

Georgina Morley, RN (UK), MSc, PhD

Center for Bioethics, Clinical Transformation, Cleveland Clinic

Denise Sese, MD

Department of Pulmonary and Critical Care Medicine,
Respiratory Institute, Cleveland Clinic

Prabalini Rajendram, MD

Department of Critical Care Medicine,
Respiratory Institute, Cleveland Clinic

Cristie Cole Horsburgh, JD

Center for Bioethics, Clinical Transformation,
Cleveland Clinic

Addressing caregiver moral distress during the COVID-19 pandemic

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■ ABSTRACT

Moral distress is the psychological distress that is experienced in relation to a morally challenging situation or event. Although it was first observed within nursing, caregivers across all disciplines—including physicians, respiratory therapists, social workers and chaplains—experience moral distress. In this consult, we discuss 5 types of moral distress using examples of changes to clinical practice that have occurred due to COVID-19. We also provide suggestions for responding to moral distress and outline the resources available at Cleveland Clinic.

■ MORAL CHALLENGES DUE TO COVID-19

The Coronavirus Disease 2019 (COVID-19) pandemic has created new challenges for caregivers, leaders, patients, and families. Health care organizations have been required to respond to changing logistical needs in ethically supportable ways. This includes increasing testing and treatment capability equitably and with sensitivity to need; expanding hospital capacity while maintaining safety for patients and honoring obligations to caregivers; and minimizing risks to caregivers, patients, and the community while continuing to provide compassionate patient-centered care. The ethical frameworks that guide organizational responses to these value-laden decisions shift in a pandemic from a patient-centered approach toward a community-based approach. In short, some ethical priorities have changed, and as a result, caregivers are now caring for patients in ways that might not have been considered optimal in the context of pre-pandemic ethical frameworks. This shift heightens the potential for moral distress.¹

Moral distress is the psychological distress that

is experienced in relation to a morally challenging situation or event.² While first observed within nursing, caregivers across all disciplines (eg, physicians, respiratory therapists, social workers, and chaplains) experience moral distress.³ In this consult, we explore 5 types of moral distress (**Table 1**)—moral-constraint, moral-uncertainty, moral-dilemma, moral-conflict, and moral-tension²—using examples of changes to clinical practice that have occurred due to COVID-19. We also provide suggestions for responding to moral distress and outline resources available at Cleveland Clinic.

■ VISITATION RESTRICTIONS AND THE IMPACT ON PATIENTS, FAMILIES, AND HEALTH CARE WORKERS

One of the most significant changes that has affected patients and caregivers across health care organizations is visitation. Generally speaking, a patient-centered approach strongly favors generous visitation policies. Actively facilitating patients' access to their support systems optimizes the healing environment and patient well-being. However, with the COVID-19 pandemic, visitation policies have been restricted to minimize risk of spreading the disease over the interests of individual patients.

This shift in ethical priorities is not without a cost. Patients now rely more on caregivers to provide emotional support or facilitate it in innovative and novel ways. Health care workers are experiencing and witnessing intense suffering as a result, which understandably raises questions about whether the application of community-focused policies are ethically justified.

Consider, for example, the health care team caring for an oncology patient who has an aggressive disease course and is undergoing chemotherapy as an inpatient. They are in pain and constantly nauseous and terrified but their condition is not considered terminal. As such, they must go through treatment alone each day. The physician and nurse believe that keeping this patient isolated from their loved ones is not

The statements and opinions expressed in COVID-19 Curbside Consults are based on experience and the available literature as of the date posted. While we try to regularly update this content, any offered recommendations cannot be substituted for the clinical judgment of clinicians caring for individual patients.

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TABLE 1
Recognizing moral distress in oneself and others²

Type of moral distress	You are feeling distressed because...	Common emotions	Trigger phrases
MORAL-CONSTRAINT DISTRESS	You are constrained from doing what you think is the ethically appropriate action.	Angry, frustrated, sense of injustice, powerless	<i>"I feel like I'm not doing the right thing."</i> <i>"I feel like I am complicit in causing suffering."</i>
MORAL-UNCERTAINTY DISTRESS	You are uncertain about whether you are doing the right thing.	Torn, conflicted, uncertain, frustrated	<i>"I feel torn about what we should do."</i> <i>"I don't know whether this is the right thing to do."</i>
MORAL-DILEMMA DISTRESS	You are unable to choose between 2 or more ethically supportable options.	Guilt, regret, torn, sense of injustice, sad	<i>"I feel like I'm stuck between a rock and a hard place."</i> <i>"Both options seem to be equally bad."</i>
MORAL- CONFLICT DISTRESS	You are conflicted about the most appropriate ethical action.	Conflicted, frustrated, angry, sad	<i>"I feel like they don't understand my point of view."</i> <i>"I feel like we have different moral perspectives."</i>
MORAL-TENSION DISTRESS	You are unable to share your beliefs with others (this might include your colleagues, manager, or other providers).	Sad, angry, frustrated, powerless	<i>"I don't feel like I can talk to anyone about my beliefs."</i>

justified. This is considered **moral-constraint distress** because they believe they know the right thing to do but they are constrained from doing it.

In this and similar cases, caregivers meet their obligations to their patients by utilizing resources that are available to facilitate emotional supports. Limited exceptions in visitation policies and increased access to virtual technologies to facilitate patient-family interactions mitigate the relational losses of visitation restriction. Even with these efforts, some losses will still occur.

In addition to the relational cost, restricted visitation policies may also affect the decision-making process. Many patients may be temporarily unable to communicate or lack the capacity to make decisions for themselves. This situation requires input from the

patient's surrogate and yet, the surrogate is being asked to make these decisions remotely. Even when virtual visits are possible, caregivers may wonder whether the surrogate understands the medical complexity of the case when they are unable to see their loved one or the machines required to sustain their life.

The inability to account for daily experience can challenge a surrogate's ability to assess whether their decisions are aligned with the values of the patient. This can cause **moral-uncertainty distress** for the health care team because they feel uncertain about whether the surrogate is using a substituted judgment standard that is in the patient's best interest or stems from a hope to see their loved one alive again.

Less considered in the literature is the moral distress experienced by the remote decision maker who

is unable to see what their loved one is experiencing but yet must still make important care decisions.⁴ While this is not a unique scenario in the context of COVID-19 (consider the out-of-state surrogate unable to visit their loved one in person), it may be more prevalent now.

■ RISK TO PERSONAL SAFETY AND LOVED ONES

Health care workers have been asked to be courageous when caring for patients during the pandemic as the scientific community learns more about the risk profile of COVID-19. They are required to weigh the (not fully understood) risks of personal illness and death and of being an asymptomatic carrier with their responsibilities to patients, the community, their employer, and their families. This causes *moral-dilemma distress* as caregivers feel torn and conflicted when faced with these obligations.

The requirement to conserve personal protective equipment (PPE) increases the emotional and mental strain on bedside caregivers who must disproportionately carry the burden of risk. Bedside caregivers are assured that they are not obligated to provide care if the risk threatens their own safety (eg, adequate PPE is not available). However, this may create *moral-conflict distress* for providers if they feel that maintaining their own safety leads to substandard care (eg, taking an additional few minutes to don PPE as a patient suddenly experiences cardiac arrest). These changes in practice may feel like a violation of one's professional duties, but at the same time, these circumstances call for health care workers to protect themselves and their future patients from exposure. These changes to the delivery of care must be balanced so that caregivers remain safe but without unjustifiably compromising patient care.

■ REDUCED PROVISION OF HEALTH CARE SERVICES

Limiting exposure to COVID-19 has severely impacted what is considered 'non-essential' health care services and procedures. There are frameworks and guidance on how to decide whether a service or procedure is 'essential' based on the impact it has on patients' activities of daily living. However, the broader impact on patient care and the psychological impact is less clear. Outpatient providers whose visits have been limited to virtual visits or limited face-to-face interactions may experience *moral-dilemma* and *moral-uncertainty distress* as they try to balance their obligation to provide high-quality reliable care with the need to maintain current infection prevention and social distancing precautions.

In addition, patients with existing co-morbidities or those experiencing symptoms (possibly not related to COVID-19) may avoid accessing the health care system due to a fear of being exposed to the virus, potentially placing them at increased harm. This can cause *moral-constraint distress* for caregivers who may unjustifiably feel responsible for these patients' outcomes. A multitude of factors outside a caregiver's control may contribute to a patient's autonomous choice not to seek out care.

Caregivers may also experience *moral-constraint distress* because of an inability to perform in-person physical examinations. While the provision of patient care via virtual technologies is not novel, caregivers may feel frustrated as they adjust to the new skills required to deliver virtual care. Furthermore, sharing life-altering diagnoses or a poor prognosis virtually adds a layer of complexity to difficult conversations as it eliminates the "caring touch." This can result in feeling constrained and forced to provide care that is felt to be suboptimal.

The support of caregivers and transparent communication about ongoing development of best practices and policies in the context of the evolving infection-risk profile may alleviate some fears and concerns. These steps are necessary to appropriately balance safeguarding quality with infection prevention needs.

■ TRIAGE AND ALLOCATION OF RESOURCES

Clinical decisions that are made based on resource scarcity occurs when there is a shift to crisis standards of care. The need to make such difficult decisions feels inconsistent with the core values of many health care professional who want to deliver patient-centered care. This shift can be painful and distressing. The requirement to choose between two equally undesirable moral options causes *moral-dilemma distress*.

Protocols have been developed to help ensure decisions are equitable and consistent and with the express aim of relieving the burden from bedside providers. However, some might experience *moral-constraint distress* if they feel that the circumstances and protocols constrain their ability to make independent ethically supportable decisions and violate their own values.

Some caregivers might feel unable to express or discuss their moral perspectives with others during this uniquely trying time and therefore experience *moral-tension distress*. This might be because they feel that they lack the vocabulary to discuss the ethical issues or they work in a team in which it doesn't feel safe to express their views.

TABLE 2**Evidence-based recommendations for leaders to address moral distress****See and seek moral distress**

- Look for ethical concerns and signs of moral distress.
- Inquire and consider whether an Ethics Consultation is indicated.

Understand moral distress

- Understand through active listening.
- Be receptive to diverse perspectives.
- Model a self-reflective process: be aware of your own biases, remember that ethical issues often are not black and white, and avoid responding with correction/rebuke.

Pay attention and assess workplace climate

- Acknowledge ethical challenges and moral distress.
- Assess the unit climate, culture, tone.
- Work to mitigate power differentials between caregivers.
- Explore and note repeated occurrences and problems.
- Assess professional risks of speaking up.

Promote a receptive environment and engage team members

- Encourage and create spaces for moral dialogue.
- Encourage and role-model respectful communication across disciplines.
- Promote team-based dialogue and discussion when ethical issues arise.

Open opportunities for dialogue

- Encourage debriefing.
- Ask whether members of the team might benefit from further discussion with an ethics expert: consider whether a Moral Distress Reflective Dialogue or Debrief is indicated.
- Utilize resources: bring team members to multidisciplinary meetings, invite bedside nurses to family meetings, and participate in Bioethics rounds.

Reflect, evaluate, and revise

- Establish self-care as a custom, ask team members how they are doing, and explore whether they need any additional support.

Transform negative environments

- Acknowledge that the environment is changing, be transparent and ready to answer questions.

Developed and adapted from reference 7.

TABLE 3**Cleveland Clinic caregiver resources for coping with moral distress**

Effective strategies to manage moral distress: consider the need to address the moral event and the distress (psychological/emotional/spiritual) caused by the event.

Moral Event and Distress

Moral Distress Reflective Dialogues and Debriefs (MDRD) are facilitated by a clinical ethicist and independently licensed social worker or chaplain to provide caregivers with a safe space to reflect on the moral event(s) that cause them to experience distress. During the COVID-19 pandemic, virtual MDRDs are available.

Moral Event

Targeting the moral event often necessitates a critical examination of the underlying ethical frameworks and consideration of the perspective of others (perspective-taking).

The Ethics Consultation Service (ECS) provides support to patients, loved ones, and health care professionals grappling with ethical issues in the provision of patient care. At Cleveland Clinic, the ECS is available 24/7 by paging 22512, placing an EPIC order, or referring to the on-call directory via the intranet.

During COVID-19, clinical ethicists in the Center for Bioethics have provided recommendations on a number of issues, including how to decide whether surgery should be considered essential and whether exceptions to the visitation policy are warranted, how to develop ethically robust triage protocols, and how to deal with conflicting ethical values. Clinical ethicists are also available to assist with organizational ethics issues that may cause moral distress, including supporting the development of processes that can be considered fair, equitable, and transparent.

Distress

Caring for Caregivers is available to support caregivers through life's challenges, providing counseling and Critical Incident Response services. During the COVID-19 pandemic, 30-minute Boost appointments are also available to talk through feelings and provide support.

Call Caring for Caregivers at 216.445.6970 for support.

Office of Professional Staff Affairs provides confidential services for employees to support psychological distress. We recommend their services for any caregiver who is concerned about stress or Post-Traumatic Stress Disorder.

Spiritual Care is available 24/7 for coping with loss, stress, suffering, and more as well as for faith-based concerns. All visits are conducted via phone or FaceTime and are free. Anonymous calls are welcome. Call the Grief and Relief Support Line at 844.204.7433 for support.

When health care providers are repeatedly faced with extremely complex moral challenges, they are at increased risk for intense and frequent experiences of **moral-constraint distress** and with it, intention to leave one's position or profession altogether.³ Not

only is this concerning because of the impact it has on individual lives but this would also pose a unique challenge in a pandemic situation where individu-

als with specialized training are instrumental to the pandemic response.⁵ To mitigate these risks, a multi-pronged approach must be adopted in which caregivers utilize resources and incorporate self-care techniques into their work lives and leaders pay attention to the ethical climate of their units and organization.

■ RESPONDING TO MORAL DISTRESS

Moral distress is an inevitable byproduct of a pluralistic society and a natural response to morally difficult encounters in the provision of patient care.⁶ When addressing moral distress, the aim is not to eradicate the phenomenon but rather to mitigate its negative effects, including preventing caregivers from feeling unable to provide compassionate patient-centered care, feeling withdrawn, unable to return to work or continue in their profession.

While few evidence-based interventions have been found to effectively mitigate moral distress, there are some promising directions. When responding to moral distress, it is important to utilize approaches that target the moral event and, either separately or in conjunction, the resulting psychological distress. One dual approach to address both the moral event and psychological distress is group reflective debriefing.^{7,8}

■ GUIDANCE FOR LEADERSHIP

Leaders play an important role in providing support when moral distress is experienced by their teams. It is critical to note that a team experiencing moral distress is not indicative of poor leadership given that moral distress is a natural response to morally complex situations. However, moral distress is more likely to occur in work environments that are perceived to have a poor ethical climate.^{3,9} Ethical climate can be understood by exploring caregiver perceptions of organizational practices such as the way in which ethical decisions are addressed and whether the organization creates the conditions required to engage in ethical reflection.¹⁰ If individuals within units or teams perceive either of these to be absent, then this suggests they have a poor perception of the ethical climate. Perceptions of ethical climate may be organized according to one's perception of interactions with peers, patients, managers, the hospital, and physicians.¹⁰

Being proactive and anticipating potential situations that are likely to cause moral distress in teams and specific areas of the organization will likely be beneficial. Utilizing a continuous improvement approach to the ethical climate of one's unit or organization is

one strategy leaders can utilize to proactively manage moral distress. Evidence-based recommendations for leaders to address moral distress are listed in **Table 2**.⁷

Recognizing the burden that COVID-19 is already placing on leaders and managers, it is increasingly important to know the resources available to help facilitate ethical workplace climate and to mitigate moral distress (**Table 3**).

■ CONCLUSION

We have provided a brief overview of the ethical issues that are likely to cause moral distress for caregivers. These examples are by no means comprehensive. Undoubtedly, there will be other ethical issues (and likely new and emerging issues) as we progress through the COVID-19 pandemic. In order to address the moral distress that is experienced by all health care workers, it is vital that we learn to recognize it in ourselves and in others, pay attention to the ethical climate of our units and our organization, and utilize the resources available to address the moral event and resulting psychological distress.

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