

# COVID-19: Mental health and clinical equipoise in the face of moral injury

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Healthcare workers in South Africa are facing extraordinary times due to the COVID-19 pandemic, considering expected increased cases and shortages of resources resulting in moral injury, emotional trauma and possibly mental illness. Constant self-reflection, continuous adherence to scientific critical reasoning and management support may lessen the psychological impact, and possibly the chances of moral injury and mental illness.

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Healthcare workers (HCWs) in South Africa (SA) are in an unprecedented situation due to the COVID-19 pandemic, with increasing cases and mortality expected in the coming months. Efforts to flatten the curve have seemingly been successful, buying time to ensure adequate staffing and resources for healthcare facilities to prepare for worst-case scenarios.

However, there are worldwide fears that resources may run out, including in SA. The pandemic will put healthcare professionals under extreme pressure. They will be expected to make impossible decisions, for example, how to allocate scarce resources to provide care for all severely ill patients. Such situations can result in moral injury when having to say to a relative, 'We did our best with the available resources' rather than 'We did all that we could'. Moral injury is defined as the psychological distress that results from actions, or their absence, that violate someone's moral or ethical code.<sup>[1]</sup> Moral injury is not a mental illness, but those who do develop moral damage are likely to see themselves negatively, question their actions and experience feelings of guilt and shame.<sup>[2]</sup> These negative thoughts may contribute to the development of mental illness, including depression, suicidal ideation and post-traumatic stress disorder (PTSD).<sup>[3]</sup>

SA's future reality resulting from the COVID-19 pandemic involves growing financial losses, economic pressures and shortages of resources such as personal protective equipment and ventilators. These stressors can result in HCWs having to render a service to infected patients without adequate protection against infection. They are faced with the unique nature of COVID-19, limited treatment options and increased workloads. They are also confronted with their own physical and mental health needs, which must be balanced with the needs of the patient.

What is then needed to safeguard the mental health of healthcare workers and protect them against moral injury, while adhering to the principle of clinical equipoise? Under these circumstances, doctors may become overly reliant on anecdotal evidence, and as healers may feel compelled to 'do something'. In the process they may unconsciously rely on limited experience instead of scientific evidence.<sup>[4]</sup> With information overload and uncertainty-related

anxiety, as in the COVID-19 pandemic, doctors may lose clinical equipoise and fall victim to cognitive errors including availability bias, confirmation bias and anchoring.

Availability bias is a tendency to favour recently acquired information inappropriately, while confirmation bias favours information that reinforces preconceived notions, at the expense of contradictory information. The urgency to 'do something' increases the likelihood of anchoring: closing our decision-making process prematurely, before exploring reasonable alternatives.<sup>[4]</sup>

To mitigate the potential adverse moral and psychological effects of the COVID-19 pandemic, staff must be sufficiently prepared for these challenges. The possible ethical dilemmas must be discussed honestly, and straightforward messages must be delivered. Should this be avoided, and a worst-case scenario materialise, anger and resentment will result.<sup>[2]</sup>

Given that most COVID-19 cases will be identified and treated in healthcare settings by workers with little to no mental health training, it is essential that assessment and intervention also take place in those settings. The integration of mental health considerations into COVID-19 care should be addressed at the organisational level.<sup>[5]</sup> Managers should help staff make sense of morally challenging decisions and their psychological response to unfolding events. Support from colleagues and line managers helps to protect the mental health of HCWs.<sup>[2]</sup>

One way of providing a psychologically safe space for HCWs to reflect on current events is the introduction of 'Schwarz rounds', which provide a forum for all healthcare staff to safely discuss the emotional and social challenges of caring for patients.<sup>[6]</sup> Avoidance is a core symptom of trauma, and team leaders should reach out to staff who are 'too busy' or repeatedly 'not available' to attend these discussions. Those who persistently avoid meetings may require sensitive support from a suitably experienced person such as an occupational health nurse or staff psychologist, if available.<sup>[2]</sup> If their distress is persistent, they will require active support or, if severe, referral for professional mental health support. Using single-session psychological debriefing approaches may cause additional harm.<sup>[7]</sup> Managers should look out

for suicidal ideation, which may necessitate immediate consultation with a mental health professional.<sup>[8]</sup>

After the crisis, supervisors should reflect and learn from its extraordinarily difficult experiences to create a meaningful rather than traumatic narrative. The National Institute for Health and Care Excellence guidelines on PTSD recommend 'active monitoring' of staff to identify the minority who become unwell, and assist them in accessing evidence-based care.<sup>[9]</sup> It is essential to ensure that HCWs do not suffer lasting psychological damage.<sup>[10]</sup> Healthcare managers in supervisory positions must acknowledge the challenges that staff are facing, and minimise the psychological risk.<sup>[11]</sup>

Despite these challenges, some people who live through significant, traumatic, challenging times experience post-traumatic growth, meaning a bolstering of psychological resilience, esteem, outlook and values after exposure to highly challenging situations. The development of psychological injury or the experience of psychological growth are likely to be influenced by the way HCWs are supported before, during and after a challenging incident.<sup>[12]</sup>

However, when emotions predominate, our reliance on anecdotes increases, particularly personal experiences that may carry excessive weight. Journalists use the power of stories to connect with readers and stir their emotions. However, doctors, as scientists, are expected to follow a hypothesis-driven, rational, evidence-based approach to clinical decisions.<sup>[4]</sup>

During this biopsychosocial crisis, doctors must be the voice of reason. They should lead by example, reason critically and reflect on the biases that may influence their thinking, critically appraise evidence in deciding how to treat patients and use anecdotal observations only to generate hypotheses. They should be skeptical of alleged therapeutic strategies until convincing statistical evidence becomes available that one treatment is superior to another.<sup>[13]</sup>

Healthcare systems must address the stress of HCWs by continuously monitoring reactions and performance, adjusting call rosters and creating mechanisms to offer psychosocial support.

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1. Litz BT, Stein N, Delaney E, et al. Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clin Psychol Rev* 2009;29(8):695-706. <https://doi.org/10.1016/j.cpr.2009.07.003>.
2. Greenberg N, Docherty M, Gnanapragasam S, Wessely S. Managing mental health challenges faced by healthcare workers during COVID-19 pandemic. *BMJ* 2020;368:m1211(epub ahead of print). <https://doi.org/10.1136/bmj.m1211>
3. Williamson V, Stevelink SAM, Greenberg N. Occupational moral injury and mental health: Systematic review and meta-analysis. *Brit J Psychiatr* 2018;212(6):339-346. <https://doi.org/10.1192/bjp.2018.55>
4. Zagury-Orly I, Schwartzstein RM. Covid-19 – a reminder to reason. *N Engl J Med* 2020;April 28. <https://doi.org/10.1056/NEJMp2009405>
5. Pfefferbaum B, Schonfeld D, Flynn BW, et al. The H1N1 crisis: A case study of the integration of mental and behavioural health in public health crises. *Disaster Med Public Health Prep* 2012;6(1):67-71. <https://doi.org/10.1001/dmp.2012.2>
6. Flanagan E, Chadwick R, Goodrich J, Ford C, Wickens R. Reflection for all healthcare staff: A national evaluation of Schwartz rounds. *J Interprof Care* 2020;34(1):140-142. <https://doi.org/10.1080/13561820.2019.1636008>
7. Brooks SK, Rubin GJ, Greenberg N. Traumatic stress within disaster-exposed occupations: Overview of the literature and suggestions for the management of traumatic stress in the workplace. *Brit Med Bull* 2019;129(1):25-34. <https://doi.org/10.1093/bmb/ldy040>
8. Pfefferbaum B, North CS. Mental health and the Covid-19 pandemic. *N Engl J Med* 2020;April 13. <https://doi.org/10.1056/NEJMp2008017>
9. National Institute for Health and Care Excellence. Post-traumatic stress disorder (PTSD) evidence update, December 2013. NICE Guide. London: NICE, 2013.
10. Iversen AC, Fear NT, Ehlers A, et al. Risk factors for post-traumatic stress disorder among UK Armed Forces personnel. *Psychol Med* 2008;38(4):511-522. <https://doi.org/10.1017/S0033291708002778>
11. Jones N, Seddon R, Fear NT, McAllister P, Wessely S, Greenberg N. Leadership, cohesion, morale, and the mental health of UK armed forces in Afghanistan. *Psychiatry*. 2012;75(1):49-59. <https://doi.org/10.1521/psyc.2012.75.1.49>
12. Brooks S, Amlôt R, Rubin GJ, Greenberg N. Psychological resilience and post-traumatic growth in disaster-exposed organisations: Overview of the literature. *J R Army Med Corps* 2018;1:1-5. <https://doi.org/10.1136/jramc-2017-000876>
13. Freedman B. Equipoise and the ethics of clinical research. *N Engl J Med* 1987;317(3):141-145.

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