Moral Distress During COVID-19: Residents in Training Are at High Risk

Breanne Jacobs, MD, MA, and Rita A. Manfredi, MD, FACEP

The ethics and moral dilemmas of rationing care are particularly acute to all health-care providers as we tackle the COVID-19 crisis. In normal times, first responders and clinicians face moral angst in situations when they are not able to follow their inner values; however, studies show this angst is highly intensified in a disaster setting.[1–3] Why? Public health emergencies may require clinicians to change their practice, such as the need to prioritize the community above the individual in fairly allocating scarce resources. Furthermore, adapting to low-resource contexts, such staff, personal protective equipment (PPE), or ventilator shortages may impose particular stress on providers who are accustomed to the availability of basic resources in a health care system like we have in the United States.[2,4] During this pandemic, clinicians are at high risk of feeling they are compromising their integrity as the gap between what we can do and what we want to do widens with resource rationing.[4] Residents in training programs are particularly vulnerable to these effects. The objective of this paper is to identify the unique challenges that residents face, specifically moral distress, as it plays out during the COVID-19 pandemic. Further we offer strategies that residency program leadership can implement to support residents within their training programs.

WHAT IS MORAL DISTRESS?

"Moral distress" is a phrase Jameton[5,6] coined in 1984 to describe the psychological reaction to situations where the individual knows what is morally right, but is unable to act accordingly because of institutional or other constraints. Most research on moral distress in medicine originates from nursing literature. Nurses are tasked to work stoically to administer plans of care that they themselves do not have the power to create, while acting as patient advocates and caregivers.[7] Most cases of moral distress cited occur among those working in critical care settings. The leading causes of moral distress reported include: 1) continuing artificial life support despite the perception of futility, 2) inadequate communication about end of life care between clinicians and patients and families, 3) perceived inappropriate use of health care resources, 4) inadequate staffing or staff who are not adequately trained to provide the required care, 5) insufficient pain relief for patients, and 6) unclear communications with patients and families resulting in "false hope."[8,9] Many of these causes of moral distress have been echoed in physician literature.[9–11] Similar to our nursing colleagues, most physicians and residents report experiencing moral distress most prominently on intensive care shifts and rotations.[11]

WHY ARE RESIDENTS AT RISK?

Residents in training are cogs in the hierarchy of medical care. The role as a perpetual learner, suffering from long work hours, sleep deprivation, and lack of control of their schedule is stressful.[12] Residents are at risk for moral distress, because like nurses, they are often responsible for implementing plans of care that they do not have the authority of developing.[11,13]

The COVID-19 pandemic exacerbates a number of these distress-provoking situations. For example,

From the Department of Emergency Medicine, The George Washington University School of Medicine and Health Sciences, Washington, DC.
Received May 8, 2020; revision received May 27, 2020; accepted May 29, 2020.
The authors have no relevant financial information or potential conflicts of interest to disclose.
Supervising Editor: Wendy C. Coates, MD.
Address for correspondence and reprints: Breanne Jacobs, MD, MA; e-mail: brjacobs@mfa.gwu.edu.
AEM EDUCATION AND TRAINING 2020;4:447–449

doi: 10.1002/aet2.10488

adequate communication between patients, family members, and clinicians is significantly strained by the fear of spreading infection. Whereas before COVID-19, palliative care teams could have in-person "family meetings" for discussing advance care planning, this now has been thwarted to shorter and often less personal telemedicine or phone conversations. Furthermore, the fear of rationing both PPE and ventilators exacerbates moral distress among resident physicians who feel they are not particularly well equipped to make these hard choices.

WHY IS MORAL DISTRESS HARMFUL?

Studies from humanitarian organizations found that moral distress increases dropout rates and sick leave among disaster responders,[14] a trend that has also been shown in studies of medical residents.[11] Repeated episodes of moral distress in the workplace cause clinicians to become isolated[15] and morally numb to challenging situations, develop a loss of moral identity, and finally succumb to moral injury, where a physician begins to question their own moral framework for continuing to work within the system.[6,16] Studies of both clinicians and nurses find that moral distress cases cause frustration, anger, guilt, anxiety, depersonalization of patients, and finally a high risk for burnout and leaving the profession.[6,17–20]

With the COVID pandemic in mind, the surge of patients in certain hotspots and the inability of the physician and nurse workforce to keep up with demand, as well as a clinician's fear for his or her own health, is anxiety provoking for all health care providers. There are things program directors can do, however, to help residents manage this tension and mitigate moral injury. Table 1 provides specific suggestions for enhanced awareness of preexisting programs within our hospitals and universities that can be employed to support residents. Further, program directors can enhance established curriculum with additional ethical training, cognitive therapy, and small-group forums to provide residents the opportunity to reflect on difficult patient cases.

Table 1
What Can Residency Directors Do to Combat Moral Distress and Prevent Moral Injury Among Residents?

Have organized support programs • Develop an early residency ethics curriculum in graduate medical education to help residents anticipate difficult ethical situations they may experience.[21] • Advertise existing institution support structures such as crisis counseling programs, employee assistance programs, and grief counseling programs.[2]
Awareness of collective ethics decision making structures in the hospital • Encourage residents to seek assistance from hospital ethics, rationing, and/or palliative care teams.
Mindfulness[22] programs • Encourage mindfulness and mediation training or structured thought self-regulation patterns to help disrupt negative thinking and behavior and reflect on how they have overcome difficult situations in the past.
Structured reflection • Create small group forums or conferences designed for collective sharing on difficult ethical cases, enhancing communication, and conflict management development.[21] • Offer "narrative ethics" in which residents journal or write short stories about ethical challenges.[23]
Time off from clinical duties • Flexibility with assigning residents to electives or non-clinical training modules to allow time to process grief. • Adequate scheduling of residents on shifts to allow for call-outs or short-term leaves of absence. This will allow residents to reestablish existing support systems outside of residency.

CONCLUSION

We are seeing sicker patients, facing longer work hours, and feeling the burden of low staffing, all which have been linked to increasing moral distress. With more clinicians being trained to assist in the critical care settings for COVID-19 outbreaks, a large population of providers who have not previously seen such stark ethical challenges in their training may face moral distress. Education about moral distress and its consequences may strengthen residents' capacity to cope and seek support during the COVID-19 pandemic and throughout their residency. This training will hopefully mitigate the development of moral injury among this critical physician workforce.

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