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Commentary

Continuing Education

Moral Distress, Trauma, and Uncertainty for Midwives Practicing During a Pandemic

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Pandemics are marked both by the infection itself and by the disruption it can cause in the ability of health care providers to support the well-being of themselves and their patients. In 2020 to 2021, midwives experienced frequent changes in policies due to rapidly-evolving understanding of coronavirus disease 2019 (COVID-19), the secondary trauma of death and illness of both patients and fellow providers, and the potential disruption of the usual midwife-patient relationships related to public health recommendations.

The COVID-19 pandemic arose early in 2020, following a limited epidemic of the respiratory illness caused by the novel coronavirus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in Wuhan, China, in late 2019.[1] The first case in the United States was identified in Washington State in January 2020[2] and was quickly followed in February 2020 by a lethal outbreak that occurred within a long-term care facility in King County, Washington.[2] The national and global spread, facilitated by then-unknown asymptomatic transmission and likely airborne transmission, was extraordinarily rapid, with 112,554,307 known cases worldwide by February 2021.[3] As the pandemic progressed, shortages of personal protective equipment (PPE) and widely varying public health responses and risk factors led to significant disparities in both infection rates and in deaths, but as of February 2021, COVID-19 had resulted in 2,497,814 deaths globally, including 505,890 deaths in the United States.[3] These deaths were not evenly distributed but instead reflect existing social and political inequities. Black and Latinx people in the United States experience infection and death rates significantly higher than white residents of the United States.[4] Disproportionately high rates of morbidity and mortality are also present in pregnant individuals,[5] older people,[6] and those with underlying medical conditions.[6]

Most research on the effects of the COVID-19 pandemic on health care providers has focused on the effects on emergency department and intensive care staff. However, the nature of perinatal care, as well as the emerging evidence of pregnancy-specific sequelae of COVID-19,[7] also calls attention to the specific needs of midwives. In this pandemic, as with the experience of HIV 40 years ago, there is a need to protect both the physical and emotional health of providers—and, as with HIV, the systems in place to protect the physical well-being of health care providers may be inadvertently harming the emotional well-being of those same providers.

Midwifery is a highly relational health profession.[8] Pregnant people's expectations of birth as a family and personal life event rather than illness emphasize the importance of interactions with and emotional support from caregivers, including midwives.[9] Birth outcomes are improved for laboring people who have continuous support,[10,11] which incentivizes midwives and facilities to encourage that support. The rapid and ever-changing policies of the COVID-19 pandemic have profoundly interrupted these professional norms, creating confusion and loss for midwives and patients alike. This confusion and uncertainty in turn carried the potential for relational disruption, both between midwives and patients, and midwives and the systems in which they work. If health care providers, like anyone, do not know who or what to trust, relationships become difficult to maintain.

The core philosophies of the midwifery profession include shared decision-making,[12] a process in which a trusting relationship between patients and providers is a key component.[13] Both the midwife's role as patient advocate and role as team member prioritize relationships between the midwife and the individuals they serve. Indeed, even the title *midwife* is derived from "with woman [sic]," which emphasizes the relational role of the midwife in giving care. The physical separation, emotional distance, and reduced schedule of prenatal visits that are the result of required contact and respiratory precautions in response to the COVID-19 pandemic decrease the opportunity for midwives to build these trusting relationships. This in turn creates a friction between the midwifery orientation toward shared decision-making and the lack of relational trust needed to fulfill that role, which may lead to dissatisfaction with the relationship. Although much of the research that exists on relational dissatisfaction comes from the nursing literature, it is likely that midwives, who work in a similarly relational health care role and who often practiced as nurses prior to their work as midwives, would experience similar outcomes. For these health care providers, failure to find satisfaction in the patient-provider relationship can lead to dissatisfaction with the professional role, which in turn is associated with depression,[14] missed care,[15] and

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leaving the profession.[16] This disruption can present as moral distress, burnout, or trauma, with long-lasting implications for the health care system.

Moral distress is defined as being "unable to translate their[sic] moral choices into moral action."[17] For midwives, moral distress is specifically associated with asymmetry of power and authority,[18] which is present in many of the ethical dilemmas of the COVID-19 pandemic. Midwives and other health care providers are asked to care for patients in new ways, including use of extensive PPE, strict visitor policies, and requirement for COVID-19 testing on admission, which can violate many of the priorities of patient-centered care that midwives have embraced. Rather than as people transitioning to parenthood, midwives must view their patients, and patients' families, as potential vectors for infection.

These are all situations in which midwives are required to enact authority on their patients, whether by their own beliefs about the best ways to mitigate risk of COVID-19 or as agents of the health care system in which they provide care. This may have been particularly true earlier in the pandemic, when some systems were separating newborns from their parents if they tested positive for COVID-19. This kind of forced participation in removal of newborns from parents has been previously identified as particularly traumatic for midwives and a source of significant moral distress.[19] In March 2020, midwives in some settings found themselves abruptly moved into the role of enforcer of norms they might not either understand or endorse. They also moved into the official role of essential worker, whose profound value was acknowledged when, at the same time, performing that essential work placed them at personal risk.

This disconcerting identity transition from caregiver to at-risk worker is exacerbated by the rapidly changing recommendations from both government agencies and from institutions. Since March 2020, the Centers for Disease Control and Prevention (CDC) recommendations for infection control for health care providers have changed significantly at least 3 times, as new information about the pandemic become more available.[20] Given concerns about lack of transparency and unusual policy and personnel decisions made by the Department of Health and Human Services, including the US Food and Drug Administration as well as the CDC,[21] during 2020, some providers and others have been concerned about the national pandemic response being politicized.[22] This lack of trust in some of the primary governmental authorities that deal with infectious disease, combined with widely-disparate local and state responses to the pandemic, may have exacerbated the distress experienced by some providers. This includes, in some cases, the experience of trauma, by reducing the perceived control that the midwife had over their safety. If the agency tasked with ensuring the safety of patients and health care workers cannot be relied upon to provide the best recommendations, where can providers find safety?

Trauma, the perceived or actual risk of harm to one's well-being or life,[23] has well-established negative effects both on the individual and on their relationships with those around them.[24,25] Trauma can be either primary, experienced by the individual themselves, or secondary trauma, experienced by those who are near or caring for the primary person experiencing trauma.[23] Health care providers can experience secondary trauma when they witness harm or excessive risk experienced by patients or other providers, both of which have been prevalent in a pandemic with relatively few treatments and imperfect infection-control mechanisms in place. Midwives caring for birthing families are also witness to the traumatization of families who may experience direct and indirect harm from both the pandemic and from the efforts to mitigate that harm, including visitor limitations for antepartum and intrapartum care. Prior research with midwives identified fatigue, conflict with colleagues and systems, and the loss of what participants perceived as midwifery care as risks for increased chronic traumatic stress.[26] In research with nurses, the effects of both primary and secondary trauma can include depression, anxiety, and posttraumatic stress disorder (PTSD).[27] PTSD in particular may presage departure from the profession, since one of its characteristics is the desire to avoid reminders of the traumatic event or situation—in this case, health care settings.

IMPLICATIONS FOR CLINICAL PRACTICE

Midwives have experienced epidemics before, including the recognition of HIV in the 1980s, severe adult respiratory syndrome in the early 2000s, and the H1N1 influenza epidemic of 2009. The lessons of HIV may be particularly salient for clinical practice in COVID-19. As with the current pandemic, the transmission of HIV was initially unclear, which provoked strong fear responses in many health care providers at the time,[28] and the lack of clear or effective treatment meant that many providers experienced recurrent traumatization from patient illness and death. Likewise, the uncertainty about how the virus was transmitted may have contributed to moral distress in unwillingness to provide the close hand-on care characteristic of midwifery and nursing, a practice change that was highly stressful for many. Finally, both HIV and COVID-19 were marked by significant politicization of an infectious disease, which caused an initial inconsistent and uncertain public health response.[29]

The trauma response felt by midwives is substantial and requires attention to better support those working during the COVID-19 pandemic. Trauma theory supports several best practices for trauma-informed care.[30] Trauma-informed care should include practices to protect patients and their caregivers from retraumatization, including practices that support patient empowerment, choice, collaboration, safety, and provider trustworthiness.[30] Examples of these practices for patient care can include reconsideration of excluding partners and other support people from pregnancy and other outpatient care; including patients in transparent discussion about policies, including their limitations; ensuring that doulas and support people are able to be present in hospital birth settings, including in the operating rooms and postanesthesia care units; and re-evaluating the abbreviated prenatal care schedule.

Given much of the trauma experienced by midwives secondary to the COVID-19 pandemic is the result of rapidly changing policies within the health care systems in which they work, the impetus must be on the systems, not solely on staff, to implement changes related to trauma-informed care for their employees. As was seen with the HIV epidemic,

the use (and availability of) universal precautions including appropriate PPE and further education to combat fear and stigma are essential.[31] Although many midwives are familiar with universal precautions in the context of blood-borne pathogens like HIV, the application to a respiratory-transmitted virus is often new, because relatively few pathogens require higher-level PPE like N95 masks for occupational exposure. Midwives may require some further education to feel comfortable both with the precautions and with the level of protection that these higher-level PPE devices offer. Access to appropriate PPE and following international recommendations for best practices for universal precautions during perinatal care will improve feelings of trust and reduce fears of exposure. Health care systems can also work toward a transparent accountability structure for policies and policy rollout, encouraging feedback and input from staff, and addressing concerns that arise. Last, changes in policy and procedures need associated education to provide staff with the knowledge they need to feel comfortable and safe enacting these changes within the context of care provision. Similarly, policy changes need to be communicated effectively with patients to reduce conflict between patients and caregivers.

It is also imperative that midwives identify resources to support their individual mental health and ease feelings of burnout and moral distress, as well as health care system support for trauma-informed practice. Because provider well-being is a systems-level issue, it requires a systems-level approach. Sperlich et al described the development of trauma-informed perinatal care practices, which include recognizing the prevalence and effects of traumatic experiences for patients,[32] but the aftermath of the COVID-19 pandemic will require extension of these practice norms to providers as well as to patients. Midwives and other health care providers need trauma-informed systems for their own healing as well as that of their patients, and although this pandemic was perhaps underestimated in its all-encompassing impact on health care and health care providers, there will be another pandemic or other disaster in the future. Future-proofing health care systems requires us to follow the principles of trauma-informed care and recognize and respond to the needs that trauma has created for many providers and patients alike. Although the trope of the Good Midwife (or Good Nurse) may require self-sacrifice and denial of individual needs for support, a postpandemic system cannot.

Individual-level interventions, such as resources for mental health counseling, and the time allowed to receive such care, are also vital in supporting midwives' ability to continue providing quality care. Considering the relational nature of the midwifery profession, encouraging alternate, innovative forms of communication between patients and providers, such as using video conferencing for discussions without masks and PPE or including photos and names of care providers in prominent locations, can help increase connection and sense of caring. Psychological first aid, the mental health equivalent of physical first aid that focuses on basic psychological needs like safety and connectedness, is suggested as possible intervention for provider trauma, with lower risk of increasing distress than other modalities like immediate critical-incident debriefing.[33] Empirical evidence for psychological first aid is limited at this time, but as a low-risk intervention that employs the connected relationships and safety that are the hallmarks of midwifery, it may be a powerful way to begin recovery from months of secondary or direct trauma.

Finally, it is often necessary to resist harmful policies and practices to enact change, and in doing so, one can experience a sense of power and control over a harmful situation. Given the health disparities magnified by the COVID-19 pandemic, it is especially important to recognize the disparate impact of the pandemic on people of color and to act to mitigate those impacts. Restrictions to having the presence of support people for individuals in labor has been highlighted as such a policy that has a disparate impact, and one that intensely affects midwives and families at a profoundly vulnerable time.[34] Midwives, nurses, policy makers, managers, and physicians must critically examine policies for unintended impacts that disproportionately affect families of color and, more importantly, take steps to address them. As health care providers, midwives are in a relatively powerful position to ally with others to challenge these well-meaning attempts at risk reduction that may nonetheless be harming patients already at risk in the health care setting.

It is not enough to note the effects of the pandemic on midwives and patients with a restrained clinical eye. Instead, midwives are ethically obligated to speak up, and speak loudly, when these policies create additional or unintended harms. Identifying and giving voice to harmful policies or practices creates the opportunity to resolve moral distress, by directly addressing the tension between what one can do, and what one should do, and to reclaim the sense of autonomy and power that is often lost in trauma. When midwives are presented with great upheaval in their professional and personal lives, raising one's voice can promote positive change for health systems, patients, and themselves. The sweeping wave of new policy brought by COVID-19 has the potential for harm but also the opportunity to enact change, and midwives can be at the forefront of that change.

CONFLICTS OF INTEREST

Ira Kantrowitz-Gordon, CNM, PhD, is a Deputy Editor of the *Journal of Midwifery & Women's Health* and was excluded from the peer review and editorial decision for this article. [Correction added on June 15, 2021 after first online publication: The preceding conflict of interest disclosure was added.]

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