



ANALYSIS

Managing mental health challenges faced by healthcare workers during covid-19 pandemic

Neil Greenberg and colleagues set out measures that healthcare managers need to put in place to protect the mental health of healthcare staff having to make morally challenging decisions

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The covid-19 pandemic is likely to put healthcare professionals across the world in an unprecedented situation, having to make impossible decisions and work under extreme pressures. These decisions may include how to allocate scant resources to equally needy patients, how to balance their own physical and mental healthcare needs with those of patients, how to align their desire and duty to patients with those to family and friends, and how to provide care for all severely unwell patients with constrained or inadequate resources. This may cause some to experience moral injury or mental health problems.

Moral injury

Moral injury, a term that originated in the military, can be defined as the psychological distress that results from actions, or the lack of them, which violate someone's moral or ethical code.¹ Unlike formal mental health conditions such as depression or post-traumatic stress disorder, moral injury is not a mental illness. But those who develop moral injuries are likely to experience negative thoughts about themselves or others (for example, "I am a terrible person" or "My bosses don't care about people's lives") as well as intense feelings of shame, guilt, or disgust. These symptoms can contribute to the development of mental health difficulties, including depression, post-traumatic stress disorder, and even suicidal ideation.² Equally, some people who have to contend with significant challenges, moral or traumatic, experience a degree of post-traumatic growth,³ a term used to describe a bolstering of psychological resilience, esteem, outlook, and values after exposure to highly challenging situations. Whether someone develops a psychological injury or experiences psychological growth is likely to be influenced by the way that they are supported before, during, and after a challenging incident.

Moral injury has already been described in medical students, who report great difficulty coping with working in prehospital

and emergency care,⁴ where they were exposed to trauma that they felt unprepared for. This may be similar to the unprecedented nature of the challenges healthcare staff are currently facing. In the UK, most NHS staff may have felt, with some justification, that with all its faults, the NHS gives the sickest people the greatest chance of recovery. As such, staff should and usually do feel that it is something to be proud of.

The huge current effort to ensure adequate staffing and resources may be successful, but it looks likely that during the covid-19 outbreak many healthcare workers will encounter situations where they cannot say to a grieving relative, "We did all we could" but only, "We did our best with the staff and resources available, but it wasn't enough." That is the seed of a moral injury. Not all staff members will be adversely affected by the challenges ahead (table 1) but no one is invulnerable, and some healthcare workers will hurt, perhaps for a long time, unless we begin now to prepare and support our staff.

Early support

Several potential mechanisms can help mitigate the negative moral effects of the current situation. All healthcare workers need to be prepared for the moral dilemmas they are going to face during the covid-19 pandemic. We know that properly preparing staff for the job and the associated challenges reduces the risk of mental health problems.⁶ They should not be given false reassurance but a full and frank assessment of what they will face, delivered without euphemisms and in plain English. To do anything else may add to the feelings of anger when reality bites.

As the situation progresses, team leaders should help staff make sense of the morally challenging decisions being made. This could be achieved by using discussions based on Schwarz rounds,⁷ which provide a forum for healthcare staff from all

backgrounds to safely discuss the emotional and social challenges of caring for patients. The discussion should be led by team leaders and could be done remotely if needed.

Avoidance is a core symptom of trauma, so team leaders should reach out to staff who are just “too busy” or repeatedly “not available” to attend these discussions. Most people find that support from their colleagues and immediate line manager protects their mental health.⁸ Staff members who persistently avoid meetings or become overly distressed may require and welcome sensitive discussion and support from a suitably experienced person such as their team leader, trained peer supporter, or chaplain. If their distress is severe or persistent they should be actively supported or, for more serious cases, referred for professional mental health support. Single session psychological debriefing approaches should not be used as they may cause additional harm.⁹

Routine support processes (such as peer support programmes) available to healthcare staff should include a briefing on moral injuries, as well as an awareness of other causes of mental ill health and what to look out for. Even the most resilient team members may become overwhelmed by situations that have personal relevance, such as providing care for someone who reminds them of a relative or a friend. Even staff members experienced in breaking bad news to relatives may be overcome by having to do this many times a day for weeks on end, especially if they have genuine feelings of guilt. In such situations both moral injury and burnout may affect mental health.

Although there is a wealth of evidence that having a supportive supervisor protects your mental health,¹⁰ supervisors are human too. As such, more senior managers should keep an active eye on more junior ones and check how they are doing. If they show signs of presenteeism—that is, working less effectively because of poor mental health—this will directly affect the operational capability and health of all team members, and thus early identification and support are key.

After care

Once the crisis is over, supervisors should ensure that time is made to reflect on and learn from the extraordinarily difficult experiences to create a meaningful rather than traumatic narrative. The National Institute for Health and Care Excellence recommends “active monitoring” of staff to ensure that the minority who become unwell are identified and assisted to access evidence based care.¹¹ Clinicians who provide care for moral injuries and associated mental illness should also be aware of the potential to avoid speaking about guilt and shame and focus on other stressors during therapy. This therapeutic avoidance can lead to poorer outcomes.¹²

These are extraordinary times. There is a pressing need to ensure that the tasks ahead do not cause long lasting damage to healthcare staff. They will be the heroes of the day, but we will need them for tomorrow. For hundreds of years, the military have recognised the critical role of junior leaders in maintaining the will and capability of troops to continue to fight even in the most arduous of conditions. Similarly, healthcare managers in supervisory positions must now acknowledge the challenge staff face and minimise the psychological risk inherent in dealing with difficult dilemmas, and those in charge of resources must provide them with the opportunity to do so.

Key messages

- Healthcare staff are at increased risk of moral injury and mental health problems when dealing with challenges of the covid-19 pandemic
- Healthcare managers need to proactively take steps to protect the mental wellbeing of staff
- Managers must be frank about the situations staff are likely to face
- Staff can be supported by reinforcing teams and providing regular contact to discuss decisions and check on wellbeing
- Once the crisis begins to recede, staff must be actively monitored, supported, and, where necessary, provided with evidence based treatments

Contributors and sources: This article is based on our collective professional experience and a review of published material. The authors have extensive experience of conducting research during and after major incidents, including the London bombings, Ebola, and infections such as swine flu. NG is a specialist in the understanding and management of psychological trauma, occupational mental ill health, and post-traumatic stress disorder and was president of the UK Psychological Trauma Society during 2014-17. MD is an expert clinical adviser to NHS England's adult mental health clinical policy and strategy group. SG has carried out research in disaster risk reduction with Public Health England colleagues and is currently undertaking clinical work in liaison psychiatry at King's College Hospital. SW is past president of the Royal College of Psychiatrists and president of the Royal Society of Medicine. He serves on numerous government committees for the Department of Health, Cabinet Office, and Ministry of Defence and recently chaired the independent review of the Mental Health Act. The article was conceptualised by SW and NG. The original draft was led by NG. The manuscript was reviewed and edited by NG, SW, MD, and SG prior to submission. NG is the guarantor.

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Table

Table 1 | Potential for moral injury: analogous examples of events or actions in military settings⁵ and the covid-19 pandemic

Military examples	Expected healthcare examples
Following orders that were illegal, immoral, or against the Rules of Engagement or Geneva Convention	Following clinical decisions by others that the individual believes were unethical, immoral, or against guidance from registered professional bodies
Failing to report knowledge of a sexual assault or rape committed against yourself, a fellow service member, or civilians	Failing to report serious clinical incidents, near misses, or bullying of yourself, colleagues, or patients
Change in belief about the necessity or justification for a conflict, during or after military service	Change in belief about the necessity or justification for treatment plans or protocols that have affected people's lives
Putting a colleague in serious danger because of own inexperience or indecision	Putting patients or colleagues in danger because of your inexperience, indecision, or working outside your normal competency
Returning home from deployment and hearing of the atrocities that occurred "on your watch"	Returning home from a shift and hearing of seriously worsening health outcomes in the facility in which you were working
Being told that you are unable to treat a seriously ill civilian (especially someone you perceive as vulnerable, such as a child) brought to the gates of your camp, who subsequently dies	Having to choose which of two equally sick patients is provided with specific care, one of whom does not survive, because of the non-availability of healthcare equipment
Giving orders during combat that result in the injury or death of a fellow service member or innocent civilians	Giving clinical orders or establishing protocols that result in the death of colleagues or patients
Using deadly force in combat and causing the harm or death of civilians, knowingly but without alternatives, or unintentionally	Responding acutely in medical emergency and causing the harm or death of patients, knowingly but without alternatives, or unintentionally
Feeling let down when the chain of command does not provide you with adequate reinforcements	Feeling let down because you are working with insufficient resources or staffing, especially when you perceive this was avoidable