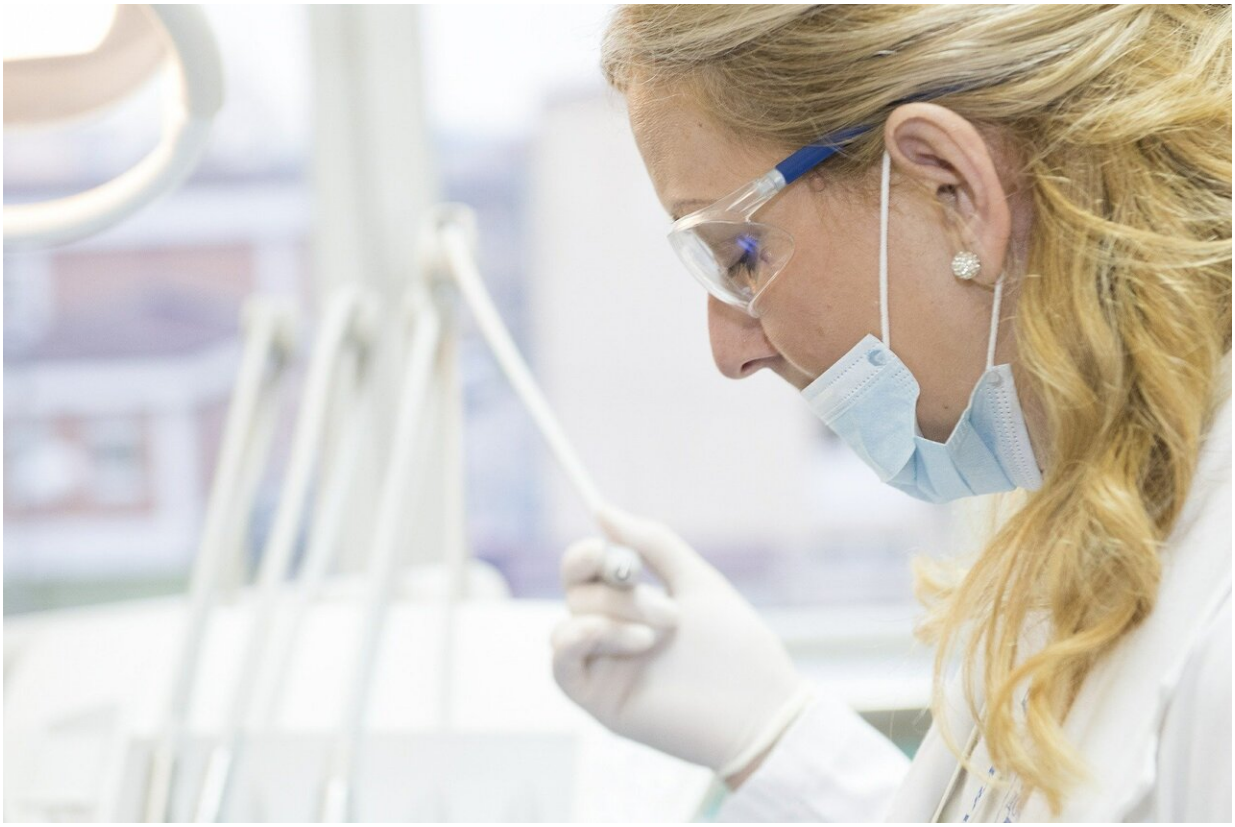
Hard choices put health workers at risk of mental anguish, PTSD during pandemic

May 15 2020, by Margaret McKinnon and Ruth Lanius



Credit: CC0 Public Domain

Initial reports from the front line of the COVID-19 pandemic suggested that health-care workers were at high risk for moral injury.

Moral injury, often associated with post-traumatic stress disorder (PTSD), is thought of in two ways. It can involve witnessing or being involved in events that violate deep moral beliefs. Or, it can involve a deep sense of betrayal when a organization fails to protect its people.

As clinicians and scientists studying PTSD, we expected that health-care workers and administrators facing COVID-19 might be forced to choose between "wrong" and "wronger." For example, having to decide who does or does not receive access to the last remaining ventilator on the intensive care unit.

Health-care workers might also feel betrayed if they did not have enough personal protective equipment (PPE) to protect them from the virus. Not having adequate PPE would also increase the risk of infecting otherwise healthy family members.

Moral injury is a major concern because it is linked to increased rates of PTSD, depression and suicide.

Infection risk, stigma and privacy

Our experience in the field tells us that many health-care workers are afraid of being stigmatized if they become infected with COVID-19.

The public or colleagues may make judgements about a nurse or physician who becomes infected, believing that they became ill because they did not use PPE properly. This spectre of stigma is a real concern for some health-care workers, who should instead be entitled to care and compassion.

Openly sharing these concerns and discussing how they might be addressed could increase group cohesion and social connection, reducing the risk of moral injury.

When a health-care worker becomes ill with COVID-19 in a hospital or care setting, there is often a duty to protect the confidentiality of that person. This duty has been questioned, given that concealing a health-care worker's identity makes contact tracing more difficult, thus increasing risk to other workers and to family members.

One solution might be to ask an infected worker if she is willing to disclose her identity to make this tracing more successful. Under all circumstances, however, it is important to share this information on a need-to-know basis only, reducing the risk of perceived betrayal.

Vulnerable patients

We know now that Canada has not faced the expected overwhelming surge of COVID-19 in our hospital system. But other factors that increase risk of moral injury remain.

Vulnerable older adults in nursing homes and people living in group homes and shelters are dying of COVID-19 in circumstances previously unthinkable (for example, covered in feces and urine after days of neglect). Health-care workers have not been prepared for these circumstances, if preparation for such things is even possible.

SARS and MERS have already left their mark on health-care workers, like respiratory therapists who vividly recollect terrible deaths as the result of these illnesses, and may link these deaths to expectations and risks in the current pandemic.

Health-care workers have been taught to save lives, not lose them. But COVID-19 is an unknown enemy that does not respond to available treatments. Faced with a desperately ill COVID-19 patient, physicians and other health-care workers are unable to use their knowledge and skills to provide life-saving treatment.

Other challenging decisions involve non-COVID-19 patients in hospital for illness or surgery. Some patients may prefer to remain in hospital for monitoring if a case of COVID-19 is discovered on the same unit while others will wish to go home immediately despite the need for continued care.

Patients may also avoid hospitals or physicians' offices for urgently needed assistance if they perceive the danger of potential exposure to COVID-19 to be greater than the need for medical assistance. It is unknown how many lives have been lost (for example, to heart attack or suicide) due to these tragic decisions.

There are no simple answers here, more the need to discuss openly with health-care workers and patients alike the difficulty of this situation and its potential for moral injury.

Health-care workers at risk

These are the types of circumstances now occurring regularly in the Canadian health-care setting. In addition, the current pause in non-essential care has created difficulties, such as postponed surgeries for conditions that are not life-threatening, but are associated with pain and suffering. All bring the potential for moral injury and a deep sense of betrayal and anger among Canadian health-care workers and citizens.

Health-care workers have called for a voice in decision-making and for compassionate, inclusive leadership. One recent study found that the wishes of health-care workers during COVID-19 could be summarized in five key phrases: hear me, protect me, prepare me, support me, care for me.

During this pandemic, health-care workers need their humanity to be perceived, with unique strengths such as experience and knowledge, as

well as unique vulnerabilities. For example, health-care workers are just as likely as the rest of us to have pre-existing physical and mental health conditions and vulnerable family members at home. As our knowledge around COVID-19 and its treatment shifts moment to moment, health-care workers must be prepared with the best available knowledge.

And, in the inevitable cases where health-care workers become infected with COVID-19, they must be provided care, free of judgment.

Provided by The Conversation