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COMMENTARY

COVID-19 Is Making Moral Injury to Physicians Much Worse

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Physicians and other healthcare professionals experienced significant moral injury before the COVID-19 pandemic. Physicians routinely encountered barriers to providing the kind of care they knew their patients needed. Moral injury is defined as "… perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations."

Those deeply held moral beliefs are the oaths clinicians took to put patients first. The struggle for patient primacy was universal in the pre-COVID-19 business framework of healthcare.

In the midst of the COVID-19 pandemic, those same challenges have morphed and magnified, joined by new threats that come with severely constrained resources. It will be more critical than ever for administrators and clinicians to work together during this time to assess resources, to manage those that are limited, and to face the profound risks attendant in this rapidly evolving environment. Failure to work together may leave a generation of clinicians doubting and distrustful of the moral fabric of our healthcare system and its leadership.

SARS-CoV-2 represents a worst-case scenario for a novel infectious disease. It is a highly transmissible, very virulent respiratory illness with a period of asymptomatic infection and viral shedding whose presentation is highly variable.

By definition, there was no preparation for this disease, neither diagnostically nor therapeutically.

Physicians watched, fearing that a tsunami of patients would overwhelm their healthcare systems, preventing them from adequately caring for the ill or managing their own substantial risk. Despite clear evidence of a pathogenic wildfire tearing through China and Italy, consuming personal protective equipment (PPE) at unprecedented rates, many US hospitals continued to perform elective procedures—burning through PPE that would soon be critical to protect healthcare workers—for weeks after the first alarms sounded.

Some hospitals continued to schedule elective surgery despite recommendations from many organizations to cease. There were clear predictions of worldwide demand for PPE and consequent supply chain challenges; just-in-time purchasing readily fails in a crisis.

The first case of COVID-19 was diagnosed in mid-November 2019. Now, only a few weeks into the US spread, but fully 4 months after the disease appeared, the dire straits of many US hospitals, and their failure to adequately prepare, is becoming clear. In a survey conducted last week, nearly one third of hospitals responding were out, or nearly out, of masks, face shields, and respirators. This represents an untenable situation for doctors: Patients will be in desperate need and doctors will face unacceptably high risk to care for them.

For administrators, canceling nonessential procedures and appointments could not have been an easy decision. Doctors in the United States perform 53 million elective procedures every year, generating $472 billion in revenue. As one healthcare system stated, "Elective surgeries are the cornerstone of our hospital system's operating model—and the negative impact due to the

cancellations of these procedures cannot be overstated." With elective procedures and all nonessential patient visits canceled indefinitely, administrators probably worried whether their *systems* would survive the pandemic.

Moral injury is also coming to the forefront as physicians consider rationing scarce resources with too little guidance. Which surgeries truly justify use of increasingly scarce PPE? A cardiac valve replacement? A lumpectomy? Repairing a torn ligament?

Each denial has profound impact on both the patients whose surgeries are delayed and the clinicians who decide their fates. Yet worse decisions may await clinicians. If, for example, New York City needs an additional 30,000 ventilators but receives only 500, physicians will be responsible for deciding which 29,500 patients will not be ventilated, virtually assuring their demise.

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. It will be a wrenching restructuring.

Here are the essential principles for mitigating the impact of moral injury in the context of COVID-19. (They are the same as recommendations in the time before COVID-19.)

1. Value physicians

a. Physicians are putting everything on the line. They're walking into a wildfire of a pandemic, wearing pajamas, with a peashooter in their holster. That takes a monumental amount of courage and deserves profound respect.

b. Protect the workforce. Skilled, experienced professionals and support staff are the most valuable asset that any institution possesses. Losing them to COVID-19, whether for the short term or the long term—through death or disillusionment—will take a terrible toll. Doing whatever it takes to keep them safe must be a priority.

c. Leadership, you must show up in every way you possibly can. Be on site at least occasionally, if at all possible, so that you know firsthand exactly what your physicians are facing. Once you know that, have their backs. They need you to protect them while they go out on the narrowest limb for you.

d. Acknowledge the profound moral and ethical challenges they will face. Put structures in place to help manage those challenges.

2. Value the physician-patient relationship

a. Patients are not just numbers to physicians. Many COVID-19 patients are hospitalized for a long time. Physicians get to know them and their families and will feel their losses sharply. Some of those patients will be colleagues. Providing support through reflection rounds, one-on-one check-ins, or remote meet-ups may be helpful.

b. Delivering bad news is hard. Most physicians will not have the experience of giving very bad news to families many times each day. It may be enough to overwhelm even the most resilient physician. Colleagues and leadership should be alert for signs that a team member needs support.

3. Build community and work together

a. Physician-administrator dyads can be powerful problem-solving structures. Physicians are resourceful beyond imagination and MacGyver around innumerable bureaucratic obstacles every day. Administrators understand how to fast-track through the institution. Use those complementary skillsets together to address issues of limited resources or necessary new guidance.

b. Redeployment is a humbling equalizer. Physicians are stepping up to cover services they have not seen perhaps for decades. Internists and psychiatrists are relearning intensive care medicine during precious hours away from work. We can use this as a reminder that no matter our specialty, we are all, at our cores, physicians with the goal of making patients well again.

c. No one should be sacrificing alone. If clinicians must be notified of a pay cut in the midst of the pandemic, others (ie, leadership) must sacrifice commensurately.

The crisis of pandemic preparedness, and the crisis of moral injury, both grow from the same toxic roots: administrators and clinicians with opposing incentives.

Clinicians demanded to cancel elective surgery and stop nonessential visits for two reasons: to protect their patients from healthcare facilities that become pathogen stews during disease outbreaks, and to preserve the PPE they would very shortly need to protect themselves during the COVID-19 surge.

Yet administrators insisted on business-as-usual because when patients stay away, their institutions hemorrhage revenue, risking survival.

The concerns of each are very real. But until there is recognition, renegotiation, and realignment of the goals pursued by each side of the House of Medicine—clinical and business—moral injury will remain a significant challenge. The time to renegotiate

the contract of American healthcare is not in the midst of a global pandemic.

But the time to reestablish the societal contract and human commitment between institutions, their employees, and their communities is absolutely right now. If we cannot manage that, the aftermath of the pandemic will require rebuilding from the foundation of trust up, and that may take a generation.

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