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Conceptual Paper

Moral Injury, Mortal Wounds and the COVID-19 Pandemic

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We are currently fighting a virulent, often deadly, and highly contagious virus, Sudden Acute Respiratory Syndrome Coronavirus-2 [SARS-CoV2]. This disease, now generally referred to as COVID, arose in the Wuhan district of China at the end of 2019 but has since become a global pandemic with more than 32,000,000 confirmed cases and more than 1,000,000 deaths at the time of this writing.

Coronaviruses are not new but, until recently, most coronaviruses that infect humans caused relatively mild upper respiratory illnesses such as the common cold. However, in 2002, Sudden Acute Respiratory Syndrome [SARS] virus, a virus endemic in bat populations, jumped to humans causing serious respiratory illnesses, including about 900 deaths, worldwide. In 2012, Middle East Respiratory Syndrome [MERS] virus jumped from dromedary camels to humans and, to date, has also caused around 900 deaths, mostly in the Middle East.

COVID is not as deadly as SARS or MERS on a case by case basis, but it is much more contagious and, in the US alone, has caused more than 7,000,000 illnesses and over 200,000 deaths [1]. It's also poised to have a devastating effect on the upper echelons of the United States government. The long-term complications in survivors are still being evaluated but, so far, they include profound fatigue and exercise-intolerance, persistent cough and shortness of breath, kidney and lung damage, and cognitive dysfunction and other neurologic deficits [2]. Resources to fight the pandemic have been strained past the breaking point in many areas of the country at various times, placing almost impossible demands on local and regional healthcare systems.

In the early weeks of the pandemic, New York City was the epicenter for COVID in the U.S. and a stress test for our healthcare system [3]. Public hospitals, already stretched thin serving low-income residents who lacked adequate access to routine healthcare, were particularly hard hit. In early March, some public hospital emergency rooms experienced doubling to quadrupling of patients admitted with serious respiratory symptoms. Gurneys and beds were running out and some sick patients had to wait in chairs for hours for a hospital bed. Much to the chagrin of hospital personnel, a few died in their chairs. Disposable, single use personal protective equipment such as masks, gowns and paper surgical suits were running out and had to be reused. Refrigerated trucks had to be ordered from FEMA to handle the overflow of bodies. Ventilators were in critically short supply. New York-Presbyterian hospital, for example, jury-rigged its ventilators so that a single one could support multiple COVID patients, a bold and untested accommodation to the crisis.

The chasm between what someone feels duty-bound to do and what circumstances permit can create a moral dilemma and associated cognitive dissonance, both of which cause emotional distress. When moral dilemmas are profound, repetitive and/or prolonged and cognitive dissonance is severe and pervasive, they can culminate in a form of psychological harm referred to as "moral injury."

Moral injury has recently been recognized in active duty military and veterans of war and, while it may contribute to and overlap with post-traumatic stress syndrome [PTSD], there are distinct differences [4]. PTSD is, at its heart, a memory disorder, but in this case, it's the inability to **forget** traumatic events. The nervous system is triggered by internal and external stimuli into "flight, fight or freeze" mode causing associated physiological symptoms such as rapid heartbeat, sweating, hypervigilance, intrusive thoughts and aggression. Moral injury, on the other hand, is an affliction that Rita Nakashima Brooks with Volunteers of America describes as:

"*...a negative judgment we pass on ourselves in response to violating our core moral values or being contaminated by exposure to evil. It can lead us to feel unforgivable for something we did, failed to do, witnessed, or endured...Such judgments fuel a host of moral emotions, such as guilt, shame, grief, remorse, disgust, and outrage…*" [5]

Severe and/or unrelenting moral injury, like PTSD, is strongly associated with depression, anxiety, substance abuse and suicide.

Healthcare professionals- whether they be doctors, nurses, therapists, emergency medical technicians or other licensed medical professionals- are trained to practice their craft assiduously and may perceive anything less than optimal care and positive outcomes as personal and professional failures. Moral injury can occur insidiously as they contend with everyday time-constraints, insurance company denials, dysfunctional electronic medical records systems and other distractions from their primary duty of patient care.

As they struggle to provide optimal patient care in the face of organizational chaos and insufficient time, knowledge and resources, healthcare professionals on the frontlines will experience emotional and moral trauma. They may perceive the unnecessary suffering and death of patients who, in any other circumstance might have survived, as deeply shameful. Those who've witnessed the death of a colleague may experience, not only grief, but also survivor's guilt. Hospital staff who are pressed into working in emergency departments or intensive care units where they feel unqualified may experience additional anxiety. Everyone who has

worked on the frontlines of the pandemic, especially in its early days, must also cope with the fear of passing COVID to their loved ones or contracting it themselves.

Dr. Wendy Dean MD, a psychiatrist and co-founder and president of the organization "Moral Injury of Healthcare" addressed this dilemma in a recent Medscape article [6]. She wonders, "*How will physicians make those decisions? How will they cope? The situation of finite resources will force an immediate pivot to assessing patients according to not only their individual needs but also to society's need for that patient's contribution.*"

The trauma of working on the frontlines of the pandemic has already contributed to physician suicides. In an article in the New York Times, "I Couldn't Do Anything: The virus and an E.R. Doctor's Suicide," the authors recount the last weeks of Dr. Lorna Breen, an accomplished and meticulously organized emergency physician who worked during the early months of the pandemic. After recovering from COVID herself, Dr. Breen struggled unsuccessfully to uphold her standards in the midst of the chaos. Caught in a downward spiral of exhaustion, disillusionment, helplessness and shame, on April 26, Dr. Breen took her own life [7].

Even after the acute crisis has passed, the deleterious effects of the pandemic on the healthcare profession may linger for years. The attrition of medical personnel from the most affected specialties may accelerate as some transition to less stressful subspecialties or retreat from the rigors of clinical practice altogether. Those who survived COVID infection may suffer serious lifelong physical and emotional health sequelae that limit or preclude their ability to practice. In his impassioned article in the Washington Post, Dr. Thomas Kirsch, an emergency physician and expert in disaster management wrote:

I sometimes wake up at night, suddenly, sharply aware and deeply sad. Haiti comes back to me again. It's been 10 years. After the earthquake, I worked there in a cramped, hot, ill-equipped tent on the grounds of a half-destroyed Haitian hospital, trying to care for the sick and injured as they poured in, overwhelming our capacity to help them all. Now I lay awake dreading what might be coming as the covid-19 pandemic sweeps the world. [8]

While the medical profession recognizes that stress, burnout and moral injury are endemic within the profession, it tends to view mental illness and substance abuse as expressions of psychological weakness and moral failure; its sufferers may be stigmatized, lose their jobs or be formally disciplined for their purported shortcomings. Aware of the potential adverse consequences of being discovered, stricken physicians may deny their problems, intentionally avoid seeking treatment, or resort to self-treatment which, ironically, is itself a violation of medical ethics [9].

Prior to the pandemic, suicide rates among physicians were already significantly higher than that of the general population. The American College of Graduate Medical Education [ACGME] issued the following statement:

"*Suicide generally is caused by the convergence of multiple risk factors – the most common being untreated or inadequately managed mental health conditions. Among physicians, risk for suicide increases when mental health conditions go unaddressed, and self-medication occurs as a way to address anxiety, insomnia or other distressing symptoms. Although self-medicating, mainly with prescription medications, may reduce some symptoms, the underlying health problem is not effectively treated. This can lead to a tragic outcome.*" [9]

Decades ago, recognizing physicians' need for support and guidance during difficult times, volunteer doctors created informal safe harbors where their ailing colleagues could receive appropriate, compassionate and confidential care, as well as monitoring of their clinical practice during treatment and recovery. Over the years, however, peer support groups gradually became codified and monetized. Now generally referred to as Physician Health Programs [PHPs], these organizations have strong reciprocal relationships with their respective medical boards, allied medical consultants, and the inpatient drug treatment facilities to which physicians diagnosed with substance use disorders are often referred[1].

Once a physician presents to a PHP for care, whether of his own free will or at the behest of a third party, he gives up the right to make decisions about his own care, as well as the guarantee of patient confidentiality and access to his own medical records. Diagnoses are often made after brief evaluations by paid medical licensing board or PHP consultants who often already know the purported diagnosis. PHP protocols rather than individualized assessments often dictate treatment plans. Physicians who don't follow treatment regimens scrupulously may be referred to their medical boards for alleged "non-compliance." They may then be subjected to a number of different sanctions including license limitations, suspension and even permanent revocation. Formal board decisions, along with any associated mental health diagnoses, are posted on the internet for anyone with a browser to view and are reported to the National Provider's Data Bank, a website that catalogues adverse actions taken against physicians [11].

While no formal retrospective case-controlled studies are available, there is abundant anecdotal evidence to suggest that physicians with mental health issues who enter the PHP system experience more stress, shame, substance abuse and career damage and have a greater risk of suicide than those who receive appropriate and confidential treatment in their own communities. PHPs sometimes impose medical regimens on patients that exacerbate rather than ameliorate existing mental health problems causing additional harm without any perceivable benefit [12].

The COVID pandemic arose thousands of miles away and arrived on our shores almost without warning. Like a tidal wave, it inundated emergency departments and critical care units that were totally unprepared for its power and scope. Pandemonium ensued as staff in overwhelmed hospitals struggled to respond to this unseen, unfamiliar and deadly enemy. Working without adequate equipment, personnel or knowledge, they strove valiantly to care for their patients yet often watched helplessly as many struggled and suffered and sometimes died.

For many of these brave warriors on the frontline of the pandemic, the onus of perceived failure hangs heavy. It's a burden they may carry for the rest of their lives. Their risk of future mental illness and substance abuse may be compounded by the moral injury and psychological trauma they've experienced. If their mental health disorders continue to be perceived as professional and moral failure, like so many of their colleagues, they may self-treat or remain untreated, sometimes with fatal consequences. Those who try to seek confidential care in their own communities may be referred to PHPs where their fundamental patient rights and their very lives could be further at risk.

[[1]Other health professional licensing boards, including nursing boards clinical psychology boards have similar health programs and may impose similar adverse actions against their licensees.]

We have an obligation as a society to ensure that every individual who suffers from physical or mental illness receives appropriate support and care. All treatment must follow the four basic principles underlying ethical medical care: autonomy, justice, beneficence, and non-maleficence. Autonomy is the patient's right to make their own treatment decisions unless such treatment is mandated by a judge or a court of law. Beneficence demands that all healthcare providers must strive to do the most good for the patient regardless of the circumstances.

Nonmaleficence requires that the benefit of a treatment outweighs any suffering or harm the patient might experience in the process. Justice demands that accepted standards of medical care are upheld regardless of the patient's race, religion, personal identity or profession.

Like all other patients, those heroic healthcare providers who risk their physical and emotional well-being on the frontlines of the COVID pandemic, deserve no less that the best medical care for any physical or mental health problems that may ensue.

Conflicts of Interest

The Author did not participate in any studies and has no conflicts of interest to disclose.

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