For Health Workers, COVID19 Can Be a Moral Injury Pandemic

Being forced to implement life-death algorithms may cause more than PTSD

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**This article was co-written with Dr. Almas Merchant*

We are living in an Orwellian novel, where healthcare workers are sending off countless corpses to refrigerator trucks, having to make life-saving or life-ending decisions hourly, and even triaging their own lives. This applies for medical and mental healthcare professionals alike, and, if not addressed, can result in a new kind of pandemic of moral injury.

On the Frontline

When Governor Cuomo of NY closed off non-essential businesses in early March, the change to telemedicine was swift in the private practice settings. As those therapists began using video conferencing tools, many mental health clinicians employed by public hospitals and clinics were unable to move with a similar ease.

Part of the issue was the negotiations that needed to occur with for profit insurers of Medicaid and Medicare to reimburse telehealth at the same rate as in-person visits. So, while waiting, health workers who could have maintained social distance and provided essential care remotely, continued to come to work, potentially infected or were infected by patients, then brought the infection to their families. In the corporate world of healthcare, “Do No Harm” is second to “Do No Harm to the number of daily billable encounters.”

Medical personnel are also giving us a glimpse at their impossible Sophie’s choice-esque situation through heartbreaking editorials describing directives about who gets to receive healthcare once hospitals are full. A life-death algorithm that puts them in a precarious position—to have to deny healthcare to those with compromised health (Achkar, 2020), or disabilities (Baker, 2020). The very people that healthcare professionals have sworn a Hippocratic oath to protect. And then, there are the divided loyalties: to our patients, to our community, to ourselves, and to our families.

Moral Injury

We have long known that making such decisions can pose a challenge to our moral compass (see Litz et al., 2009). The concept of moral injury is known to those of us working with military trauma as a deep wound to our conscience or moral code, resulting from committing, failing to prevent, or witnessing acts that go against our beliefs, values, or code of ethics. It is an injury to our sense of self as a moral being, and while sometimes equated to PTSD, poses an additional challenge to recovery.

In war, a moral injury can occur after hurting a child in the line of fire, or after failing to report an assault for fear of retaliation. On the frontlines of a pandemic, it can be in having to follow poorly communicated COVID19 safety procedures while running out of time to resuscitate a patient, in the absence of appropriate protective gear. Physicians also face the impossible choice of denying care to someone’s grandfather to save someone’s mother because of lack of resources, and as parts of a system that’s gravely failing to ensure that care is available to ALL its citizens.

The system also psychologically (consciously and unconsciously) manipulates health care workers to think of themselves as “heroes” all the while making slashes to Medicaid budgets that impacts the availability of services to the neediest populations (Salles & Gold, 2020; Assemblymember Yuh-Line Niou, 2020). The result: we constantly take it upon ourselves to “do better” by our patients. To add further insult to (moral) injury, doctors who have voiced their moral outrage have been disciplined and even fired. (Carville, Court, & Brown, 2020).

The Cost of Moral Injury

“Moral injury can take the life of those suffering from it, both metaphorically and literally.” (The Moral Injury Project)

Metaphorically, moral injury is profoundly debilitating in the way it unconsciously impacts an individual’s psyche and self-view (Litz et al., 2009). People living with moral injury can often lose sight of the impossible circumstances in which the moral injury occurred, only to assume full blame for a tragedy. A person’s life becomes filled with self-loathing and self-punishment, hijacking the ability to find meaning, experience joy, or sense of belonging in society. It can destroy families and relationships, along with one’s sense of self as a loving and lovable, caring and worth being cared-for, human being.

Literally, moral injury has been associated with higher rates of self-injurious behaviors and suicidal ideation (Bryan et al., 2014), a relationship which is likely mediated by shame, guilt, social isolation, and spiritual/existential crisis. The American Foundation of Suicide Prevention has warned that physicians are not only more susceptible to high degrees of distress but also less likely to seek help. They warn that suicide risk for physicians prior to COVID19 was 1.5 to 2.25 times higher than the general population. We believe that in the months to come these numbers may grow.

What can we do?

This is not going to be over once the pandemic has ended. The moment when healthcare workers can catch their breaths, after months of sleepless nights and adrenaline-filled 24-hour shifts, will be the moment when the brutal tragic reality of it all will hit. The suggestions we offer below are far from exhaustive or uncomplicated. We offer them as trauma psychologists and as healthcare workers ourselves.

1. Make the unconscious conscious: Grieve.

One of the hallmarks of psychological trauma is to ward off feelings of helplessness, sadness, terror, and grief by assuming responsibility of an inherently uncontrollable situation. We do this by blaming ourselves for actions we took in moments of significant duress, facing an impossible choice. Individually and collectively, we will have to allow ourselves to grieve all that we have lost in the past months, and the belief in a "just world" in which bad things only happen to bad people. Normalizing feelings of helplessness, we will have to grieve the illusion that we can make sense of the senseless, that only if we had tried harder, people would have lived.

2. Resilience is relational: Talk.

Healthcare workers who share their moral dilemmas, pain, grief, guilt, and outrage make it possible for others to conquer silence and shame. This means talking to your family and loved ones but also to your colleagues. Data from formal support groups (such as AA) highlights the importance of sharing with others who have experienced a similar difficulty.

All of us can talk to our government representatives and administrative leadership. It may be psychologically easier to live with the fear of losing one's job than the moral injury of going along with directives we disagree with. Currently, we are in a crisis but when the dust settles, those of us who remain, can come together as a community to demand systemic change. Organizing for something bigger than ourselves is motivating, energizing, and reduces overall isolation.

3. Normalize complexity: Humanize.

The urge to call healthcare workers “heroes” is a double-edged sword. Use it sparingly and not as a means of coercing already burned out professionals into sacrificing more. Along with recognizing and celebrating bravery and self-sacrifice, we need to also acknowledge the fear, grief, anger, and despair that go hand-in-hand with being in the front lines. Heroes should be allowed darker days, tears, and to hang their cape from time to time without worry of betraying society’s expectations.

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