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ORIGINAL ARTICLE

Moral distress of medical family therapists and their physician colleagues during the transition to COVID-19

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Abstract

The COVID-19 pandemic has transformed healthcare for both clinicians and patients. This conceptual article uses ideas from the moral distress literature to understand the challenges MedFTs and physicians face during the COVID-19 pandemic. The authors highlight earlier themes from the moral distress literature and share current reflections to illustrate similar challenges. Some clinicians who were already experiencing a rise in burnout due to the mass digitization of healthcare are now facing increased moral distress due to ethical dilemmas, pervasive uncertainty, boundary ambiguity, isolation, and burnout brought about by emerging COVID-19 policies. Fears about personal safety, exposing loved ones, financial concerns, self-doubt, and frustrations with telehealth have contributed to increased moral distress during the COVID-19 pandemic. Building resilience by setting one's personal moral compass can help clinicians avoid the pitfalls of moral distress. Five steps for developing resilience and implications for guiding trainees in developing resilience are discussed.

KEYWORDS

Delivery Systems < Professional/Practice Issues, Legal/Ethical Issues < Professional/Practice Issues, Practice Setting < Professional/Practice Issues

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MORAL DISTRESS OF MEDICAL FAMILY THERAPISTS AND THEIR PHYSICIAN COLLEAGUES IN RESPONSE TO THE COVID-19 PANDEMIC

As COVID-19 cases increased in the United States, many healthcare settings quickly transitioned to telehealth services. Telehealth is the "provision of healthcare services using various telecommunications technologies" such as live video and virtual visits (UC Davis Health Center for Health & Technology, 2020). Clinicians, some with little or no training in providing telehealth services, contacted patients to orient them to scheduling and accessing online services. This rapid shift challenged beliefs about the ingredients of high-quality, effective care, which often includes a professional intimacy characterized by in-person conversation and observation of subtle nonverbal cues (Burgoyne & Cohn, 2020). The importance of physical and emotional closeness with vulnerable patients is often guided by clinicians' personal mission and values, and the changes in response to COVID-19 presented challenges to clinicians' identities and sense of mission (Hartzband & Groopman, 2020).

At the beginning of the COVID-19 pandemic, faculty and supervisors in our primary care medical setting quickly recognized that unfamiliar stressors and risks, such as the ones described in the preceding paragraph, could easily overwhelm the clinical staff. As the faculty sought clarity, they read an editorial in the *New England Journal of Medicine* (*NEJM*) about trainees' initial responses to COVID-19 at the University of Washington School of Medicine during spring of 2020 (Gallagher & Schleyer, 2020). The editorial used a sampling from the 316 responses to describe trainees' initial fears and concerns and described some trainees' sense of *moral distress*, which Dean et al. (2020) defined in the following way:

> [A] phenomenon that occurs when "an individual believes he or she knows the right thing to do, but institutional or community constraints make it difficult to do what is right . . . Moral distress happens at the intersection between the clinician's own moral framework, which remains intact, and the values of the healthcare system (p. 923).

During the same period, physicians from other medical schools wrote an editorial for the *Journal of the American Medical Association* (*JAMA*) that delineated "the language of distress" (Dean et al., 2020). The moral distress literature provided a framework for understanding some of the most intense and personal concerns some clinicians had.

While COVID-19 ushered in a host of restrictions and changes in healthcare delivery, our clinical and educational community initially experienced some moral distress. The rise of moral distress was linked to both ethical dilemmas about caring for patients via telehealth services and pre-existing professional burnout that was exacerbated by COVID-19's mandated professional and personal isolation, in addition to other forces affecting health service delivery (Hartzband & Groopman, 2020). Using the moral distress papers published in the *NEJM* and *JAMA* as a guide, we sought to understand the challenges MedFTs and their colleagues faced during the COVID-19 pandemic, including facing personal health risks and transitioning to telehealth to deliver care.

MORAL DISTRESS

Merriam Webster's online English dictionary defines "moral" as "of or relating to principles of right and wrong in behavior; conforming to a standard of right behavior" (Moral, n.d.). Alternatively, the definition of "value" is the "relative worth, utility, or importance" of an object or a principle (Value,

n.d.). The concept of moral distress is not new. The term was first used to describe the experience of Vietnam war veterans who displayed signs of PTSD but whose symptoms did not fit the diagnosis exactly and who did not respond to standard PTSD treatment. The main distinction between moral distress and PTSD is that those with PTSD experienced an impending threat to their *mortality*, whereas those with moral distress experienced repeated assaults to their *morality*. After repeated attacks to one's own moral code of conduct, the morally distressed person is left to question whether he is still, in essence, a "good" or moral being (Dean et al., 2019).

Moral distress has been linked to burnout. Dean et al. (2020) suggest that the literature "discriminate among the terms *moral dilemmas, moral distress* and *moral injury*, rather than simply discussing burnout" (Dean et al., 2020, p. 923). Moral dilemmas occur when clinicians inevitably face difficult decisions where more than one answer is morally defensible but none leads to an ideal outcome (Kvalnes, 2019). He goes on to explain that facing numerous moral dilemmas can lead to experiencing *"moral residue*," or unresolved emotional and psychological conflicts. Thus, persistent and unresolved moral challenges can eventually result in *moral injury* and burnout. Moral injury is an erosion of a person's moral framework and results from a single egregious violation or persistent, repeated moral violations.

Typical responses to moral distress and burnout include: learned helplessness, changing careers, cynicism, depersonalizing one's work, stopping self-care behaviors, and isolating (Dean et al., 2020). Some pre-pandemic causes for the rise in physician burnout were due to the nearly universal implementation of both the electronic medical record (EMR) and performance metrics. The dissonance between clinicians' values and the new technology-dominated health system was already stoking the fire of widespread burnout before COVID-19 (Hartzband & Groopman, 2020).

Many family therapists consider their work a moral enterprise (Doherty, 1995; Walsh, 1998). Their values as healers may make them vulnerable to moral distress when they cannot provide appropriate care to their clients. Doherty (1995) calls caring "an essential lubricant for the flow of mutual understanding" (p. 119). In his book, *Soul Searching*, Doherty describes the work of philosopher Nel Noddings, who defines three elements of caring: (1) Receptivity—feeling "with" the other, a form of intense empathy; (2) Engrossment—focused attention on the other with no distractions; and (3) Motivational shift—attending to the needs and preferences of the other (Noddings, 1984). Caring comes naturally to family therapists, but even the most gifted therapists encounter occasional barriers to care. Barriers can include: not liking a client, unrest or trauma in one's personal life, limitations in the number of sessions one can provide due to financial constraints, or current events, which can erode a therapist's ability to be fully present in his work.

MORAL DISTRESS DURING COVID-19

Information is beginning to emerge about the moral distress of clinicians during the pandemic (Alexopoulos & Liston, 2020). The biological features of COVID-19 present uniquely challenging situations that could lead to moral distress. COVID-19 is highly contagious but invisible during incubation. It can spread through a population by asymptomatic carriers and it can be lethal for vulnerable populations (Klompas, 2020). In addition, there was no vaccine during the early months of the pandemic when clinicians responded to our questions. Clinicians do not usually have to consider personal health risks when seeing their patients; however, this has become a requisite consideration during the era of COVID-19.

Clinicians working in medical settings during the pandemic identified social isolation as a major stressor (Alexopoulos & Liston, 2020). Feelings of isolation heighten clinicians' distress about risking

the well-being of family and friends versus meeting their own needs for connection. Gallagher and Schleyer's (2020) survey of medical students working directly with COVID-19 patients in the early months of the pandemic revealed their moral distress about patient isolation. Students woefully watched ill patients suffer alone because family members were prohibited from visiting due to hospital restrictions. This painful disconnection from patients was exacerbated by the students having to wear masks that hid their facial expressions, making them feel even more incapable of comforting their sick patients. Moral distress was heightened by ethical concerns, such as shortages of personal protective equipment (PPE), rationing of care and/or equipment, lack of treatment guidelines, and feeling helpless to alleviate suffering.

Additionally, students and trainees reported painful feelings of ambivalence related to their desire to serve their sick patients while also feeling anxious about contracting the virus and becoming ill themselves. One clinician summarized his ambivalence by saying, "It's a constant dialogue of 'Am I safe? Is my patient safe? Is this care adequate? Am I doing all I can?'" (Gallagher & Schleyer, 2020, p. 2). On top of these moral and ethical worries, practical concerns such as needing childcare, fears about getting adequate clinical experience or graduating on time, and anxieties about maintaining financial aid distracted students from caring for their patients. Most of the early inquiries into the effects of COVID-19 on clinicians in medical settings focused exclusively on medical professionals. Did teams of medical and mental health professionals have similar experiences that, in some cases, led to moral distress?

CLINICAL CONSIDERATIONS FROM WORKING IN COLLABORATIVE CARE

To better understand moral distress in our healthcare setting during the pandemic, we asked 34 clinicians working in our collaborative, primary care medical setting between May and July 2020 about their experiences. We sent an informal questionnaire by email to colleagues in the Family Medicine Clinic. The informal questionnaire, which we created and was approved by IRB, was informed by the brief, anonymous survey created at the University of Washington for medical trainees (Gallagher & Schleyer, 2020). Our survey drew heavily on the University of Washington responses from medical trainees working directly with COVID-19 patients in the early months of the pandemic. We modified our questionnaire by adding questions specific to our setting. (See Appendix). We compared our responses to the responses from the University of Washington medical trainees and also the responses from medical staff who faced previous pandemics such as SARS or Ebola (Griffith, 2020). We found that the clinicians' responses mirrored themes in earlier literature from previous pandemics and other contexts that had resulted in clinicians' moral distress (Griffith, 2020; Iacoviello & Charney, 2014; Stockdale, 1993). Below, we highlight some of the earlier themes of the moral distress literature and share quotes from our setting to illustrate similar challenges. We also provide suggestions for responding to the moral challenges that clinicians face during the COVID-19 pandemic and other global health crises.

In collaborative care (also called integrated behavioral health), clinicians from multiple disciplines work together as a team to ensure that patients get the best possible treatment for mental health concerns in the primary care setting (Patterson et al., 2002). The clinicians in our collaborative care setting include MedFTs, MedFT trainees, family physicians, and family medicine residents. Their responses provide an incomplete snapshot of early responses to a threatening and confusing crisis. They answered open-ended questions about their personal and professional experiences during the pandemic, with topics including: personal sense of safety, guidance on clinical protocols and policies,

access to clinical information, workload issues, effects on personal life, relationships, wellness, and challenges. Other questions focused on ethical and practical challenges to assess their risk of burnout. Their strengths were highlighted by their answers to questions about coping resources/strategies and resiliency.

Clinicians universally felt supported by their institutional and departmental leadership, but many identified a range of challenges that impeded their ability to fully demonstrate their care to patients. Many clinicians transitioned to telehealth with no training and little preparation. Equipment was sometimes inadequate and, at least initially, clinicians were often dependent on personal computers and software at their homes. Concerns about privacy and HIPAA violations heightened clinician anxiety. Elderly patients sometimes struggled with telehealth technology and precious appointment minutes were spent trying to connect. In some cases, clinicians and patients gave up and used the phone or rescheduled. The rapid and total transition to telehealth highlighted the lack of control the clinicians already felt.

Clinicians wondered if their personal concerns were worthy of attention during the pandemic. Some clinicians noted that their incomes declined rapidly at the start of the pandemic due to seeing fewer patients, and trainees worried about the depth of their clinical training and accruing enough clinical experiences to graduate. While these clinicians felt conflicted about being concerned about their salaries, training, and job security, their anxiety grew as COVID-19 initially led to a decrease in both outpatient and inpatient appointments. Thus, whether a student, resident, or licensed professional, COVID-19 had far-reaching effects on all areas of life for healthcare clinicians. Many stressors, such as the rapid transition to telehealth, led to feelings of confusion and lack of control. Over time, clinicians became more comfortable with telehealth and began to see its merits, including the opportunity for patients to stay home rather than risk exposure to COVID-19. But in the early weeks of COVID-19, clinicians felt stressed and, at times, fearful.

Although there have been other global tragedies and mental health crises that have affected healthcare clinicians' experiences in recent years, COVID-19 is unique in its total omnipresence across the globe. It has affected virtually every area of life for both clinicians and patients (Lebow, 2020). The challenges the collaborative care clinicians described fell into four areas: (1) Ethical Dilemmas Associated with Telehealth; (2) Pervasive Uncertainty; (3) Boundary Ambiguity; and (4) Isolation and Burnout.

ETHICAL DILEMMAS ASSOCIATED WITH TELEHEALTH

Clinicians all experienced a gap between the standard of care they usually provide and the modified care mandated by COVID-19 restrictions. The rapid transition to telehealth raised questions about the quality of care being offered. Physicians could not physically examine their patients and therapists could not offer a box of tissues to a weeping patient or note subtle nonverbal cues. MedFT trainees, already known for experiencing self-doubt caused by lack of confidence in their therapeutic competence, now had to adapt to an unfamiliar online format.

Clinicians also struggled with access to quality video and audio tools and had not received training in telehealth, which raised personal concerns about the potential for unethical care. Video visits administered through phone and/or tablet applications were often interrupted by flickering video and inconsistent audio. Audio was especially difficult with couples and families due to the system's lack of sensitivity to multiple voices in the room. Having a clear understanding of how a family or couple interacts by observing their interactions in session is a key element in systemic-focused couple and family therapy (Patterson et al., 2018). However, MedFTs commented that with telehealth they could

adequately hear about 70% of what each family member said, which was particularly problematic during emotionally laden and conflictual interactions. The limitations of remote services contributed to clinicians' fears about offering inferior services at a time when patients need even more support, which was evident in the clinicians' quotes below:

> - The slow slide into offering sub-par services through telehealth . . . teletherapy is not real therapy and is completely inadequate for patients in the long term.
>
> - I hate telehealth. I don't feel that I am providing good care for my patients. I can't get lab tests. I feel guilty that I am charging them (or their insurance carrier) the same or higher fees for substandard care. It feels ethically wrong to me to practice in this fashion. If telehealth was to continue for much longer, I would seek a career change or retire.

Another clinician concurred:

> I feel guilty about not providing the care I went into medicine to provide. I feel like telehealth is about generating money, not about providing excellent care. I'd rather be working in urgent care or in the hospital. I can't stand looking at a computer all day and miss the interpersonal contact with co-workers and colleagues and with my patients. I AM BURNT OUT!

In general, clinicians received no previous instruction in telehealth even though the use of telehealth was increasing before the pandemic hit. In fact, faculty members at several COAMFTE-accredited graduate programs interviewed about telehealth just months before the eruption of COVID-19 concurred that they were grappling with how to incorporate telehealth training into their curriculums, acknowledging that integrating technology into mental healthcare "is no longer a possibility but a reality" (Cravens Pickens et al., 2019, p. 198). Another difficulty with telehealth is how to maintain the integrity of systemic-based treatment models, where technical difficulties make it difficult to balance the conversation in session as well as ensure appropriate privacy. Furthermore, the 2015 AAMFT Code of Ethics states that a clinician can only "commence electronic therapy or supervision after appropriate education, training, or supervised experience" (Springer et al., 2020, p. 215).

Although the goal of collaborative care is to work as a team, during COVID-19 physicians inevitably took more risks than their non-physician collaborative care colleagues. They returned to the clinic earlier and began close patient proximity earlier as they began examining their patients again. In fact, medical students and student therapists were given strict limitations about direct contact with patients. Therefore, some clinicians felt conflicted about the level of COVID-19 risk they faced compared to their colleagues, especially students who often felt guilty about not being able to help after being prohibited from providing patient care. Another clinician said that he felt challenged by his desire to "help, learn and serve while also preserving my own life. I have a health condition and am extremely scared of getting [COVID-19] but also need to [fulfill] my obligation. I feel guilty for not wanting to be on the front lines, but I also want to survive this…" Student versus faculty, in-clinic clinician versus at-home clinician, therapist versus physician—the clinician's context affected the unique risk he faced and influenced the angst he felt about his role and responsibilities.

Sometimes when a clinician confronts a moral dilemma like the clinician above who had an underlying health condition, he may defer to authority even if the situation causes him moral distress. On the other hand, he may also choose to follow his conscience regardless of the consequences. One MedFT trainee reported:

> I can reflect back on times in my previous career . . . when I knew the right thing to do for that particular person was to stay on the phone past policy or to help them by offering outside resources which would cause a breach of procedure . . . I did it anyway, because it was best for the person's safety and overall well-being. I was willing to take the write up or reprimand if it came, knowing I had done my best and provided the most help possible for that person at that time. Institutions have to have policies and procedures to function and to protect against liability. But it doesn't always mean they are right or even that those procedures are the best practices . . . If someone does not raise concerns . . . in a professional and considerate way, then that's when we end up with things like institutionalized racism. That authority really only holds the power that we allow it to have. Furthermore, institutions rely on individual employees to make decisions as how to best function and operate within those confines. I think in any career in which you are working with humans in such a vulnerable, personal and direct way, there will be times when "do no harm" really means doing what is best for the patient and not the institution. If there is a way to work within those confines and do both, then do it. But I think my moral compass has always pointed me to doing what is best for my patients within reason.

As cases decreased in the late summer, our setting began communicating policies for a return to limited in-clinic visits. The institution's desire to increase in-clinic visits was met with concerns from many clinicians about return dates that seemed premature and safety protocols that were perceived as underdeveloped. Clinicians wanted to provide the best possible care for their patients and also ensure that personal safety was prioritized. This led to feelings of great uncertainty.

Pervasive uncertainty

During the early weeks of the pandemic when the team was queried, research had not yet clarified how easily COVID-19 could be transmitted and what the mechanisms of transmission were. One clinician felt confident that he was protecting himself and providing adequate care for his patients; therefore, he did not want to move to telehealth. However, during one patient visit, an elderly patient wearing a mask started coughing. The patient instinctively pulled his mask off and simultaneously coughed in the clinician's face. The clinician began doing more telehealth the next day.

Pervasive uncertainty has affected every area of a clinician's life, not just her work life. Perhaps the fundamental questions focused on personal safety as the above example illustrates. One clinician reported:

> I am concerned about . . . COVID-19 as there had not been a previous virus . . . and the reaction of the public to either over or under estimate its potential impact.

> In a world where we have had limited testing and tracking capacity . . . going to work then coming home to my family made me continuously perseverate on the fear of exposing [my family].

When asked if she feared for her safety, one clinician highlighted how much remains unknown, especially in the early months of COVID-19:

> Yes! Especially early on when face masks were not only not mandatory but were discouraged! Are these surgical face masks really sufficient? Are these work spaces clean? Should I be this close to my [colleagues]? Why are my patients removing their masks all the time?

Finally, two clinicians summarized their overall feelings by commenting:

> It is frustrating how rapid things changed at first . . . I don't feel anyone could have predicted such an eventful year.

> It's the uncertainty, lack of preparation [for mental health crises] and constant changes that make it stressful.

The moral distress literature presumes that the clinician has an inner sense of "the right thing to do," but in the case of COVID-19, clinicians were left with uncertainty about many issues (Dean et al., 2020). For MedFTs, the situation was compounded by the fact that they were working in medical settings where they felt increased risk because ill patients came to their clinical site for care. Licensed MedFTs were considered "essential" clinicians by the State, and thus could keep working in any clinical setting. But, should they? Was there a difference in what their physician colleagues knew and the risks physicians could take compared to MedFTs? Student MedFTs had been taught that coordinated care, hallway consults, and raw data supervision were foundations of collaborative care. But, at least for a period of time, they provided care from the screens in their homes with less oversight and coordination than when they worked in the clinics. Initially, there was little clarity about the future nor was there assurance about personal safety.

In addition, the rules for providing care changed frequently, making it difficult for students and teachers to determine the correct course of action. Students also had to navigate between the rules of their MFT Program and the rules of their clinic. There was little coordination between universities. Thus, in some cases, it was briefly left to students to understand their work parameters. After the initial crisis, students' work guidelines were gradually clarified.

Maintaining boundaries

New issues arose because of COVID-19 in terms of boundaries. What rules or guidelines had to be followed for patients to access care? What authority existed to enforce those guidelines and what were the consequences if the rules were not followed? Masks and PPE became symbols of both protection, and for some patients, an expression of personal freedom by choosing not to wear a mask. Each clinic had to establish guidelines for their patients. Are masks required? Can testing be done in the parking lot? In what circumstances (if any) can a patient be seen in person? What guidelines existed and could be enforced?

In one case, a community clinic had nurses taking temperatures of patients before they could enter the clinic. They also asked the patients to wear masks. In one dramatic case, an angry older patient attacked the security guard standing at the entrance because the patient did not want to wear a mask. A pediatrician who happened to be nearby saved the security guard when the two of them subdued the patient.

When clinicians started working from home, what protections and boundaries were in place to ensure confidentiality? What was it like for patients to see the bookshelves, the kitchen cabinets, or

other details of the clinician's home? Was there any distinction between work space and home space when clinicians were working only from home?

As already mentioned, the move to telehealth frequently meant that the clinician was delivering care from his bedroom, his home office, or even his kitchen table. When clinicians working from home met virtually with patients, they were faced with privacy issues: How do I protect my privacy and my patient's privacy and focus on my work when I cannot find private space in my home? What can I do if my patients cannot find privacy in their homes? One clinician detailed the unique challenges she faces while working from home:

> It has been challenging to maintain a private workspace in my one-bedroom apartment with my fiancé sometimes present. I go to another room and close the door. I wear headphones and try to keep my voice down. I cannot have my window open because the neighbors would hear, and I do not have AC. It gets hot in my makeshift bedroom/office. I use my dog's staircase and a box as my "table." My wooden rocking chair becomes painfully uncomfortable after 2 sessions.

The moral distress literature notes that moral distress can occur based on a single egregious violation or repeated moral dilemmas. An example of moral distress in this second category is a MedFT who fears she cannot provide adequate care because she cannot ensure confidentiality due to her living situation. She is distracted by her own personal fear/distress, held back by her lack of relevant (telehealth) training, and questioning vague clinical, personal, and professional boundaries. Some MedFT trainees noted that they chose to become therapists because they wanted to improve patients' mental health; however, in recent months they found themselves overwhelmed by the challenges inherent in addressing the COVID-19 crisis and questioned their ability to help at a time when their own urgent needs—both physical and mental—materialized.

Isolation and burnout

At times, some clinicians found themselves exhausted and wondered, “What's the point?” These responses came partially because of the clinician's self-identity as a caregiver and as a professional who takes risks to care for others even at his own personal expense. Inherent in this self-identity is the risk of burnout and isolation.

During the COVID-19 crisis, public health officials stressed the need for “social distance.” But the healthcare clinicians noted that they in fact needed social closeness even while they had to maintain physical distance. Ironically, COVID-19 resulted in both physical distance and social distance. Clinicians could not meet together in the lunchroom or hallway to exchange greetings or information. When they arrived home, they changed their clothes in the garage and delayed entering their house for a period of time if they feared exposing a high-risk family member.

One hallmark of collaborative care is the chance for different professionals to learn from each other, especially by sharing patients. Physicians and MedFTs learn to rely on the strengths of their colleagues from different disciplines. However, transitioning to telehealth services means that clinicians work in isolation. A “hallway consult” could not occur when clinicians work from home. Thus, patient care can easily become more fragmented because using a shared patient chart is the only communication the sequestered clinicians have during COVID-19. This can lead to a decrease in referrals from physicians.

Many clinicians in our survey described intrapersonal and interpersonal challenges during the pandemic:

> I feel exhausted and depressed. I feel a sense of guilt not being able to support my patients and colleagues like I normally do. I worry about my colleagues being overwhelmed and committing suicide, an issue that was already increasingly present in healthcare providers. I'm also worried about the tsunami about to hit mental health as this crisis lifts. We hold the pain and trauma for our teams and patients. Our teams are holding all their pain in currently to make it through the storm. What will happen to us once they all let it out at once . . . ? Who will flatten our curve? Will we be protected?

Another clinician described her loneliness and isolation:

> I live alone and am single. I haven't touched (hugged, etc.) another human in 45 days and by the end of this it will be 60+ days. It's a weird feeling, a lonely feeling. My friends and family reach out but it's not the same and I am getting tired of the screen, which is my only way to connect with them.

Lastly, a clinician recounted her desire to isolate after a long day in the clinic:

> Too tired to want to interact with household members by the end of the work day. I just want to isolate. I haven't been able to personally see family members outside of my immediate household, and haven't been able to hug my grandchildren.

As demonstrated in the examples above, moral distress caused by isolation and burnout during COVID-19 resulted in some clinicians feeling powerless, considering changing careers, developing cynicism, distancing from their work, and finding that usual self-care techniques no longer worked. As opposed to seasoned clinicians, early career professionals also struggled with their lack of experience balancing the needs of their patients with their own personal needs. Clinicians who were coping with both overwhelming challenges in their personal and professional lives over an extended period of time-experienced depression, anxiety, and worsening psychological symptoms (Czeisler et al., 2020; Pfefferbaum & North, 2020).

BUILDING RESILIENCE TO MORAL DISTRESS AND INJURY IN THE ERA OF COVID-19

Case studies and literature on moral distress and moral injury have focused on their distinctive clinical features. There have been few attempts to describe preventive strategies for individuals likely to be placed in settings where moral distress is a high concern, such as healthcare settings. Clinicians for COVID-19 patients can anticipate experiencing the burden of moral decision making when faced with questions such as: Do I align with my professional commitment to provide care for ill patients? Or, do I align with my responsibility to keep my family safe?

Surveys of frontline physicians have revealed a unique profile of COVID-19 stressors compared to past contagions, such as tuberculosis or HIV/AIDS (Griffith, 2020). This profile is exceptional in the severity of uncertainty, self-blame, and guilt, in addition to the personal threat of infection. Self-blame and guilt have been largely attributed to perceived risks for infecting one's own family members

inadvertently by bringing the virus home from work (Griffith, 2020). Thus, training clinicians to cope with moral distress should be as important as training them to properly use personal protective equipment or use technology to deliver care.

Clinical supervisors can set their own moral compass by going through the steps listed below that were developed from previous literature on pandemics such as AIDS, Ebola, and SARS (Iacoviello & Charney, 2014). In addition, supervisors can also guide a trainee through the steps of setting a moral compass before entering clinical spaces where COVID-19 risk may be encountered (Sahebi, 2020). When a trainee finds this process to be difficult, a supervisor's skills for managing uncertainty, clarifying purpose, and organizing a supportive community can be invaluable.

In addition to literature from previous pandemics, guidance for preparing clinicians to cope with moral distress can be gleaned from research on clinical procedures, ethics, and resilience (Boss, 1999; Catapano & Griffith, 2019; Griffith, 2018; Levinas, 1961; Southwick et al., 2011). Setting a moral compass has been identified as a major resilience factor. Five principles are presented as steps to take in setting one's "moral compass" before entering a situation that risks moral distress (Iacoviello & Charney, 2014; Stockdale, 1995). The five resilience factors are as follows:

(1) *Do not wait for circumstances to force a decision when facing a moral dilemma*. It can feel tempting to avoid, delay, or freeze when facing a difficult dilemma. Some clinicians become stuck in ambivalence during this first step by ruminating over what is "the right thing to do." However, effective coping with moral distress begins by accepting the reality of the dilemma and the necessity of making a choice. For COVID-19, this might consist of making a decision about whether to provide care for COVID-19 patients despite awareness of personal risks. On page 13, one clinician notes that she is wrestling with personal risk when she states, "… going to work, then coming home to my family made me continuously perseverate on the fear of exposing [my family]." But, she is still going to work. Assertive coping lies at the heart of nearly every strategy for strengthening psychological resilience. Facing a moral dilemma head-on, rather than avoiding making a decision, is the first step.

(2) *Establish clarity about one's values and commitments*. A range of questions can invite reflective dialogue on what really matters to clinicians. A supervisor might ask, "In your *heart of hearts*, who are you? What is your life really about? Who is the person you most aspire to be? As you look back upon your life in years to come, what is most essential in how you have lived? What are the values or commitments that matter most?"

(3) *Create a community of support who can support and understand one's values and commitments identified in step two*. A key to coping with moral distress is open access to a group of friends, colleagues, partners, or family members who can both comprehend one's moral distress while also providing unqualified support whether or not they agree with the decision. Partners and family members are a natural source for such support. Earlier in this article, quotes from clinicians mentioned the lack of touch and not seeing beloved grandchildren as examples of stressors leading to exhaustion.

Unfortunately, moral dilemmas can also divide families and communities. Colleagues may bias support according to the impact that decisions have upon their lives or organization. Parents may fear harmful consequences for their child or other family members. Clinicians need a small group who, fully informed, can provide sustained and unqualified support.

(4) *Align your choices with the values and commitments from step two that define your identity*. This step does not guarantee the "best choice." It sometimes helps to clarify that a dilemma has no right solution; otherwise, it would not be a dilemma. Shifting focus from "the right thing to do" to "what you will least regret" often opens movement. On page 11, a clinician said, "It feels ethically wrong to me to practice in this fashion. If telehealth was to continue for much longer, I would seek a career change…" This clinician was clear about his values and commitments.

(5) *Take action while simultaneously depending on important personal relationships identified in step three*. Once clinicians have gathered a supportive community and clarified their values, they can act on their values, such as deciding to treat patients in spite of personal risk. On page 12, a MedFT trainee discusses making decisions such as offering outside resources or staying on the phone longer than required even though it was a breach of procedure because it was best for her patient.

Step five presents challenges to supervisors who both want to support trainees' moral development/decision making and simultaneously ensure that trainees' decisions do not inadvertently increase risk. In one earlier situation, a MedFT trainee, who was serving as a translator for a Spanish language patient, gave the patient her personal cell phone number because she wanted to help the patient in any future medical situation when she needed a translator. She made this choice without informing her supervisor. A few days later, the patient called the student translator in the middle of the night to tell her that she felt suicidal. These situations can be partially avoided by having clear, written policy/guidelines and by supervisors having frequent communication with their supervisees beyond the hour of individual supervision each week. A trainee has no more important personal relationship in her work than her relationship with her supervisor.

In addition to their clinical supervisors, trainees need the support of their professors and fellow students. One of the most damaging effects of COVID-19, at least initially, was the impact of social isolation. During the first months, clinicians had few ideas about how to both follow the guidelines for social distancing and simultaneously provide and receive needed contact and support. While these challenges will exist until COVID-19 is eradicated, some efforts have been made to create the connection. Students and supervisors have met in parks for socially distanced meals. Small groups with shared interests such as "therapists with children" have been created. Many clinicians have participated in Mindfulness-Based Stress Reduction courses that have been offered free of charge to clinicians. None of these options are solutions in themselves nor do they target moral development directly, but each option creates the space for connection and dialogue, which are precursors to the process of setting one's moral compass.

Other components of taking action include maintaining hope for the future and the ability to reappraise potentially traumatic experiences (Iacoviello & Charney, 2014; Wade, 1997). Recognizing that stress is an ingredient for growth and connecting the stressful experiences to one's sense of purpose helps clinicians stay resilient in the face of adversity. For example, adopting a belief that, "I'm doing the best I can under difficult conditions" can lead to self-acceptance, perseverance and the ability to stay present with patients.

These five steps provide a framework for setting one's moral compass prior to entering a setting in which moral distress likely will occur. When applied to moral distress associated with COVID-19 patient care, this approach can be expanded to encompass other established factors for strengthening resilience. For example, seeking as much education as possible about the unique profile of emotional stressors of COVID-19 and the illness itself can be valuable. Similarly, seeking role models or mentors by talking with more experienced clinicians who have provided care for COVID-19 patients can be helpful.

COVID-19 resulted in challenges that most clinicians never experience during their entire career. The personal dilemma of knowing that caring for your patients in a medical setting might put you and your family at risk is one example of COVID-19 dilemmas. Supervisors in one collaborative care setting searched the medical literature from other pandemics and the initial literature from the COVID-19 pandemic to find ways to conceptualize what they and their trainees were experiencing. Ideas from the moral distress literature helped "clarify the language of clinician distress" (Dean et al., 2020, p. 923). In addition, the moral distress literature provided a framework for ways to help clinicians set their own moral compass during one of the most challenging experiences of their careers.

Moral dilemmas and moral distress are part of the landscape of living. Addressing moral dilemmas in training reflects the importance of both self-care and professional ethics in clinical work. Like grief, demoralization, or spiritual crises, moral distress is not a professional weakness but rather part of the "normal suffering" that every person faces at some point. The COVID-19 pandemic, however, stands out for the serious risks of moral injury due to its biological profile of high risk of contagion, placing both clinicians and their family members at risk. Scholars examining physicians' responses to an earlier crisis, the AIDS epidemic, wrote, "Medicine is an inherently moral enterprise, the success and future of which depend… on the integrity of individual professionals as they face the duties the calling of healer entails" (Zuger & Miles, 1987, p. 1928). The COVID-19 pandemic has given clinicians an opportunity to deeply reflect and act on their primary motivation for becoming healing professionals in the first place.

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APPENDIX 1

SURVEY

Work/school environment

1. Have you had concerns about the safety of your work/school environment? If yes, please explain.
2. Have you had concerns about guidance on clinical protocols and policies? If yes, please explain.
3. Do you have concerns about access to centralized information and/or updates regarding Covid-19? If yes, please explain.
4. Do you have concerns about your clinical workload and/or coverage? If yes, please explain?

Personal experiences

5. Please describe what, if any, unique or challenging ethical or practical challenges you have experienced as a result of the Covid-19 pandemic.
6. Have you had concerns about moral injury or burnout? If yes, please explain.
7. What has helped you the most in facing the ethical and practical challenges?
8. Have you had concerns about your physical wellness and level of activity? If yes, please explain.
9. How has Covid-19 affected your personal relationships?
10. What have been the most significant personal challenges you've faced during Covid-19?
11. What personal resources have helped you address your personal stressors?

Education and training

12. In reviewing the previous questions, what professional resources have helped you the most in facing challenges related to Covid-19?
13. How could your training/education have better prepared you for the Covid-19 pandemic?
14. Is there anything else you would like to tell us about your experience during the Covid-19 pandemic?