

Ethics and Well-Being: The Health Professions and the COVID-19 Pandemic

Mark T. Hughes, MD, MA, and Cynda H. Rushton, PhD, RN

Abstract

The COVID-19 pandemic has had a profound impact on health professionals, adding to the moral suffering and burnout that existed prepandemic. The physical, psychological, and moral toll of the pandemic has threatened the well-being and integrity of clinicians. The narrative of self-sacrifice and heroism bolstered people early on but was not sustainable over time. For health professions students, the learning environment changed dramatically, limiting opportunities in direct patient care and raising concerns for meeting training requirements. Learners lost social connections and felt isolated while

learning remotely, and they witnessed ethical tensions between patient-centered care and parallel obligations to public health. Worries about transmission of the virus and uncertainty about its management contributed to their moral suffering. Educators adjusted curricula to address the changing ethical landscape. Preparing learners for the realities of their future professional identities requires creation of interprofessional moral communities that provide support and help develop the moral agency and integrity of its members using experiential and relational learning methods. Investing in the well-being and

resilience of clinicians, implementing the recommendations of the National Academy of Medicine, and engaging learners and faculty as cocreators of ethical practice have the potential to transform the learning environment. Faculty need to be trained as effective mentors to create safe spaces for exploring challenges and address moral adversity. Ethics education will need to expand to issues related to health systems science, social determinants of health, and public health, and the cultivation of moral sensitivity, character development, professional identity formation, and moral resilience.

The COVID-19 pandemic has had a profound and sustained impact on society. Health care leaders have needed to confront difficult ethical questions around topics such as staffing overburdened health systems, protecting health care workers, allocating scarce resources, equitably distributing therapeutics and vaccinations, and addressing “COVID fatigue.” These realities impose new burdens on the health professions, atop the challenges they already faced before the COVID-19 pandemic.

Before the pandemic, the National Academy of Medicine (NAM) acknowledged the extent of work-related stress and its impact on clinician well-being in its 2019 consensus report, *Taking Action Against Clinician Burnout: A Systems Approach to Professional*

Well-Being. The report documented that 35%–54% of nurses and physicians reported suffering from burnout, as did from 45% to 60% of medical students and residents.¹ Burnout is characterized by 3 dimensions: emotional exhaustion, depersonalization, and loss of sense of professional efficacy. Clinicians suffering burnout are more likely to limit their clinical duty hours, make medical errors, and consider leaving the workforce early.¹ Burnout results in adverse physical and mental health consequences.¹ The NAM Report viewed moral distress as a contributing factor to the erosion of clinician well-being and integrity and concluded that burnout demands a systems approach to address accountability, professionalism, and culture.¹ The perspective set forth in *Moral Resilience: Transforming Moral Suffering in Healthcare* holds that designing sustainable systems and creating a culture to support ethical practice in the workplace can help mitigate moral distress, decrease the susceptibility to burnout, and enhance well-being.²

encompassing physical, psychological, moral, social, spiritual, and economic characteristics that support the resilience essential to individual growth and life satisfaction.³ For clinicians, the personal dimension is necessarily influenced by their professional roles and responsibilities, codes of ethics, compliance with regulatory and legal standards, and the climate and culture of the health care organization where clinicians practice. Depending on leadership, systemic structures and processes, budget allocations, and priority given to wellness programs, individual clinician well-being is enabled or disabled.⁴ Beyond the health care organization, clinicians’ well-being is influenced by the characteristics, culture, and resilience of the community where they live and practice. All of these factors are reciprocally influenced by the broader societal norms, practices, and context.

Alongside the physical and psychological dimensions of well-being, one’s sense of integrity is central to appraisal of well-being. This moral dimension encompasses one’s values, commitments, and worldview. Skills in self-awareness and self-regulation, character development, cultivation of conscience and self-sanctioning abilities, and moral sensitivity contribute to personal

Please see the end of this article for information about the authors.

Correspondence should be addressed to Mark T. Hughes, General Internal Medicine, 601 N Caroline St., JHOC Room 7143, Baltimore, MD 21287-0941; telephone: (410) 955-1733; email: mhughes2@jhmi.edu.

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Concept of Well-Being and Its Convergence With Ethics

A multidimensional concept, the core of well-being is the personal dimension,

integrity and moral agency.² The ultimate integration of these dimensions is moral wholeness that encompasses a coherence between what one says, chooses, and does. Through professional identity formation and socialization, individuals learn what it means to be a good professional.⁵ One's personal integrity is intertwined with the integrity of others and this relational integrity converges with the ethical mandates of one's profession to inform how a clinician responds to moral adversity.² Professional norms are learned through role models and interactions within the interprofessional moral community. The moral community provides a space where moral language can flourish and members of the community can share core values and beliefs.⁶

Moral stress arises when there is a state of heightened awareness of the potential for degraded integrity and well-being.² When this stress is unrelieved, clinicians can experience moral distress, defined as: "The distress that arises when the ethically appropriate action is not taken because of internal or external constraints."⁷ Actions or inactions of individuals or others that lead to psychological distress include witnessing, participating in, or directly causing a range of negative moral outcomes because of transgressions of core moral values. In extreme circumstances, unresolved moral distress can leave a moral residue of unmet obligations and consequences that has the potential to lead to moral injury.² Moral injury occurs when violations of one's moral or ethical code dismantle the sense of moral identity and wholeness essential to well-being.⁸ Moral injury in clinicians is associated with a greater risk of posttraumatic stress and depression, increased correlation with suicidal thoughts, and strong associations with both burnout and medical errors.⁹ When moral injury arises from betrayals by those with legitimate power, such as health care or government leaders, it can deepen already diminished well-being and further erode integrity.

Impact of COVID-19 on Well-Being, Ethics, and Professionalism

Clinicians rose to the challenge posed by the early phases of the pandemic. In the absence of standard treatments for the disease, they worked to

accommodate changes in care delivery as the understanding of the disease evolved and gave rise to new treatment protocols. As the numbers of cases and deaths mounted, clinicians struggled with feelings of helplessness and futility. Initial shortages of personal protective equipment (PPE) led to concerns for personal safety and required some team members to work in full PPE for long periods. Underresourced and highly stressed COVID-19 care units posed new challenges to teamwork, further adding to clinicians' burdens and moral distress.¹⁰ Prolonged exposure to critically ill and dying COVID-19 patients led to feelings of grief. Clinical demands and exhaustion at the end of the workday did not allow the time necessary to acknowledge and process the grief. Left unresolved, grief itself was accompanied by profound moral distress alongside physical and emotional exhaustion.⁷

The well-being of clinicians during the pandemic was affected not only by moral distress encountered at work but also by the threat of COVID-19 infection for themselves and their loved ones. Many health care workers were exposed to the virus outside of the work setting.¹¹ Physical illness due to the coronavirus occurred among many, and some succumbed to the disease. Quarantine policies took a toll on clinicians who tested positive for COVID-19, even if they had only mild symptoms. Separated from peer support at work, they felt they were abandoning their colleagues and patients at a critically urgent time. Clinicians who practiced in areas that served patients of color and the economically disadvantaged—areas with disproportionately high infection and death rates—bore witness to the effects of systemic inequities and health disparities. During the pandemic, the psychological well-being of clinicians was also degraded. Some health care workers were the target of hostility and aggression from members of the public. The soaring mental health consequences of a "parallel pandemic" raised concerns that burned-out caregivers would leave the workforce at a time when they were desperately needed.¹² Studies during the pandemic found that 58% of American physicians struggled with burnout.¹³ National surveys of nurses during the pandemic also documented mental health consequences: 72% reported

being "exhausted," 64% stated they felt "overwhelmed," and 87% were "afraid to go to work."¹⁴ Burnout symptoms and other psychological issues can result in negative consequences not only for nurses and their families but also for health care organizations.¹⁵ In one survey, nearly 30% of health care workers considered no longer working in the field.¹⁶

Balancing professional duties with personal health created an ethical dilemma for health professionals, and some felt ethically betrayed by the systemic failure of governmental and organizational leaders. Clinicians working in unsupportive work environments experienced increased moral injury.¹⁷ Early in the pandemic, the sources of moral injury included severe shortages of resources and equipment (i.e., PPE) and staff, policies impacting personal safety, constraints and retribution when concerns were identified, and the impact of systemic injustice on patients and the clinicians providing care.¹⁸ The pandemic placed health care professionals and the health care system under excruciating pressure. It exacerbated chronic sources of distress, such as high workloads, fatigue, onerous documentation requirements, exposure to patient suffering and death, and residual effects of prior unresolved ethical dilemmas. New contributors to stress were issues related to resource allocation under conditions of extreme scarcity. The tension between patient-centered care and public health initiatives came to the forefront. Painful ethical decisions affecting patients needed to be made, including who would be admitted and where and who would receive which treatment. Isolation policies put in place to limit infection kept family members from the bedside, unable to support their sick loved ones, help with difficult decision making, or be near them as they lay dying—roles nurses often stepped in to fill, putting patients' well-being above their own.¹⁹

The pandemic challenged everyone's capacity to adapt to the velocity and intensity of changes that occurred. Even well-resourced clinicians experienced periods of degraded well-being, not because they lacked resilience, but because they were overpowered by the incongruence between resources and demands of the situation. Many

clinicians rightly assumed that because the infrastructure in health care was so tenuous, their presence was necessary to avoid a full-scale implosion of the health care system and ultimately more harm to greater numbers of people. Early in the pandemic, a narrative emerged that self-sacrifice and heroism were required by all.²⁰ This assumption is a long-standing element of the culture of medicine and nursing and perhaps was one of the elements leading to more medical and nursing school applications during the pandemic. Reinforcing a standard of heroism, however, is not attainable by some and unsustainable by most.^{21,22} Prolonged self-sacrifice can lead people to seek other career paths or to leave the profession altogether.¹⁶

Professional norms acknowledge that investment in clinician's well-being is not optional but fundamental to their professional roles. Nurses and physicians have an ethical mandate to promote self-care and protect their well-being and integrity.^{23,24} Both the American Nurses Association and the American Medical Association acknowledge that the workforce is not an unlimited resource, and they support setting the boundaries necessary to preserve well-being and integrity in the workplace and to ensure clinicians will be available to provide care in the future.^{25,26} Health care organizations have long counted on clinicians to go above and beyond for the benefit of their patients—often without the requisite resources to do so in ways that do not degrade their well-being. Moral distress or injury may arise when clinicians feel their organization takes for granted that they will always rise to the occasion for their patients. The public may also take for granted that clinicians will be present whenever they need health care. This reliance on the heroic narrative was made visible during the pandemic when segments of society disregarded basic public health guidance and became infected with COVID-19. This led clinicians to harbor profound feelings of betrayal after sacrificing so much to deliver care.

Contributing to moral stress and distress were concerns about the capability to provide safe patient care. Health professionals from other areas of practice were called upon to staff COVID-19 units, where they had to acquire new skills (or resurrect old ones). Working

with colleagues who were not skilled enough or were thought to be unsafe were prime sources of moral distress.²⁷ Established staff needing to work with unfamiliar colleagues, who sometimes were being paid more for the same work, led to feelings of resentment that their organization undervalued them. Before the pandemic, the work environment was already witness to poor communication, horizontal violence and bullying, and blaming/shaming responses. With the added stress of the pandemic, communication was more complex and uncertain because of the changing understanding of the virus and its management. The operational standards of clinical care were often influenced by mandates from state health agencies that stopped short of enacting crisis frameworks that would have clarified expectations. This rapidly changing landscape fueled fear and conflict among health care workers, intensifying concerns about harms to patients, families, and themselves.

Nursing and medical students, resident physicians, and fellows shared many challenges with experienced clinicians in the practice setting, while facing challenges borne of their lack of experience or skills to confront the challenges of a pandemic. They too needed to deal with hopelessness and helplessness.²⁸ Virtual learning, available on demand, offered flexibility in scheduling, but for some students, it eroded the relational aspects of engaging with patients, other members of the health care team, or their peers.²⁹ Disruptions in clinical placements and clinical rotations left many learners concerned about their competence by graduation. Many medical students desired a return to the clinical environment and would accept the risk of infection even though they acknowledged the stress and anxiety brought on by the pandemic.³⁰

At a time when students are forming their professional identities and moral compasses, they saw health care go beyond traditional patient-centered approaches to ethical decision making to include the needs of an entire population. They witnessed the ethical tensions of attempting to care for the person in front of them in the context of parallel obligations to public health.³¹ These shifts intensified moral distress for both

students and faculty as the realities of these dual obligations were played out in health care environments during the pandemic. Worries about transmission of the virus to housemates and family members, challenges of social distancing and isolation from peers, social unrest surrounding issues of police violence against people of color, and political unrest all added to the baseline stress of being a nursing or medical student. Some students lacked general skills to foster resilience and well-being, and as they attempted to navigate the COVID-19 crisis in health care settings, they experienced high levels of moral distress and, in some cases, burnout.

Effective Learning and Engagement in Ethics and Well-Being

The pandemic showed that it is necessary for academic health systems to support a strong public health response while also ensuring that learners master concepts to promote human health. Responding to urgent community needs showed students that professional ethics must also address population health and the social determinants of health through health systems science.³² The University of California San Francisco School of Medicine revamped its longitudinal course on professional identity formation to explore themes of uncertainty and ambiguity, the tensions between personal and professional duties, prioritization of resources, and health care disparities highlighted by the pandemic.³³ At Mount Sinai Medical Center during the peak of the New York City crisis, more than 500 medical and nursing students formed a volunteer workforce to perform necessary tasks. Connecting to a bigger purpose reduced their sense of isolation and helped them see themselves capable and useful rather than powerless.³⁴

Prepandemic data showed that nursing and medical students needed more training in ethics. The Commission on Education of Health Professionals for the 21st Century called on professionals to acquire competencies, such as teamwork, ethical conduct, critical analysis, coping with uncertainty, and leadership.³⁵ With the increased prevalence of moral distress among practicing clinicians, there is an urgent need to expand content within medical and nursing curricula to specifically address recognizing moral

adversity and developing skills to respond to it.³⁶ Programs such as the Mindful Ethical Practice and Resilience Academy have demonstrated improvements in ethical competence and confidence, mindfulness, resilience, and work engagement.³⁷ During the pandemic, development of new health care worker community groups reduced feelings of isolation and allowed clinicians to process the experience of practicing during pandemic conditions, address the moral residue of competing ethical commitments, and make sense of loss and grief.³⁸ Increasing dialogue about grief, moral suffering, and mental health must include efforts to “destigmatize” access to wellness resources.

Efforts to transform the educational experience of nursing and medical students will necessarily have to acknowledge the interrelated sources of adversity inside and outside of the learning environment that impact student engagement and learning. Further research is needed to understand the impact of the COVID-19 pandemic on notions of medical and nursing students’ professional responsibility and identity formation.³⁹ The pandemic has created an opportunity to explore the interplay of the moral community and student’s development of moral agency and professional identity. Enhanced flexibility in methods to achieve learning goals and empowerment of students will require attention to the range of student concerns that have arisen during the pandemic. The goal is to prepare students for the realities of their professions in ways that do not add to their stress but arm them with the resources to meet those challenges with integrity and well-being.

Ten recommendations for moving forward

1. Create a new narrative. The pandemic provides an important opportunity to reexamine the culture of health care and shift from a self-sacrificing and heroic model to a more humane acknowledgement of the central role of integrity and well-being in accomplishing our goals. The heroic narrative has the potential to create unrealistic and unattainable goals, portraying clinicians in ways that deny their humanity and unique contributions to health and health care and contribute to degraded well-being and integrity. Adopting the

“Declaration of Human Experience,” developed by the Beryl Institute, offers a tangible way to expand health care organization’s commitment to investment in the well-being of clinicians to reach desired patient outcomes and workforce stability.⁴⁰

2. Enhance the learning environment by implementing recommendations of the NAM and leading professional organizations.

The pandemic has intensified the need for health care professional programs to implement the NAM recommendations to enhance well-being in learning environments.¹ Both the American Association of Colleges of Nursing and the Association of American Medical Colleges support a learning culture that values the well-being of faculty, staff, and learners.^{41,42} The American Association of Critical Care Nurses states that a culture of well-being and ethical practice can be advanced by incorporating 6 essential ingredients that have been used in clinical settings: skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership.⁴³

3. Engage end users as cocreators.

Consistent with the NAM recommendations, resources should be customized to meet diverse needs of students and the faculty that teach them. Top-down decision making is insufficient to meet the needs of the workforce and students alike. A WIKI Wisdom Forum that engaged practicing nurses, students, and faculty outlined 5 overarching recommendations to address the gap between academia and practice in the areas of resilience and ethical practice: (1) modernize curricula for 2021, (2) make education more like real life, (3) expand support systems for students and new nurses, (4) strengthen connections between students and experienced nurses, and (5) support the whole student.³⁷ Engaging students, faculty, and leaders in new ways has the potential to transform the learning environment.

4. Expand ethics education to include public health ethics; health systems science; and diversity, equity, and inclusion. The social and political unrest that have accompanied the pandemic highlight the inequities faced by underrepresented patients and students.

The National Academies Committee on the Future of Nursing advocates that nursing schools should improve recruitment, hiring, and advancement of diverse faculty with expertise in the social determinants of health.⁴⁴ Addressing the factors that contribute to structural racism and dismantling the interpersonal dynamics that contribute to degraded well-being will be critical in postpandemic education and training. This will require attention to the cultivation of cultural humility in all aspects of the curricula and fostering it among faculty and students.⁴⁴

5. Integrate ethics and moral resilience skills in clinical training.

A more robust pedagogy for teaching ethics in nursing and medical school training should include the cultivation of moral sensitivity, character, and identity formation. Curricula for nursing and medical students should include content related to the reality of moral suffering and the capacities and skills to develop moral resilience as a protective resource to mitigate the detrimental impact of moral suffering. Elements of moral resilience that should be taught include personal and relational integrity, buoyancy, self-regulation and awareness, moral efficacy, and self-stewardship.⁴⁵ Offering nursing and medical students the opportunity to proactively develop and amplify these skills during their training positions them for a more sustainable future in their professions.

6. Provide social support. The pandemic disrupted usual social gatherings, leaving practicing clinicians and students with a pervasive sense of isolation. New means of connecting became necessary because of requirements for physical distancing. Creation of mechanisms, either by students or by learning institutions, to enhance social support and connection is vital in reducing isolation and lack of belonging. Leaders should spearhead efforts to build structured opportunities for social engagement and group identification among trainees.⁴⁶

7. Develop the coaching/mentoring skills of faculty. One-on-one coaching is a means of offering support to students so they can address their moral, social, and mental health concerns. Simply having an unbiased person to offer suggestions can go a long way in reducing

feelings of isolation and helplessness.² Mentors who have self-stewardship skills, self-awareness of their resources and limitations, and competence in intentionally strengthening and expanding their skills can provide invaluable guidance on how to remain resilient amid adversity.

8. Foster learning communities as moral communities. The challenges of the pandemic provide an opportunity to transform the learning environment for health professionals.³³ One way to transform the learning environment is the explicit creation of moral communities where shared moral/ethical commitments are acknowledged, social bonds are strengthened, and a commitment to relational integrity is fostered.² Situating students within a moral community can aid in the development of moral agency and professional identity formation. Learning communities are associated with greater empathy and enhanced well-being among students.⁴⁷ Being intentional in creating opportunities to talk about ethical challenges faced throughout one's training and career facilitates socialization and discernment. Opportunities to build community include debriefings after clinical rotations or seminal events, regular ethics case discussions, or moral resilience rounds.

9. Establish interprofessional wellness programs with communities of practice. Wellness training offers students the opportunity to learn essential life skills they will need in clinical practice. Starting wellness practices, such as mindfulness, compassion, cognitive appraisal, and physical well-being, at the beginning of school and continuing them throughout training and into practice can build resilience and lead to culture change.⁴⁸ Organizations should sponsor programs that promote interdisciplinary wellness and resilience.⁴⁹ Creating communities of practice leads to collective resilience through which group members build solidarity and provide collective sources of support to deal with adversity.⁵⁰ One example of this is the R³ Resilient Nurses Initiative, which takes a holistic approach to building resilience and ethical practice skills in students, faculty, and new nurses and strengthens the bridge from education to clinical practice. Organizations must also dismantle the system contributions

that are barriers to the use of wellness and resilience programs. Offering wellness and ethics resources as one-size-fits-all is unsustainable and ineffective; it can intensify resistance and cynicism rather than engagement by those it is designed to serve. Engaging end users in the design and selection of wellness and ethics resources that are perceived to be useful, feasible, and meaningful increase the likelihood of adoption and utilization.

10. Create spaces for relational and experiential learning. Expanding educational methods to include relational and experiential learning is necessary to examine and process the moral, psychological, and spiritual aspects of clinical care with students in training. Creating such a fully integrated ethical framework will require increasing the numbers of medical and nursing faculty with formal training in bioethics as well as adding to the repertoire of experiential teaching methods.⁵¹ Health professional programs should invest in training faculty to be skillful facilitators to enhance the student experience and avoid potential negative consequences. Shifts in virtual learning environments, in particular, require special attention to create psychologically safe spaces for learners to name and explore challenges to their ethics, mental health, and well-being. Innovative ways to teach and learn about ethics include use of the humanities, simulation, and case-based, interprofessional reflective learning to strengthen learners' sense of integrity.

Conclusion

The COVID-19 pandemic offers educational leaders an opportunity to nurture and further develop faculty and to enhance the well-being and integrity of learners. Investments in building individual capacities for resilience and ethical practice must be accompanied by systemic changes that create healthy learning environments. Lessons learned during the pandemic can build upon the foundational concepts for building resilience before the pandemic to create new paradigms for the ethics education of tomorrow's health professionals.

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M.T. Hughes is assistant professor, Department of Medicine, Johns Hopkins University School of Medicine, and core faculty, Johns Hopkins Berman Institute of Bioethics, Baltimore, Maryland.

C.H. Rushton is Anne and George L. Bunting Professor of Clinical Ethics, Johns Hopkins University School of Nursing and Johns Hopkins Berman Institute of Bioethics, Baltimore, Maryland.

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