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Invisible Moral Wounds of the COVID-19 Pandemic: Are We Experiencing Moral Injury?

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For all its power to terrify, COVID-19 can't keep us from marveling at the courage of frontline human service workers all over the world.
Dr William P. Nash, US Navy, retired[1]

The sighs of the ventilator for the latest patient with COVID-19 remind me how scarce resources are. I see the ones who waited too long and the ones who arrived too late because they live in an underserved community and didn't have access to testing or treatment. When I close my eyes at night, I recall a patient, full of catheters and tubes and attached to machines, who breathlessly whispers words I cannot decipher as his life recedes. Again, I watch the monitor document the last moments of life as he lay there alone. I hear the pained conversations informing family members that they cannot visit because the risk of spreading the virus is too great; exceptions are made only if we are able to predict when death is near—but now it is often and unpredictably near. And I wonder, "Was I a good nurse today? What kind of person have I become?" A year ago, I was one sort of nurse—attentive, compassionate, diligent, quick with a smile and a hug. Being a good nurse aligned with being a good human being.

Sleep proves elusive, and I feel a fracture between who I want to be and who I sense I am becoming. It hurts. How did this happen? Blame and shame arise for things done or left undone, and for harms witnessed but not prevented, both inside and outside the hospital. In the intensive care unit and in the streets, I see that we sink or swim together. What is my contribution? Am I lifting

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others up or dragging them down? I don't know anymore and wonder where I lost my moral compass.

This nurse's experiences have been exacerbated by coronavirus disease 2019 (COVID-19), but they are not entirely unfamiliar. Nurses have for millennia confronted and borne witness to suffering, especially moral suffering. Moral suffering is the "anguish experienced in response to moral harms, wrongs or failures and unrelieved moral stress,"[2] and it is triggered by witnessing, participating in, or directly precipitating situations that produce negative moral outcomes and imperil integrity and well-being.

The COVID-19 pandemic has escalated long-standing ethical issues within our health care system and its enactment of the structural inequalities of society. The frequency at which ethical dilemmas now occur does not allow for nimble adjustments to systems and often intensifies the distress clinicians experience. Clinicians face resource limitations and the uncertainty of evolving and often conflicting guidance about what protection is needed in order to deliver safe care to patients. They confront hard decisions about who will receive which potentially life-saving treatment—decisions made on the basis of explicit criteria and processes that reveal unconscious biases about vulnerable patients. Others struggle with the dissonance of departing from evidence-based standards of care; they flood patients with benzodiazepines, immobilize them, keep their families away, and through cold glass bear witness to the delirium that ensues. The ethical question of how to allocate nursing staff has turned medical care inside out. Instead of focusing on how to maximize the benefit to each patient, care teams are now considering how the *fewest* people can spend the *least* time with a critically ill human being.

Who has access to personal protective equipment? Who is put in harm's way? Who gets to work from home? Who is considered "essential" and why? These moral questions are for a society in which injustice and violence disproportionately afflict workers according to race and sex, distress that may be amplified for those whose history in the United States is tied to the structural inequalities that put them and their families at greater risk of infection and death. These systemic and societal disruptions can accumulate at a pace that neither frontline nurses nor their leaders can effectively respond to, and they can lead to overwhelming feelings of betrayal and moral compromise. The lasting consequences of the pandemic on medical professionals, combined with an already overwhelmed health care system and continuing injustice and hate crimes in society, require us to identify and address the moral suffering of all health care workers.

The Many Faces of Moral Suffering

In its many forms, moral suffering can be viewed along a continuum of responses to moral adversity that imperil integrity.[2] The intensity, duration, and consequences vary depending on the sources of adversity and the roles and unique characteristics of the persons involved and the organizations where they work. Moral alarm can initially occur as a quivering of awareness in our bodies when we perceive that something we value is being threatened; this perception then activates a neutral state of readiness to appraise and respond to the source of the adversity.[2] This threat appraisal may lead an individual to garner necessary resources, determine a course of action, and release or resolve the moral stress. When the intensity of moral stress exceeds the person's capacity to remain grounded and whole, moral distress or moral injury can ensue.

Moral Distress

Moral distress, initially described in the nursing literature, is the inability to translate moral choices into actions because of internal or external constraints, producing anguish characterized by feelings of guilt, shame, anger, or powerlessness.[3] It is an embodied experience: a person in distress perceives physical sensations or symptoms before becoming cognitively aware of it.[4-6] The distress occurs in response to various sources of moral adversity that "produce morally objectionable, troublesome, or unfortunate circumstances that can imperil integrity and well-being (individually or collectively)."[2(p35)] Critical care nurses practicing during the COVID-19 pandemic are confronting complex ethical challenges, and their actions are constrained by circumstances beyond their control. Nurses may perceive their choices—or their lack thereof—as moral failings, which can cause feelings of anger, shame, or regret.[7] They may view their distress as

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reflecting how their moral conscientiousness is attuned to the moral dimensions of their role, and consider moral trade-offs as an inevitable aspect of caring for high-acuity patients under conditions of medical uncertainty and diverse value systems.[2] A physician in a neonatal intensive care unit wrote, "I think if one does not experience moral distress occasionally in our environment they should not be working with our patients."[8(pF443)] This physician implies that such a colleague would lack moral sensitivity, a prerequisite for ethical care. When an individual recognizes moral distress, they can leverage various strategies to restore integrity and interventions to address the systemic contributors to the distress.[9] Recognizing moral distress does not imply that clinicians working in health care are singularly responsible for adjudicating the systems-level factors within their organizations and the broader society that create the conditions for moral distress to thrive.[9] Targeted interventions at individual and systemic level are critical.

Moral Injury

When moral distress is unrelieved or becomes chronic, or the intensity of it overwhelms a person's capacity to remain whole, it can lead to more severe forms of moral suffering, such as moral injury. *Moral injury* is a term put forth by Jonathan Shay[10] in his 1994 book, *Achilles in Vietnam: Combat Trauma and the Undoing of Character*, in which he described his observations as a clinician working with veterans of the war in Vietnam. Since writing that book, Shay has succinctly defined moral injury as being present when what is right has been "betray[ed] . . . by someone who holds legitimate authority (e.g., in the military—a leader), in a high stakes situation. All three."[11(p183)]

In 2009 a team of clinicians from the Veterans Administration expanded Shay's definition to include the violation of one's own inner code of moral conduct, so that moral injury can occur by

> *Perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations.* This may entail participating in or witnessing inhumane or cruel actions, failing to prevent the immoral acts of others, as well as engaging in subtle acts or experiencing reactions that, upon reflection, transgress a moral code. . . . Moral injury requires an act of transgression that severely and abruptly contradicts an individual's personal or shared expectation about the rules or the code of conduct, either during the event or at some point afterwards. . . . The individual also must be (or become) aware of the discrepancy between his or her morals and the experience (i.e., moral violation), causing dissonance and inner conflict.[12(p700)]

Moral injury, like moral distress, emerges from harm or the inability to prevent harm, and it can develop in several ways. It can be the consequence of undischarged moral distress—as Litz et al[12] note, "engaging in subtle acts or experiencing reactions that, upon reflection, transgress a moral code"—that can accumulate to the extent that it transitions into feelings of transgression or betrayal, generating intense inner pain and leading to a negative change in character. Moral injury may also emerge from a single devastating incident that overruns a person's capacity to understand it or integrate it into their existing meaning system, leaving them outraged by betrayal, bereft of trust, socially isolated, and unmoored from their life's purpose. It may also emerge because a training process (eg, military boot camp) or high-stakes circumstances such as those during a pandemic overwhelm a person's values to the point that they willingly engage in behavior that betrays their previous moral code and their typical protective mechanisms have been rendered ineffective. The person might not fully recognize this inner shift in values until they realize that their conscience and integrity have been violated by the change.[11]

Finally, moral injury can be a consequence of having one's core sense of worth and meaning eroded to the point of despair by having to work and survive within a system that is at odds with one's core values. As an invisible wound to a person's entire meaning system and sense of worth, moral injury damages the core of a person's humanity—their soul or spirit. Recent research on combat Marines found a correlation between moral injury as betrayal and higher rates of posttraumatic stress disorder (PTSD).[13] Shay[11] argues against the use of the term *disorder*, as if PTSD mechanisms are pathologies rather than effective neural mechanisms that humans use to survive combat and that have become chronic, much the way any untreated serious injury can become debilitating. Pathologizing fear-driven responses in PTSD as originating from maladaptive coping mechanisms fuels the stigmatizing of human suffering that is based in

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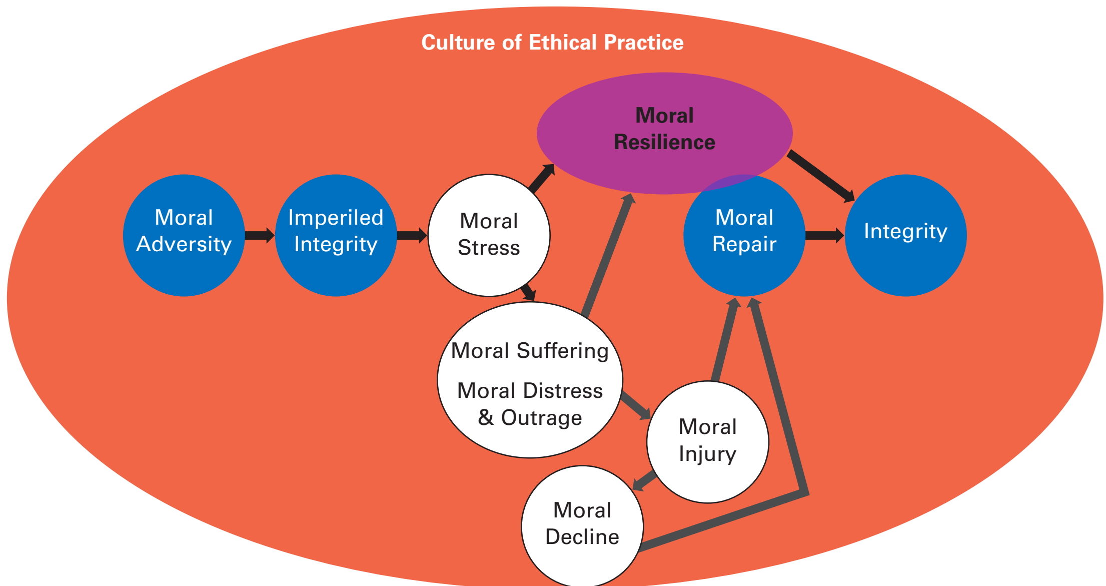

Figure: A conceptual map of related concepts. Reprinted with permission from Oxford University Press.[2]

moral struggle and legitimate fear.[14] One can also experience moral injury without PTSD symptoms, as a crisis of identity or faith. Hence, the relationship between moral injury and PTSD continues to be studied, and its application to health care professionals is in the early stages of exploration.

Moral injury can be far more difficult to treat than a physical wound one can see and bandage, but it requires acknowledgment and attention nonetheless. If symptoms of moral injury are recognized and a process of moral repair is initiated by leveraging the clinician's capacities for moral resilience, integrity and well-being may ultimately be able to be restored. When the wound remains unrecognized or unaddressed, moral impairment and decline are likely to set in.

As with all forms of moral suffering, complex interplay occurs between individuals and the broader moral ecosystem. Individuals are situated within families, organizations, communities, and society; these domains are interconnected, and each responds to the conditions of the others. The internal and external landscapes will determine individual and collective responses to moral suffering, as the Figure shows.

Context of Moral Suffering in Critical Care

Critical care clinicians experience a range of moral adversities in their practice. As described earlier, situations or circumstances that challenge, threaten, or violate a clinician's inherent goodness and moral core are aspects of critical care practice. Clinician responses can range from mild to severe distress, to a cascade of physical, emotional, cognitive, and spiritual consequences that can lead to temporary or permanent impairment or degraded well-being.[2]

Clinicians' suffering is compounded by the moral ecosystem within their workplace and embedded in the broader society. Even before the COVID-19 pandemic, the health care environment was riddled with myriad factors that contribute to clinician burnout, including imbalanced job demands and resources that habitually erode clinicians' ability to provide care without compromising their own health and well-being.[15] The pandemic has instigated other sources of moral adversity that compound these already existing elements. Throughout the pandemic, clinicians have recounted instances of inadequate personal protective equipment, scarcity of resources including staff shortages, and inconsistent or contradictory communication or policies.[16] They have also described being "emotional surrogates" for patients whose family members are unable to visit or witness their death.[17] Regardless of the term used to signify the type of moral suffering, recognizing its contours, manifestations, and consequences is a starting point for devising targeted solutions.[18] In

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parallel, an expanded understanding of patterns within teams, health care organizations, and society that consistently and corrosively erode the integrity of those working at the front lines is essential to creating a culture that intentionally supports ethical practice on a daily basis, rather than just during heroic events.

The intersection of clinical care with the broader structural injustices in society has likewise amplified the moral adversity produced by the pandemic. Clinicians from vulnerable populations experience both the routine stress that their more privileged colleagues also face as well as distress that is particular to their social standing, including their own direct injury from discrimination and inequality in the health care context. Their unrecognized moral suffering is an even greater weight to carry. Not only are clinicians confronted with trying to provide critical care to sick patients without all the resources they have come to expect, they meet discrimination in the workplace. Some have also had to face anti-Asian racism and threats as they travel to work or care for patients.[19] Still others may experience more extensive moral adversity that emerged openly during this pandemic, for example, by witnessing and rewitnessing George Floyd's death as he was held under the knee of Derek Chauvin for almost 9 minutes. The accumulation of such instances of excessive violence against and murder of people of color in police custody again exposes the fissures in our society and can deepen despair about systemic racism and feelings of powerlessness commonly associated with all types of moral suffering.

During this pandemic, clinicians have seen, at an unprecedented scale, the ways in which social injustice manifests in those who occupy our hospital beds and those who survive and go home. They may feel helpless to stem the tide of injustice in the face of so much suffering and death. They may also be troubled when they consider how their position—and potentially their unintended complicity in upholding unjust and inequitable structures—impacts their experiences of power and vulnerability.[20] We can no longer deny, overlook, or minimize the intersections of conditions underpinning moral suffering, for the grief, guilt, shame, and trauma that health care clinicians carry intertwine with larger and more recalcitrant societal ills that directly and indirectly impact the clinical care they provide and erode their integrity. An urgent need exists: we must acknowledge the various forms of moral suffering that arise in clinical practice and work together to dismantle systems of white supremacy, with their attendant social and economic disparities.

How Does Moral Injury Apply to Health Care?

Litz et al[12(p696)] asked, "What happens to service members who are unable to contextualize or justify their actions or the actions of others and are unable to successfully accommodate various morally challenging experiences into their knowledge about themselves and the world?" What happens to clinicians struggling with the same things in the hospitals, nursing homes, and prisons where they practice? When the sight of the stricken, solitary patient with COVID-19, dying behind glass, comes to feel like a television show, it is a sign that the work has become too painful to be engaged with as real, particularly when such situations cannot be remedied. Physician-anthropologist Arthur Kleinman[21(p1376)] noted, "I hadn't reckoned with people's capacity to routinize and objectify others' suffering and fears in the quest to render their tasks manageable." The COVID-19 pandemic has left clinicians feeling like they have gone over the edge of a cliff into a detached, objectifying abyss. They may wonder, as the nurse does at the beginning of this article: "Am I one of *them*?"

Moral injury may also happen during the course of routine practice, because clinicians harm those in their care through acts of commission or omission, or witness a trusted colleague cross a line and inflict harm, or indifferently ignore harm rather than stop it. For these clinicians, a chasm has opened between the virtuous people they believe themselves to be when in their street clothes and what they find themselves to be capable of when wearing scrubs. They may consciously or unconsciously attempt to mitigate shame and guilt through avoidant or compensatory behaviors that are likely exacerbated when they are exhausted.[22] The moral injury can cause them to question their own moral framework or that of their profession, or even the health care enterprise itself.[18] Clinicians experiencing moral injury may view their roles in situations as diagnostic evidence that something is wrong with them as human beings.

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The discussion of moral injury in medicine—particularly moral injury as a factor contributing to clinician suicide, poor medical outcomes, and departure from careers—began in earnest in 2018.[23] That discussion focused on a clash in values: the patient-centered, altruistic service that inspired many to undertake the rigors and costs of a career in medicine versus commodification of health care workers and patients within a for-profit, transactional system. Systems-level factors such as efficiency benchmarks and documentation requirements can habitually distract clinicians from their core purpose and degrade their capacity for empathic responsiveness.[23] Some health care workers encounter microaggression, verbal abuse, and frank violence from patients, visitors, or coworkers. Regardless of the source of such violence, clinicians' personal and relational integrity is fundamentally compromised and their sense of meaning and purpose eroded.

What may be unique about moral injury in health care is that it involves current or retrospective recognition of a compromise of one's conscience by witnessing, participating in, or perpetrating actions that would otherwise be incongruent with one's professional code of ethics. Nurses, like physicians, are mandated by professional codes to "first do no harm" and to provide respectful, compassionate, and equitable care.[24] During this pandemic, discrepancies in standards for initiating cardiopulmonary resuscitation, betrayals of trust by health care leaders or the government regarding the provision of essential resources, or the need to adjudicate tensions surrounding family visitation may become instances that eventually produce moral injury. Although compelling reasons may justify or support these actions, they do not erase the moral residue that accompanies them. Living with the awareness of these discrepancies, and attempting to make meaning from them and find peace with the inevitable moral trade-offs necessary during the pandemic, will require attention to healing the personal wounds and systemic fractures that created them.

The result can be moral injury, which until recently has been largely unrecognized in health care. Although in 2009 Litz et al[12] proposed the heuristic of moral injury in the military setting as a way to identify suffering that other mental health diagnoses do not adequately address, Nash et al[25] did not publish their "Psychometric Evaluation of the Moral Injury Events Scale" until 2013. That scale is not a diagnostic instrument but rather interrogates exposure to morally injurious experiences; thus the concept of moral injury within the military has only been able to be identified as a vulnerability for less than a decade. Hence, moral injury—as originally defined by Jonathan Shay[10] and developed further by Shay himself[11] and by Litz et al[12] and Nash et al[25]—is still a relatively new concept and remains a type of suffering without a formal assessment or intervention protocol.

Until July 2020, no valid instrument existed to examine health care professionals' exposure to moral injury. An adaptation of the Moral Injury Events Scale and a study validating its use among health care professionals in China offer an assessment of "10 theoretically-grounded dimensions of moral injury assessing betrayal, guilt, shame, moral concerns, religious struggle, loss of religious/spiritual faith, loss of meaning/purpose, difficulty forgiving, loss of trust, and self-condemnation."[26]

During a pandemic, when health care providers are extraordinarily distressed and find themselves on the "front line," tools such as the event scales that Nash et al[25] developed for use by the military and that Wang et al[26] created for use in health care are necessary. Although no validated events scale is currently available to evaluate structural injustice and the traumas it inflicts, investigation is warranted to determine how those people most affected by racialized violence, economic disparities, and inequality in access to health care experience the additional burdens of moral distress and moral injury.

Conclusion

The concept of moral injury points to another dimension of moral wounding and the subsequent suffering that clinicians experience during their work. Although more empirical research is needed in order to understand its contours, moral injury, as a concept, offers us an opportunity to see our experiences with new eyes and to understand more fully what we previously have not seen or have turned away from. Acknowledging the many forms of moral suffering we experience as critical care clinicians and documenting the patterns in our health care systems and society that contribute to them are vital steps toward addressing such distress. The COVID-19 pandemic

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and the structural injustices it illuminates make starkly visible the moral wounds and deep fissures in our social fabric, which clinicians increasingly carry into their daily practice. We must resist prematurely declaring victory in addressing their moral suffering or concluding that lack of engagement with mental health services or other programs is evidence that intervention is not needed. Instead, we must continue to explore the contours of moral suffering in critical care practice, to remain vigilant in locating the sources of it, to devise strategies that allow us to proactively identify the signs of moral suffering before it progresses to moral injury or burnout, and to test and invest in effective programs for supporting those experiencing it. Despite the overlapping definitions of the various types of moral suffering in health care, each illuminates important dimensions of the moral landscape that are essential to protecting and preserving clinicians' basic goodness, wholeness, and capacity to serve, especially in such complex, uncertain, and changing times.

Crucial in the moral landscape is the outrage about betrayals by structural racism and inequality that compel many to risk infection in order to protest, and the grief of clinicians who witness the disproportionate burden of sickness and death because of systemic injustice across generations. Their moral suffering must not be stigmatized as a mental health disorder. Their outrage and grief are evidence of "strong ethical values and a capacity for empathy . . . an example of character and resilience [that] should be treated as such."[27(p207)] To begin with this affirmation requires us to resist decoupling the alleviation of moral suffering from the struggle for justice. To move beyond our own distress, we must transform both ourselves and the systems in which we practice.

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