as a medical social worker to maintain this focus and address clients’ needs and can be applied to HWs in general, to mitigate the distress of the work and build resilience in battling MDA. The reflective and transformative models lend themselves to “post-traumatic growth” regarded as “positive psychological change” to help cope with our feelings of MDA (Tedeschi and Calhoun 2004, p.1). This experience can also illustrate “shared resilience in a traumatic reality” (Nuttman-Shwartz 2014, p. 1) in that both HWs, patients, and their family members can undergo positive transformations and interpret their experiences through a different lens.

The model of reflective learning cycle (Gibbs 1988) can be implemented in a group process or one on one. The cycle includes processing an event in terms of description, feelings, evaluation, conclusion, and action. This sequencing enables reflection and critical thought about incidents and occurrences in order to learn from them. For example, a registered nurse (RN) was experiencing MDA as a result of their uncertainty about how to respond to a patient saying, “I think I am going to die today.” The RNs found themselves trying to ease the patient’s fears by saying “It’s going to be OK. We are here to help you.” The RN was hopeful and focused on the patient recovering. Unfortunately, however, the patient died, and the RN in retrospect felt their response to the patient, meant with great empathy, had been inadequate and unprepared; looking forward, the RN feared dealing with any similar situations with future patients.

The reflective model facilitates a reevaluation of what occurred and possible future responses should it occur again. It helped the RN to envision processing the patient’s fears from a stance of not fixing the situation but instead just being and bearing witness. Should a patient state they are dying in the future, the RN might respond with “I hear you” and/or “Do you want to talk about what you are feeling?” During COVID-19, social workers as well as all HWs are treating an unprecedented number of critically ill patients fearful they are going to die. Many of the patients prior to contracting the quickly debilitating virus were healthy. The reflective model offers HWs a quick, agile tool to recalibrate one’s thoughts and personal reactions to the fear of death, allowing them to continue the work feeling more prepared for situations as they unfold. I carry a copy of the model in my work papers. It helps me not to dwell endlessly on self-doubt over what I feel I might have done wrong. Instead I can acknowledge the issue and critically develop alternative responses.

Another approach, transformative learning (Mezirow 1990), seeks transformation in regard to psychological subjective responses, beliefs/values, and behavioral knee-jerk reactions. It describes a planned course of action which includes acquiring knowledge and skills for the purpose of understanding and validating clinical practice, with a focus on questioning how we know versus what we know. For example, an HW may experience an MDA conflict around questions of treatment benefits versus burdens for the patient and the patient’s family. One HW experienced MDA witnessing the volume of pain management medications administered
to a patient, medications which controlled physical pain but left the patient unable to communicate with their family due to sedation. The HW understood it is humane to have the patient comfortable and without pain; however, they also expressed sadness watching how the medication limited the patient’s communication with loved ones. In another example, the HW had the opposite experience: the patient’s family wanted only a minimal dose of sedation, even though the patient was uncomfortable, and their pain level was not properly addressed. The HW felt powerless. In both cases, education and critical thinking regarding the efficacy or futility of treatments may help HWs clarify the situation in their own minds and, possibly, in communication with patients’ family members going forward. Treating COVID-19 is especially a challenging time when HWs need guidance on how to be kind to ourselves while responsive to the needs of our patients, caregivers, and colleges. The reflective and transformative models lend themselves to “post-traumatic growth” regarded as “positive psychological change” to help understand and cope with our feelings of MDA (Tedeschi and Calhoun 2004, p.1).

Witnessing the substantial level of MDA among HWs involved in such agonizing situations, one question becomes poignantly obvious: How do HWs care for themselves? A crucial first step in helping HWs deal with MDA is acknowledging the existence of MDA and their struggles with it. MDA is inevitable for most HWs, a matter of when, not if. HWs must set aside the notion that MDA is a sign of emotional or physical weakness and acknowledge their strengths, while assessing their coping abilities and resources for resilience. Resilience influences how an event is appraised (Fletcher and Sarkar 2013). Resilience is “not just an attribute or capacity”; it is a “process to harness resources to sustain well-being” (Panter-Brick and Leckman 2013, p.334). COVID-19 has facilitated a shared resilience (Nuttman-Shwartz 2014) as HWs battle the virus in emergency departments, intensive care, and other hospital units. The feeling is we are stronger in numbers and we will adjust to what is needed fighting this horrific virus together.

To aid HWs’ recovery and maintaining personal wellness, organizational policies and therapeutic practices must be directed toward acknowledging, understanding, and addressing their feelings of moral distress and moral anguish. Hamric and Epstein (2017) described three well-recognized approaches to addressing healthcare workers’ moral distress: a direct approach (e.g., journaling, retreats, systematic reflection), an indirect approach (e.g., education, ethics conversations discussing examples and different views), and a general approach (e.g., policies that target institutional restraints and interprofessional relationships) (p. 128).

Many institutions pre-COVID-19 developed wellness collaboratives to address MDA. For example, Schwartz Center Rounds is a group forum organized for case reflection, along with psycho-education projects, interactive competency workshops, and systematic rapid/ongoing response teams. With regard to maintaining social distancing, many Internet resources are available, e.g., Social Work Hospice and Palliative Care Network (SWHPN) and Center to Advance Palliative Care (CAPC). HWs themselves often take responsibility for identifying MDA issues and searching for solutions in a grassroots fashion. The self-determination to do so initiates the self-care process, heightening autonomy and ownership of one’s welfare.
Conclusion

Acute care requires critical thought and moral courage to underpin engagement with difficult biopsychosocial circumstances. This challenging work requires management of time, tempo, and negotiating and maintaining boundaries, while dealing with the complexities of detachment, commitment, desensitization, and compassion (Breaden et al. 2012). HWs must be engaged in self-care and understand the potential for MDA to arise, as well as interventions available to lessen its effects. The implementation of educational programs has proven to mitigate moral distress in acute care settings (Brandon et al. 2014; Rogers et al. 2008). However, such resources and accommodations are not always offered by organizations. The insights of this chapter come from case examples exploring circumstances, determinants, and therapeutic modalities related to understanding and addressing MDA in a time of COVID-19. The case vignettes provided are brief narratives of representative experiences of MDA, which have affected HWs across disciplines during the most challenging of times in acute care. The therapeutic approaches Gibbs’ reflective cycle and Mezirow’s transformative learning warrant consideration as interventions to understand and facilitate a strengthening of the self amid the ever-evolving situation unfolding around treatment of COVID-19.

This chapter identifies shared trauma inflicted by the surge of COVID-19 on social workers and those they treat in hospital settings and demonstrates helpful therapeutic approaches to address MDA among HWs practicing in acute care settings. It is a privilege to be a social worker and care for patients and their caregivers during the most challenging of times. I find the work coincides with sadness, bittersweet expression, and often, outstandingly courageous events. Never has this been truer than during the COVID-19 crisis and its particular brand of shared trauma. I make moral sense of the work guided by professional ethics and personal values. Prior to the pandemic, I experienced a greater separation from patients’ experiences. Now, however, we all share a collective experience of loss, fear, and uncertainty. COVID-19 has impacted all of our lives. We are living a shared trauma which has yet to fully unveil the biopsychological toll it will have on humanity, but certainly that toll will be unfolding for decades to come.

While this crisis has underscored the reality of shared trauma, I have long contemplated that social workers are foremost humans sharing in the experience of their clients. Upon coming home from work some years ago, I would routinely be asked by Anne, my 93-year-old mother-in-law, “How are you?” and would routinely reply, “I’m fine.” On one occasion, Anne answered, “Sure, Miss Fine, you work in the hospital all day with sick and dying patients and you are fine” (Cerone 2005). Her comment was said with concern and realism. To set aside and rationalize feelings of MDA fall under the “Miss Fine philosophy,” which works in the short term but is not sustainable over time. At this time, I especially remember her words and have learned from my personal and professional experience with COVID-19 that it is OK to be vulnerable and seek the support of my colleagues. In fact, it is imperative to do so to maintain a semblance of normality in a time of which is not normal.
Going forward by acknowledging, working to understand, and addressing our shared challenges of MDA in this time of COVID-19, I hope to ease our distress, build our resilience, and bolster our courage to carry on our truly compassionate work.

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