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# Support for clinicians with moral loss after the pandemic

**Clare Delany** and **Rosalind McDougall** argue more attention should be given to moral distress as part of health system recovery plans

Clare Delany, [1, 2, 3] Rosalind McDougall[4, 5]

Much of the focus on the state of health services since the height of the pandemic has been on healthcare financing, workforce shortages,[1 2] and physician burnout.[3 -5] Less attention has been given to the physical, psychological, and moral distress healthcare workers experienced because of increased and changed work demands,[6] personal protection requirements,[7] and isolation from peers and workplace supports.[4] Moral loss, for example, occurred when staff had to say no to grandparents visiting their dying grandchild, when a nurse rather than a family member held a dying patient's hand while holding a tablet computer to the family, or from the everyday awareness of how masks prevented patients from hearing and understanding.

Rallying cries to learn from the covid crisis call for regeneration, transformation, and systems change.[8] Such language is ambitious and aspirational, and is largely directed at policy makers, institutions, and health systems.[8] Although structural changes to ease the burden on healthcare workers and ensure they do not experience the particular traumas of the covid-19 pandemic again are important to help healthcare workers recover, post-covid regeneration needs to acknowledge, take seriously, and respond to the moral dimensions of frontline health workers' experiences during the pandemic. Approaches such as facilitated ethics discussions can help clinicians to acknowledge and process their struggles[9] and should be an integral part of covid recovery efforts.

## Moral dimensions arising from the pandemic

When clinicians' agency is constrained or undermined, as occurred in the pandemic, a sense of moral disorientation arises involving a loss of coherence between their sense of moral identity and imposed workplace requirements.[1] As clinical ethicists working in large metropolitan hospitals in Australia we observed loss of moral identity and agency, moral distress, and moral injury among clinicians (box 1).

**Box 1: Moral identity and harms**

- *Moral identity* for clinicians refers to a self-conception that develops from belonging to a community of practitioners who share a framework of values and principles which shape their overall commitment to caring for patients[10]
- *Moral distress* occurs when an individual is required to act contrary to deeply held professional values[11]
- *Moral injury* refers to a disorienting and painful experience that follows violation of deeply held moral commitments.[10] It is a more sustained form of moral distress, originally described in the military veteran literature

In the early phases of the pandemic, clinicians faced overwhelming numbers of patients, distressing triage decisions,[12] and anxiety about their own and their family's wellbeing.[3 12] Across all areas of clinical practice, clinicians had to pivot from their ethical orientation of individual based patient centred care to accommodate public health ethical values of protecting population health and safety.[13] Protecting their own safety at work became a pressing concern[4] and an ethical imperative to preserve the health workforce.[7] Governments and hospital leaders imposed constraints related to infection control, including personal protective equipment,[3 5] visitor restrictions for inpatients,[3] and disruptions to established and evidence based clinical care pathways.[14] For example, delaying cancer surgeries and stopping cancer screening services because of government mandated restrictions was frustrating and distressing for staff who believed the long term consequences and burdens for these patients were greater than the benefits of preventing covid infections.[15] Staff were redeployed, their responsibilities were changed, and in some situations they lost professional control over care decisions.[1 3 5 6 12]

A UK mixed-methods survey study of 257 NHS staff in a single organisation and a US based qualitative study both found that staff burnout and moral distress were linked to loss of control of their work through imposed redeployment and new working patterns.[1 5] A Chinese survey study similarly concluded that a substantial proportion of clinicians in the region were at risk of moral injury symptoms, and that clinicians caring for patients with covid-19 experienced a 28% greater risk than their colleagues caring for other patients.[12] In Spain, a mixed methods study investigating the impact of the pandemic on intensive care staff found that participants perceived a "dehumanisation of care."[3]

These studies highlight that being required to care for patients in ways that conflicted with fundamental health ethics values of patient centred care was distressing for clinicians, inducing feelings of shame and guilt and a loss of moral identity.[14 16] When clinicians are prevented from doing what they believe is right for their patient by a workplace authority (eg, health administrators or governments) their moral distress may lead to an erosion of trust in self and in leadership,[17] feelings of professional powerlessness,[5] and loss of professional integrity to be able to perform their role in accordance with their values.[1] While

many of the underlying factors causing distress among healthcare staff were present before the pandemic and are likely to continue as health systems face backlogs and workforce shortages, the intense and large scale disruption caused by covid-19 greatly worsened the situation, tipping clinicians into a state of moral loss.

## Strategies to repair moral loss

Although the knowledge that structural efforts to improve healthcare staffing, the state of essential equipment, and working conditions (including fair rotas and vacation time approved well in advance, for example) are under way is essential for sustaining healthcare workers in the wake of the pandemic and to avoid future harm, these will not resolve the moral injury that individuals have experienced.

Similarly, systematic interventions that avoid clinicians having to ask for and seek out mental health support, such as peer programmes, reinforcement of social bonds between colleagues, and close monitoring and mentoring by supervisors or managers,[8 13] are important but may not deal with moral injury. Such programmes are often grounded in a deficit perspective (an individual clinician is either lacking in psychological resources or resilience)[18] and include approaches which promote cognitive reappraisal of a past event or response to a past event.[19] However, moral injury and moral loss have been described not as a psychological injury or an erroneous appraisal of past experience but as an injury to a person's moral integrity, professional identity, and sense of morality.[18] Responding to moral injury requires strategies directed specifically at moral repair—for example, by acknowledging the norms that have been violated and listening to and validating emotions of guilt, shame, and resentment.[20]

To ensure frontline clinicians are able to function optimally, recovery efforts should include individual level strategies designed to respond to moral loss as well as other psychological distress or poor mental health. Health leaders must acknowledge the moral dimensions of clinicians' experiences during the pandemic and provide workplace support to counter reactive behaviours such as self-preservation responses, shutting down, disengaging, and avoiding patients.[9] In healthcare, interventions that have been reported as mitigating moral distress include educational interventions, facilitated discussions of 30-60 minutes, specialist consultation services, multidisciplinary rounds, self-reflection, and narrative writing.[21-24]

Evidence is emerging linking workplace supports in the form of facilitated ethics discussions to increased moral agency and professional integrity for individual clinicians. This, in turn, empowers them to provide feedback and take on advocacy for change within their clinical community and at a systems and health policy level.[16] Facilitated clinical ethics discussion and debrief give clinicians an opportunity to name and process their reactions and experiences, to hear from others and therefore situate and make sense of their own experiences, and to make connections between their feelings of moral distress and possible causes. They enable clinicians to distinguish between moral distress arising from constraints on their practice that may or may not have been avoidable[11] and situations where something of value was lost despite appropriate moral balancing informing the decision.[25] Clinicians being able to name the ethical values they believe were being promoted, balanced, or traded-off and identify the constraints placed on them as decision makers, validates their experiences of moral loss and distress, normalises their responses and feelings, and creates a safe space for nurturing the understanding[16] and fostering the resilience required for professional growth and repair to occur despite repeated adversity.[9 26]

Such discussions require a facilitator with specialised clinical ethics expertise who understands the scope and limits of their role, including the potential beneficial and adverse effects of the facilitation approach. Not all health institutions have this expertise readily available.[27 28] These discussions also take time, which is scarce in healthcare settings. However, the potential ongoing damage from failing to acknowledge feelings of resentment in staff who experienced a lack of support from health leaders is more burdensome than the repair work, especially as moral distress contributes to staff attrition.[29] In the absence of a clinical ethicist, some of the benefits of facilitated ethics discussion can be achieved through other avenues such as clinician mentors or "buddies" who partner with colleagues and regularly check wellbeing,[10] peer support groups, and professional supervision.[28] These types of discussions nurture a supportive moral community of colleagues[10] to assist clinicians to make sense of and re-orient their professional moral identity to care for patients.[9 10 28]

The types of questions that can help clinicians to process and heal from experiences of moral loss, distress, and injury are underpinned by a disposition of empathic curiosity[30] and of availability.[10] The facilitator needs to convey genuine curiosity about the clinician's experience and their capacity to understand and make sense of past moral challenges in their clinical practice (box 2). Importantly, the questions and focus of the facilitated ethics dialogue should be pitched at the level of the moral loss clinicians have experienced during the covid pandemic. They are designed to allow clinicians to identify ways of repairing their agency and sense of moral identity and to provide an avenue for clinicians to contribute to redesigning and restructuring processes necessary to repair systems of care after covid.

**Box 2: Questions to support clinicians to process, make sense of, and reframe moral loss**

- Describe what was ethically concerning:
  - What has stayed with you about the clinical experience/event?
  - What was your reaction at the time? How did you feel at the time?
  - Was there something you felt was wrong or unethical?
- Further elaborate:
  - Can you say more about this ethical concern?
  - Does your concern relate to a particular treatment decision?
  - Does it relate to burdens or harms to the patient, or family members?
  - Does it relate to someone's wishes not being respected?
- Highlight possible decision points and options for responding:
  - Can you see any points at which a different decision could have been made?
  - What other options were available at that time, with what was known then?
  - What would have to be in place for other options to have worked?
- Encourage clinician to analyse the ethical pros and cons of each option. For each of the other options identified:
  - What would have been the effect on all those involved?
  - What ethical values would those options have served or promoted?
- Come to a form of resolution:

- Can you see how someone else (also well intentioned) with the same information could have a different view about what should have been done?
- Was this a situation where more than one pathway would have been ethically justifiable?
- Do you now think that a wrong was done (the response being moral distress) or that what was done was the "least worse" option, where any option chosen would have involved some moral loss or compromise (moral regret at unavoidable but justifiable moral loss)?
- If something wrong was done, how could that be avoided in a similar situation in future?

The process of attaining greater clarity and resolution about what was possible or not possible in the circumstances[28] directly addresses experiences of moral loss. Giving clinicians the opportunity to discuss their experiences and interpretations and to listen to others' perspectives and accounts provides an avenue for psychological repair[26] and fosters the capacity to open up thinking rather than close down ways of responding and working with others.

The supportive and safe space of ethics discussions promotes the development of resilience to respond positively to distress and adversity caused by an ethically complex situation.[26] In this way, facilitated ethics discussions offer the possibility of transformative learning and renewal both for individual clinicians and at the interface between the clinician and the health system in which they work.[1 29] As such they should be considered as essential as structural change in policies to renew and repair our health services after covid-19.

**Key messages**

- Patient centred care, moral identity, and professional autonomy over clinical practice were restricted by public health regulations at the height of the covid-19 pandemic
- Frontline health staff experienced moral distress and loss as a result of these restrictions and are unlikely to have recovered
- Facilitated ethics discussions are a way of acknowledging and responding to clinicians' experiences and to repair their sense of moral identity
- They also provide an avenue for them to contribute to redesigning and restructuring health system processes as part of covid recovery plans

Contributors and sources: CD works as a clinical ethicist in two specialist tertiary hospitals in Melbourne and as a consultant ethicist with other health facilities. RM is a clinical ethicist at a large public tertiary hospital. The paper was conceptualised by CD, and both authors drew on their practical experience of clinical ethics consultations, discussions of ethical dilemmas and challenges with clinicians during the past two years, and from the literature documenting moral challenges in healthcare during covid. CD wrote the first draft. RM made substantive contributions throughout. CD is the guarantor.

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1 Navuluri N, Solomon HS, Hargett CW, Kussin PS. Distressed work: chronic imperatives and distress in covid-19 critical care. *Hastings Cent Rep* 2023;53:-45. doi: 10.1002/hast.1458 pmid: 36840335

2 Sharifi M, Asadi-Pooya AA, Mousavi-Roknabadi RS. Burnout among healthcare providers of covid-19; a systematic review of epidemiology and recommendations. *Arch Acad Emerg Med* 2020;9:e7.pmid: 33490964

3 Moreno-Mulet C, Sansó N, Carrero-Planells A, etal. The impact of the COVID-19 pandemic on ICU healthcare professionals: a mixed methods study. *Int J Environ Res Public Health* 2021;18:. doi: 10.3390/ijerph18179243 pmid: 34501832

4 Bismark M, Willis K, Lewis S, etal. *Experiences of health workers in the covid-19 pandemic: in their own words.* Taylor and Francis, 2022doi: 10.4324/9781003228394 .

5 Gemine R, Davies GR, Tarrant S, Davies RM, James M, Lewis K. Factors associated with work-related burnout in NHS staff during COVID-19: a cross-sectional mixed methods study. *BMJ Open* 2021;11:e042591. doi: 10.1136/bmjopen-2020-042591 pmid: 33509850

6 Tian YJA. The ethical unjustifications of covid-19 triage committees. *J Bioeth Inq* 2021;18:-8. doi: 10.1007/s11673-021-10132-0 pmid: 34964927

7 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* 2020;47:. doi: 10.1136/medethics-2020-106557 pmid: 32978305

8 Shapiro J, McDonald TB. Supporting clinicians during covid-19 and beyond - learning from past failures and envisioning new strategies. *N Engl J Med* 2020;383:e142. doi: 10.1056/NEJMp2024834 pmid: 33053277

9 Morley G, Horsburgh CC. Reflective debriefs as a response to moral distress: two case study examples. *HEC Forum* 2023;35:-20. doi: 10.1007/s10730-021-09441-z pmid: 33501627

10 Cahill JM, Moyse AJ, Dugdale LS. "Ruptured selves: moral injury and wounded identity". *Med Health Care Philos* 2023. doi: 10.1007/s11019-023-10138-y pmid: 36780060

11 Jameton A. *Nursing practice: the ethical issues.* Prentice Hall, 1984.

12 Wang Z, Koenig HG, Tong Y, etal. Moral injury in Chinese health professionals during the covid-19 pandemic. *Psychol Trauma* 2022;14:-7. doi: 10.1037/tra0001026 pmid: 34043381

13 Thompson AK, Faith K, Gibson JL, Upshur RE. Pandemic influenza preparedness: an ethical framework to guide decision-making. *BMC Med Ethics* 2006;7:E12. doi: 10.1186/1472-6939-7-12 pmid: 17144926

14 Delany C, Benhamu J, McDougall R, etal. Supporting cancer care clinicians to 'hold' their patients during and beyond the covid-19 pandemic: a role for reflective ethics discussions. *Intern Med J* 2021;51:-5. doi: 10.1111/imj.15375 pmid: 34278682

15 Delany C, Benhamu J, McDougall R, etal. Supporting cancer care clinicians to 'hold' their patients during and beyond the COVID-19 pandemic: a role for reflective ethics discussions. *Intern Med J* 2021;51:-5. doi: 10.1111/imj.15375 pmid: 34278682

16 Greenberg N, Docherty M, Gnanapragasam S, Wessely S. Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ* 2020;368:. doi: 10.1136/bmj.m1211 pmid: 32217624

17 Williams RD, Brundage JA, Williams EB. Moral injury in times of covid-19. *J Health Serv Psychol* 2020;46:-9. doi: 10.1007/s42843-020-00011-4 pmid: 32363349

18 Litam SDA, Balkin RS. Moral injury in healthcare workers during covid-19 pandemic. *Traumatology* 2021;27:doi: 10.1037/trm0000290

19 Williamson V, Murphy D, Greenberg N. COVID-19 and experiences of moral injury in front-line key workers. *Occup Med (Lond)* 2020;70:-9. doi: 10.1093/occmed/kqaa052 pmid: 32239155

20 Antal CJ, Yeomans PD, East R, etal. Transforming veteran identity through community engagement: A chaplain–psychologist collaboration to address moral injury. *J Humanist Psychol* 2019. doi: 10.1177/0022167819844071.

21 Browning ED, Cruz JS. Reflective debriefing: a social work intervention addressing moral distress among ICU nurses. *J Soc Work End Life Palliat Care* 2018;14:-72. doi: 10.1080/15524256.2018.1437588 pmid: 29488856

22 Amos VK, Epstein E. Moral distress interventions: AN INTegrative literature review. *Nurs Ethics* 2022;29:-607. doi: 10.1177/09697330211035489 pmid: 35144497

23 Morley G, Field R, Horsburgh CC, Burchill C. Interventions to mitigate moral distress: a systematic review of the literature. *Int J Nurs Stud* 2021;121:103984. doi: 10.1016/j.ijnurstu.2021.103984 pmid: 34214894

24 Haan MM, van Gurp JLP, Naber SM, Groenewoud AS. Impact of moral case deliberation in healthcare settings: a literature review. *BMC Med Ethics* 2018;19:. doi: 10.1186/s12910-018-0325-y pmid: 30400913

25 Gasdaglis K. Moral regret and moral feeling(s). *Inquiry* 2021;64:-52. doi: 10.1080/0020174X.2019.1592701

26 Rushton CH. Cultivating moral resilience. *Am J Nurs* 2017;117(Suppl 1):-5. doi: 10.1097/01.NAJ.0000512205.93596.00 pmid: 28085701

27 Machin LL, Wilkinson M. Making the (business) case for clinical ethics support in the UK. *HEC Forum* 2021;33:-91. doi: 10.1007/s10730-020-09416-6 pmid: 32696205

28 Delany C, Jones S, Sokol J, Gillam L, Prentice T. Reflecting before, during, and after the heat of the moment: a review of four approaches for supporting health staff to manage stressful events. *J Bioeth Inq* 2021;18:-87. doi: 10.1007/s11673-021-10140-0 pmid: 34741699

29 Baines P, Draper H, Chiumento A, Fovargue S, Frith L. Covid-19 and beyond: the ethical challenges of resetting health services during and after public health emergencies. *J Med Ethics* 2020;46:-6. doi: 10.1136/medethics-2020-106965 pmid: 33067314

30 Anzaldua A, Halpern J. Can clinical empathy survive? Distress, burnout, and malignant duty in the age of covid-19. *Hastings Cent Rep* 2021;51:-7. doi: 10.1002/hast.1216 pmid: 33630324

31 Tolksdorf KH, Tischler U, Heinrichs K. Correlates of turnover intention among nursing staff in the COVID-19 pandemic: a systematic review. *BMC Nurs* 2022;21:. doi: 10.1186/s12912-022-00949-4 pmid: 35787700